

Brian Sandoval
Governor

MICHAEL J. WILLDEN
Director



RICHARD WHITLEY, MS
Administrator

TRACEY D. GREEN, MD
State Health Officer

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

Health Facilities/Lab Services
727 Fairview Dr, Suite E
Carson City, Nevada 89701
(775) 684-1030
Fax (775) 684-1073

Health Facilities/Lab Services
4220 S. Maryland Parkway
Suite 610, Building D
Las Vegas, NV 89119
(702) 486-6516
Fax (702) 486-6520

Radiation Control
4150 Technology Way
Suite 300
Carson City, Nevada 89706
(775) 687-7650
Fax (775) 687-7652

Radiation Control
2080 E. Flamingo
Suite 319
Las Vegas, Nevada 89119
(702) 486-5280
Fax (702) 486-5024

April 5, 2011

Ms. Jacqueline Diasio, Administrator
Visiting Angels
1701 N Green Valley Pkwy #9A
Henderson, NV 89074

Re: Focused State Re-licensure Survey

A Focused State Re-licensure Survey was conducted at your facility on March 24, 2011 and finalized on March 29, 2011. There were no deficiencies cited. Therefore no further action is required.

Retain this letter for your files.

Should you have any questions concerning this matter, please contact our office at (775) 626-3286.

Sincerely,

M. Jeanne Hesterlee RN

M. Jeanne Hesterlee, RN, Health Facility Surveyor III
For Wendy Simons, Bureau Chief

Enclosures: 1 page Statement of Deficiencies & Plan of Correction

WS/af

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5291PCA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2011
NAME OF PROVIDER OR SUPPLIER VISITING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N GREEN VALLEY PKWY #9A HENDERSON, NV 89074		
(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
P 000	<p>Initial Comments</p> <p>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.</p> <p>This Statement of Deficiencies was generated as a result of the Focused State Relicensure survey conducted in your agency on 3/24/2011 to 3/29/2011. The Focused State Relicensure survey was conducted at your agency by authority of Chapter 449, Personal Care Agencies.</p> <p>The patient census was 502. Fifteen client records were reviewed. One client home visit was conducted. Five client telephone interviews were conducted. Twelve employee files were reviewed.</p> <p>Reviewed the following documentation: Complaint/Incident logs; Agency Policies and Procedures; Infection Control Policies and Training; PCA Training Materials; New Client Packet and Agency Marketing Brochures; PCA Evaluations and Supervisor's Visits to Client's Homes.</p> <p>No regulatory deficiencies were identified.</p>	P 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