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 08/18/2025

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 IL169408 295.6000a)2)13)	A 000		
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: 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment. 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. This requirement is not met as evidenced by: Based on record review and interviews the facility failed to ensure all residents remain free of abuse. This failure resulted in one resident (R1) being physically restrained, deliberately hit in the face and pushed causing R1 to fall backward onto the floor and hit his head on the airconditioner in the room as he fell to the floor. This failure also creates a substantial probaility of harm to residents.	A6000		

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Findings include:

On 7/29/25 at 11:30AM E1 (Executive Director) stated the facility uses Safely You (SY), a video monitoring system that uses AI (Artificial Intelligence). SY will activate when a resident or anything goes down onto the floor.

E1 and this surveyor reviewed the video of the abuse of R1 by E3. The video showed the date and time of the occurrence was dated 7/12/25 with the incident lasting from 10:51PM-11:01PM. E1 stated E3 works the evening shift from 10:00PM-6:00PM

On 7/12/25 between 10:51PM and 11:01PM the video recorded the following:

Resident R1 was sleeping in bed.

E3 (Caregiver) entered room and began to change R1's incontinent brief but didn't try to wake the resident.

R1 woke up and began to physically resist care. R1 and E3 began violently wrestling on the bed with E3 observed physically restraining the resident. E3 slapped R1's face. E3 began walking away and R1 began following E3 to the door. E3 pushed R1 who stumbled back, fell to the floor and hit his head on the heating/air-conditioning wall unit. R1 got up off floor and sat on the bed. E3 turned off light, left the room and partially closed the door. R1 got off the bed and walked around in room then went into the hall outside the room.

E1 stated E3 returned to work on his next scheduled shift and wasn't allowed near residents. When interviewed E3 repeatedly

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denied any incident between he and R1 and continued to deny abuse until he was shown the video. E1 got E3's statement, terminated E3 and notified the police who arrested E3.

E1 showed this surveyor a picture of the right side of R1's face which showed a bruise that occurred after the physical altercation with E3 that stretched from R1's temple and down the side of R1's face.

E4 (nurse)was identified as the nurse who worked 7/12/25 on the evening of the abuse incident between E3 and R1. Per E4 E3 and she work the evening shift. On 7/31/25 at 2:44PM E4 was interviewed by phone. According to E4 the monitoring system notified her of R1 having fallen. When she went to R1's room he was standing in the hall. E4 assessed him, found no bruising, lacerations skin tears or sign of injury. R1 denied falling or being injured and E4 left.

Per E4 she didn't have the necessary username and password to access the Safely Yu video and had to wait until the day shift nurse arrived. After the day shift nurse arrived E4 stated she was able to view the video and observed the aggression between E3 and R1.

E4 stated the video showed E3 had been trying to change R1 who was sleeping. R1 woke up and began physically wrestling with E3, who was observed physically restraining R1. E3 hit R1 and later pushed R1 onto the floor causing him to fall backwards and hit his head on the air conditioner.

E1 was notified after E4 observed the Safely Yu video showing R1's and E3's physical altercation.

E4 did say E3 continued working the entire shift

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because E4 didn't have a username or password to allow her to access full Safely Yu system so didn't have access to access to the full video regarding R1
.
E4 stated from the time stamp on the video at approximately 10:35PM-10:45PM until the video was seen (between 7:15AM-7:30AM) E3 continued working. E1 was notified immediately when E4 saw the video but by that time E3 had gone home.

E4 stated if residents are aggressive and or resistant to care staff is to leave, allow the resident to calm down and approach later to try to provide care.

Review of the police report filed by Z1 also documented the abusive incident between R1 and E3.

Review of R1's Observation Notes documented R1's aggression when staff attempted to provide ADL (Actiity of Daily Living) care. In the 7/12/25 at 10:55PM observation note E4 documented she responded to the Safely Yu activation at that time when asked R1 stated he had fallen and denied pain.

Observation Note 7/13/25 at 9:43AM documented R1 complained of shoulder pain and had redness on the right side of his head and was transferred to an area hospital because of the "overnight incident" and the resident's complaint of pain. The same day at 5:31PM R1 returned to the facility with diagnoses including Closed head injury and fall. Notes of 7/14/25 and 7/15/25 mention R1's right forehead bruise and discoloration near his right eye.

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A6000	Continued From page 4 R1's current service plan (7/14/2025) identified the resident's aggressive behavior and resistance to care. On 7/29/25 at 3:45PM E3's employee file was reviewed for the information available and copies were obtained. There wasn't any employee application in E3's file. Nurse Aide Registry was notified of E3's termination at the time the facility transmitted the information. As stated by E1 there wasn't any employee application because the employee had been working at the facility before the new owner took over and the previous owner hadn't left the employee files with the new owners. On 7/30/25 at 4:30PM this surveyor attempted to interview R1 who was seated in a chair in the hall. When approached the resident was noted to be irritable. When asked if he'd been to the hospital or if anyone had hit or pushed him to the ground R1 didn't remember and told this surveyor to leave him alone. REVIEW OF ABUSE FILE FOR R1/E3 The following information was observed in the file: -- Card from the Plainfield Police Department given by Z1 (Plainfield Police) badge # 143 and Case # 25-7125 --Staff inservices regarding Abuse and Neglect --Incident Reporting Form completed by E4 (nurse) detailing her involvement and what she observed after E3 and R1's interaction. The Form indicated the resident had an unwitnessed fall and documents R1's statement saying he'd fallen, E4's assessment of R1 and his lack of injury. --Evidence of notification of IDPH on 7/13/25 of the incident between R1 and E3 as well as	A6000		

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A6000	Continued From page 5 additional description of the abuse (as verified by the facility's video recording of the abuse. --Plainfield Police Department Notice of Trespass Warning dated 7/13/25 given to E3 informing him that he had to remain off facility property --Written and signed statement from E4 regarding her knowledge of the alleged abusive incident between R1 and E3. E1 provided verification E3 had been inserviced on Abuse and Neglect and inservices and provided verification of E3 having continued working the entire shift after the abuse of R1. E1 also provided evidence of staff having been inserviced on abuse by showing multiple sheets regarding abuse signed by staff. Review of the facility's policy on Abuse showed the policy was followed once E4 and E1 were notified of the abuse.	A6000		