STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018103	A. BUILDING: _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRUMLIN RESERVE	111 EAST REYNOLDS AVENUE COTTAGE GROVE, WI 53527

(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 10/02/2024, Surveyor conducted a self-report review at Drumlin Reserve, a CBRF located in Cottage Grove, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued.	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure supervision appropriate for Resident 1 who suffered burns and died as a result. Findings include: On 10/01/2024, Surveyor conducted a self-report review. On 10/01/2024 at 10:00 AM, Surveyor reviewed facility documentation dated 10/01/2024, regarding an incident on 09/30/2024 when Resident 1 sustained fatal burns from cigarette ashes that started his/her shirt on fire.	N 426		

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

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N 426	Continued From page 1 According to facility documentation dated 10/01/2024: On 09/30/2024, Resident 1 was smoking in the courtyard. Caregiver B was alerted by another resident that something was wrong. Caregiver B ran to the courtyard door and saw that Resident 1's shirt was engulfed in flames. Caregiver B removed Resident 1's shirt and yelled for help. The flames were extinguished, 911 was called, and Resident 1 was transported to the emergency room. Resident 1 passed away on 10/01/2024 due to the 2nd and 3rd degree burns sustained. Caregiver B's written statement dated 10/01/2024, documented Resident 1 was in the courtyard smoking a cigarette at approximately 12:45 PM. Caregiver B was alerted by another resident and went to see what was going on. When Caregiver B looked out the courtyard window, s/he saw that Resident 1's shirt was on fire. Caregiver B removed Resident 1's shirt and started yelling for help. Resident Care Coordinator C's (RCC-C) written statement dated 10/01/2024, documented RCC-C heard Caregiver B yelling for help and ran to the courtyard. RCC-C called 911 and Resident 1 was transported to the hospital via ambulance. On 10/02/2024, Surveyor reviewed Resident 1's Individual Service Plan (ISP) dated 03/20/2024 which documented Resident 1 needs some supervision, assistance with cares and self-direction. Resident 1 was non-verbal and used pen and paper to communicate needs. Resident 1 was identified as a fall risk. Resident 1 has memory loss and needed redirection, cues and assistance to be safe in his/her environment.	N 426		

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N 426	Continued From page 2	N 426		

Resident 1 needs supervision to be aware of location and/or redirection. Resident 1 needs physical/environmental assistance and/or cuing to find way/navigation throughout community. Resident 1's ISP directed staff to conduct safety checks daily at 8AM, 12PM, 4PM, 8PM and as needed.

On 10/02/2024 at 10:30 AM, Surveyor interviewed Administrator A who confirmed Resident 1 was nonverbal but could communicate with pen and paper. Administrator A stated that the door to the courtyard was a delayed egress door and then the actual courtyard is fenced in to prevent elopements. On 09/30/2024 at approximately 12:45 PM, Resident 1 was in the fenced in courtyard smoking a cigarette. Another resident noticed that Resident 1's shirt was on fire and attempted to get the attention of Caregiver B, who was approximately 50 yards away at the time. Caregiver B walked to the courtyard door and saw Resident 1 attempting to open the door. Administrator A said that Caregiver B told him/her that, "all I could see was fire, and I opened the door and ripped Resident 1's shirt off and yelled for help." Caregiver B got a fire extinguisher, put out the flames, and then called 911. Resident 1 was transported via ambulance to the hospital. Administrator A stated that Resident 1 was put on comfort measures and eventually passed away on 10/01/2024. Administrator A acknowledged that Resident 1 needed assistance from staff due to being a fall risk, having memory impairments and trouble communicating verbally. Administrator A acknowledged that Resident 1 was unable to open the door or call for help. Administrator A acknowledged that staff should have been with Resident 1 while smoking in the courtyard. Administrator A stated that after the incident, there were currently 2 other residents

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N 426	Continued From page 3 that smoke cigarettes and would now require a staff be with them when smoking to help prevent future incidents.	N 426		