STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510185	A. BUILDING: _____ B. WING _____	C 10/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CIEL AT PLAINFIELD	12446 S VAN DYKE ROAD PLAINFIELD, IL 60585

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident IL197571 and IL197848 - 295.6000 a) 13) IL198015 - 295.5000 f) 1)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 1 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; Based on record review and interviews, the establishment failed to have a policy and or procedure in place for reordering medications that the residents family supplies. This failure resulted in one of three sampled residents (R3) going without a prescribed medication for over three months. This failure has a substantial probability of increasing the chance of R3's prostate cancer cells to grow again. Findings include: R3's current face sheet, service plan, physician's orders and medication administration records	A5000		

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A5000	Continued From page 1	A5000		

note that R3 was admitted to the establishment on 6/7/25 and has a primary diagnosis of metastatic prostate cancer. R3 service plan notes that R3 requires a licensed nurse to administer his medications. R3's physician's order report notes that R3 has a prescription for Abiraterone Acetate 250 mg tablet to be taken daily. This medication used to treat advanced prostate cancer.

R3's incident report dated 10/10/25 reads, "Resident receives all but 1 medication from our in house pharmacy. Medication Abiraterone Acetate is a specialty medication that the family orders 90 day supply of from outside pharmacy. Resident (R3) ran out of the medication and nursing was attempting to re-order it from in house pharmacy, unaware that the medication is to come from outside pharmacy. HWD (E2) contacted the POA / Daughter (Z3), who reordered the medication and resident is back receiving the medication as scheduled. No adverse effects noted. PCP and POA aware. Staff have been instructed to call POA for refill when there is a 2 week supply remaining."

On 10/18/25 at 11:40 A.M., E1 (Executive Director) stated that there was no procedure in place to make sure that R3's family would be contacted to reorder R3's Abiraterone Acetate. E1 stated that the facility nursing staff failed to contact R3's family to reorder the medication which resulted in R3 not receiving the Abiraterone Acetate for over three months.

R3's medication administration records from July 2025 through October 2025 notes that R3 did not receive the Abiraterone Acetate from July 2, 2025 until October 10, 2025. A total of 101 doses were missed.

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A5000	Continued From page 2 On 10/20/25 at 3:20 P.M., Z3 (R3's POA and Daughter) stated that the facility staff did not contact her to let her know R3 was out of the Abiraterone Acetate for over three months. Z3 stated that she was under the impression that the facility staff was taking care of ordering and refilling the medication. Z3 stated she does not understand why all of the nursing staff would let this go on for so long knowing that R3 is not getting this medication the entire time. On 10/20/25 at 10:45 A.M., Z1 (Medical Doctor Hematology / Oncology) stated that Abiraterone Acetate is used for prostate cancer and it suppresses testosterone production. Z1 stated that stopping this medication for a lengthy period of time has a risk of allowing those cancer cells that rely on testosterone to grow again.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		

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A6000	Continued From page 3 Based on record review and interviews, the establishment neglected to provide adequate supervision for one of three sampled residents (R2) at risk for falls. This failure resulted in R2 falling off the toilet, hitting head and causing a laceration above her left eyebrow. Findings include: R2's current face sheet and service plan notes that R2 was admitted to the facility on 5/23/25. Service plan notes that R2 is a high risk for falls and requires staff assistance and supervision when toileting. On 10/21/25 at 11:20 A.M., Z2 (R2's POA and Daughter) stated that she was informed by staff that on 9/26/25, that R2 had fallen off the toilet and suffered laceration to her eyebrow. R2 had to go to the hospital to have the laceration closed with a type of glue. Z2 stated that they have a camera in the room, so she reviewed the video during the time of the incident. Z2 stated that the video noted that the caregiver (E4) had left R2 on the toilet unsupervised, while she went back in R2's room to get some supplies. When E4 heard R2 had fallen, E4 did not even go into the bathroom to check on R2. E4 just acted as if it bothered her, threw her hands in the air and walked out of the room. E4 must have let the nurse know, because the nurse came in a few minutes later. Z2 stated she doesn't understand why E4 would not have just stayed with R2 and called the nurse with her phone, instead of leaving R2 on the floor alone. On 10/18/25 at 11:40 A.M., E1 (Executive Director) stated that E4 had first said that she just turned around for a second and when she turned	A6000		

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A6000	Continued From page 4 back around, R2 fell as E4 was reaching for her. E1 stated that after her investigation, talking with Z2, and reviewing the video, E1 determined that E4 was not being truthful. E1 stated that E4 actually walked out of the bathroom, leaving R2 unsupervised on the toilet when R2 fell. E1 stated that E4 was terminated due to this incident and falsifying documentation regarding the accounts of the incident. E4's termination form dated 9/29/25 reads, "TM (E4) worked 9/26/25 and was scheduled 6a - 2p. TM stated that she turned around and resident (R2) fell off the toilet. TM wrote a statement stating, 'I turned around for 1 sec and she fell'. On 9/29 ED/BOM spoke with POA (Z2) per email request and saw the video incident and TM did not turn around for 1 sec as stated, TM walked out of bathroom and started to look through resident closet at which time resident (R2) fell from toilet face first. TM proceeded to turn around and saw resident on the floor and then instead of checking resident and calling for help, TM threw her hands up in the air and walked out of the room. She didn't check resident at anytime after resident fell to the floor."	A6000		