

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Austin Oasis, The		STREET ADDRESS, CITY, STATE, ZIP CODE 901 South Austin Blvd Chicago, IL 60644	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store and distribute food in accordance with professional standards for food service safety. This failure affected one resident (R5) and has the potential to affect all 182 residents that reside in the facility receiving oral diets. Findings include: On 06/30/26 at approximately 10:00am R5 entered room with surveyor stating that R5 was served spoiled milk for breakfast. R5 stated that the milk carton that R5 was given that morning was expanded and the milk was warm and had a bad taste. R5 stated that she informed a staff member that was in the dining area, and the staff member removed the milk and gave R5 a new carton of milk. On 06/30/26 at 11:00am observed facility's walk-in refrigerator with water and ice covering the entire floor of the refrigerator. The water observed on the floor approximately over 1 inch in height. Walk in refrigerator's thermometer observed at 66 degrees Fahrenheit. Observed 8 boxes of milk stored in walk in refrigerator. Observed V23 (Dietary Director) check temperature of one carton of milk which tempted at 50 degrees Fahrenheit. On 06/30/26 at 11:01 V23 (Dietary Director) stated that the water and ice observed on the walk-in refrigerator's floor is not safe or sanitary. V23 stated that the refrigerator's temperature is not within normal range. V23 stated that she was made aware of the refrigerator not working properly that morning and did not serve the residents the milk that was previously stored in the refrigerator. V23 stated that the milk currently observed was from the shipment that just came in. V23 stated that the milk's temperature is not within normal range and would need to be discarded. V23 stated that serving the milk that is not at a safe range could make the residents sick. On 06/30/26 at 11:08am V24 (Cook) stated that she first observed the walk-in refrigerator not working properly the day before. V24 stated that she informed the dietary director the day before that the refrigerator wasn't working properly. V24 stated that water was dripping in the refrigerator and food boxes were getting wet. On 06/30/26 at 11:20am V25 (Dietary Aide) stated that the milk that was stored in the walk-in refrigerator was given out first to the residents and when that milk was all gone, they served the milk that was delivered that day. On 06/30/26 at 2:34pm V7 (Certified Nursing Assistant/CNA) stated that R5 complained to her that R5's milk was spoiled. V7 stated that she replaced R5's milk with new milk and discarded the old milk. V7 stated that the milk carton felt soft. V7 stated that she reported R5's concerns to V23 (Dietary Manager). V7 stated that V23 came out and replaced all the milk at that time with new milk. Facility's policy titled Storage of Refrigerated Foods revised 2017 documents in part, Policy: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Procedure: Refrigerated foods are stored at 41 degrees F (Fahrenheit) or below. Facility's policy titled Time/Temperature Control for Safety Food revised 2017 documents in part, Policy: Foods that require time and temperature control to prevent the growth of microorganisms (bacteria) which cause foodborne illness are known as TCS (temperature control safety) foods. TCS foods may also be referred to as (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	potentially hazardous food (PHF). Some foods are more likely than others to be TCS foods. They include: Milk and Dairy Products. Procedure: Special attention is paid to foods that are Time/Temperature Controlled for Safety (TCS).		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that one resident (R1) was discharged to a safe place back to the community. This failure affected 1 of 3 residents reviewed for discharges. Findings include: R1's medical diagnoses include but are not limited to bipolar disorder, schizoaffective disorder, pneumonia, type 2 diabetes, asthma. R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status score of 15, indicating R1's cognition is intact. R1's progress note entered by V11 (Registered Nurse/RN) dated 03/31/26 documents in part, Patient was d/c (discharged) today all belongings and medications was sent with patient no issues was noted. R1's document titled Discharge Instructions Plan of Care dated 02/11/26 documents in part, 1. General Information: This section is to be completed by Nursing. 1a. discharge date [DATE]. 1b. 8:00am. 1c. Who is accompanying resident? Son V27. 1d. How is resident being transported? Car. 1e. Schizoaffective Disorder, Bipolar type. 1f. Person Completing this section V10 (Psychiatric Rehab Service Coordinator/PRSC). On 06/29/26 at 9:58am V27 (R1's family member) stated that he was not aware that R1 was discharged from the facility. V27 stated that no one from the facility discussed R1's discharge with him. V27 stated that he found out that R1 was discharged from the facility when R1's brother arrived at the facility to bring R1 some food and R1 was no longer there. V27 stated that R1 was not allowed to live with V27 due to R1's mental instability. V27 stated that R1 was found homeless and living on the train. V27 stated that the paperwork found on R1 showed that it was documented that V27 picked R1 up from the facility in a car. V27 stated that he did not pick R1 up from the facility. V27 stated that he does not own a car and has not owned a car in a couple of years. On 06/29/26 at 2:14pm V9 (Psychiatric Rehab Service Coordinator/PRSC) stated that R1 informed her that he resided at the facility because R1 was kicked out of the house by R1's son. V9 stated that she was assisting R1 with applying for subsidized housing and the plan was for R1 to discharge back to the community when his subsidized housing was approved. On 06/29/26 at 2:40pm V10 (Psychiatric Rehab Service Coordinator/PRSC) stated that a safe discharge consists of a resident leaving the facility with someone. V10 stated that the facility doesn't allow a resident to leave the facility by themselves unless the resident is leaving AMA (Against Medical Advice). V10 stated that R1's discharge was a safe discharge which required R1 to be picked up by someone. V10 stated that the facility is supposed to confirm who would be picking the resident up at the time of discharge. V10 stated that she thinks that she is the one who spoke to R1's son about discharge. V10 stated that R1's son came to pick R1 up from the facility in a car. V10 then stated that she can't confirm or deny if R1's son came to pick R1 up from the facility. V10 stated that she can't confirm that she seen R1's son when R1 left the facility. V10 stated that R1's discharge instructions is dated 02/11/26 because R1 was supposed to initially discharge with a girlfriend but R1 was not able to live with that friend and the date was never changed. On 06/29/26 at 3:25pm V12 (Receptionist) stated that she observed R1 leaving the facility at the time R1 was discharged . V12 stated that social service walked R1 to the door and R1 left the building. V12 stated that R1 did not get in a car and that R1 left the facility by himself walking. On 06/29/26 at 3:11pm V11 (RN) stated that she was informed by R1 and social service that R1 was being discharged . V11 stated that she believes that she got a discharge order from V16 (Nurse Practitioner/NP). V11 stated that if she got the discharge order then it would be in R1's records. V11 stated that she does not know how R1 left the facility and who R1 left the facility with. On 07/01/26 at 2:20pm V2 (Director of Nursing) stated that the facility doesn't (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allow the residents to discharge without a place to go. V2 stated that the facility has whoever the resident is going to live with come to pick the resident up from the facility. V2 stated that the facility does not allow residents to discharge and get on the bus. V2 stated that social service is supposed to verify where the resident is discharging to. V2 stated that the nurse should call the physician for a discharge order. V2 stated that if R1's chart indicates that R1 left the facility with R1's son then that should have been what happened. Review of R1's physician's orders does not show that R1 had a discharge order entered. On 06/30/26 at 12:53pm V15 (Certified Nursing Assistant/CNA) stated that she was R1's CNA at the time R1 was discharged. V15 stated that she is unsure of what time R1 left the facility. V15 stated that after R1 was discharged, V15 saw R1 standing at the bus stop outside of the facility with a backpack. On 06/30/26 at 3:31pm V16 (NP) stated that she did not know that R1 was discharged from the facility. V16 stated that she does not recall giving the nurse a discharge order for R1. V16 stated that even if the nurses get a verbal order, the nurse should enter the order into the record. Facility's policy titled Discharge/Transfer of Resident dated 11/2025 documents in part, Purpose: To provide safe departure from the facility. To provide for continuity of care and treatment. Procedure: 1. Explain discharge procedure to resident and family. Provide additional health education or medication instruction information for resident or family as indicated in lay terms. 2. An attending physician order is required to discharge/transfer.		