

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/07/2024
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NAME OF PROVIDER OR SUPPLIER OASIS ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
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(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}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00425761 completed on January 10, 2024. This visit was in conjunction with a Post Survey Revisit (PSR) to the State Residential Survey and the PSR to the Investigation of Complaint IN00424876 completed on January 2, 2024.</p> <p>Complaint IN00425761 - Corrected</p> <p>Survey dates: March 6 & March 7, 2024</p> <p>Facility number: 013613</p> <p>Residential Census: 63</p> <p>Oasis Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00425761.</p> <p>Quality review completed on March 11, 2024.</p>	{R 000}		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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