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 _____	R-C 05/12/2023

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 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 Complaint IN00403865 completed on 3/23/23. Quality review completed on May 16, 2023.	{R 000}		