STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Warren Barr Buffalo Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 150 North Weiland Road Buffalo Grove, IL 60089	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review the facility failed to ensure a resident's (Tablet Computer) was not misappropriated for 1 of 3 residents (R1) reviewed for misappropriation of property. The findings include: The facility's Abuse Report Final Form dated 6/18/25 shows, On 6/6/25 when [R1]'s friend came to visit her, she reported to the daughter that the (Tablet Computer) was missing and the daughter reached out to [V3] unit manager to inform her .On 6/9/25 [V1], administrator was able to identify that one of the daughter's friends came to see [R1] 6/4/25 around dinner. [R1] was sitting in the nurse's station with her (Tablet Computer) and when the friend arrived, she removed it from the nurse's station and place back in room .On 6/14/25, [V10], Nursing Supervisor called [V1], Administrator around 2:00 PM stating that [V7], [R1]'s daughter called her and informed her that the (Tablet Computer) had been pinged in a proximity of [local hotel] [Local Police] were informed of the allegation of the missing (Tablet Computer) and will investigate . The schedule for 6/4/25 and 6/5/25 was reviewed. V5, Certified Nursing Assistant (CNA) was assigned to R1 on 6/4/25 PM shift, V6 (Agency CNA) was assigned to R1 on 6/4/25 Night shift and V4 (CNA) was assigned to R1 on 6/5/25 Day shift. On 6/25/25 at 12:46 PM, V5 said that she took care of R1 on the PM shift of 6/4/25. V5 said that she remembers R1's (Tablet Computer) being on her night stand plugged in when she put her into bed for the evening. V5 said that R1 uses her (Tablet Computer) daily and she would have noticed if it was not there. On 6/25/25 at 12:16 PM, V6 was contacted with no answer. On 6/25/25 at 12:08 PM, V4 said that he went in to get R1 up around 7:20 AM on 6/5/25 and noticed the (Tablet Computer) was missing. V4 said that the (Tablet Computer) is always plugged in and placed on her night stand when she is not using it. V4 said that R1 uses her (Tablet Computer) daily. (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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Buffalo Grove	150 North Weiland Road Buffalo Grove, IL 60089

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated Police Incident/Offense Report shows, On June 14, 2025, I was dispatched to [Facility] for a theft. According to dispatch, the complainant reported that her mother's (Tablet Computer) Wi-Fi + Cellular had been stolen . said that she was able to locate the (Tablet Computer) by using the Find My Phone app. According to the app, on today's date, the (Tablet Computer) was online at [Local Hotel] .[V1] noted that only one Certified Nursing Assistant [Redacted] was temporarily hired by [Facility] on 4/4/25 I requested [Local Police Department] visit [Local Hotel] to determine if anyone with the name [Redacted] was staying there. According to [Local Police Department] , they made contact with the hotel clerk, who stated that [Redacted] checked out from the motel on today's date . On 6/25/25 at 2:07 PM, V1 (Administrator) verified that it was V6's name that was redacted on the police report. V1 said that V6 is an agency CNA that only worked at the facility on 6/4/25 and was the CNA that provided care to R1 that night. V1 said that V6 was seen on camera going into R1's room a couple times throughout the night. V1 said that she has tried to contact V6 on multiple occasions with no returned call. V1 said that the police have also tried to contact her with no returned call. The facility's Abuse and Neglect Policy revised on 4/25/25 shows, It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect or mistreatment .Financial abuse includes, but not limited to deliberate misplacement, misappropriation, exploitation or otherwise taking advantage of a resident's money or property temporarily or permanently .

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