Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4576HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 09/01/2010 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SAINT ROSE DOMINICAN HOSPITAL - SAN M. | STREET ADDRESS, CITY, STATE, ZIP CODE 8280 W WARM SPRINGS ROAD LAS VEGAS, NV 89113 | | |

| (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 |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 9/1/10 and finalized on 9/2/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital.<br><br>Complaint #NV00026326 was unsubstantiated.<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 regulatory deficiencies were identified. | S 000 | | |

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