

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 08/08/2025
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their medication administration policy by not administering scheduled pain medication within the hour timeframe as ordered and failed to notify the physician of the missed dose for one (R1) out of three residents reviewed for medication administration in a total sample of four. R1 is a [AGE] year old with the following diagnosis: idiopathic neuropathy, chronic pain syndrome, and venous insufficiency. On 8/5/25 at 3:08PM, R1 said on 7/19/2025 she did not receive the scheduled morning medications at any time during the day shift (7:00 AM - 3:00 PM). R1 said the day shift nurse (V4) did not come into R1's room the whole shift. R1 stated that V4 did not check vitals and did not ask R1 for her pain level. R1 said the CNA (V10) had gotten R1 up from bed around 10:30 AM that morning. R1 said her family members came to visit her from 12PM to 3:00 PM. R1 said at approximately 3:00 PM she asked the evening nurse why she hadn't received her day time medication. R1 told the evening shift nurse she had not refused her morning medication. R1 said that V4 finally offered R1 the day time medication after 3:00 PM after it was brought to V4's attention that R1 had not received the medication. R1 stated she did not want to take the medication at that time because it was so close to the next scheduled dose. R1 stated she voiced her concerns to a manger on duty and ADON after 3PM on 7/19/2025. R1 stated that she takes duloxetine and gabapentin for her neuropathy pain. R1 said her pain level from a scale of 0 to 10 is usually a 5/10 on the pain scale and feels tingling sensation which she described as a frost bite burned sensation. R1 reported R1 needs the duloxetine and gabapentin to keep the pain under control. On 8/5/25 at 1:03PM, V1 (Food Service Manager) stated V1 was the manager on duty on 7/19/25. V1 reported R1 told V1 that R1 did not receive any medication during the morning shift. V1 reported the DON was notified and handled by nursing staff. V1 stated R1 didn't want to take any medication after lunch time because it was too close to the next dose. On 8/5/24 at 1:24PM, V2 (ADON) stated R1 told V2 that R1 didn't receive scheduled morning medication on 7/19/25. V2 denied knowing what medication was not administered. V2 reported the nurse came back to give the medication at a later time but R1 refused to take the medication because it was too close to the next dose. V1 stated scheduled medications should be given one hour before or one hour after the scheduled time. V1 reported the nurse didn't give the medication to R1 on time because R1 was not in R1's room. V2 stated the expectation is for the nurse to check the common areas for the resident if they are out of their room. V1 reported if the medication is not administered within the hour after the scheduled time then the physician has to be notified to give additional orders if needed. V2 stated the nurse should document the conversation with the physician and any attempts to give the medication. On 8/5/25 at 3:31PM, V4 (Nurse) stated all scheduled medication can be found in the electronic medical record so the nurse know when to administer it. V4 reported all scheduled medications can be given one hour before or after the schedule time. V4 stated if a resident refuses a medication or if it must be taken later than the hour after it is scheduled then the doctor must be notified so they are safe and aware of what is going on. V4 reported V4 begins morning med pass around 8AM. V4 stated V4 couldn't remember the exact time V4 first went in R1's room but R1 was not in the room. V4 reported it was sometime between 8-9AM. V4 stated V4 finished the med pass and went back to check but R1 was still not in the room. V4 reported R1 had family in the room but R1 was not in the room. V4 was unaware of what time R1 got back to the room. V4 denied looking for R1 throughout the facility. V4 stated V4 went to administer the 9AM medication around 2Pm but R1 refused to take the medication. V4 denied calling the physician about the missed medication. V4 reported the medications scheduled were some vitamins and gabapentin. On 8/6/25 at 12:06PM, V7 (Nurse Unit Manager) stated V7 was manager on duty for nursing that weekend but V7 was not in the building on 7/19/25. V7 reported being notified of the incident the next day by R1 during rounds. V7 stated V4 told V7 that R1 was out of the room during medication pass visiting with family. V7 reported getting a phone call but was unable to remember from who that the medication was never administered. V7 stated V7 instructed V4 to try to administer the medication sometime after 3:30PM after the second shift had started and to call and notify the doctor. V7 reported R1 told V7 the next day that R1 didn't take the medication because it was too close to the next scheduled dose. V7 stated R1 told V7 that r1 was only offered the medication once at 3PM. V7 reported the nurse should go look for the resident in the facility to offer the medication and put in a progress note on everything that happened. V7 stated the physician must be called to notify them of a missed dose. On 8/6/25 at 1:46PM V10 (CNA) stated R1 gets out of bed everyday at 10:30AM V10 denied ever getting</p>		