STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3888	A. BUILDING _____ B. WING _____	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR CARE HAVEN 2	4353 JODI AVE, 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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 08/11/26. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files and five employee files were reviewed. The facility received a grade of A.			

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Y 0104 SS= D	**NAC 449.200** **Personnel files** (1) (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 4 employees completed the required five-year renewal of fingerprints and background check (Employee #3). Finding include: Employee #3 (E3) was hired on 09/14/98 as the Administrator. Review of E3's file revealed a clearance letter dated 07/12/2021; however, the file lacked documented evidence E3 had completed the required five-year renewal of fingerprints and background check. On 08/11/2026 in the morning, the Administrator acknowledged the background check had expired and had not completed the required renewal of their fingerprints and background check. Severity: 2 Scope: 1	Y 0104	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation pertaining to employee background check, a fingerprint was performed. 2. What measures or systematic change will be put will be put into place to ensure the deficient practice does not recur? The administrator of the facility will maintain the personnel records and audit and update files constantly so that all requirements will be met and carried on at all times. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? All documents will be maintained in the employees file and will be available at anytime.The administrator takes responsibility to ensure employees file will be available at all times. 4.The title of the person responsible for ensuring the plan of correction is implemented. The administrator of the Joyful Senior Care Haven 2 is responsible. 5. The date the corrective action will be completed. The corrective action was completed on August 27, 2026. 6. You must attach all supporting documents into the system. ATTACHMENT (1) 7. How you will identify and correct other areas having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	08/27/2026

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	3888	A. BUILDING _____ B. WING _____	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL SENIOR CARE HAVEN 2	4353 JODI AVE, 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
Y 0995 SS= F	**NAC 449.2756 andR043-22** (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times Inspector Comments: Based on observation and interview, the gate leading to the street and the gate leading to the pool were unsecured. Findings include: On 08/11/26 in the morning, the gate in the side yard, which lead to the street was unsecured. The gate in the backyard leading to the pool was unsecured. On 08/11/26 in the morning, the Administrator acknowledged the gates were unsecured and should have been locked. Severity: 2 Scope: 3	Y 0995	1. How will you correct the specific finding stated in the statement of deficiencies? In order to become compliant with the regulation, the administrator of Joyful Senior Care Haven 2 locked the gate in the front gate and pool gate on the day of the survey. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator takes responsibility to ensure gates on front gate and pool gate be locked at all times. The administrator will check daily so that facility is in compliance with the regulations. 3. How the corrective action will be monitored to ensure the deficient practice will not recur? The administrator will check the gates daily so that facility is in compliance with regulations. 4. The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date of corrective action will be completed. The corrective action was completed on August 12, 2026. 6. You must attach all supporting documents. ATTACHMENT (2) 7. How will you identify and correct other areas having potential to e affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	08/12/2026

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Y 1825 SS= D	**NAC 449.0109 Designation and training of person responsible for infection control.** 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training.	Y 1825	1. How you will correct the specific findings stated in the statement of deficiencies? In order to become compliant with regulation, Employee #2 and Employee #3 have 15 hours of infection control trainings. 2. What measures or systematic changes will be put into place to ensure the deficient practice does not recur? The administrator of Joyful Senior Care Haven 2 will maintain all trainings of each employee and audit and update the files constantly so that all requirements will be met and carried on in timely manner. 3. How the corrective action will be monitored to ensure the deficient practice does not recur? The administrator of the facility will maintained the personnel records for each employee and audit and update the files so that all requirements will be met and carried on in timely fashion. 4. The title of the person responsible for ensuring the plan of correction is implemented? The administrator is responsible 5. The date of corrective action will be completed. The corrective action was completed on August 18, 2026. 6.You must attach all supporting documents into the system. ATTACHMENT (3) 7.How you will identify and correct other areas having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	08/18/2026

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	Inspector Comments: Based on record review and interview, the facility failed to ensure the primary and secondary infection control managers completed 15 hours of annual infection control training (Employee #2 and #3). Employee #2 (E2) was hired on 04/20/00, as the secondary infection control manager. E2 completed infection control training on 04/25/24. E2's file lacked documented evidence of annual infection control training. Employee #3 (E3) was hired on 09/14/98, as the primary infection control manager. E3 completed infection control training 01/17/24. E3's file lacked documented evidence of annual initial infection control training. On 08/11/26 in the morning, the Administrator confirmed E2 and E3 had not completed annual infection control training for. Severity: 2 Scope: 1			
Y 1840 SS= D	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves;	Y 1840	1. How you will correct the specific findings stated in the Statement of Deficiencies? In order to become compliant with the regulation, Employee #1 and Employee #4 has infection control training for unlicensed caregiver. 2. What measures or systematic change will be put into place to ensure the deficient practice does not recur? The administrator will maintain the personnel records for each employee and audit and update the files constantly so that the facility is in compliance with the regulation. 3. How the corrective action will be	08/25/2026

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	(c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the agency failed to ensure infection control training, for unlicensed caregivers, was completed for 2 of 4 employees (Employee #1 and #4). Employee #1 (E1) was hired on 06/29/09, as a Caregiver. E1 completed infection control training for unlicensed caregivers on 04/27/24. E1's file lacked documented evidence of annual infection control training. Employee #4 (E4) was hired on 08/01/25, as a Caregiver. E4's file lacked documented evidence of initial infection control training for unlicensed caregivers. On 08/11/26 in the morning, the Administrator confirmed E1 and E4 had not completed annual infection control training for unlicensed caregivers. Severity: 2 Scope: 1		monitored to ensure the deficient practice will not recur? The administrator takes responsibility on maintaining employees files and audit and update files so that requirements will be met and carried on at all times. 4, The title of the person responsible for ensuring the plan of correction is implemented. The administrator is responsible. 5. The date the corrective action will be completed. The corrective action was completed on August 25, 2026. 6. You must attach all supporting documents into the system. ATTACHMENT (4) 7. How you will identify and correct other areas having the potential to be affected by the same practice? All residents have the potential to be affected by the alleged practice. The specific corrective action adequately addresses other residents.	