

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                         |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>08/27/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MELROSE ASSISTED LIVING LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>7101 HIGHWAY 41 NORTH,<br>EVANSVILLE, , 47725 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                           | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                         | ID PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                          | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Intake 466484.</p> <p>Intake 466484 - State<br/>deficiencies related to the<br/>allegations are cited at R0297</p> <p>Survey date: August 27, 2026.</p> <p>Facility number: 014866</p> <p>Residential Census: 56</p> <p>This State Residential Finding is<br/>cited in accordance with 410<br/>IAC 16.2-5.</p> <p>Quality review completed on<br/>September 1, 2026.</p> | R 0000                                                                                        |                                  |                                                                 |  |                                                 |  |
| R 0297                                                          | <p>Pharmaceutical Services -<br/>Noncompliance</p> <p>410 IAC 16.2-5-6(c)(1)</p> <p>(c) If the facility controls, handles,<br/>and administers medications for a<br/>resident, the facility shall do the<br/>following for that resident:</p>                                                                                                                                                                                                   | R 0297                                                                                        |                                  |                                                                 |  | 09/17/2026                                      |  |

(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.

Based on interview and record review, the facility failed to ensure residents were given medications as ordered by the physician for 1 of 3 residents reviewed for pharmaceutical services. (Resident B)

Finding includes:

On 8/27/26 at 1:33 p.m., Resident B's clinical record was reviewed. Diagnoses included but were not limited to, bilateral low back pain related to sciatica, peripheral vascular disease, idiopathic peripheral neuropathy. Resident B was discharged from the facility on 3/5/26.

A care plan for medication management administration dated 10/3/25, indicated - I require staff to administer all medication.

Physicians orders for December 2025 were reviewed and included but were not limited to:

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gabapentin (anticonvulsant) tab  
800 mg (milligram) give one  
tablet by mouth three times a  
day, order date 12/4/25.

The EMAR (Electronic  
Medication Administration  
Record) for December 2025  
was reviewed.

The medication was  
documented as not given on the  
following dates:

12/18- 8:00 p.m.

12/19- 8:00 a.m., 2:00 p.m.,  
8:00 p.m.

The note section on the EMAR  
indicated the reason not given  
on 12/18 as out of stock  
reordered, 12/19 not available.

A pharmacy packing slip dated  
12/6/25 indicated 90 gabapentin  
800 mg tablets were delivered  
to the facility, the slip was  
signed as the drug received by  
the nurse.

On 8/27/26 at 2:12 p.m., the  
Administrator indicated 90  
tablets of the medication had  
been delivered to the facility on  
12/6/26, she was unsure why it  
was not given on 12/18, and  
12/19 and marked as not  
available.

The facility indicated they did  
not have a policy related to  
residents not receiving

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FORM APPROVED

OMB NO. 0938-0391

|  |                         |  |  |  |
|--|-------------------------|--|--|--|
|  | medications as ordered. |  |  |  |
|--|-------------------------|--|--|--|

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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