

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/21/2013
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NAME OF PROVIDER OR SUPPLIER

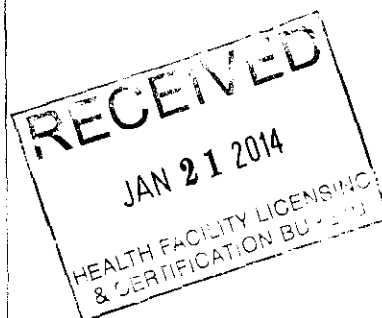
STREET ADDRESS, CITY, STATE, ZIP CODE

BEE HIVE HOMES OF RIO RANCHO II

**2709 CHESSMAN DRIVE
RIO RANCHO, NM 87124**

(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 NM00029055 on 8/22/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was substantiated with no deficiencies cited.	A 000		

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1/24/14
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Division of Health Improvement

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

TITLE

(X6) DATE

STATE FORM

6899

H7YT11

If continuation sheet 1 of 1

Administrator

1-5-2013