DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR CARE	**5408 TOPAZ STREET, LAS VEGAS, NEVADA ,89120**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility between 05/14/21 and 05/18/21, in accordance with Nevada Administrative Code 449, Residential Facilities for Groups. The facility was licensed for 10 Residential Facilities for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. The sample size was two employee and three resident files. One complaint was investigated. Complaint #NV00063841 with two allegations was investigated with two allegations unsubstantiated. Allegation #1 - Misappropriation of property was found to be unsubstantiated based on record review of text messages asking the complainant to retrieve the resident's possessions. Allegation #2 - Admission, Transfer & Discharge Rights was found to be unsubstantiated based on a record review of discharge documents. The resident was discharged to another qualified facility after five instances of non-payment/returned checks, and requirement of more advanced care of the resident. The resident's condition and size were also considered in the transfer. Due to the size of the resident, they always required at least two staff members to provided care. The investigation into the allegations included: Interviews with one staff member and the owner. Review of two staff files. Review of admission agreements and text messages between the facility and the complainant. Observations around the facility of care provided by the staff to all residents and storage of resident personal belongings. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.

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	relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is required at this time. Please retain this Statement for your records.			