

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS6143OPF</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>A ALL WOMEN CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7908 W. SAHARA AVENUE LAS VEGAS, NV 89117</b>
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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><b>Initial Comments</b></p> <p>This statement of Deficiencies was generated as a result of a State Permit Renewal Survey conducted in your facility on 5/10/16, in accordance with Nevada Administrative Code, Chapter 449, Outpatient Facilities.</p> <p>Five patient records were 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 to be in substantial compliance. No further action is necessary with this survey. 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 \_\_\_\_\_