Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2274	A. BUILDING: _____ B. WING _____	R 11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF CLOVIS	**2305 NORTH NORRIS CLOVIS, NM 88101**

(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 Revisit survey for an Initial survey dated 07/18/15 was completed on 04/14/116 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. New and repeat deficiencies were cited as result of the survey. A Revisit survey for an Initial survey dated 07/18/15 and Revisit Survey dated 04/14/16 was completed on 11/15/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. No deficiencies were cited as result of the survey and the facility is now in compliance. .	{A 000}		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE