STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018638	A. BUILDING: _____ B. WING _____	09/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A PLACE FOR US	35 TOWER DR SUN PRAIRIE, WI 53590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 09/03/2026, Surveyor conducted a standard survey at A Place For Us. Three deficiencies were identified. Census: 10	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure: the individual service plan (ISP) was updated when there was a change in residents' needs for 3 of 3 residents reviewed. Resident 1's ISP did not identify his/her use of side rails. Resident 2's and Resident 3's ISPs did not identify when their side rails were to be used or how side rail safety would be monitored.	N 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 389	Continued From page 1 Findings include: The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 18 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment. 2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less	N 389		

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N 389	Continued From page 2	N 389		

restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach... Bed Rail Safety Guidelines If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. 1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped. 2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. 3. Care should be taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress. 4. Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. 5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable. 6. The space between the bed rails and the mattress and the headboard and the mattress

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should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. 7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken. 8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings 11 9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items (See Appendix 1: Glossary) should be ongoing. " (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 09/04/2026)).

On 09/03/2026 at 9:59 AM, Surveyor observed Resident 1 in his/her room sitting on a chair. Bilateral 1/4 siderails were on his/her bed, both in the up position (photo 1). Surveyor assessed the siderails safety by grasping each rail, checking for sway and measuring for gap between side rail and mattress. Each rail swayed approximately 1" from side to side and an approximate 2" gap was measured for the left rail.

On 09/03/2026 at 10:11 AM, Surveyor interviewed Caregiver B who stated Resident 1's side rails were in the up position whenever s/he was in bed, the bed was delivered with siderails when Resident 1 was admitted, and Resident 1 used the side rails to assist with repositioning from lying to sitting.

On 09/03/2026 at 10:11 AM, Surveyor

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accompanied Caregiver B to Resident 2's room and observed 1/4 bilateral side rails on Resident 2's bed (Resident 2 was not in bed). The side rail on bed's wall side was in the up position and the side rail on room side was down (photo 2). Caregiver B stated hospice delivered the bed with siderails attached about on 08/31/2026 or 09/01/2026, and s/he did not know purpose of the side rails.

On 09/03/2026 at 10:14 AM, Surveyor accompanied Caregiver B to Resident 3's room and observed bilateral 1/4 side rails on Resident 3's bed (Resident 3 was not in bed). Both siderails were in the up position (photo 3). Caregiver B stated the siderails were up whenever Resident 3 was in bed to prevent falling out of bed and the siderails had been on the bed since Resident 3 was admitted.

On 09/03/2026, Surveyor reviewed Resident 1's, Resident 2's and Resident 3's records.

Example 1- Resident 1
Resident 1 was admitted 07/21/2026. Diagnoses included: repeated falls; unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance; and anxiety.

Siderail assessment (signed and dated 07/23/2026 by Licensee A) (summarized) identified reason for side rails was for positioning, to aid in turning side to side, moving self up and down in bed, pulling and holding self over and pulling self from laying to sitting position.

ISP dated 07/23/2026 identified (summarized):
In the area of Altered Sleep Cycle - " ...Resident 1

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is alert and independent with transfers and requested with [Power of Attorneys] approval that [s/he] does not need to be checked on night shift as [s/he] can come out if [s/he] needed something or even use the call light ...[Please] DO NOT DISTURB [RESIIDENT 1] AT NIGHT TO CHECK ..."
In the area of General Mobility- " ...independent in mobility uses a walker for ambulation ..."
In the area of Assistive Devices- "Walker 4 [wheeled walker]"
Resident 1's ISP did not identify use of side rails.

Example 2- Resident 2
Resident 2 was admitted 08/31/2026. Diagnoses included dementia.

Hospice Care Plan faxed from hospice agency to Licensee A on (per date/time stamp) 09/03/2026 at 1:13 AM (summarized):
Patient's address was the CBRF's address.
In the area of Durable Medical Equipment (DME)- Hospital bed with rails effective 07/15/2026
In the area of Mobility- Impaired balance, no mobility limitations, independent for all mobility needs
The hospice care plan did not identify when the side rails were to be used and how side rail safety would be monitored and managed.

Siderail assessment (signed and dated 08/31/2026 by Licensee A) (summarized) identified reason for side rails was for positioning, to aid in turning side to side, moving self up and down in bed, pulling and holding self over and pulling self from laying to sitting position.

ISP dated 09/01/2025 (summarized):
In the area of General Mobility- Independent

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ambulation, uses 4 wheeled walker outside and " ...uses grab bar, ½ siderail for bed mobility ..."
The ISP did not identify when the side rails were to be used and how side rail safety would be monitored and managed.

Example 3- Resident 3

Resident 3 was admitted 04/03/2026. Diagnoses included Huntington's disease.

According to Drugs.com, " ...Huntington's disease causes certain nerve cells in the brain to stop working properly. It leads to mental deterioration and loss of control over major muscle movements ..." (Source: https://www.drugs.com/health-guide/huntington-s-disease-chorea.html..." (retrieval date 09/04/2026)).

Side rail assessment (signed and dated by Licensee A on 04/07/2026 (summarized) identified reason for side rails was for positioning, to aid in turning side to side, moving self up and down in bed, pulling and holding self over and pulling self from laying to sitting position.

ISP dated 04/02/2026:
In the area of General Mobility " ...Having the ¼ siderails for bed mobility is a big help for repositioning ..."
The ISP did not identify when the side rails were to be used and how side rail safety would be monitored and managed.

On 09/03/2026 at 2:39 PM, Surveyor discussed concerns regarding ISPs missing information regarding side rails with Licensee A who stated s/he was leery about siderail use due to risks and was aware of less restrictive bed repositioning

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N 389	Continued From page 7 devices. Licensee A stated because Resident 1 did not allow staff to check on him/her at night it was vital his/her side rails were used correctly and monitored closely. Licensee A stated s/he would discuss side rail risks with legal representatives and request occupational therapy to assess appropriateness of continued side rail use.	N 389		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the clothes dryer's vent consisted solely of rigid material. The clothes dryer was vented with a combination of flexible and rigid vents. Findings include: The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 18 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. On 09/03/2026 at 2:30 PM, Surveyor observed the laundry rooms dryer vent with Licensee A. One end of a flexible dryer vent tube was attached to a rigid vent elbow leading to the	N 488		

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N 488	Continued From page 8 dryer's exhaust. The other end of the flexible dryer vent tube was attached to a rigid vent elbow leading into exterior wall vent (Photo 4). On 09/03/2026 at 2:30 PM, Surveyor discussed concern regarding the flexible dryer vent with licensee A who stated the new dryer was professionally installed and since s/he only saw rigid venting material without actually looking behind the dryer, s/he assumed only rigid venting material was used. On 09/03/2026 at 2:39 PM, Surveyor discussed concerns the dryer venting with Licensee A who stated s/he knew the dryer vent needed to be rigid and assumed it was vented correctly by the professionals. Licensee A stated s/he would contact the company and have them change vent to all rigid material. Cross Reference: N0526 DHS 83.47(2)(e) Other Evacuation Drills	N 488		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually during 2024 and 2025. Findings include:	N 526		

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N 526	Continued From page 9 The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 18 residents within the client groups of advanced age and irreversible dementia/Alzheimer's. On 09/03/2026 at 9:30 AM, Surveyor requested the 2024 and 2025 other emergency drill documentation from Licensee A. On 09/03/2026 at 12:14 PM, Surveyor interviewed Licensee A who stated s/he reviewed what to do during a tornado warning with staff but did not conduct emergency evacuation drills, except fire drills during 2024 and 2025. On 09/03/2026 at 2:39 PM, Surveyor discussed concern regarding not completing other emergency evacuation drills with Licensee A who stated s/he would begin conducting other emergency evacuation drills. Cross Reference: N0488 DHS 83.44(1)(c) Clothes Dryers Enclosed And Vented	N 526		