Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2143	A. BUILDING _____ B. WING _____	C 05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF SAN PEDRO - BUILDING	6401 CORONA NE ALBUQUERQUE, NM 87113

(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 complaint investigation was completed for intake NM00028452 on 05/09/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Substantiated with no deficiencies cited. A complaint investigation was completed for intake NM00028328 on 05/09/12 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was Substantiated with no deficiencies cited.	A 000	Scanned 05-31-12 J.D.	

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Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5-18-12

STATE FORM 6899 GF8O11 If continuation sheet 1 of 1

EX: 9/30/12

2143-16-02

ORIGINAL