

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014866</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/06/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MELROSE ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7101 HIGHWAY 41 NORTH EVANSVILLE, IN 47725</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00459340.</p> <p>Complaint IN00459340 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 5 &amp; 6, 2025</p> <p>Facility number: 014866</p> <p>Residential Census: 42</p> <p>Melrose Assisted Living LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00459340.</p> <p>Quality review completed on June 12, 2025.</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE