| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MELROSE ASSISTED LIVING LLC | 7101 HIGHWAY 41 NORTH, EVANSVILLE, , 47725 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaint IN00444274.<br><br>Complaint IN00444274: No deficiencies related to the allegations are cited.<br><br>Survey dates: October 9, 2024<br><br>Facility number: 014866<br><br>Census Bed Type:<br><br>Residential: 24<br><br>Total: 24<br><br>Census Payor Type:<br><br>Medicaid: 2<br><br>Other: 22<br><br>Total: 24<br><br>Melrose Assisted Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint | R 0000 | | |

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|---|---|---|---|---|
| | IN00444274.<br><br>Quality review completed on October 15, 2024. | | | |

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.)

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