Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A 01	OPENING REMARKS Surveyor: 20402 The following deficiencies were cited during a complaint investigation conducted on 05/28/09 for NM Regulations Governing Adult Residential Care Facilities, 7 NMAC 8.2. One complaint was investigated: NM #27095 and was SUBSTANTIATED with deficiencies cited.	A 01		
A34	7 NMAC 8.2.34 Resident Rights 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding. B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority. (1) the resident's spouse; (2) any of the resident's adult children; (3) either of the resident's parents; (4) any relative the resident has lived with for six or more months before admission; (5) a person who has been caring for, or paying benefits on behalf of the resident; (6) a placing agency; or (7) any other person, e.g., Ombudsman. C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility: D. The facility, to protect resident rights must: (1) Treat all residents with courtesy,	A34	Response - A34 ED Scanned 11-24-09 All restraint orders will be entered in medication book. Employees have access to medication book which will state which individual needs restraints which does not.	05/30/09

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X6) DATE: 10/19/09

STATE FORM 6899 EAJ811 If continuation sheet 1 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 1 respect, dignity and compassion. (2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality. (3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes. (4) Assure that residents have a safe and sanitary living environment. (5) Provide humane care. (6) Assure the resident's rights to privacy in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records. (7) Protect and assure the resident's right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 2 resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds.	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 3 (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.34 D. (9) Based on observation, record review and interview, the facility failed to ensure that 2 of 6 sample residents (R#'s 1 and 2) were not being restrained in their wheelchairs by the use of gait belts in which both residents were unable to remove. The facility also failed to ensure physician orders were obtained for the use of the gait belts. This deficient practice had the potential of affecting all residents in the facility. The census at the time of the survey was 6. The findings are: A. On 05/28/09 at 8:45 am during initial tour of the facility, residents #1 and #2 were observed sitting in their wheelchairs facing the television. Resident #1 was observed sitting in a high back	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 4 wheelchair with a white gait belt wrapped around her waist and buckling in the back of the wheelchair. Resident #2 was observed sitting next to R#1 in her wheelchair with a white gait belt also wrapped around her waist and buckling in the back of the wheelchair. B. On 05/28/09 at 8:50 am during interview, Caregiver #2 stated that she thought the purpose of the gait belts being wrapped around residents #1 and 2 was for safety and because a lot of times they bend over and pick things up. Caregiver #2 stated, "I know they both have Dr.'s order for them." When caregiver #2 was asked how long are R#'s 1 and 2 in their wheelchairs with the gait belts on, the caregiver stated, "They are not in them more than two hours I would say, and yes, I would consider them a restraint." C. On 05/28/09 at 9:00 am during interview, a Hospice Certified Nursing Assistant (CNA) caring for R#1 arrived and stated that she thought the gait belt was being used for R#1 becasue she "leans forward and doesn't like being in bed. We had a Interdisciplinary Team (IDT) Meeting on March 17 and all I see are orders just to get her out of bed. I'm not seeing anything or any orders for a gait belt." The Hospice CNA then stated that within the last two weeks, "I haven't known her to have any falls and we would not send them out without a physicians order because I know they are considered restraints." The Hospice CNA then stated, "I believe it's used to keep her from falling and leaning forward." The Hospice CNA then stated that she found a black gait belt in R#1's bedroom that she thought was ordered from [name of the hospice company] and then stated, "She should have this one on her." The Hospice CNA proceeded to remove the white gailt belt that was around R#1's waist and placed	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 5 the black gait belt over R#1's waist and buckling it in the back of the wheelchair and then left the facility. 1. At 9:50 am the Hospice CNA came back to the facility and stated to the surveyor, "All I was told was that she was to have a tab alarm on only. I just called the Hospice nurse who told me she was here two weeks ago and told the staff she [referring to R#1] is not to have that on her because we don't have an order for it, and to have the staff take it off her now." Caregiver #2 was observed at this time saying to the Hospice CNA, "Oh, we've been putting in on her." D. On 05/28/09 review of the medical record for R#1 revealed no physicians orders in the record for the use of a gait belt to be applied. 1. Review of the Progress report dated March 3, 2009 does not indicate any falls or the use of a gait belt. 2. Review of the Assessment Sheet dated 03/9/09 states: Falls frequently- "Yes." Is physically restrained- "No" E. On 06/05/09 at 1:40 pm the Surveyor received a phone call from R#1's Hospice nurse who stated in a phone interview that "There is no order for the gait belt to be used in that way while she is sitting up in her wheelchair. I didn't see an order for it." The Hospice nurse stated that she actually found the gait belt in place the previous week before and told the staff at the facility to remove the gait belt because there was no reason to be using it." The Hospice nurse then stated, "It was a gait belt and I didn't see any reason why she should have it. The Hospice nurse then stated "It's not on our plan of care for the CNA's to even be applying it so I've asked our CNA to have it removed becasue it should not have ever been applied."	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 6 F. On 05/28/09 at 11:15 am, 11:39 am, 1:00 pm and at 1:50 pm observations of resident #2 were made with the resident again sitting in her wheelchair with the white gait belt wrapped around her waist and buckled in the back. 1. During interview at 11:15 am Caregiver #2 stated "I know I was told she was supposed to have the gait belt on. I didn't see the Dr.'s order though but I know she had it on this morning." 2. Two Hospice CNA's [responsible for caring for R#2] were observed asking Caregiver #2 if she was supposed to have the gait belt on or not becasue they were unsure. 3. At 11:19 am, the two Hospice CNA's were asked what was the purpose of using the gait belt for R#2, they responded by saying, "I guess it would be because she leans forward." G. On 05/28/09 review of the medical record for R#2 revealed the following: 1. The Assessment form dated 03/09/09 indicated: Falls frequently- "No", Is physically restrained- "No". 2. An Incident Report dated 04/12/09 states, "Rsd. [resident] was sitting in w/c [wheelchair] watching TV was found on floor on knees, her head next to another rsd. [residents] w/c... Steps taken to prevent Recurrence: "Gait belt used as a safety belt while in chair." (This was the first indication the gait belt was being applied with no physician order) 3. Progress Notes (with no signature of the caregiver) and dated 04/22/09 state "When she was in her w/c she kept on trying to get out-going forward so I got a guard belt on her so she doesn't have a fall." (This was the second indication the gait belt was being applied with no physician order) 4. Physician Orders dated 05/05/09 state	A34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LI'/ING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A34	Continued From page 7 "Tab alarm in bed, gait belt in w/c, assess safety."	A34		
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medica'ions. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:	A36	Response - A36 At the time of the findings the staff was still in training under Licensed individual. The test was going to be administered at a future date. In the future Staff assisting with medication, the facility will have on file for each staff member dates of training, documentation that written test was administered, and passed by staff member.	05/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From page 8 (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions: (1) The resident is capable of determining when the medication is needed. (2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From page 9 errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Based on observation, record review and interview, the facility failed to provide documentation to ensure that 4 of 7 caregivers (#'s 2, 3, 4, and 5) who were assisting residents with medications had successfully completed an approved assistance with medication training program. This deficient practice had the potential to impact 6 of 6 sampled residents in the facility. (R #'s 1-6). The census at the time of the survey was 6. The findings are: A. On 05/28/09 at 9:45 am after review of the employee personnel file for Caregiver #2, she was interviewed. The caregiver stated, "I handle the medications a little bit. I took the med assist test I think last week." The caregiver then stated, "I thought I took the med assist test like two weeks ago and it just depends on the medications. Sometimes [name of the Administrator] will come in and prepare the meds for me and then I will go ahead and assist in giving them." 1. Review of the personnel file for Caregiver #2 revealed no documentation of a Certificate to Assist residents with medications and no documentation that the written test was taken. B. On 05/28/09 review of the employee personnel file for Caregivers #'s 3, 4, and 5 revealed no Certificates to Assist residents with medications	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From page 10 and no documentation that a written test was taken. C. On 05/28/09 review of the May 2009 Medication Administration Records (MARS) for resident #2 revealed the following days (05/17/09, 05/20/09, 05/21/09, 05/22/09, 05/26/09, 05/27/09, and 05/28/09) during which caregiver #2 was initialing as giving Clonazepam 0.5 mg (milligram) tablets 1/2 by mouth every 12 hours. Further review of the MARS for the residents revealed the initials of caregivers (#'s 3,, 4, and 5) as verifying giving the residents the medications. D. On 05/28/09 at 11:25 am during interview, the Administrator stated that only three of his employees for sure do the medications on their own. With the medications, he stated, "I supervise my staff. I let them assist with the meds and I watch them. With [name of caregiver #2], she took her test and we are waiting for her certificate." When the Administrator was asked if there was any documentation showing that caregivers (2, 3, 4, and 5) had taken the medication assistance test or had any certificates, he stated, "No." E. On 05/28/09 at 11:37 am during interview, caregiver #6 stated, "Today is only my third day here and on my first day, I did the medications with one of the other caregivers but I haven't taken a test yet." F. On 05/28/09 at 1:35 pm during interview, Caregiver #2 stated, "This is such a broken system and I know that unless something is done, I just do what I'm told and that's it." The caregiver confirmed that she had been signing her initials on the MARS as giving the medications and then stated, "I know its' a broken	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From page 11 system. Sometimes [name of the administrator] is pouring the meds and I give them, then other times, I just give them. I really don't know what the right thing to do is." Caregiver #2 stated that the way she was interpreting the MAR was that "Who ever signs on the MARS and initials is the person who gave the medications, that's what I know." G. On 05/30/09 at 8:28 am surveyor received a phone call from caregiver #5 who stated that she was passing out the medications even though she knew she was not licensed to and only took the medication assistance test a few days ago.	A36		
A66	7 NMAC 8.2.66 Related Regulations & Codes 7.8.2.66 RELATED REGULATIONS AND CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to Title 7 Chapter 1 Part 9 Caregivers Criminal History Screening Requirements Issued 01/06/06 Refer to 7.1.9.8 F Timely Submission.	A66	Response A-66 Adopt a new policy to only hire individuals who have completed all of the paper work and the background check has been started prior to employemt. At the time of the finding the employees were awaiting on birth certificates due to their out of state identifications being expired	5/30/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A66	Continued From page 12 Based on record review and interview, the facility failed to have documentation available to ensure that all fees and pertinent application information for Caregivers Criminal History Screening was provided within twenty days of date of hire for 6 of 7 caregivers (#'s 2, 3, 4, 5, 6, and 7). This deficient practice had the potential of affecting 6 of 6 sampled residents (R#'s 1-6) in the facility. The census at the time of the survey was 6. The findings are: A. On 05/28/09 review of the employee personnel files for caregivers #'s 2, 3, 4, 5, 6, and 7 revealed the following: 1. caregivers #'s 2 and 3 were hired for employment on 03/16/09. There was no documentation that the caregivers fingerprints were submitted for the Caregivers Criminal History Screening within twenty (20) calendar days of the first day of employment. 2. Caregiver # 4 was hired for employment on 03/17/09. There was no documentation that the caregivers fingerprints were submitted for the Caregivers Criminal History Screening within twenty (20) calendar days of the first day of employment. 3. Caregiver # 5 was hired for employment on 03/20/09. There was no documentation that the caregivers fingerprints were submitted for the Caregivers Criminal History Screening within twenty (20) calendar days of the first day of employment. 4. Caregiver # 6 was hired on 05/13/09. There was no documentation that the caregivers fingerprints were submitted for the Caregivers Criminal History Screening within twenty (20) calendar days of the first day of employment. 5. Caregiver #7 was hired on 04/06/09. There was no documentation that the caregivers	A66		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2073	A. BUILDING _____ B. WING _____	C 05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS OF THE LIVING TREASURE	10405 THERESA PLACE NE ALBUQUERQUE, NM 87111

(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
A66	Continued From page 13 fingerprints were submitted for the Caregivers Criminal History Screening within twenty (20) calendar days of the first day of employment. B. On 05/28/09 at 9:45 am during interview, when caregiver #2 was asked if she had a background check, she replied by stating, "What is a background check. I got my fingerprints like three weeks ago and I gave my stuff to the owner." C. On 05/28/09 at 9:15 am during interview, the Administrator stated, "You probably won't get a whole lot of stuff from the files because I'm remodeling the office and everything is a mess and in piles so I probably won't have a lot for you. If I had known you were coming, I could have gotten things prepared for you." 1. At 11:25 am during interview the Administrator stated "that with the fingerprints, if they don't bring me the paper showing that they were done, then I will have to call them to get their fingerprints to me."	A66		