| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2040 | Section 295.2040 Disaster Preparedness<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.2040 Disaster Preparedness<br><br>a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment.<br><br>b) Each establishment shall:<br><br>5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.<br><br>e) Drills shall include residents, establishment personnel, and other persons in the establishment.<br><br>g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own | A2040 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2040 | Continued From page 1 | A2040 | | |

evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply.

These requirements were not met as evidenced by:

Based on record review and interview the establishment failed to:

-include a list of residents who were involved in the actual fire drill and their level of evacuation assistance for 6 of 6 residents in the sample (R1, R2, R3, R4, R5, R6).

-orient each resident to the emergency and evacuation plans within 10 days after move in for 6 of 6 residents (R1, R2, R3, R4, R5, R6) reviewed for resident orientation. Resident orientation is mentioned in the resident handbook but is not signed or dated;

These failures have the substantial probability to cause severe harm to a resident or residents.

Findings include:

On 12/2/25 the fire drills from January 2025 through November 2025 were reviewed. None of these fire drills had a list of residents who may have participated or refused to participate in the fire drills nor their level of evacuation assistance.

On 12/3/25 surveyor asked for resident orientation that was presented to R1, R2, R3, R4, R5, R6 upon move in. E9 (executive director) presented a copy of the resident handbook that is presented to new residents. The handbook, page

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2040 | Continued From page 2<br>4 addresses what residents are to do in the event of a emergency evacuation and fire drill and fire safety. However there is no indication if establishment staff reviewed this information with the resident or the resident's responsible party. There is no signature or date to show the resident or their POA received this information.<br><br>On 12/5/25 at 3:45pm during the exit conference, these concerns were shared with E9. E9 said she has a list of residents who require evacuation assistance but wasn't aware that list should be attached to every fire drill. | A2040 | | |
| A2050 | Section 295.2050 Incident and Accident Reporting<br><br>This Regulation is not met as evidenced by:<br>Type 3 Violation<br><br>Section 295.2050 Incident and Accident Reporting<br><br>a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident.<br><br>b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the | A2050 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2050 | Continued From page 3<br>Department within 24 hours after the occurrence of the incident or accident.<br><br>c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident.<br><br>These requirements were not met as evidenced by:<br><br>Based on record review and interview the establishment failed to report to the Department 3 separate incidents of physical aggression towards staff and other residents for 1 residents (R1) out of 5 reviewed for resident to resident physical abuse. R1 has a history of physically aggressive behavior, including towards R2 who is his spouse.<br><br>These failures has the probability to affect all residents who reside in the establishment.<br><br>Findings include:<br><br>R1 is a 89 year old resident who moved into the establishment 9/18/25. R1 resides in the memory care unit. R1 has diagnoses including Dementia, Depression, Expressive aphagia and type 2 Diabetes Mellitus.<br><br>The progress note dated 10/2/25 shows the nurse was in the activity room and summoned to the family room. R1 was sitting in a chair with blood noted to the right side of his head and right hand. Care partners said they heard a noise and found another resident (R7) getting up from the floor and R1 leaving the scene. R1 went to the nurse's station looking for a trash can, saw R7 asked R7 for a trash can, R7 came close and hit R1. R1 hit | A2050 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2050 | Continued From page 4 | A2050 | | |

R7 back and R7 fell. R7 was sent to the local hospital. R1 was sent to another hospital. R1 returned to the community 10/3/25.

The progress note dated 11/8/25 shows R1 was aggressive during lunch, R1 had a altercation with another resident (R8). Staff tried to separate them. R1 got aggressive with R8 and started kicking R8 in the kneess. Staff tried to redirect R1 who was aggressive and punched R8 in the right shoulder, R1 monitored one to one for safety because of R2 (wife). R1 requested to go to his room. R2 requested to go with R1. Due to aggressive behavior, staff monitoring R1 in his room for the safety of R2.

At 1:23pm the psych nurse practitioner was contacted. Due to altercation with R8, R1 needs outside treatment. All paper work printed out. Involuntary Petition. filed and signed by nurse.

At 2:51pm, ambulance arrived to transport R1 to hospital due to involuntary petition.

R1 returned to the community on 11/14/25.

The progress note 11/12/25 shows R1 very aggressive with dietary staff, trying to grab her during serving. Dietary staff placed salad bowl in front of his wife (R2). R1 got upset with the server, the server tried to move back. R1 got up to tried to hit the server. Staff tried to redirect R1, R1 got more resistive, aggressive and trying to hit other staff & nurse. R1 came back to the table yelling and threw soup on the resident sitting at the same table. Also tried to hit R2 who was speaking to R1. Psychiatric NP (nurse practitioner) notified, R1 being sent out 911 to nearest hospital with an open bed.
R1 returned to community 11/22/25.

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A2050 | Continued From page 5<br><br>On 11/24/25 the Safely You camera alerted a resident on the floor. The nurse assessed R1 and R2. Both were laying in bed. R2 said, "he hit me, he hit me." Upon reviewing the camera it shows R1 was laying in bed and R2 rolled over and hit R2 with a closed fist multiple times and both falling off the bed. R1 sent out to psychiatric hospital for evaluation. R1 returned to the community on 12/2/25. The Incident and accident report mirrors the progress note of the same date.<br><br>On 12/4/25 surveyor requested the inicdent and accident reports for 10/2/25, 11/8/25 and 11/12/25. E9 (executive director) responded via email saying for 10/2 & 11/8 she did not have a state reportable in the binder. E10 (health and wellness director) is on vacation until Monday (12/8/25). E10 may have that in his email as E10 is the one who reports incidents.<br><br>On 12/5/25 during the exit conference, E9 said moving forward she will do the incident reports so she will have access to them. E9 said as of now, she doesn't have access to E10's email. E9 said she wasn't aware that if a resident assaults a staff person that a report should be sent to the department. Both send outs were not involuntary petitions. | A2050 | | |
| A4000 | Section 295.4000 Physician/s Assessment<br><br>This Regulation is not met as evidenced by:<br>Type 3 Violation | A4000 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4000 | Continued From page 6<br>Section 295.4000 Physician's Assessment<br><br>a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition.<br><br>b) A physician's assessment shall be completed by a physician upon identification of a significant change in the resident's condition. This requirement was not met, as evidenced by:<br><br>Based on record review and interview, the establishment failed to ensure that the resident physician's assessments were completed by a physician. This failure involves 5 of 6 residents reviewed for this requirement (R1, R2, R3, R4, and R6).<br><br>This failure has the probability to affect all residents.<br><br>Findings include:<br><br>During record review on 12/2/25 it was noted that R1 and R2's (husband and wife) physician's POC (plan of care) was not signed by a physician but by Z1. R1's physician's POC is dated 9/5/25. R2's physician's POC is dated 9/8/25.<br><br>During record review on 12/3/25 it was noted that the physician's POC for R3 dated 3/14?/25 was | A4000 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4000 | Continued From page 7<br>signed by Z2 who is not a physician.<br><br>The physician's POC for R4 dated 10/21/25 was signed by Z3 who is not a physician.<br><br>The physician's POC for R6 dated 10/15/25 was signed by Z5 who is not a physician.<br><br>On 12/5/25 at 3:45pm during the exit conference, these concerns were shared with E9 (executive director). E9 said she didn't know that the doctor has to be the one to sign the physician's POC. | A4000 | | |
| A4010 | Section 295.4010 Service Plan<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.4010 Service Plan<br><br>a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan.<br><br>c) The service plan shall be signed and dated by all individuals involved in its development.<br><br>e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 8<br>cognitive, or functional condition (see Section 295.4000).<br><br>g) Service plans shall address:<br><br>1) The level of service the resident is receiving, including:<br><br>2) The amount, type, and frequency of health-related services needed by the resident<br><br>These requirements were not met as evidenced by:<br><br>Based on record review and interview the establishment failed to:<br><br>-ensure the service plan was signed and dated by all individuals involved in its development for 6 of 6 residents in the sample (R1, R2, R3, R4, R5, R6) reviewed for service plans;<br><br>-review and revise the service plan immediately after a significant change in the resident's condition as it relates to unwitnessed falls for 4 of 6 residents (R1, R3, R4, R5) reviewed for falls and physically aggressive behaviors toward residents and staff for 1 of 6 residents (R1) reviewed for behaviors;<br><br>-address the amount, type and frequency of outside health-related services (home health, physical and occupational therapy for 2 of 2 residents (R4, R5), and hospice care for 2 of 2 residents (R4, R6);<br><br>-indwelling urinary catheter care for 2 of 2 residents (R3, R5) reviewed for urinary catheter care; | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 9<br><br>-address with interventions the application of medical devices for one of 6 residents (R6) reviewed for medical devices.<br><br>These failures have the probability to affect all residents who reside in the establishment.<br><br>Findings include:<br><br>1. R1 is a 89 year old resident who moved into the memory care unit of the establishment 9/18/25. R1 has diagnoses including Dementia, Depression, type 2 Diabetes Mellitus and Expressive dysphagia.<br><br>Review of the observation notes from October 2025 through November 2025 show the following:<br>-10/2/25: nurse was in activity room and summoned to family room sitting in a chair with blood noted to the right side of his head and right hand. Care partners said they heard a noise and found another resident (R7) getting up from the floor and R1 leaving the scene. R1 went to the nurse's station looking for a trash can, saw R7 asked R7 for a trash can, R7 came close and hit R1. R1 hit R7 back and R7 fell.<br><br>-10/22/25: Safely You alerted of a fall in R1's room. The nurse on duty and care partner responded and saw R1 standing in his room. When asked what happened, R1 said he was trying to pick up a napkin from the floor when he lost his alance and fell. The POA (power of attorney) declined to have R1 sent to the hospital<br><br>10/25/25: Safely You detected a fall.Checked on resident who was in the bathroom. R1 denied falling however the video footage showed R1 standing next to bed, bending over to pick up | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 10 | A4010 | | |

shoes and fell to his knees, got back up and proceeded to the bathroom.

-11/8/25: R1 was aggressive during lunch. R1 had a altercation with R8 . Staff tried to separate them. R1 got aggressive with another resident and started kicking this other resident in the legs. Staff tried to redirect R1 who was aggressive and punched another resident in the right shoulder. R1 was sent out via involuntary petition

-11/12/25. The most recent physically agressive behavior was on 11/24/24 where the Safely You camera alerted R2 on the floor. nurse assessed R1 and R2. Both were laying in bed. R2 said, "he hit me, he hit me". Upon reviewing the camera it shows R2 was laying in bed with R1. R1 rolled over, wrapped his legs around R1's legs, wrapped his left arm around R2's head and proceeded to hit R1 with a closed fist multiple times. Both R1 and R2 falling off the bed. R1 sent out to psychiatric hospital for evaluation. R2 was sent out for evaluation and treatment as well

11/19/25: R1 was checked on, was agitated with sksilled nurse

The service plan dated 10/20/25 does not include interventions to address R1's physically aggressive behaviors toward other residents and staff as well as R1 hitting R2 with a closed fist. This service was not signed and dated by R1's POA (power of attorney).

2. R2 is a 87 year old resident and the spouse of R1. R2 also resides in the memory care unit. R2 has diagnoses including Dementia, Anxiety, Atrial fibrillation, CHF (congestive heart failure), Aortic stenosis, Hypertension, Macular degenartion and

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 11 | A4010 | | |

Anemia.

Per the face sheet, R2's receives a bi-weekly Retacrit injection from the Hematologist for Anemia.

The observation note dated 11/26/25, Safely You was activated, upon staff entering the room, R2 was observed sitting on the floor near her bed. When asked what happened, R2 replied, I fell. Get me up.

The service plan dated 10/20/25 does not include interventions to address biweekly Retacrit injection from the Hematologist for Anemia.

This service was not signed and dated by R2's POA.

3. R3 is a 76 year old resident who moved into the memory care unit on 3/14/25. R3 has diagnoses including Depression, Anxiety, Hydrocephalus with presence of VP shunt, BPH, Obstructive uropathy, Hypertension, recurring UTIs (urinary tract infections), Dysphagia, GERD (gastroesophageal reflux disease) and vitamin deficiency. R3 has a history of falls.

The observation notes show the following:

-3/14/25: R3 has a indwelling urinary catheter, which will be managed by a home health agency

-3/21/25: R3 observed on the floor hitting head. Emesis on the floor, 911 called and R3 sent out to hospital

-3/22/25: R3 returned at 3:30pm from local hospital, treated for UTI (urinary tract infection). Urinary catheter changed at the

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 12<br>hospital<br><br>-3/26/25: R3 slipped off his wheelchair during activity because the cushion in his wheelchair is very slippery<br><br>-9/4/25: R3 observed in the family room (Activities Room) lying on the floor<br><br>The service plan dated 10/5/25 was not revised with interventions to address the fall incidents that occured on 3/21/25, 3/26/25 and 9/4/25. There is no correlation of care between establishment staff and home health care staff for urinary catheter care and R3 receiving PT/OT (physical therapy/occupational therapy).<br><br>This service was not signed and dated by R3's POA.<br><br>4. R4 is a 78 year old resident who moved into the establishment 10/28/25.R4 has diagnoses includingtype 2 Diabetes Mellitus, Chronic kidney disease, Hypertension and shortness of breath. R4 has a history of frequent falls.<br><br>The observation notes: show the following:<br>-11/4/25: R4 stated to nurse that he got up from the toilet seat, turned so fast, felt dizzy and fell to the floor. Sustained a small skin tear to left elbow<br><br>-11/12/25: nurse called to R4's room by caregiver after finding R4 on the floor in his kitchen. R4 states his legs gave out<br><br>-11/25/25: nurse called to R4's room around 9:50pm. R4 was observed on the floor next to his recliner. Fall was unwitnessed. R4 said he slipped off the recliner when he tried to turn his head to | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 13<br>look at the door<br><br>-11/26/25: nurse called to R4's room by caregiver. Caregiver found R4 on the floor of his bedroom just outside of his bathroom. R4 said he was going to the bathroom and felt dizzy causing him to fall. R4 fell onto his let side. R4 sustained a bump to right side of his forehead<br><br>-11/29/25: per concierge, R4 was informed how bad it was snowing, R4 insisted he had to go outside and smoke. R4's motor scooter skidded in the snow, R4 slid from his scooter and fell. 911 called to assist R4 from the snow. R4 said he was ok and refused to go to the hospital.<br><br>The observation notes also show R4 receives PT/OT from home health.<br><br>The service plan dated 11/28/25 does not interventions to address R4's history of falls and not revised after each fall of the 5 unwitnessed falls. The PT/OT R4 receives is not addressed. The service plan is not signed or dated by POA or E10 (health and wellness director).<br><br>This service was not signed and dated by R4's POA.<br><br>On 12/5/ 25 at 3:45pm during the exit conference, E9 (executive director) stated, "We don't do smokers, but R4 is alert and oriented. We con't have a caregiver to go out with R4 when he wants to smoke."<br><br>5. R5 85 year old resident who moved into the establishment 5/23/25. R5 has diagnoses including CHF (congestive heart failure) and recurring UTIs (urinary tract infections). R5 | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 14<br>receives hospice care<br><br>The observation notes show the following:<br>-5/23/25: R5 moved in with a indwelling urinary catheter. R5 has orders to receive 4 liters of oxygen via nasal cannual as needed.<br><br>9/6/25: Care partner informed the nurse at 11:55pm that R5 was observed sitting on the floor in front of her bed, R5 stated she did not fall, she sat down on the floor to pick something up and couldn't get up<br><br>9/13/25: R5's family contacted the establishmenbt to report R5 was on the floor. Staff member entered room and found R5 on the floor next to the wheelchair.<br><br>9/14/25: nurse walked in R5's room at 3:09am for wellness check, observed R5 sitting in front of her bed with diaper off and feces spread on her bed and floor.<br><br>9/16/25: at about 7:30pm, R5's family member notified the establishment that the camera shows R5 on the floor. The nurse found R5 on the floor face down on top of the bedside table bar. The care partner present was applying pressure to bleeding on the left side of the head. R5 complained to the caregiver about left sided rib pain<br><br>9/26/25: nurse called to R5's room, R5 observed resident lying on floor in bedroom on left side. Nurse applyed pressure to laceration on left side of forehead above eye to control bleeding. R5 complaining of head, neck, left shoulder and left pain pain. Didn't move R5, called 911. Per caregiver, she placed R5 on toilet and turned around to grab clothing to dress R5 when she | A4010 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 15 | A4010 | | |

turned back R5 was leaning to the left side. R5 fell before caregiver was able to stop the fall. Hospice notified

10/24/25: hospice visit, new order for wound care to right lower leg Monday, Wednesday, Fridays, cleanse with wound cleanser, pat dry, apply vaseline gauze, covered with padded dressing wrap and kerlix, apply ace wrap

The Change of Condition service plan dated 10/1/25 shows a note that says:
Returned from hospital 6/4 - 6/13 for dysarthria, returned with indwelling urinary catheter.

This service plan does was not revised with interventions to address the the unwitnessed falls. The service plan also does not address a correlation of care between establishment staff and home health staff for care and monitoring of the urinary catheter and wound care for the right lower leg, hospice care and the use of oxygen as needed. The only intervention for the urinary catheter is for the carepartner to empty the catheter bag.

This service was not signed and dated by R5's POA.

6. R6 is a 80 year old resident who moved into the establishment 10/18/25. R6 has diagnoses including Parkinson's disease, Dementia, Dysphagia, Adult failure to thrive, Dysphagia, Flexion deformity shoulder, right hand contraction, Hypertension and Benign prostatic hypertrophy.

The physician's order sheet shows the following:

-12/20/24: apply left elbow hinge splint daily after

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4010 | Continued From page 16<br>lunch for 2 hours<br><br>-10/6/25: apply splint/brace (carrot hand contracture orthosis) to left upper extremity and right upper extremity 4-6 hours DALY as tolerated befor breakfast, remove befor HS (bedtime). Check skin integrity before/after splint/brace application for skin breakdown<br><br>-11/6/25: wound care to sacrum, cleanse with NS (normal saline), pat dry and apply foam dressing<br><br>The observaton notes show R6 is receiving home health and was admitted to hospice care on 10/19/25<br>R6 has contracted hands and needs assistance with adls (activities of daily living) from staff.<br><br>The service plan dated doesn't address hospice care nor the correlation of care between the establishment staff and hospice care staff. Under Dietary, Dining moderate assist: care manager to cue the resident throughout meals and snacks<br><br>This service was not signed and dated by R6's POA. The POA's name is listed but no signature or date.<br><br>On 12/5/25 at 3:45pm during the exit conference these concerns and the feeding status of R6 were shared with E9. E9 stated, "no, we feed him. We send the service plan out to the POA but they don't sign and return them." | A4010 | | |
| A4060 | Seciton 295.4060 Alzheimer's and Demential Programs | A4060 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4060 | Continued From page 17<br>This Regulation is not met as evidenced by:<br>TYPE 2 VIOLATION<br><br>Section 295.4060 Alzheimer's and Dementia Programs<br><br>a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act)<br><br>b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act)<br><br>d) Individual residents shall be assessed prior to admission to the establishment using any one or a combination of the following assessment tools, based on the resident's condition and stage in the disease process:<br><br>F) Mini-Mental State Examination (MMSE)<br><br>e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act) | A4060 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4060 | Continued From page 18<br><br>f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act)<br><br>5) Provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination;<br><br>2) Staff training:<br><br>A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics:<br><br>ii) techniques for creating an environment that minimizes challenging behavior;<br><br>These requirements were not met as evidenced by: | A4060 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4060 | Continued From page 19<br><br>Based on record review and interview the establishment failed to provide and secure appropriate care for one out of five residents (R1) who has a history of physically aggressive behavior towards staff and residents, including his spouse (R2). R1 resides in the memory care unit of the establishment.<br><br>These failures has the probability to affect all residents who reside in the memory care unit of the establishment.<br><br>Findings include:<br><br>R1 is a 89 year old resident who moved into the establishment 9/18/25. R1 has diagnoses including Dementia, Depression, Expressive aphagia and type 2 Diabetes Mellitus. R1 resides in the memory care unit with his spouse, R2.<br><br>The progress note dated 10/2/25 shows the nurse was in the activity room and summoned to the family room. R1 was sitting in a chair with blood noted to the right side of his head and right hand. Care partners said they heard a noise and found another resident (R7) getting up from the floor and R1 leaving the scene. R1 went to the nurse's station looking for a trash can, saw R7 asked R7 for a trash can, R7 came close and hit R1. R1 hit R7 back and R7 fell. R7 was sent to the local hospital. R1 was sent to another hospital. R1 returned to the community 10/3/25.<br><br>The progress note dated 11/8/25 shows R1 was aggressive during lunch, R1 had a altercation with another resident (R8). Staff tried to separate them. R1 got aggressive with R8 and started kicking R8 in the kneess. Staff tried to redirect R1 who was aggressive and punched R8 in the right | A4060 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4060 | Continued From page 20 | A4060 | | |

shoulder, R1 monitored one to one for safety because of R2 (wife). R1 requested to go to his room. R2 requested to go with R1. Due to aggressive behavior, staff monitoring R1 in his room for the safety of R2.

At 1:23pm the psych nurse practitioner was contacted. Due to altercation with R8, R1 needs outside treatment. All paper work printed out. Involuntary Petition filed and signed by the nurse.

At 2:51pm, ambulance arrived to transport R1 to hospital due to involuntary petition.

The progress note 11/12/25 shows R1 very aggressive with dietary staff, trying to grab her during serving. Dietary staff placed salad bowl in front of his wife (R2). R1 got upset with the server, the server tried to move back. R1 got up to try to hit the server. Staff tried to redirect R1, R1 got more resistive, aggressive and trying to hit other staff & the nurse. R1 came back to the table yelling and threw soup on the resident sitting at the same table. Also tried to hit R2 who was speaking to R1. Psychiatric NP (nurse practitioner) notified, R1 being sent out 911 to nearest hospital with an open bed.
R1 returned to community 11/22/25.

On 11/24/25 the Safely You camera alerted that a resident was on the floor. The nurse assessed R1 and R2. Both were laying in bed. R2 said, "he hit me, he hit me." Upon reviewing the camera it shows R1 was laying in bed and R2 rolled over and hit R2 with a closed fist multiple times and both falling off the bed. R1 sent out to psychiatric hospital for evaluation. R1 returned to the community on 12/2/25. The Incident and accident report mirrors the progress note of the same date.

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A4060 | Continued From page 21<br><br>On 12/5/25 during the exit conference, E9 said both send outs were not involuntary petitions. | A4060 | | |
| A6000 | Section 295.6000 Resident Rights<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.6000 Resident Rights<br><br>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:<br><br>13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.<br><br>This requirement was not met as evidenced by:<br><br>Based on record review, interview and review of video footage, the establishment failed to ensure 1 of 6 residents (R2) reviewed for abuse was free from resident to resident physical abuse from R1. R1 has a history of physical aggression towards residents and staff.<br><br>This failure has the probability to affect all residents in the memory care unit.<br><br>Findings include:<br><br>R1 is a 89 year old resident who moved into the | A6000 | | |

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A6000 | Continued From page 22 | A6000 | | |

memory care unit of the establishment 9/18/25. R1 has diagnoses including Dementia, Depression, Expressive aphasia and type 2 Diabetes Mellitus.

R2 is 87 year old resident who is R1's spouse. R2 also moved in 9/18/25. R2 has diagnoses including Dementia, Anxiety, Atrial fibrillation and Hypertension.

Both R1 and R2 reside in the same room in the memory care unit.

The observation note dated 11/24/25 shows Safely You camera alerted staff that a resident was on the floor. Both were laying in bed. R2 stated, "he hit me, he hit me." Upon reviewing the camera it shows R2 was laying in bed and R1 rolled over and hit R2 with a closed fist multiple times and both falling off the bed. R1 helped R2 off the floor and back into bed as E10 (health and wellness director) entered the room. E10 signed involuntary petition paperwork for psych admission. R1 sent to hospital for psych admission.

The incident accident report dated 11/24/25 shows R1 was sent out 911 to the hospital for a psychiatric evaluation. R2 was sent out to the hospital as well for evaluation and treatment.

The observation note dated 11/25/25 (2:08am) shows R1 was admitted to the hospital. R1 returned to the community on 12/2/25.

On 12/3/25 at 10:00am, surveyor along with E9 (executive director) reviewed video footage of R1 and R2 in their bedroom. After coming out of the bathroom, R2 attempted several time to get into the bed. R1 was laying in bed covered. R1

| 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 _____ | 12/05/2025 |

| 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 |
|---|---|---|---|---|
| A6000 | Continued From page 23<br><br>attempted to assist R2 into bed and was able to get to R1 into bed. R1 got back in bed and proceeded to wrap his legs around R2's legs, then wrapped his left arm aound R2's head and punched R2 in the head approximately 3 to 4 times. After R1 let R2 go, R2 then slipped off the bed but was able to get back in bed prior to E10 (health and wellness director) entering their bedroom.<br><br>R1 has had 3 other incidents of physical aggression involving residents including R2, R7, R8, and staff (10/2/25, 11/8/25 and 11/12/25).<br><br>On 12/3/25 at 9:45am E9 (executive director) said R1 was sent out to the hospital on 11/24/25 to the local hospital for a psychiatric evaluation. | A6000 | | |