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
	310407	A. BUILDING: _____ B. WING _____	R 09/09/2026

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 09/03/2026, with information obtained through 09/09/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit 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. The deficiency is a repeat deficiency. See Statement of Deficiencies (SOD) Z7CS11, dated 03/26/2026. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. 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	{N 432}		

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

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{N 432}	Continued From page 1 provided medication administration appropriate to the needs of Resident 3 regarding his/her prescribed clonidine patches and lactulose solution. This is a repeat deficiency. See Statement of Deficiencies (SOD) Z7CS11, dated 03/26/2026. Findings include: On 09/03/2026, Surveyor reviewed Resident 3's face sheet. Resident 3 was admitted to the provider on 08/28/2015 with diagnoses including Prader-Willi syndrome and constipation. Resident 3's prescriptions included clonidine 0.3 mg/24 hour patches with instructions to, "Apply one patch topically weekly on Saturday," and lactulose 10 gm/15 mL solution with instructions to, "Take 15 mL by mouth three times daily." At approximately 9:55 a.m., Surveyor observed the medication storage area. Surveyor observed 2 baggies of clonidine patches with pharmacy labels on them, prescribed to Resident 3. The pharmacy labels identified the same prescription instructions as on Resident 3's face sheet, and both identified that the starting quantities within each baggie were 4 patches. One baggie, the label for which contained a dispense date of 07/06/2026, contained 1 of 4 patches with a handwritten annotation of "9/5/26" (Photos 1 and 2). The second baggie, the label for which contained a dispense date of 08/20/2026, contained 4 of 4 patches (Photos 3 and 4). From the above observations, Surveyor noted that from the first baggie's dispense date on 07/06/2026, the last of the 4 patches should have been applied on 08/01/2026 if administered as prescribed. Surveyor noted that there then would have potentially been an administration gap of 2	{N 432}		

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{N 432}	Continued From page 2	{N 432}		

administrations before the next set of 4 patches were dispensed. Surveyor noted that from the second baggie's dispense date on 08/20/2026, 2 patches should have been used/applied if administered as prescribed.

While observing Resident 3's medications Surveyor observed 4 total bottles of Resident 3's lactulose solution. One bottle was open and appeared to be approximately 15% full. The pharmacy label on the bottle identified the same prescription instructions as on Resident 3's face sheet, identified a dispense date of 07/15/2026, and identified that it was part of an initial fill of 3 bottles, each containing 473 mL of solution for a total starting quantity of 1,419 mL (Photos 5 and 6). The other 3 bottles were contained in bag, each still unopened. The pharmacy labels on the baggie (1 for each bottle) identified the same fill pattern - each bottle containing 473 mL of solution for a total quantity of 1,419 mL. The pharmacy labels identified that the set of 3 bottles were dispensed on 08/12/2026 (Photos 7, 8, and 9). Surveyor noted that from Resident 3's prescribed amount, a set of 3 bottles containing 473 mL each would constitute an approximate 31.5 day supply, and that Resident 3's final lactulose bottle from 07/15/2026 should have already been out with the bottles from August being used.

At approximately 11:45 a.m., Surveyor reviewed the above medications with Program Coordinator B and interviewed him/her about them. Program Coordinator B confirmed that staff administered Resident 3's medications and that s/he was not known to refuse his/her clonidine patches or lactulose solution. Program Coordinator B reported that when Resident 3 went on home visits staff sent his/her medications with him/her

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{N 432}	Continued From page 3 for his/her family to administer. Regarding the patches, Program Coordinator B reported s/he knew that they were typically delivered in sets of 4 per baggie every time but s/he wasn't sure how the administration gap occurred. Upon sharing the concern regarding Resident 3's lactulose administration, Program Coordinator B reported s/he understood Surveyor's concern. On 09/03/2026, Surveyor reviewed Resident 3's medication administration records (MARs) from 07/01/2026 through 09/03/2026 which showed the same above prescriptions and instructions. Of 8 potential clonidine patch administrations starting from 07/06/2026 (the date the July baggie was dispensed), staff initialed off on 7 administrations. The remaining administration was marked as Resident 3 being out with his/her family. Of 148 potential lactulose solution administrations starting from 07/16/2026 (the day after Resident 3's lactulose was dispensed), staff initialed off on 124 of them. Surveyor noted that this alone consisted of 1,860 total mL of solution that would have had to be administered - at least 1 set of 3 bottles from July and almost all but approximately 2 administrations-worth of medication from 1 August bottle. The remaining administration entries consisted of 23 administrations marked as Resident 3 being out with his/her family and 1 blank entry. At approximately 12:34 p.m., Surveyor again reviewed the above concern with Program Coordinator B that Resident 3 did not appear to be receiving all doses of his/her lactulose solution and clonidine patches as prescribed and as staff were initialing off the administrations for. Program Coordinator B reported s/he understood Surveyor's concern and was taking notes of potential solutions to implement to address the	{N 432}		

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{N 432}	Continued From page 4 concern. On 09/09/2026, at approximately 9:42 a.m., Surveyor interviewed Pharmacy Representative D from the pharmacy that dispensed Resident 3's medications. Pharmacy Representative D verified Resident 3's clonidine patch delivery quantities and dates, with 4 patches each being delivered on 05/15/2026, 06/11/2026, 07/07/2026, and 08/20/2026. Pharmacy Representative D confirmed that these were an approximate 1-month supply each. Regarding the gap greater than 1 month from 07/07/2026 to 08/20/2026, Pharmacy Representative D reported that this was due to difficulties obtaining a refill order from Resident 3's medical provider despite multiple attempts. Pharmacy Representative D verified Resident 3's lactulose solution delivery quantities and dates since 03/06/2026. Surveyor noted that prior to 06/18/2026, the quantity supplied varied such that an oversupply was initially generated and then less supply was intentionally sent to even out from the initial oversupply provided. Pharmacy Representative D confirmed this intentional pattern of dispensing and delivery. From the lactulose delivery dates and quantities, Surveyor noted that the break even date of Resident 3's lactulose supply occurred on approximately 06/19/2026, which correlated with the initiation of the regular dispensing of 1,419 mL of his/her lactulose solution on 06/18/2026. From that date, the same quantity of solution was dispensed and delivered on 07/15/2026 and 08/12/2026. Surveyor again noted that 1,419 mL of solution equated to an approximate 31.5-day supply of solution in accordance with Resident 3's prescription instructions. From the dispensing dates and quantities and when administered as prescribed, Surveyor noted that all of Resident 3's July bottles should have been used and at least	{N 432}		

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