

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER MELROSE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 This visit was for the investigation of Intake IN00465815. Intake IN00465815: No deficiencies related to the allegation(s) are cited. Survey dates: November 3 & 5, 2025 Facility number: 014866 Census Bed Type: Residential: 51 Total: 51 Census Payor Type: Medicaid:14 Other: 37 Total: 51 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	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

to the investigation of Intake
IN00465815.

Quality review completed on
November 7, 2025.

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