STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310407	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET RUTH HOME	N8007 LAKEVIEW DR IXONIA, WI 53036

(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 03/19/2026, with information obtained through 03/26/2026, the Bureau of Assisted Living, Southern Regional Office, conducted an abbreviated licensing survey at Margaret Ruth Home, a community-based residential facility (CBRF), located in the town of Ixonia, WI. As a result of the survey, 1 deficiency was identified. Census: 8	N 000		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the CBRF provided medication administration appropriate to the needs of nasal spray administration for Resident 1 and Resident 2. Between 10/01/2025 - 03/19/2026, staff initialed off on the administration of approximately 3.3 bottles' worth of azelastine nasal spray for Resident 1, however, all 5 bottles that had been	N 432		

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

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N 432	Continued From page 1 dispensed by the pharmacy since 08/28/2025 were observed on hand, 4 of which appeared near or completely full. Resident 1 self-administered his/her azelastine spray with staff supervision, and staff were responsible for the daily storing and management of it. Between 10/01/2025 - 03/19/2026, staff initialed off on the administration of approximately 4.4 bottles' worth of fluticasone nasal spray for Resident 2, however, from the supply observed on hand, at most approximately 3.5 bottles' worth of fluticasone could have been used. Resident 2 self-administered his/her fluticasone spray with staff supervision, and staff were responsible for the daily storing and management of it. Findings include: Example 1 - Resident 1 On 03/19/2026, at approximately 9:15 a.m., Surveyor observed Resident 1's medications in the medication room with Caregiver A. Surveyor observed 5 bottles of azelastine 0.1% nasal spray within Resident 1's medications. One bottle was in a bowl and the remaining 4 bottles were in a bin. Of the 4 bottles from the bin, 3 were in individual baggies with pharmacy labels. The remaining bottle from the bin was not in a baggie. The pharmacy labels on each of the 3 baggies, as well as labels on each of the 5 bottles themselves, identified that the nasal spray was prescribed to Resident 1 with the instructions, "Use 1 spray in each nostril twice a day as directed." The manufacturer's label on the bottles identified that each bottle contained 200 metered sprays of medication. The pharmacy label on the bottle in the bowl identified that it was dispensed on 10/10/2025. The pharmacy labels on the 3	N 432		

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bottles located within individual baggies identified that 1 bottle each was dispensed on 08/28/2025, 11/25/2025, and 02/25/2026. The pharmacy label on the remaining bottle from the bin indicated that it was dispensed on 01/09/2026. The 4 bottles of nasal spray from Resident 1's bin appeared to be mostly, if not completely, full.

While observing the bottles, Surveyor interviewed Caregiver A. Caregiver A confirmed that the bottle that was in the bowl was the one Resident 1 was currently using for administration. Caregiver A reported that Resident 1 preferred to administer his/her nasal spray him/herself, so staff would hand him/her the spray bottle that s/he then administered for each administration within the supervision of staff. Caregiver A denied that Resident 1 was known to refuse administering his/her nasal spray or have any issues with administering it him/herself. Caregiver A confirmed that staff managed most of Resident 1's medications, including his/her azelastine nasal spray.

On 03/25/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 11/04/2005 with diagnoses including Prader-Willi syndrome and allergic rhinitis. Resident 1 was documented as having a legal guardian. Resident 1's medications included a prescription for azelastine 0.1% nasal spray with the same instructions as observed on the bottles, active since at least 08/29/2025. Surveyor reviewed medication administration records (MARs) for Resident 1 from 10/01/2025 - 03/19/2026, where Resident 1's azelastine was tracked for administration daily at 7:00 a.m. and 8:00 p.m. and where staff initialed off on its administration. During the review period, staff initialed off on 323 total administrations of

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N 432	Continued From page 3 Resident 1's azelastine nasal spray. With each administration calling for 1 spray per nostril (2 total sprays per administration), Surveyor noted that 672 total individual sprays of azelastine would have been administered per the initialed administrations. With each bottle containing 200 metered sprays per each bottle's manufacturer's label, Surveyor noted that 672 sprays administered would have utilized approximately 3.3 bottles between 10/01/2025 and 03/19/2026. On 03/26/2026, at approximately 12:58 p.m., Surveyor interviewed Pharmacy Representative C, from the pharmacy that dispensed Resident 1's medications. Pharmacy Representative C confirmed that 1 bottle of Resident 1's azelastine nasal spray was dispensed each on 08/28/2025, 10/10/2025, 11/25/2025, 01/09/2026, and 02/25/2026. Surveyor noted that this was consistent with all 5 bottles having been observed on site. On 03/26/2026, at approximately 2:40 p.m., Surveyor interviewed Program Coordinator B regarding Resident 1's nasal spray administration. Program Coordinator B confirmed that the process for administering Resident 1's nasal spray was that staff handed him/her the nasal spray bottle from the staff-controlled medication room which s/he then used to self-administer before handing it back to staff. Program Coordinator B confirmed that staff were responsible for supervising this process. Program Coordinator B reported that s/he did not believe Resident 1 was administering his/her nasal spray correctly. Program Coordinator B expanded that s/he watched his/her nasal spray administration that morning and did not think the spray was coming out of the bottle. Program Coordinator B reported that when the bottle head was pushed	N 432		

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s/he did not see anything come out of the nozzle. Program Coordinator B reported that s/he had since spoken with a registered nurse from the provider's company to attempt to address this issue.

Example 2 - Resident 2

On 03/19/2026, at approximately 9:15 a.m., Surveyor observed Resident 2's medication in the medication room with Caregiver A. Surveyor observed 3 bottles of Resident 2's fluticasone 50 mcg/act[uation] nasal spray, with each bottle located within an individual baggie with a pharmacy label. The pharmacy label on each baggie indicated that the bottles were prescribed to Resident 2 with the instructions, "Spray twice in each nostril once a day *shake gently*." The pharmacy labels on the baggies indicated that 1 bottle each was dispensed on 11/08/2025, 02/09/2026, and 03/06/2026. The manufacturer's label on the bottles indicated that each bottle contained 120 metered sprays of medication. Surveyor observed that each bottle appeared near or completely full.

While observing the bottles, Surveyor interviewed Caregiver A. Caregiver A reported that Resident 2 was out of the home on a home visit that lasted multiple days. Caregiver A reported that one bottle of his/her fluticasone was sent with him/her for administration while s/he was on the home visit. Caregiver A reported that Resident 2 administered his/her nasal spray him/herself, so staff would hand him/her the spray bottle that s/he then administered for each administration within the supervision of staff. Caregiver A reported that Resident 2 took his/her fluticasone the "majority of the time" but estimated that s/he refused administering it approximately 5% of the

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time. Caregiver A denied awareness of any other concerns regarding the administration of Resident 2's fluticasone. Caregiver A confirmed that staff managed most of Resident 2's medications, including his/her fluticasone nasal spray.

On 03/25/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 08/20/2003 with diagnoses including Prader-Willi syndrome and unspecified intellectual disability. Resident 2 was documented as having a legal guardian. Resident 2's medications included a prescription for fluticasone 50 mcg/act[uation] nasal spray with the same instructions as observed on the bottles, active since at least 09/15/2025. Surveyor reviewed medication administration records (MARs) for Resident 2 from 10/01/2025 - 03/19/2026, where Resident 2's fluticasone was tracked for administration daily at 8:00 a.m. and where staff initialed off on its administration. During the review period, staff initialed off on 134 total administrations of Resident 2's fluticasone nasal spray. With each administration calling for 2 sprays per nostril (4 total sprays per administration), Surveyor noted that 536 total individual sprays of fluticasone would have been administered per the initialed administrations. With each bottle containing 120 metered sprays per each bottle's manufacturer's label, Surveyor noted that 536 sprays administered would have utilized approximately 4.4 bottles between 10/01/2025 and 03/19/2026.

On 03/26/2026, at approximately 12:58 p.m., Surveyor interviewed Pharmacy Representative C, from the pharmacy that dispensed Resident 2's medications. Pharmacy Representative C confirmed that 1 bottle of Resident 2's fluticasone

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N 432	Continued From page 6 nasal spray was dispensed each on 09/15/2025 (15 days before the review period), 10/10/2025, 11/08/2025, 12/15/2025, 01/09/2026, 02/09/2026, and 03/06/2026. If administered as prescribed, Surveyor noted that the bottle dispensed on 09/15/2025 would have been approximately half full by the review period start on 10/01/2025. Surveyor noted that 3 of the dispense dates were consistent with the full bottles observed on site - 11/08/2025, 02/09/2026, and 03/06/2026. Surveyor noted that even without considering the unseen residual medication amount in the bottle that would have been sent home with Resident 2, at most approximately 3.5 bottles of fluticasone would have been used from 10/01/2025 - 03/19/2025 (approximately half the bottle from 09/15/2025 if it was administered as prescribed and the bottles from 10/10/2025, 12/15/2025, and 01/09/2026), which was inconsistent with the approximate 4.4 bottles' worth of fluticasone that staff initialed as having been administered. On 03/26/2026, at approximately 2:40 p.m., Surveyor interviewed Program Coordinator B regarding Resident 1's nasal spray administration. Program Coordinator B confirmed that the process for administering Resident 2's nasal spray was that staff handed him/her the nasal spray bottle from the staff-controlled medication room which s/he then used to self-administer before handing it back to staff. Program Coordinator B confirmed that staff were responsible for supervising this process. Program Coordinator B reported that s/he did not believe Resident 2 was administering his/her nasal spray correctly. Program Coordinator B reported that s/he had since spoken with a registered nurse from the provider's company to attempt to address this issue.	N 432		