

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 10/29/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEE HIVE MEMORY LOSS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 AIRPORT DRIVE FARMINGTON, NM 87401</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>No deficiencies were cited during a Revisit/Follow up survey completed on 10/29/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.</p>	{A 000}		

Division of Health Improvement LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>10/22/19</b>
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