

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>4033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/14/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEEHIVE HOMES OF RATON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4811 HARDWARE DRIVE NE, BLDG D2 ALBUQUERQUE, NM 87109</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 14, 2017 an initial Life Safety Code survey was conducted at the above referenced facility per the provider's request.</p> <p>The following deficiencies were found:</p> <ol style="list-style-type: none"> <li>1. The one ADA handicapped residents room bathroom failed to have the seat in the shower was constructed on the wrong side.</li> <li>2. The linen closets have a penetration above the door for ventilation shall be removed.</li> </ol> <p>On December 28 correspondence and photos of the corrected deficiencies were received by this office via email from Casey the quality assurance director.</p> <p>The facility is found to be in substantial compliance with the Life Safety Code portion of the New Mexico State Regulations for Assisted Living Facilities for Adults, 7 NMAC 8.2. Therefore, I recommend temporary licensure.</p>	A 000		

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