STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS ASSISTED LIVING, INC	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 the Investigation of Complaint IN00403865 completed on 3/23/23. Complaint IN00403865: Corrected Survey date: May 12, 2023 Facility number: 013613 Census Bed Type: Residential: 69 Total: 69 Census Payor Type: Medicaid: 29 Other: 40 Total: 69 Oasis Assisted Living, Inc. was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of	R 0000		

	Complaint IN00403865 completed on 3/23/23. Quality review completed on May 16, 2023.			

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