

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>2141</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2020</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BEEHIVE HOMES OF SAN PEDRO, BUILDING C</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6401 CORONA NE<br/>ALBUQUERQUE, NM 87113</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>Initial Comments</p> <p>An offsite suviallance survey was conducted related to COVID`19 infection prevention and control on 05/07/20.. No deficiencies were found.</p> | A 000         |   |                    |

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