

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS7982OPF	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAFE AND SOUND FOR WOMEN, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3131 LA CANADA #110 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 000	<p>Initial Comments</p> <p>This statement of deficiencies was generated as the result of an initial State Permitting Survey that was conducted at your facility on 8/29/14 and finalized on 9/4/14, in accordance with Nevada Administrative Code (NAC), Chapter 449, Outpatient Facilities: Permit for Services of General Anesthesia, Conscious Sedation and Deep Sedation.</p> <p>One mock clinical record was reviewed.</p> <p>The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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.</p> <p>The facility was found in compliance with the regulations for Outpatient Facilities, please retain this copy 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