STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013613	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS ASSISTED LIVING, INC	4301 WASHINGTON AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00418900 and IN00418642. Complaint IN00418900 - No deficiencies related to the allegations are cited. Complaint IN00418642 - No deficiencies related to the allegations are cited. Survey date: November 8 & 9, 2023 Facility number: 013613 Residential Census: 66 Oasis Assisted Living, INC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00418900 and IN00418642. Quality review completed on November 15, 2023.	R 000		