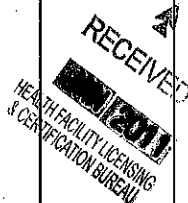


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2011
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF SANTA FE		STREET ADDRESS, CITY, STATE, ZIP CODE 3838 THOMAS ROAD SANTA FE, NM 87507		
(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 1/6/2011. No deficient practices were cited as a result of this survey.	A 000	<i>Scanned 4-4-11 CP</i>	



Division of Health Improvement

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

STATE FORM

TITLE

(X6) DATE

Administrative

1-16-11

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874211

If continuation sheet 1 of 1

ORIGINAL