

Division of Health Improvement

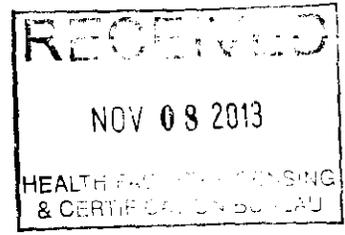
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2225	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/11/2013
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NAME OF PROVIDER OR SUPPLIER BEE HIVE HOMES OF EDGEWOOD II	STREET ADDRESS, CITY, STATE, ZIP CODE 102 B QUAIL TRAIL EDGEWOOD, NM 87015
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(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
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A 000 Initial Comments	<p>A complaint investigation was completed for intake NM00029124 on September 11, 2013 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was substantiated with no deficiencies cited.</p>	A 000		
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Scanned 11/13/13 KH



B. A. Murphy
Director
11/4/13

Division of Health Improvement
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 TITLE
(X6) DATE