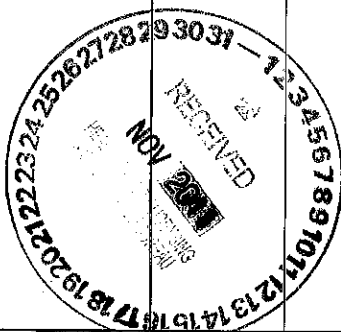


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2011
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF SAN PEDRO - BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 CORONA NE ALBUQUERQUE, NM 87113		
(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 #NM000 28187 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Unsubstantiated.	A 000 <i>Scanned J.D. 11-03-11</i>		



Division of Health Improvement

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

STATE FORM

TITLE

Administrator

(X6) DATE

10-27-11

3PKM11

If continuation sheet 1 of 1

ORIGINAL