STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295108	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver State Pediatric Skilled Nursing Facility	2496 W Charleston Blvd Las Vegas, NV 89102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure 1) sanitizer test strips were available to measure the concentration of the sanitizing solution of the three-compartment sink, 2) the refrigerator and nourishment room did not contain expired food items and 3) dented cans were discarded. The deficient practice had the potential to compromise food safety and cause foodborne illness.Findings include:1)On 02/24/2026 at 8:30 AM, the Dietary Manager was unable to perform the test strip verification for the threeˆcompartment sink because the facility had run out of test strips. The Dietary Manager could not verify the parts per million (ppm) concentration without the required test strips. The Dietary Manager indicated test strip verification for the threeˆcompartment sink should have been performed daily.A review of the threeˆcompartment sinks sanitation log dated 02/24/2026 showed documentation indicating the test strip verification had been completed that morning. When questioned about the discrepancy, the Dietary Manager acknowledged the entry was incorrect and stated it should have been dated 02/23/2026.The facility policy titled SSP SNF Sanitization, revised September 2025, documented when chemical sanitizing solutions used in the three-compartment sink, the sanitizer concentration shall be verified using manufacturer-appropriate test strips.2)On 02/25/2026, at 9:53 AM, the Cook, indicated expired food could lead to crossˆcontamination and may cause harm to both individuals and residents. The cook verbalized, I'm not sure how we missed the expired food. On 02/25/ 2026, at 10:25 AM, the Dietary Manager indicated any expired food must be thrown away upon discovery. The Dietary Manager indicated they did not want to risk making the children sick, and consuming expired food can result in crossˆcontamination.3)On 02/25/2026 at 9:53 AM, the [NAME] indicated when a canned food item was dented, it may have been compromised or partially opened, which allowed contaminants such as dirt or bacteria to enter the product. The [NAME] explained dented canned food must be removed from use and discarded to prevent illness.On 02/25/2026 at 10:30 AM, Dietary Manager stated any dented canned food must be removed from the kitchen because the can was considered damaged. The Dietary Manager explained dented cans could become crossˆcontaminated, may leak, and because they were made of aluminum, an opening or crack could allow unknown contaminants to enter the product. The Dietary Manager emphasized such items could cause illness, and therefore, they are immediately discarded to ensure food safety.The facility policy titled SSP SNF food receiving and storage, revised September 2025, documented all food items must be inspected prior to acceptance. The facility will reject any food product show evidence of contamination, damage, or temperature abuse; dented cans, especially dents located on seams or rims and expired products.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed for the use of a helmet device for a resident with plagiocephaly (malformation of cranial bones) for 1 of 12 sampled residents (Resident 22). The deficient practice placed the resident at risk for skin breakdown and discomfort.Findings include:Resident 22 (R22) was admitted [DATE], with diagnoses including respiratory failure of a newborn, laryngomalacia (collapse of floppy tissue above vocal cords) chromosomal abnormality and plagiocephaly.On 02/24/2026 in the morning, R22 was asleep inside a crib wearing a blue helmet device.On 02/26/2026 at 8:25 AM, R22's eyes were opened with blue helmet on while strapped in a bouncy chair. The Registered Nurse (RN) assigned to R22 explained the resident's skull did not form well so the helmet was being used as a supportive device. The helmet was removed for one hour per day where nurses were able to assess the skin underneath. According to the RN, the orthotist provider (professionals who specialize in designing, fitting, and creating orthotics supportive devices which support weakened body parts) routinely measured R22's head circumference.A physician consult note dated 11/06/2025, interpreted R22's brain magnetic resonance imaging (MRI) showed agenesis corpus callosum (a congenital brain defect where the structure connecting the left and right hemispheres were partially or completely absent). R22 needed a helmet for plagiocephaly.A physician order dated 01/08/2026, documented plagiocephaly helmet to be worn 23 hours a day; one hour break daily. This break should be during shower time. If no shower for the day, the helmet should still be removed and cleaned during the one-hour break. Make sure the helmet and hair were dried before putting back on. Every shift for plagiocephaly helmet/head should be cleaned with CeraVe baby shampoo. May use alcohol wipes to clean helmet. Do not use other soaps, shampoos, or wipes on helmet.The medication administration record (MAR) for January 2026 and February 2026 reflected the physician order for care and management of R22's head and helmet device was transcribed into the electronic MAR (e-MAR) but the signature boxes were blank from 01/08/2026 to 02/26/2026.On 02/26/2026 at 10:46 AM, the RN reviewed R22's e-MAR and confirmed the physician order for R22's helmet use was transcribed into R22's e-MAR but the entries were blank from 01/26/2026 through 02/26/2026. The RN explained the orders were entered under therapy orders and were unable to be seen by nursing who were responsible for carrying out the task. The RN stated not being able to speak for other nurses assigned to R22 but this RN personally documented R22's helmet treatment services in the nursing daily assessment.A three-day lookback of daily nursing assessments revealed nurses assigned to R22 on 02/23/2026, 02/24/2026 and 02/25/2026, lacked documentation physician orders to remove R22's helmet for one hour along with specific instructions to clean R22's head and helmet device was performed.On 02/26/2026 at 10:52 AM, an occupational therapist (OT) familiar with R22 explained when supportive devices such as helmets were delivered to the facility, therapy would initiate its use on the residents. In R22's case, therapy staff would put on the helmet device for a couple of hours for the first few days progressively increasing helmet wear until tolerance reached the goal of 23 hours. According to the OT, once R22 could tolerate 23 hours, therapy or nursing would then obtain an order from the orthotist, and the order would be entered into electronic health record (EHR) by either discipline. The OT confirmed the removal of the helmet was a nursing task and therapy staff members do not document any services in the e-MAR.On 02/26/2026 at 11:27 AM, the nurse assessment coordinator (NAC) explained removing R22's helmet was the duty of the certified nursing assistants (CNA) who were unable to document in the e-MAR but rather documented in the point of care (POC) observation. The task of cleaning R22's head and helmet could be performed by either the CNAs or licensed nurses. The NAC provided the POC report for February 2026 which revealed R22's helmet was cleaned daily.The POC task created on 01/05/2026, documented instructions for CNAs to clean orthotic helmet. Clean inner and outer portions of orthotic helmet daily with Cerave baby wash and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allow to dry fully before putting back on resident. Alcohol wipes can be used after washing with Cerave baby wash for odor control, disinfecting, and increase drying speed.The POC observation report lacked documented evidence the physician order to remove R22's helmet for one hour was performed or followed.On 02/26/2026 at 11:51 AM, the Director of Nursing (DON) explained the physician order for care and management of R22's helmet was transcribed into R22's EHR under therapy orders which resulted in nurses not being able to view the order and sign off on the task or service. The DON emphasized nursing was responsible for ensuring R22's helmet was removed for one hour and the head and helmet were cleaned as ordered. The DON confirmed the e-MAR from 01/08/2026 to 02/26/2026 was blank or unsigned by any nurse.On 02/26/2026 at 11:54 AM, the DON explained the POC observation report only addressed the cleaning of R22's helmet and did not address the rest of the order, specifically, ensuring the helmet was off for one hour and cleaning the resident's head. The DON indicated nurses who performed this task should have been documenting this in the daily nursing assessments. The DON confirmed the daily nursing assessments lacked documented evidence physician order for R22's helmet was performed on 02/23/2026, 02/24/2026 and 02/25/2026.On 02/26/2026 at 11:59 AM the DON verbalized expecting physician orders to be carried out as written and documented in the resident's EHR. The DON explained the purpose of the helmet was to help cranial remodeling for R22's plagiocephaly. The DON stated consequences of not following physician order may lead to skin breakdown and over-correction (wearing too long could cause sutures to overlap). The facility's Medication and Treatment Orders policy revised January 2026, documented medication and treatment orders shall be administered and carried out.The facility's Documentation of Medication Administration policy revised August 2025, revealed medication administration record was used to document all medications administered. All medications administered to each resident were documented in the residents' MAR.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure the resident's tube feeding (TF) bag was labeled with complete and accurate information for 1 of 12 sampled residents (Resident 3). The deficient practice had the potential to result in TF-related complications.Findings include: Resident 3 (R3) was admitted on [DATE], with diagnoses including Trisomy nine mosaic syndrome (a rare chromosomal disorder causing developmental, intellectual and physical disabilities), tracheostomy status and gastrostomy status.On 02/24/2026 in the morning, R3 was in the dining area on a stander (a supportive equipment used in physical therapy to help individuals with neurologic or mobility issues) with a physical therapist (PT). The PT indicated R3 received nutrition through a gastrostomy tube (G-tube). A physician order dated 12/11/2025, documented to administer Complete pediatric formula original 1.0 formula, 250 milliliters (ml) at 250 ml per hour four times a day.On 02/24/2026 at 9:34 AM, a tube feeding (TF) bag with liquid brown contents was connected to a tubing threaded through a pump. A sticker label affixed to the TF bag included the resident's name, room number, name of staff member who prepared the TF bag and indicated the TF bag was prepared on 02/24/2026 at 0000 (12:00am). The label information regarding formula contents, date and time the formula was hung and expiration date and time was left blank.On 02/24/2026 at 9:47 AM, the Licensed Practical Nurse (LPN) assigned to R3 explained the staff member who signed the sticker label as the preparer of the TF formula was a night shift nurse. The LPN clarified the night shift nurse hung an empty TF bag on the pole and affixed a sticker label which reflected the night nurse had prepared the TF bag on 02/24/2026 at 12:00 AM when in fact, it was the LPN themselves who poured R3's formula into the bag on 02/24/2026 at 7:30 AM this morning. The LPN acknowledged the sticker label on R3's TF bag was not only inaccurate but lacked pertinent information such as formula contents, date and time feeding was initiated, expiration date and time and the staff who initiated the feed.On 02/24/2026 at 9:54 AM, the Director of Nursing (DON) entered R3's room and confirmed the sticker label on the TF bag did not contain accurate information because it reflected the night nurse prepared the formula at midnight. In the DON's presence, the LPN acknowledged pouring R3's prescribed TF formula into the bag and initiated enteral feeding at 7:30AM this morning. The DON stated the LPN should have been the one to complete the sticker label which included resident's name, room number, formula contents and fortifier/additives if applicable, staff who prepared with dated and time, staff who initiated feed and date and time. The DON confirmed the sticker label on R3's TF bag was inaccurately and incompletely filled.The facility's Pediatric Enteral Tuber Feeding via Continuous Pump policy reviewed December 2025, documented to check the enteral nutrition label against the order prior to administration. Check the following information: Resident name, room number, type of formula, date and time formula was prepared, route of delivery, method (pump, gravity, syringe), rate. On the formula label document initials, date and time formula was hung/administered and initial the label was checked against the order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure an inhalation bag for BIPAP (bilevel positive airway pressure machine) use was dated for 1 of 12 sampled residents (Resident 3). The deficient practice placed the residents at risk for compromised quality care. Findings include:Resident 3 (R3) was admitted on [DATE], with diagnoses including Trisomy nine mosaic syndrome (a rare chromosomal disorder causing developmental, intellectual and physical disabilities), chronic respiratory failure, tracheostomy status and gastrostomy status On 02/24/2026 in the morning, R3 was in the dining area on a stander (a supportive equipment used in physical therapy to help individuals with neurologic or mobility issues) a white gauze was observed on R3's neck area.A physician order dated 11/14/2025, documented Mode: BIPAP/Bilevel 23/+14 with back up rate of 14 every night shift by respiratory therapy.On 02/24/2026 at 9:34 AM, a ventilator machine labeled RT management only was observed on the left side of R3's crib. The machine was off, a 2,000 milliliter (ml) bag of inhalation solution which was half empty was hanging by the ventilator machine. The bag was not labeled and dated.On 02/24/2026 at 9:39 AM, a respiratory therapist (RT) explained R3 had already been decannulated (the permanent, planned removal of a tracheostomy tube from a patient's neck once they can breathe independently followed by closure of the stoma) and used the ventilator machine for BIPAP treatment (non-invasive treatment for breathing disorders to assist with breathing and improve Oxygen levels) at night. The RT indicated not being certain how long an inhalation bag was good for and confirmed R3's inhalation bag was not dated.On 02/24/2026 at 9:40 AM, the RT Director entered R3's room and explained R3 was weaned off the ventilator and had already been decannulated but used the ventilator machine for BIPAP treatments at night. The RT Director indicated the bag should have been dated with initials otherwise other staff would not know when the bag was due for replacement. The RT Director indicated the bags were good for 30 days once opened per manufacturer. The RT Director explained the heater chamber along with water provided humidity to residents to prevent mucous plugs. On 02/24/2026 at 10:03 AM, the Director of Nursing (DON) confirmed the inhalation bag was not labeled and dated. The DON indicated expecting all patient care medications and supplies must be labeled with staff initials and date because all medication and supplies have a standard protocol on when to discard or replace the bag.The facility's Equipment Change and Cleaning policy updated February 2026, documented schedule and procedures for respiratory equipment cleaning and replacement were performed to ensure proper infection control, equipment function and resident safety. Humidification equipment such as sterile ventilation inhalation water bags shall be changed as needed or when empty.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and document review, the facility failed to ensure the ice machine did not have brown-colored build up and was not overdue for vendor maintenance. This deficient practice may result in contamination of ice intended for consumption.Findings include:On 02/25/2026 at 9:56 AM, the [NAME] indicated the kitchen staff only cleaned and wiped the exterior surfaces of the ice machine and did not clean the interior components. The [NAME] indicated the outside and edges of the ice machine were cleaned daily, but the inside of the machine was not cleaned as part of their routine.On 02/25/2026 at 10:23 AM, the Dietary Manager indicated staff cleaned only the bottom portion of the ice machine and did not clean the top portion. The Dietary Manager explained an outside service provider was responsible for cleaning the upper section of the ice machine. The Dietary Manager could not provide documentation when the last deep cleaning of the interior components was completed. The Dietary Manager was unaware of the schedule or frequency of internal cleanings. A sticker on the machine indicated a date of 09/16/2025. The Dietary Manager acknowledged the brown buildup observed inside the machine appeared to originate from the upper internal section.The facility policy titled SSP SNF food receiving and storage, revised September 2025, documented when cleaning fixed equipment (e.g., mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts were a) washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing(at the effective concentration); and b) the equipment was reassembled and any food contact surfaces that may have been contaminated during the process are re-sanitized.