STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145681	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Crestwood	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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to follow their Medication Administration Policy by not notifying the physician that a resident's anti-seizure medications were not available in a timely manner. This failure resulted in R10 having a seizure the next morning and being sent out to the hospital. This failure affected 1 (R10) of 3 residents reviewed for Quality of Care/Treatment.Findings include: On 2/18/2026 at 3:09PM, V2 (DON-Director of Nursing) stated pharmacy notified the DON the delivery hours for medication had a cut off time after 4:00PM on 12/24/2025 due to the holiday. V2 stated the facility nurses use the (medication dispensing system) machine to retrieve medications that have not been delivered from the pharmacy and are given to the residents as ordered by the doctor. V2 states if the medication is not available in the (medication dispensing system) machine the nurse should call and notify the doctor and family, but R10's nurse did not notify V35. V2 stated Dilantin was the only anti-seizure medication in (medication dispensing system) out of the 3 anti-seizure medications R10 takes for the seizure diagnosis. V2 states R10 was given Dilantin pulled from (medication dispensing system) the next day on 12/25/2025.On 2/19/2026 at 12:38PM, V35 (Nurse Practitioner) states on 12/24/2025 around 6:00PM, V35 was notified by R10's nurse of R10's admission into the facility. V35 stated he was not notified that the facility did not have 2 of R10's seizure medications in the (medication dispensing system) machine. V35 stated he was unaware of the pharmacy's cut-off hours because of the holiday. V35 stated R10's nurse did not call V35 on 12/24/2025 in the late evening to notify V35 that R10 did not take any of her anti-seizure medications. V35 stated if he was notified that R10's anti-seizure medications were not delivered and R10 did not take any anti-seizure medications the evening of 12/24/2025, V35 stated he would have placed an order to send R10 back to the hospital that same night.Record Review of R10's December 2025 Medication Administration Record (MAR) Topiramate Oral Tablet 200 MG give 1 tablet by mouth two times a day for Epilepsy , Phenytoin Sodium (Dilantin) Extended Capsule 100 MG give 2 capsule by mouth two times a day for Epilepsy, Oxcarbazepine Oral Tablet 600 MG give1200 mg by mouth two times a day for Epilepsy, were not administered on 12/24/2025 as instructed by R10's Hospital Discharge Medication list.Record review of R10s progress note dated 12/25/2025 at 9:55AM, documents V23 (R10's concerned party) insisted R10 go out 911 because R10 had a seizure.Record review of R10s progress note dated 12/25/2025 at 4:45PM documents R10 was admitted to (local) Hospital with seizure activity.V2 stated the evening of 12/25/2025, V2 provided an in-service to the nurses. The topic states when a new admission arrives to the facility and medications are not available, nurses are to attempt to pull from (medication dispensing system) and if not in the (medication dispensing system) notify MD (physician) and get an order to give medication upon arrival. State Surveyor observed the in-service /meeting is signed by nurses and dated 12/25/2025.On 2/18/2026 at 12:16PM, V20 (Former Administrator), states if family notifies her of a concern V20 would have addressed it right away or informed the DON right away.During Observation, on 2/19/2025, Surveyor and V2 reviewed the list of medications available on the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	(medication dispensing system) machine, only Phyentoin100mg capsule was available, but V2 stated it was not given to R10 until 12/25/2025. V2 stated the nurse did not notify V35 the evening of 12/24/2025 that the anti-seizure medications were not given.V2 provided R10s Hospital Discharge Medications, documents topiramate 200mg tablet (Take 200mg by mouth in the morning and 200mg in the evening) dose was given on 12/24/2025 at 8:23AM in the hospital, next scheduled dose in the evening time at 11:00PM. Hospital Discharge Medication Documents Phenytoin 100mg ER capsule (Take 200mg by mouth in the morning and 200mg in the evening) last dose 200mg on 12/24/2025 at 8:24AM, next scheduled dose for 11:00PM. Hospital discharge medication Oxcarbazepine 600mg tablet (Take 1,200mg by mouth in the morning and 1,200mg in the evening) last dose 1,200mg on 12/24/2025 at 8:23AM, next scheduled dose 11:00PM.During record review no progress note was written by R10's nurse to notify V35 that R10's antiseizure medications were not delivered and R10 was not given any of R10's anti-seizure medications the evening of 12/24/2025 as directed by the hospitals discharge medication list scheduled time.Facility Policy Titled Medication Administration Review date 5/2025, documents: General: Medications are administered safely and appropriately to aid residents to overcome illness relieve and prevent symptoms and help in diagnosis.Guideline:22. If medication is not given as ordered document the reason on the MAR (Medication Administration Record) and notify the health care provider.26. If the medication is ordered but not present check to see if it was misplaced and then call the pharmacy to obtain the medications. If available obtain it from the contingency or convenience box27. If the physician's order cannot be followed for any reason the physician should be notified in a timely manner depending on the situation and a note should reflect the situation in the residence medical record.