

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2211	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 03/28/2017
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON 4			STREET ADDRESS, CITY, STATE, ZIP CODE 508 B N AIRPORT DR FARMINGTON, NM 87401		
(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 000}	Initial Comments A phone/fax re-visit survey was completed on 03/28/17 for survey dated 10/06/16 for the state requirements of 7 NMAC 8.2. Regulations for Assisted Living. There were no deficiencies cited and the facility was found to be in substantial compliance.	{A 000}			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE