STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/07/2024

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 State Residential Licensure Survey and the PSR to the Investigation of Complaint IN00424876 completed on January 2, 2024 . This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00425761 completed on January 10, 2024. Complaint IN00424876 - 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 the State Residential Licensure Survey and the PSR to the Investigation of Complaint IN00424876.	R 0000		

	Quality review completed on 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