Accepted w/ POC 11/9/12

PRINTED: 10/01/2012
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong Address

(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
O 000	Initial Comments This statement of deficiencies was generated as the result of the state re-permitting inspection that was completed at your facility on 9/18/12, in accordance with Chapter 449 Nevada Administrative Code for Outpatient Facilities. An Infection risk assessment was completed. Ten patient medical records were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	O 000		
O 070 SS=E	Infection Prevention Policies Section 29. Policies for prevention of infection: Each program for the prevention and control of infections and communicable diseases must include policies and procedures to prevent exposure to blood-borne and other potentially infectious pathogens, including, without limitation, policies and procedures relating to: 1. Hand hygiene, including provisions regarding the time and procedure for hand washing with soap and water or the use of an alcohol-based hand rub. (2) Use of gloves:	O 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

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

RECEIVED
OCT 17 2012
BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 (wrong address)

(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
O 070	Continued From page 1 The proper use of medical gloves, including, without limitation, a requirement that each person who works at the outpatient facility must wear medical gloves when the person: (a) Anticipates coming in contact with blood or bodily fluids; (b) Handles contaminated instruments, items and equipment; (c) Handles biological waste or biologically contaminated waste that may cause harm to humans, animals or plants; (d) Handles linens potentially contaminated with biological waste or biologically contaminated waste that may cause harm to humans, animals or plants; and (e) Performs housekeeping activities or cleans contaminated surfaces. (3) Safe injection practices: Safe injection practices to prevent the contamination of equipment used for injections and medication, including, without limitation, a requirement that a new sterile needle and new sterile syringe be used for each patient and not used for more than one patient. (4) Handling of sharps: The proper handling of sharp instruments and the disposal of sharp instruments, which must be consistent with the standards developed by the Occupational Safety and Health Administration of the United States Department of Labor for the handling and disposal of such instruments. (5) Access of medications in vials: Techniques for accessing a vial of medication, which must comply with the requirements set forth in section 30 of this regulation.	O 070		

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong Address

(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
O 070	Continued From page 2 (6) Infusion Medications and tubing: The infusion of intravenous medications, which must provide, without limitation, that intravenous tubing and fluid bags or bottles are not to be used for more than one patient. (7) Sterilization and disinfection of medical equipment: The proper sterilization and disinfection of all medical equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to: (a) Sterilize or ascertain the sterility of items that enter sterile tissue or the vascular system, including, without limitation, surgical instruments, endoscopes, endoscopic accessories, catheters, needles and probes used for ultrasounds; (b) Perform high-level disinfection of reusable items that come in contact with nonintact skin or mucous membranes, including, without limitation, respiratory therapy equipment, anesthesia equipment, bronchoscopes and gastrointestinal endoscopes; and (c) Perform low-level disinfection of reusable items that come in contact with only intact skin, including, without limitation, tourniquets, blood pressure cuffs, linens, stands that are used to hold medical instruments and other furnishings. (8) Handling of equipment: The proper handling of equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to: (a) Sterilize and disinfect reusable items as described in subsection 7; (b) Properly dispose of single-use equipment, instruments and devices after use, if the outpatient facility has decided not to have the equipment, instruments or devices reprocessed;	O 070		

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong addres

(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
O 070	Continued From page 3 and (c) Ensure that: (1) All equipment, instruments and devices that may be reprocessed are reprocessed only by a third-party processor approved by the United States Food and Drug Administration; and (2) No equipment, instruments or devices that may be reprocessed are reprocessed at the outpatient facility. (9) The proper handling and disposal of medical waste and specimens. (10) The proper cleaning and disinfection of all areas in which patient care is provided. (11) The proper maintenance of a clean and sanitary environment. (12) Infection identification and tracking: The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must: (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility; (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and (c) Identify and address trends in such developments and transmissions of infections and communicable diseases. (13) The care of patients with a communicable disease, including, without limitation, patients who are known to have a communicable disease at the time of arrival at the outpatient facility and	O 070		

10/15/2012 AS

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong address

(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
O 070	Continued From page 4 patients who are found to have a communicable disease during the course of treatment at the outpatient facility. (14) The screening for communicable diseases as described in NAC 441A.375 of all employees and of all persons under contract with the outpatient facility who work at the facility and have exposure to patients at the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure post procedures were monitored by the facility for 10 of 10 patient records reviewed. Findings include: Ten patient medical records were reviewed. There was no documented evidence the patient's received a follow up telephone call to identify any signs and symptoms of infection. The infection control Registered Nurse (RN) was unable to provide documentation of tracking post procedural infections. On 9/18/12 at 4:10 PM, the infection control RN acknowledged there was no written documentation of tracking of post procedural infections. Severity: 2 Scope: 2	O 070	See page 23 of our Plan of Corrections	10/15/12
O 090 SS=F	Surgical Equipment Sterilization Section 31.	O 090		

CS 10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 wrong address

(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
O 090	Continued From page 5 Sterilization of Surgical items and equipment: All surgical instruments, items or equipment used in the care of patients at an outpatient facility must be sterilized or disinfected according to the program for the prevention and control of infections and communicable diseases adopted by the outpatient facility pursuant to section 28 of this regulation. (2) If such instruments, items and equipment are sterilized or disinfected by equipment or cleaning agents at the outpatient facility: (a) Before an employee or independent contractor may be assigned the responsibility for sterilizing or disinfecting any instrument, item or equipment, the employee or independent contractor must receive training concerning the instructions of the manufacturer of the device or sterilizer for: (1) Sterilizing and disinfecting the instrument, item or equipment; (2) The use and maintenance of the sterilizer or disinfecting equipment; and (3) The agents used to sterilize and disinfect the instrument, item or equipment. (b) An employee or independent contractor assigned the responsibility for sterilizing or disinfecting the instrument, item or equipment shall: (1) Receive annual training concerning the manufacturer ' s instructions described in paragraph (a); and (2) Receive training on any new equipment or procedures if there is any change in the equipment or procedures used to sterilize or disinfect an instrument, item or equipment. (c) The outpatient facility shall ensure that	O 090		

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 wrong Address

(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
O 090	Continued From page 6 documentation of all training completed pursuant to this subsection is kept in the file of the employee or independent contractor. (3) Manufacturer ' s instructions for equipment: The manufacturer ' s instructions for operating any sterilizer or performing any disinfection procedure must be located or posted near the equipment used for sterilization or disinfection. (4) The outpatient facility shall ensure that each employee or independent contractor follows the manufacturer ' s instructions concerning: (a) The instruments, items or equipment that may be sterilized or disinfected; (b) The procedures for cleaning an instrument, item or equipment before the instrument, item or equipment is sterilized or undergoes high-level disinfection; (c) The procedures for sterilizing or disinfecting an instrument, item or equipment; (d) The operation and maintenance of the sterilizer or the equipment used for high-level disinfection; (e) The frequency and type of biologic indicator testing of the sterilizer; (f) The recommended agents for sterilizing and disinfecting the instrument, item or equipment; and (g) The frequency of testing of any solution for disinfecting to ensure maintenance of the minimum level of effectiveness, but the solution must be tested not less often than daily. (5) Use of biologic indicator tests: The effectiveness of the sterilization procedures must be checked by performing a biologic indicator test: (a) At least weekly, or more frequently if recommended by the manufacturer; and	O 090		

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong address

(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
O 090	Continued From page 7 (b) While sterilizing all implantable devices. (6) Sterilization records and logs of the results of the biologic indicator test must be maintained by the outpatient facility for at least 1 year after the test is performed to ensure that the recommended testing and maintenance of the equipment is performed and the manufacturer ' s instructions regarding proper sterilization techniques are followed. Each outpatient facility shall establish a method to track and recall instruments, items or equipment previously sterilized or disinfected if there is a failure of the biologic indicator test. (7) Physical barriers: To aid in environmental control, each outpatient facility shall provide a physical barrier between the decontamination and sterilization areas of the outpatient facility. This STANDARD is not met as evidenced by: Based on interview, observation, record and document review, the facility failed to assure documentation of specialized training to the medical assistant prior to assuming the duties of sterilization of instruments. (Employee #2). The facility also failed to assure the concentration of MetriCide OPA Plus Solution was verified by a MetriCide OPA Plus Solution Test Strip prior to each use of the solution. Findings include: I) There was no documented evidence found in Employee #2's personnel file of specialized training regarding disinfection and sterilization of	O 090	See Plan of Correction Page 3, 4	10/15/2012

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 wrong address

(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
O 090	Continued From page 8 instruments. On 9/18/12 at 3:50 PM, the Infection Control Registered Nurse acknowledged there was no specialized training for Medical Assistant #1 regarding disinfection and sterilization of the instruments. II) MetriCide OPA Plus Solution (high level disinfection solution) was observed in an examination room. Daily documentation of testing the solution with a MetriCide OPA Plus Solution Test Strip was observed by the GUS Vapor Control System. On 9/18/12 at 2:05 PM, the Registered Nurse explained the MetriCide OPA Plus Solution was tested once a day with the MetriCide OPA Plus Solution Test Strip. The Registered Nurse stated there were four examination rooms with the GUS Vapor Control System. On 9/18/12 at 3:50 PM, the Registered Nurse acknowledged she was not aware the MetriCide OPA Plus Solution required the test strip to be used prior to each use. There was no documented evidence in the GUS Vapor Control Systems Model G10VP Cleaning Protocol a MetriCide OPA Plus Solution Test Strip was required prior to each use of the solution. The High-Level Disinfection - MetriCide OPA Plus Solution sheet documented: "...The concentration of your MetriCide OPA Plus Solution must be verified by a MetriCide OPA Plus Solution Test Strip prior to each use to guard against dilution that may lower the	O 090	See Plan of Correction Page 5	

10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169 Urmy addres

(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
O 090	Continued From page 9 ortho-Phithaladehyde level of the solution below its MRC..." Severity: 2 Scope: 3	O 090		
O 120 SS=F	Policies For Patients & Employee TB testing Section 34. Policies for patients of the facility, professional standards of practice: In addition to the guidelines established pursuant to section 27 of this regulation, the holder of a permit to operate an outpatient facility shall establish guidelines and maintain policies for the outpatient facility which: Ensure the health, safety and well-being of patients of the outpatient facility; (2) Provide the professional standards of practice for services provided by the outpatient facility and ensure that all persons employed by the outpatient facility or under contract with the outpatient facility comply with such professional standards; and (3) Employee TB testing: Require each person employed by the outpatient facility or under contract with the outpatient facility to have a skin test for tuberculosis in accordance with NAC 441A.375. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure 3 of 4	O 120	Plan of correction page 5 and exhibits	10/15/2012

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING _____ B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	3599 S EASTERN AVE LAS VEGAS, NV 89169

(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
O 120	Continued From page 10 employees met the requirements of NAC 441A.375 concerning tuberculosis (TB). (Employees #1, #2 and #3) Findings include: Employee #2 was hired 7/16/12. The employee received the first step TB skin test on 6/19/12. There was no documented evidence the employee received a second-step TB skin test. Employee #3 was hired 8/27/12. The employee received the first step TB skin test on 8/24/12. There was no documented evidence the employee received a second-step TB skin test. Employee #1 had a two step TB skin test on 3/3/11 and 3/10/11. There was no documented evidence an annual TB test was administered. On 9/18/12 at 3:50 PM, the Infection Control Nurse acknowledged the TB skin tests were not administered per policy. Screening employees for communicable disease policy (no identified number) documented: "...If the employee has only completed the first step of a 2-step Mantoux within the preceding twelve months, then the second step of the 2-step Mantoux or other single-step tuberculosis screening test will be administered..." There was no documented evidence found in the Screening employees for communicable disease policy addressing the annual TB skin test requirement. Severity: 2 Scope: 3	O 120	See page 5 of POC and exhibits	10/15/2012

10/15/2012

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	10/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Initial Comments This statement of deficiencies was generated as a result of a self-assessment/attestation questionnaire review. The facility completed the questionnaire on 10/02/2013, and it was reviewed in accordance with Nevada Administrative Code (NAC) Chapter 449, Outpatient Facilities. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No further action is necessary. Please retain a copy of this report for your records.	O 000		

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

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Initial Comments This statement of deficiencies was generated as the result of a state permitting survey that was conducted at your facility on October 22, 2013, in accordance with Nevada Administrative Code (NAC), Chapter 449, Outpatient Facilities: Permit for Services of General Anesthesia, Conscious Sedation and Deep Sedation. An infection risk assessment was completed. Five patient medical charts were reviewed. The findings and conclusions of any investigation by the Health Division shall not be constructed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The facility was found to be in substantial compliance. No further action is necessary. Please retain this Statement of Deficiencies for your records.	O 000		

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

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Initial Comments This statement of deficiencies was generated as the result of a complaint investigation survey that was conducted at your facility on 6/13/14, in accordance with Nevada Administrative Code (NAC), Chapter 449, Outpatient Facilities: Permit for Services of General Anesthesia, Conscious Sedation and Deep Sedation Five patient medical charts were reviewed. Complaint #NV00039454 - The allegation regarding patient medications not being given during a procedure, was not substantiated through clinical record review, interviews with facility staff, and document review. The allegation regarding patient consent not signed prior to a procedure was not substantiated through clinical record review, and interview with facility staff and patient. Allegation the patient should have been discharged by ambulance was not substantiated through clinical record review, interview with facility staff and document review. Allegation the patient was unable to receive a copy of the medical records was unsubstantiated through clinical record review and interview with facility staff. Complaint #NV00039454: The complaint investigative process was initiated by the Division of Public and Behavioral Health on 6/13/14. The investigation for the allegation of patient medications not being given during a procedure included: -Review of five medical records including the patient of concern included physician documentation, recovery room documentation, intra-operative documentation and narcotic	O 000		

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

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Continued From page 1 record. -Interviews were conducted with the Administrator/Physician and Medical Assistant. -Review of Policies and Procedures which included: Voluntary Interruption of Pregnancy Procedures Policy (no identified policy number), updated 08/2013. The investigation for the allegation of patient consent not signed prior to the procedure included: -Review of five medical records including the patient of concern included physician documentation and consents. -Interview was conducted with the Administrator/Physician. The investigation for the allegation the patient should have been discharged by ambulance included: -Review of five medical records including the patient of concern included physician documentation and consents. - Interviews were conducted with the Administrator/Physician and Medical Assistant. -Review of Policies and Procedures: 2014 Clinical Policy Guidelines, National Abortion Federation, page 39, number 13. Complications: Bleeding and Return of Patient to the Procedure Room Policy (no identified policy number), updated 08/2013. The investigation for the allegation the patient	O 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Continued From page 2 was unable to receive a copy of the medical records included: -Review of five medical records including the patient of concern included physician documentation. Medical records were provided to the patient on 6/2/14. -Interview was conducted with the Administrator/Physician. The findings and conclusions of any investigation by the Health Division shall not be constructed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No further action is necessary. Please retain a copy for your records.	O 000		

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS6143OPF	A. BUILDING: _____ B. WING _____	06/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A ALL WOMEN CARE	7908 W. SAHARA AVENUE LAS VEGAS, NV 89117

(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
O 000	Initial Comments This statement of deficiencies was generated as the result of a state permitting survey that was conducted at your facility on June 29, 2015, in accordance with Nevada Administrative Code (NAC), Chapter 449, Outpatient Facilities: Permit for Services of General Anesthesia, Conscious Sedation and Deep Sedation. Five patient medical charts were reviewed. The findings and conclusions of any investigation by the Health Division shall not be constructed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The facility was found to be in compliance. No further action is necessary. Please retain this Statement of Deficiencies for your records.	O 000		

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