

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Aliya of Crestwood		STREET ADDRESS, CITY, STATE, ZIP CODE 13259 South Central Avenue Crestwood, IL 60418	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that medication orders received include a prescribed dose, and failed to maintain a medication error rate below 5%. There were 4 medication errors out of 37 opportunities, resulting in a 10.81% medication error rate. Three of three residents (R7, R10, R12) in the medication administration sample were affected. Findings include: 1. R10's POS (Physician Order Sheets) include Escitalopram 20mg (milligrams) give 1 tablet one time a day. Special instruction: take with 10mg tablet for total dose of 30mg daily (start date: 11/21/24). On 7/15/25 at 8:30am, V11 (LPN/Licensed Practical Nurse) dispensed (1) 20mg Escitalopram tablet in R10's medication cup (with scheduled 8am medications) and affirmed she was prepared to administer them however R10's prescribed Escitalopram dose is 30mg. Surveyor inquired how much Escitalopram was dispensed in R10's medication cup V11 checked the single dose package and affirmed it was 20mg. Surveyor inquired what R10's Escitalopram order states V11 accessed R10's EMAR (Electronic Medication Administration Record) and stated, Escitalopram 20 milligrams give 1 tablet 1 time a day and take with a 10-milligram tablet. Surveyor inquired about R10's Escitalopram prescribed dose V11 responded 30 milligrams. 2. R7's POS includes Aspirin 81mg (Chewable) tablet daily (start date: 5/2/25). On 7/15/25 at 8:57am, V3 (LPN) dispensed (1) Aspirin EC (Enteric Coated) 81mg tablet in R7's medication cup (with scheduled 9am medications) and affirmed she was prepared to administer them. Surveyor inquired about R7's dispensed Aspirin V3 inspected the Aspirin container and stated, 81 milligrams of Aspirin it says low dose pain reliever enteric coated. Surveyor inquired which Aspirin was prescribed for R7 V3 accessed R7's EMAR and responded, 81 milligrams chewable. 3. R12's POS includes Calcium Carbonate-Vitamin D 600-10mg-mcg (micrograms) daily (start date: 5/18/25) and Lactobacillus 1 capsule daily (start date: 5/21/25) however the prescribed dose is excluded. On 7/15/25 at 9:30am, V12 dispensed (1) Calcium Carbonate 500mg tablet in R12's medication cup (with scheduled 9am medications) and affirmed she was prepared to administer them. Surveyor inquired about R12's Calcium Carbonate orders V12 accessed R12's EMR and stated, It says 600 milligrams, it's 600 milligrams. Surveyor inquired again about R12's Calcium Carbonate orders V12 responded Its calcium carbonate with vitamin D, I don't have that one. V12 also dispensed (1) Lactobacillus 1 billion CFU capsule in R12's medication cup and administered this medication however R12's Lactobacillus orders exclude a dose. Surveyor inquired about R12's prescribed Lactobacillus dose (after administration) V12 accessed R12's EMAR and stated, 'It's just give one capsule. The (1/2023) medication administration policy states an order is required for administration of all medication. Check medication administration record prior to administering medication for the right medication, dose, route, resident, and time. If there's a discrepancy between the MAR and label, check orders before administering medications. Verify that no contradictions exist.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145681
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to ensure that 8 of 25 residents (R8, R10, R11, R13, R14, R16, R17, R18) remained free from significant medication errors. Findings include: 1. R10's POS (Physician Order Sheets) include Escitalopram (Antidepressant) 20mg (milligrams) give 1 tablet one time a day. Special instruction: take with 10mg tablet for total dose of 30mg daily (start date: 11/21/24).</p> <p>On 7/15/25 at 8:30am, V11 (LPN/Licensed Practical Nurse) dispensed (1) 20mg (milligrams) Escitalopram tablet in R10's medication cup (with scheduled 8am medications) and affirmed she was prepared to administer them however the prescribed dose is 30mg. Surveyor inquired what R10's Escitalopram order states V11 accessed R10's EMAR (Electronic Medication Administration Record) and stated, "Escitalopram 20 milligrams give 1 tablet 1 time a day and take with a 10-milligram tablet." Surveyor inquired about R10's Escitalopram prescribed dose V11 responded "30 milligrams."</p> <p>R10's Escitalopram 20 milligram tablet (not 30 milligrams) was dispensed by the pharmacy in single pill packs, V11 affirmed they were delivered to the facility on 7/9/25 (6 days prior to observation).</p> <p>R10's MAR (Medication Administration Record) affirms staff documented 30 milligrams of Escitalopram was administered from 7/9/25-7/13/25 however 20mg was received from the pharmacy.</p> <p>2. On 7/15/25 at 10:04am, surveyor inquired why residents were highlighted red on V13's (LPN) EMAR V13 stated "I (V13) still have a couple people left, there's seven that are red. It just means they (medications) were due at 9am and once it hits after 10:00 it's overdue" and affirmed that (R8, R13, R14, R16, R17, R18) did not receive their scheduled am medications.</p> <p>R8's (July 2025) MAR includes Eliquis (Anticoagulant) 5 mg BID (Two times a day) scheduled for 8am administration.</p> <p>R13's (July 2025) MAR includes Tizanidine (Skeletal Muscle Relaxant) 4mg tablet TID (Three times a day) scheduled for 9am administration.</p> <p>R14's (July 2025) MAR includes Lamotrigine (Anticonvulsant) 150mg BID (scheduled for 8am administration).</p> <p>R16's (July 2025) MAR includes Metformin (Hypoglycemic) 500mg BID and Baclofen (Skeletal Muscle Relaxant) 20mg TID (scheduled for 9am administration).</p> <p>R17's (July 2025) MAR includes Eliquis 5mg BID and Metformin 500mg BID (scheduled for 8am administration).</p> <p>R18's (July 2025) MAR includes Metformin 1,000mg BID and Metoprolol Tartrate (Antihypertensive) 12.5mg BID (scheduled for 8am administration).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The (1/2023) medication administration policy states check medication administration record prior to administering medication for the right medication, dose, route, resident, and time. Verify that the medication is being administered at the proper time.</p> <p>3. R11's Minimum Data Set (6/27/2025) documents a brief interview of mental status summary score of 15, indicating R11 is cognitively intact.</p> <p>On 7/16/2025 at 10:03 AM, R11 stated that R11 missed medications in May 2025 on night shift. R11 could not remember all of the medications but believed one of them was Xarelto. R11 stated that V20 (Licensed Practical Nurse) was the nurse that did not administer the medication.</p> <p>Facility daily schedule indicates that V20 was assigned to care for R11 on 5/10/2025.</p> <p>R11's physician orders document an active order (revised 12/5/2025) for one Xarelto 20 mg tablet to be administered by mouth at bedtime. This order was active on 5/10/2025.</p> <p>On 5/10/2025, R11's medication administration record does not indicate that R11 was administered Xarelto 20 mg tablet.</p> <p>On 7/16/2025 at 10:17 AM, V2 (Director of Nursing) reviewed R11's medication administration record and affirmed that R11 did not receive the medication. V2 affirmed that V2 was aware of the situation and that the V20 (Licensed Practical Nurse) did not administer the medication. V2 stated that V20 no longer works for the facility after the incident. V2 affirmed that the purpose of Xarelto is anticoagulation and prevention of blood clotting.</p> <p>Facility policy titled, "Medication Administration" (3/2025) documents in part, "All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis";.</p>		