

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2024
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NAME OF PROVIDER OR SUPPLIER MELROSE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7101 HIGHWAY 41 NORTH EVANSVILLE, IN 47725
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(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
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00436529.</p> <p>Complaint IN00436529 - No deficiencies related to the allegations are cited.</p> <p>Survey date: September 3 and 4, 2024.</p> <p>Facility number: 014866</p> <p>Residential Census: 24</p> <p>Melrose Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00436529.</p> <p>Quality review completed on September 5, 2024.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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