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
	4830	A. BUILDING _____ B. WING _____	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIDS FIRST	**5245 E BONANZA ROAD, LAS VEGAS, NEVADA ,89110**

(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) COMPLETION DATE
OOOO	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. This Statement of Deficiencies was generated as a result of the on-site State licensure survey conducted at your facility. There were no regulatory deficiencies identified at the time of the survey. Inspector Comments: Reminders: Facility previously licensed for 227 but remeasured for 209 children. Contact State fire to change Certificate of Compliance.9-27 mo playground: fix latch, Pre-K playground: fill sink hole, remove garbage amd lock on door needs repair. Emergency Plan needs correction. Need log for fire/disaster drills and carpets. First Aid kit needs eye wach, triangular bandage. Child Records need Kids First name. Manju needs TB test.	OOOO		

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 Name: Title: Date: