PRINTED: 02/13/2014 FORM APPROVED

Division of Public and Behavioral Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7908 W. SAHARA AVENUE LAS VEGAS, NV 89117 CALID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX TAQ PROVIDER OR LISC IDENTIFYING INFORMATION PREFIX TAQ CROSS-HEPERINCED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
A ALL WOMEN CARE T908 W. SAHARA AVENUE LAS VEGAS, NV 89117 C(X4) ID PREFIX TAG C(ACH DEFICIENCY MUST BE PRECEDED BY FULL TAG C(ACH DEFICIENCY MUST BE PLANT TAG C(AC			NVS6143OPF	B. WING		10	/22/2013	
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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

TITLE

(X6) DATE