STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. Building B. Wing	07/31/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was not restrained in bed for 1 of 3 residents (R1) reviewed for restraints in the sample of 3. The findings include:R1's Face Sheet shows that he admitted to the facility on [DATE] with diagnoses of: aphasia, restlessness and agitation, dementia, lack of coordination, abnormalities of gait/mobility and need for assistance with personal care. On 7/31/25 at 10:45 AM, V9 (R1's Daughter) said that when she walked into R1's room to visit, R1 was lying in bed and had a thick mattress positioned on its side along one side of his bed that was being held up with a chair and the other side of his bed was against the wall. V9 said that she went and got a nurse to take it down.On 7/31/25 at 11:40 AM, V4, Licensed Practical Nurse (LPN) said that she did go into R1's room and saw a fall mattress on its side up against R1's bed and it was being held up with a chair. V4 said that she is not sure who put the mattress in that position, but it was probably because he was aggressive and always trying to get out of bed but was not safe to do so by himself. On 7/31/25 at 11:50 AM, V5 (LPN) said that fall mats should be placed on the floor next to the resident's bed to prevent injuries if they try and get out of bed on their own. V5 said that fall mats should never be upright along the side of the bed. V5 said that propping the fall mat up wound not be ok because it would be trapping them in the bed. On 7/31/25 at 2:02 PM, V1 (Administrator) said that fall mats should not be positioned in an upright position along the side of a bed. V1 said that if done, it would be considered a restraint and not appropriate. The facility's Restraints Policy revised on 7/3/25 shows, It is the facility's policy to ensure that each resident is not restrained for the purposes of discipline or convenience. Physical restraint is defined as any manual method, physical or mechanical device, equipment or material that meets all of the following criteria: attached or adjacent to the residents body, that the individual cannot intentionally remove easily, and restricts freedom of movement or normal access to one's body.

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