Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018305	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF CHILTON	323 FIELD LANE CHILTON, WI 53014

(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 07/01/2025, Surveyor conducted a verification visit and 1 complaint investigation at Abridge Care Cottage of Chilton. All previous deficiencies were corrected. One (1) of 1 complaint was substantiated. As a result of the survey, 1 deficiency will be issued. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at the time of medication administration, the person administering the medication documented and initialed the MAR (medication administration record), for 1 of 1	N 415		

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
	0018305	A. BUILDING: _____ B. WING _____	R-C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF CHILTON	323 FIELD LANE CHILTON, WI 53014

(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 415	Continued From page 1 (Resident 1) resident reviewed. Resident 1's June 2025 MAR contained 13 days where staff did not document if Resident 1 refused/received medications. Findings Include: On 06/23/2025, the Department received a complaint regarding medication administration. On 07/01/2025, Surveyor conducted an onsite visit to the facility. A sample of resident records were requested, including the resident record of Resident 1. Surveyor reviewed Resident 1's MAR for June 2025. Review of the MAR showed days where medication administration was not documented as indicated by no medication passer's initials on specific dates. RESIDENT 1: Missing Documentation on MAR: Polyethylene Glycol 510g to mix 17gm(grams) in 4-8 ounces of liquid and drink by mouth daily for constipation 5AM dose on 06/01/2025, 06/06/2025, 06/11/2025, 06/12/2025, 06/16/2025, 06/17/2025, 06/18/2025, 06/19/2025, 06/20/2025, 06/25/2025, 06/26/2025, 06/27/2025, and 06/30/2025. On 07/01/2025 at 11:00 AM, Surveyor interviewed Residence Manager A. Residence Manager A verified the missing initials on the June 2025 MAR for Resident 1. Residence Manager A indicated staff should be initialing the MAR after passing the medications indicating the resident received the medication.	N 415		