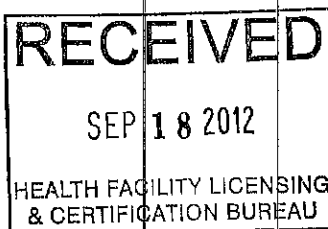


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2012
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF FARMINGTON 4		STREET ADDRESS, CITY, STATE, ZIP CODE 508 AIRPORT DR FARMINGTON, NM 87401		
(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 for NMAC 7.8.2 regulations governing Assisted Living facilities. No deficiencies were cited.	A 000 <i>Scanned 9-19-12 J.D.</i>		



Division of Health Improvement

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

STATE FORM

*TITLE

GKIP11

(X6) DATE

If continuation sheet 1 of 1

ORIGINAL