

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 03/07/2024	
NAME OF PROVIDER OR SUPPLIER OASIS ASSISTED LIVING, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE, EVANSVILLE, , 47714					
(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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00425761 completed on January 10, 2024. This visit was in conjunction with a Post Survey Revisit (PSR) to the State Residential Survey and the PSR to the Investigation of Complaint IN00424876 completed on January 2, 2024. Complaint IN00425761 - Corrected Survey dates: March 6 & March 7, 2024 Facility number: 013613 Residential Census: 63 Oasis Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00425761. Quality review completed on	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

March 11, 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
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