

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/11/2013
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD II		STREET ADDRESS, CITY, STATE, ZIP CODE 102 B QUAIL TRAIL EDGEWOOD, NM 87015		
(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 An initial survey was completed on 09/11/13 for the state requirements of 7NMAC 8.2, Regulations for Assisted Living. The facility was found to be in substantial compliance with 7NMAC 8.2, Regulations for Assisted Living. No Deficiencies were cited.	A 000		

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

TITLE

(X6) DATE