STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2133	A. BUILDING _____ B. WING _____	07/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF TAYLOR RANCH	6004 WHITEMAN DRIVE NW ALBUQUERQUE, NM 87120

(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 00	NO DEFICIENCIES This Facility is in Compliance with all New Mexico Regulations Governing Adult Residential Care Facilities 7 NMAC 8.2. No deficiencies were cited on 7/9/2008 for New Mexico regulations governing Adult Residential Care Facilites, NMAC 7.8.2.	A 00		
A 01	OPENING REMARKS Refer to 7.8.2.35 - CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. Based on record review and interview, the facility has not yet had an initial review by a registered pharmacist. The findings are: A. On 7/9/08 during review of the facility records, a faxed notice to the facility read that the consultant pharmacist visit is scheduled for	A 01	EJ Scanned 07-23-08	

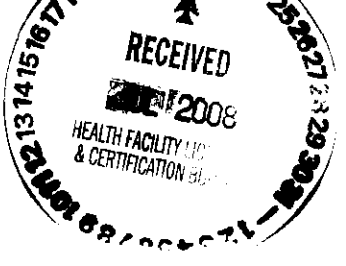
Division of Health Improvement

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

TITLE: Administrator

(X6) DATE: 7/16/08

STATE FORM 6QHV11 If continuation sheet 1 of 2



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A 01	Continued From page 1 August 2008. B. On 7/9/08 during interview with the Administrator, he confirmed that the Registered Pharmacist visit is scheduled for August 2008.	A 01		