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<br><br>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.<br><br>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.<br><br>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<br><br>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.<br><br>An infection risk assessment was completed.<br><br>Five patient medical charts were reviewed.<br><br>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.<br><br>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