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
	0018628	A. BUILDING: _____ B. WING _____	R-C 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 An investigation into a complaint and a Verification Visit for SOD XI2Z14 was conducted at Abridge Care Cottage of Kewaunee on 08/13/2026. As a result of this survey the previous deficiency was corrected. The complaint was unsubstantiated with no deficiencies identified. Per state statutes, a $200 revisit fee was assessed. Census: 17	{N 000}		

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