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 03/07/2024

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 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. Quality review completed on March 11, 2024.	{R 000}		