STATEMENT OF DEFICIEN ES AND PLAN OF CORRECTIO	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2007
NAME OF PROVIDER OR S PLIER	STREET ADDRES S	ITY, STATE, ZIP CODE	
OASIS OF THE LIVIN TREASURE	10405 THERES ALBUQUERQU	PLACE NE NM 87111	

(X4) ID PREFIX TAG	SUM (EACH D REGULAT	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	PR TI	ID X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A66	7 NMAC 8. CODES	66 RELATED REGULATIONS AND	A66			
	7.8.2.66 CODES: A to these re regulations may, from t A. He Procedures NMAC 1.7 B. He Monetary F Health, 7 N C. Ad Departmen [9-24-76, 7 NMAC - Rr This REQU by: 7.8.2.66; 7. Screening	RELATED REGULATIONS AND ult residential care facilities subject lations are also subject to other codes and standards as the same ne to time, be amended as follows: th Facility Licensure Fees and New Mexico Department of Health 7 0-31-96). th Facility Sanctions and Civil nalties, New Mexico Department of IAC 1.8 (10-31-96). dicatory Hearings, New Mexico of Health, 7 NMAC 1.2 (2-1-96). 1-86, 1-11-90, 4-7-97; 7.8.2.66 7 NMAC 8.2.66, 8-31-00] REMENT Is not met as evidenced .9 (Caregivers Criminal History equirements)				
	Based on r failed to ma history scre for 1 of 4 s are:	cord review and interview, the facility ntain records of caregiver criminal ning clearance on file at the facility mpled direct care staff. The findings				
	A. Record r screening c	view on 12/004/07 at 10:30 a.m. revealed nc evidence of caregiver criminal history larance for S1.				
	B. During a at 11:30 a.r failed to ma history scre	interview with the director of nurses, , she acknowledged that the facility ntain record of caregiver criminal ning clearance for S1.				

Scanned 01-16-08

A66
7.8.2.66; 7.1.9
Meeting has been held to address this overlook.
We decided to periodically review employee's personal records for any missing requirements documentations.

It is corrected on 12/28/07

12/28/07

Division of Health Improvem

LABORATORY DIRECTOR'S C PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE DON (X6) DATE 1/16/08

STATE FORM MROG11 If continuation sheet 1 of 1

RECEIVED
JAN - 9 2008