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 04/02/2026

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 Complaint Investigation IL00200253: unsubstantiated Facility Reported Incident IL00200318: Substantiated. No deficiencies cited. For this survey, the establishment is in compliance with Part 295 AQssisted Living and Shared Hpusimng Establishment Administrative Code and 210 ILCS 9/1 Assisted Living and Shared Housing Act.	A 000		