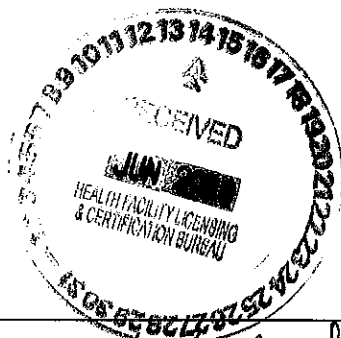


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2011
NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 102 QUAIL TRAIL EDGEWOOD, NM 87015		
(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 No deficiencies were cited on June 8, 2011 for New Mexico regulations governing Adult Residential Care Facilities, NMAC 7.8.2	A 000		

*Scanned
7.1.11
CP*



Division of Health Improvement

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

[Signature]

TITLE

Administrator

(X6) DATE

6/8/11

STATE FORM

6899

LHZ311

If continuation sheet 1 of 1

ORIGINAL