

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS6143OPF	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2015
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NAME OF PROVIDER OR SUPPLIER A ALL WOMEN CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7908 W. SAHARA AVENUE LAS VEGAS, NV 89117
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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
O 000	<p>Initial Comments</p> <p>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.</p> <p>Five patient medical charts were reviewed.</p> <p>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.</p> <p>The facility was found to be in compliance. No further action is necessary. Please retain this Statement of Deficiencies for your records.</p>	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 _____