

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2268</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/16/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEEHIVE HOMES OF HOBBS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1028 COLLEGE LANE HOBBS, NM 88240</b>
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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
A 000	<p><b>Initial Comments</b></p> <p>On December 16, 2014 a Life Safety Code Survey was conducted at the above referenced facility per the provider ' s request.</p> <p>The facility was found to be in substantial compliance with the Life Safety Code of the New Mexico State Regulations governing Requirements for Assisted Living Facilities for Adults 7.8.2 NMAC.</p> <p>I recommend occupancy of the ALF .</p>	A 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_