STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285117	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Center-Valhaven, LLC	300 West Meigs Street Valley, NE 68064

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Licensure Reference Number 175 NAC 12-006.04 Based on interview and record review, the facility failed to check the nurse aid registry for 2 of 5 sampled employee files. The facility census was 54. The findings are: Record review of the facility policy titled Staffing Requirements dated 09-2024 revealed for employment eligibility the facility must maintain evidence of registry checks. A check for adverse findings must include the following registries: Nurse Aide Registry, Adult Protective Services Central registry, Central Registry of Child Protective Services and the Sex Offender Registry. Record review of the facility policy titled Background Investigations dated 10-10-2025 revealed the facility will not employ individuals who have a finding entered in the state nurse aide registry concerning abuse, neglect, exploitation, misappropriation of property, or mistreatment by court of law. Record review of Housekeeper (HK) A's employee file revealed a hire date of 07-15-2025 and the absence of a nurse aid registry check. Record review of Nursing Assistant (NA) B's employee file revealed a hire date of 05-05-2025 and the absence of a nurse aid registry check. An interview conducted with the Nurse Consultant (NC) on 08-11-2025 at 2:00PM confirmed the nurse aide registry was not checked for HK A and NA B and should have prior to working directly with the residents in the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Arbor Care Center-Valhaven, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Meigs Street Valley, NE 68064	

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Licensure Reference Number 175 NAC 12-006.02(H) Based on observation, interview, and record review, the facility failed to notify the State Agency of an alleged elopement within the required time frame for 1 (Resident 17) of 1 sampled resident; and the facility failed to submit the written report for a resident-resident altercation within 5 days for 1 (Resident 5) of 1 sampled resident. Findings are:A.

An observation on 8/6/2025 at 12:12PM revealed Resident 17 had attempted to push open an exit door. Resident 17 had a wander guard (a wander management system designed to protect residents at risk of wandering in senior living communities) around their right ankle.

A record review of Resident 17's Minimum Data Set (MDS – a federally mandated standardized data assessment tool that measures health status in nursing home residents) revealed Resident 17 had a BIMS (Brief Interview for Mental Status – a federally mandated tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) of 7 indicating Resident 17 had severely impaired cognition (the mental process of acquiring knowledge and understanding). The MDS revealed Resident 17 uses a wheelchair.

A record review of Resident 17's Care Plan revealed Resident 17 eloped (left the facility without authorization) out of the 200 Hall exit on 7/9/2025.

A record review of a Progress Note dated 7/9/2025 at 11:45PM written by Registered Nurse RN J revealed Resident 17 had exited the facility through the back door.

A record review of the Elopement report revealed it was called to APS (Adult Protective Services) PM 7/10/2025 at 2:25PM.

An interview on 8/12/2025 at 2:52PM with the Director of Nursing (DON) confirmed the report was not called in at the time of the elopement because the DON was asleep when the floor nurse informed them via text of the elopement.

B.

Record review of Resident 5's admission Record printed 8/7/2025 revealed the facility admitted the resident on 8/27/2008 and identified the resident had diagnoses that included cerebral palsy (a disability resulting from damage to the brain before, during, or shortly after birth and outwardly manifested by muscular incoordination and speech disturbances), dysarthria (difficulty articulating words due to disease of the central nervous system), paranoid schizophrenia (a mental illness characterized especially by delusions of persecution, grandiosity, or jealousy and by hallucinations [such as hearing voices] chiefly of an auditory nature), generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities (e.g., work or school performance) that occurs more days than not, for at least 6 months), and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Arbor Care Center-Valhaven, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Meigs Street Valley, NE 68064	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 5's annual MDS assessment dated [DATE] identified the resident had a BIMS of 10 of 15. According to the MDS manual, a score of 10 indicated the resident had moderately impaired cognitive function. Record review of a 5-day investigation involving Resident 5 identified a resident-to-resident interaction occurred on 3/10/2025 where Resident 5 struck the right upper arm of another resident. Record review of e-mail submission of the 5-day investigation showed the investigation was not transmitted to the State Agency (SA) until 3/17/2025, six days after the date of the incident. An interview on 8/11/2025 at 11:42 AM with the Administrator confirmed the 5-day report was not sent to the SA until 3/17/2025 and should have been submitted no later than 3/14/2025. Review of facility policy entitled Abuse, Neglect and Exploitation dated September 2022 revealed: Policy Explanation and Compliance Guidelines: -2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations of suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. -VII. Reporting/Response -A. The facility will have written procedures that include: -1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: -a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or -b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. -B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(G)(ii) Based on interview and record review, the facility failed to provide a report to the receiving facility for an emergency transfer for 2 (Residents 4 & 40) of 2 sampled residents and the facility failed to notify the Ombudsman of transfer for 4 (Residents 1, 40, 54 & 58) of 4 sampled resdients. Findings are:A. An interview on 8/7/2025 at 10:03am with Resident 3 revealed they were admitted to hospital on [DATE] for significant hypoxia (shortness of breath) and chest pain. A record review of Resident 3's medical chart did not reveal a progress note confirming the Ombudsman had been notified of the resident discharge. B. An interview on 8/6/2025 at 11:41AM with Resident 54 revealed they were admitted to hospital in June 2025 for kidney issues. A record review of a provider progress note dated 6/6/2025 revealed Resident 54 had been hospitalized for pneumonia. A record review of Resident 54's medical chart did not reveal a progress note confirming the Ombudsman had been notified of the resident discharge. C. An interview on 8/7/2025 at 9:15AM with Resident 1 revealed they were in hospital. A record review of Resident 1's progress notes revealed a note by Registered Nurse (RN) K dated 6/5/2025 revealed Resident 1 was sent to the emergency room due to right sided weakness and altered mental status. A record review of Resident 1's medical chart did not reveal a progress note confirming the Ombudsman had been notified of the resident discharge. D. A closed record review of Resident 58's Electronic health record revealed the resident had discharged home on 7/18/2025. A record review of Resident 58's medical chart did not reveal a progress note confirming the Ombudsman had been notified of the resident discharge. An interview on 8/12/25 at 11:15pm with Social Services Director confirmed they were not aware the ombudsman needed to be notified of any resident discharges from the facility, and they did not send notifications of discharge for Resident 1, Resident 3, Resident 54, and Resident 58. (continued on next page)

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	285117	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Center-Valhaven, LLC	300 West Meigs Street Valley, NE 68064

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Transfer and Discharge Policy, dated September 2022 revealed the following: Section 12. Emergency Transfers/Discharges - h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. E. Record review of Resident 40's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-22-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status was scored as a 2. According to the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment. -had a recent surgery for a hip fracture. -required total assistance with hygiene, toileting, dressing, bathing, dressing, and transfers. Record review of Resident 40's Progress Note dated 06-11-2025 revealed Resident 40 was transferred to the hospital. Record review of Resident 40's Progress Notes dated 06-11-2025 and 06-12-2025 did not indicate the Ombudsman had been notified of the transfer. An interview with the Director of Nursing (DON) on 08-12-2025 at 1:33PM confirmed the Ombudsman had not been notified of the transfer on 06-11-2025 and should have. A record review of the facility's Transfer and Discharge Policy, dated September 2022 revealed the following: Section 12. Emergency Transfers/Discharges - h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review and interview, the facility failed to accurately enter pressure ulcer information on the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) for 1 (Resident 6) of 20 residents sampled. The facility staff identified a census of 54.The findings are:Record review of an undated facility policy entitled MDS 3.0 Completion revealed: -4. Care Plan Team Responsibility for Assessment Completion: -a. Interdisciplinary Responsibility for Completion of MDS Sections: -ii. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. -b. Coding of Assessment: -i. All disciplines shall follow the guidelines in Chapter 3 of the current RAI manual for coding each assessment.Record review of Centers for Medicare and (&) Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual) dated October 2023 revealed: -Step 3: Determine Present on admission -For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.Record review of Resident 6's admission Record printed 8/11/2025 revealed the facility admitted the resident on 1/29/2021 and identified diagnoses that included pressure ulcer of the right buttock, stage 3.Record review of Resident 6's Weekly Wound Evaluation (WWE) dated 3/26/2023 identified the resident had a new pressure ulcer to the right buttock that was first identified on 3/26/2023. Further review of the WWE identified the pressure ulcer was identified by the facility as in-house acquired.Record review of Resident 6's Wound Treatment Plan (WTP) dated 4/8/2025 identified the skin breakdown to the right buttock is recurrent in nature. Further review of the WTP showed that the wound was resurfaced (healed).Record review of Resident 6's WTP dated 4/22/2025 identified the right buttock wound had reopened on 4/22/2025.Record review of Resident 6's annual MDS dated [DATE] revealed a Stage 3 pressure ulcer that was present on admission.An interview on 8/12/25 at 11:32 AM with the Nurse Consultant (NC) confirmed the pressure ulcer on the MDS was incorrectly coded as present upon admission or reentry.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

Licensure Reference Number 175 NAC 12-006.9(I) Based on observation, interview and record review, the facility failed to ensure hot water was kept away from vulnerable residents in the dining room which had the potential to effect 1 (Resident 40) of 23 sampled residents; and the facility failed to implement interventions to prevent falls for 1 (Resident 40) of 1 sampled resident. Findings are:A.

An observation of the dining room on 8/6/25at 12:45PM revealed the kitchen staff had prepared a cart for the dirty dishes with 3 plastic tubs of water that had visible steam rising from the surface. The cart was in the dining room beside the doorway leading to the dishwashing room. A dining table was on either side of the cart. Resident 44 was seated at the table to the left of the cart. Resident 44 was observed to be independently mobile with a walker.

An observation on 8/6/25 at 12:50PM of Dietary Aide (DA) N temperature testing the water in the tubs the dishes. The temperatures were 150.9 degrees, 158.7 degrees and 161.1 degrees. The DA moved the cart to inside the dishwashing station.

An interview on 8/6/25 at 12:50PM with DA N, confirmed they had prepared the tubs with the soapy hot water. DA N confirmed they use very hot water to help dissolve the leftover food on the plates. The DA N confirmed the residents in the dining room could reach the hot water as it was located outside of the kitchen door leading to the dishwashing station. The DA N confirmed that the hot water could cause a lot of damage to an elderly persons' skin.

An interview on 8/6/25at 12:55PM with the Dietary Manager confirmed they aware that the kitchen staff used a cart with soapy hot water in tubs to place the dirty dishes after meals. DM confirmed (gender) was aware the cart was in the dining area outside the kitchen door and confirmed that the reported hot water temperatures sounded about right. The DM confirmed that the hot water was accessible to the residents who were in the dining room and could pose a risk of burns to the residents.

An interview on 8/6/25 at 1:20PM with Nurse Aide L (NA) revealed (gender) sat with residents who needed help during meals. NA L confirmed Resident 44 could have reached the hot water as it was close to their table. NA L stated Resident 44 would be most at risk because Resident 44 is mobile, has dementia and was sitting closest to the water. NA L confirmed it is not the nurse aides' task to monitor the hot water.

An interview on 8/6/25 at 1:30PM with NA M confirmed (gender) had been seated at the assisted dining table in the dining room for the lunch service. NA M confirmed they were not aware the tubs held hot water. NA M confirmed they did not know if any of the residents seated near the tubs on the cart were mobile and/or confused.

An interview on 8/6/25 at 1:45PM with Registered Nurse (RN) J confirmed (gender) were seated at the assisted dining table helping residents during lunch. RN J confirmed the nursing staff were not responsible for monitoring the hot water dishes. RN J confirmed Resident 44 was the most mobile and confused person sitting near the hot water. RN J confirmed (gender) were not aware that it was very hot water.

A record review of the Dietary Aide duties provided by the DM revealed there are two dietary aides on for AM and two for PM shift. Clearing the dish cart is the responsibility of the dietary aides.

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NAME OF PROVIDER OR SUPPLIER: Arbor Care Center-Valhaven, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 West Meigs Street Valley, NE 68064	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There are no specific instructions relating to the collection and/or presoaking of dirty dishes. B. Record review of Resident 40's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-22-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status was scored as a 2. According to the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment. -had a recent surgery for a hip fracture. -required total assistance with hygiene, toileting, dressing, bathing, dressing, and transfers. Record review of Resident 40's Comprehensive Care Plan (CCP) dated 11-02-2023 revealed Resident 40 was at risk for further falls related to severe cognitive impairment, psychoactive drug use, and poor safety awareness. The CCP also listed dates of previous falls: -11-13-24 on floor in front of wheelchair in the common area -04-17-2025 on the floor in room -06-01-2025 fall out of wheelchair -06-11-2025 on floor sitting between bed and roommates bed resulting in a fractured left femur. The goal was falls will be minimized and managed through the next review date. Interventions listed were bed in low position, reapproach to assist with transfers if the resident becomes agitated, dycem (a non-slip material that keeps objects from sliding or rolling) to the top and bottom of the wheelchair cushion, red tape to wheelchair brakes, therapy to evaluate and treat as indicated for left hip fracture, medication review, ensure resident is wearing appropriate footwear when transferring and a tilt wheelchair. An observation conducted on 08-07-2025 at 12:52 PM revealed Resident 40 was sitting in a tilt wheelchair in the dining room, wearing gripper socks and there is no red tape present on the wheelchair brakes. An observation on 08-11-25 at 6:00 AM revealed Resident was in bed, wheelchair was next to bed with no dycem on the top or the bottom of the wheelchair cushion and there was no red tape on the wheelchair brakes. An observation conducted with Nursing Assistant (NA) P and Medication Aide (MA) G on 08-12-2025 at 6:50 AM in Resident 40's room confirmed dycem was not present on the top and the bottom of the wheelchair cushion and red tape was not present on the brakes of the tilt wheelchair. An interview was conducted with MA G during the observation at 08-12-2025 at 8:00 AM revealed MA G had no knowledge of Resident 40 needing dycem or tape to the wheelchair brakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Registered Nurse (RN) I on 08-12-2025 at 9:20 AM confirmed Resident 40 was to have dycem to the top and the bottom of the wheelchair cushion and confirmed the brakes on the tilt wheelchair should have red tape on the brakes. A follow-up interview was conducted on 08-12-2025 at 11:00 AM with RN I that confirmed the dycem to the wheelchair cushion and red tape to the wheelchair brakes were not in place and have been replaced. Record review of the facility policy titled Fall Prevention and Fall Leaf Program dated 02-2023 revealed the purpose of the policy was to ensure fall risks are identified and interventions are implemented in an effort to prevent falls, as possible, and to maintain a safe environment for each resident of the facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Licensure Reference Number 175 NAC 12-006.04 Based on record review and interview the facility failed to ensure staff were tested for competency of clinical skills for 5 (Medication Aides (MA) E, F, and G, Licensed Practical Nurse (LPN) H, and Registered Nurse (RN) I)of 5 sampled nursing staff files. The facility census was 54. The findings are:Record review of MA E 's employee file revealed a hire date of 09-24-2019, and no record of competency testing for clinical skills. Record review of MA F's employee file revealed a hire date of 07-24-2019, and no record of competency testing for clinical skills. Record review of MA G's employee file revealed a hire date of 04-20-2016, and no record of competency testing for clinical skills. Record review of LPN H employee file revealed a hire date of 03-17-2025 and no record of competency testing for clinical skills. Record review of RN I's employee file revealed a hire date of 04-10-2024 and no record of competency testing for clinical skills. An interview with the Nurse Consultant (NC) on 08-12-2025 at 11:30 AM confirmed competency testing of clinical skills had not been conducted in the last year. Record review of the facility policy dated 09-2022 titled Training Requirements revealed it is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff. Competencies and skill sets for all new and existing staff must be consistent with their expected roles. Documentation of required training will be placed into the individual's personnel file.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Licensure Reference Number 175 NAC 12-006.09 Based on observation, interview, and record, review the facility failed to develop and implement a behavioral management plan for 1 (Resident 12) of 1 sampled resident. The facility census was 54. The findings are:Record review of Resident 12's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-10-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 7. According to the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment.-had physical behavior symptoms directed toward others 1-3 days a week.-had verbal behavior symptoms directed toward others 4-6 days a week.-resident's behavior puts the resident at significant risk for physical illness or injury.-resident's behavior significantly interferes with the resident's care.-residents behavior significantly interferes with the resident's participation in activities or social interactions.-resident's behavior significantly disrupts care or living environment.-resident's behavior symptoms have worsened.-required partial assistance with toileting, bathing, and dressing.-required set-up and supervision with eating and hygiene.-was independent with bed mobility, transfers and ambulation. Record review of Resident 12's Comprehensive Care Plan (CCP) dated 04-18-2025 revealed a focus area of Resident-to-resident altercation:-4-18-25 Resident-to-resident altercation, Resident 12 was hit in the left leg by another resident resulting in Resident 12 hitting the other resident back.-07-01-25 Resident-to-resident altercation, Resident 12 hit another resident in the stomach and the other resident hit Resident 12 on the left side of the face.-7-04-2025 Resident-to-resident altercation, Resident 12 hit another resident on the left upper arm-unprovoked. Guardian indicated Resident 12 can act out when (gender) doesn't get (gender) wants.-8-03-2025 Resident-to-resident altercation, Resident 12 hit another resident on the hand during the noon meal because the other resident was repeatedly tapping his fingers on the table.The goal identified on the CCP was Resident 12 will not hit another resident through the review date. Interventions on the CCP revealed the following:-04-18-2025 residents were immediately separated from each other, assessments completed, no injury observed. Offer 1-to-1, activities if agitated.-04-18-2025 encourage Resident 12 to go to nursing staff when there is a concern with other residents.-07-01-2025 discussed with Resident 12 to talk with staff if (gender) needs to express something and if needed go to (gender) room to be clear of busy areas at times of increased frustration.-07-06-2025 residents were immediately separated. Resident 12 went to their room to play with toys and Resident 12 was educated on voicing concerns or frustration with staff, and it was not appropriate to touch other residents.-07-06-2025- social services contacted Resident 12's guardian to get a psychiatric evaluation.-08-03-2025 do not sit by the other resident during meals and activities. Record review of Resident 12's Progress Notes (PN) dated 10-28-2024 revealed Resident 12's guardian had returned a call to the facility and was updated that Resident 12 hit another resident. Record review of the facility's investigation into the resident-to-resident altercation on 10-18-2024 revealed the preventative measure put into place by the facility was Resident 12 had a 1-to-1 conversation with the Director of Nursing (DON) on the importance of not striking out at others, Resident 12 was able to acknowledge what (gender) was wrong and apologized. The other resident involved was talked to about the importance of talking to the charge nurse with concerns about other residents and to try not to correct other residents on their own. Record review of Resident 12's An observation on 08-07-2025 at 12:00PM revealed Resident 12 was sitting at (gender)assigned table which places (gender) back to the aisle between 2 sets of tables. An observation on 08-11-2025 at 12:00 PM revealed Resident 12 sitting at (gender) assigned table in the dining room and (gender) was sitting away from the table enough to cross legs which (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Arbor Care Center-Valhaven, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 West Meigs Street Valley, NE 68064	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encroaches on aisle between the tables. An observation with the DON and the Nurse Consultant (NC) on 08-12-2025 at 11:30 AM of Resident 12's assigned seat in the dining room revealed Resident 12's seat placed (gender) back to the aisle between 2 tables and Resident 12 was sitting away from the table to cross legs which places Resident 12 in the aisle. A follow-up interview was conducted with the DON and NC on 08-12-2025 at 11:40 AM revealed the facility did not identify the triggers of Resident 12's aggressive behavior and had not considered moving Resident 12's assigned seat in the dining room to reduce the occurrence of those triggers. An interview with the DON on 08-12-2025 at 12:00 PM confirmed the same intervention of educating Resident 12 about going to the staff when frustrated was used after repeated aggressive behavior and confirmed that a behavior management plan had not been developed to include non-pharmacological interventions and environmental adjustments. Record review of the facility policy titled Behavior Management Plan dated 02-2020 revealed residents who exhibit behavioral concerns may require a behavior management plan to ensure they are receiving appropriate services and interventions to meet their needs. The interdisciplinary team, including the family member, should develop a behavioral plan for each resident with identified behaviors on the MDS. A behavior management plan can include a schedule of daily life events, which addresses the individuality of the resident. The plan should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Licensure Reference Number 175 NAC 12-006.04(B) and 175 NAC 12-006.04(B)(ii). Based on interview and record review, the facility failed to ensure that 2 (Nurse Aides (NA) D, and Medication Aide (MA) F) of 8 sampled staff files had ongoing abuse training; and failed to ensure ongoing dementia training for 5 (NA D, MA E, F, G, Licensed Practical Nurse (LPN) H) of 8 sampled staff files. The facility census was 54. The findings are: Record review of Nursing Assistant (NA) D's employee file revealed a hire date of 07-02-2024, and no record of abuse or dementia training. Record review of Medication Aide (MA) E 's employee file revealed a hire date of 09-24-2019, and a Course Completed History (CCH) dated 06-04-2025 revealed 5.75 hours of ongoing training was completed from 01-13-2024 to 08-06-2025 and only 1 hour of dementia training was completed. Record review of MA F's employee file revealed a hire date of 07-24-2019, and a Course Completed History (CCH) dated 06-04-2025 revealed 1.25 hours of ongoing training was completed from 03-14-2024 to 08-06-2025 with 1 hour of dementia training completed and no abuse training was recorded. Record review of MA G's employee file revealed a hire date of 04-20-2016, and a Course Completed History (CCH) dated 06-04-2025 revealed 1.0 hours of ongoing training was completed from 02-29-2024 to 08-06-2025 and no dementia training was completed. Record Review of Licensed Practical Nurse (LPN) H's employee file revealed a hire date of 03-17-2022 and no record of dementia training in the last year. An interview with the Nurse Consultant (NC) on 08-11-2025 at 2:30 PM confirmed NA D and MA F did not have annual abuse training, and NA D, MA E, MA F, MA G, and LPN H did not have 4 hours of ongoing dementia training. Record review of the facility policy dated 09-2022 titled Training Requirements revealed it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff consistent with their expected roles. Training requirements should be met prior to staff providing services to the residents, annually and as necessary based on the facility assessment. The training includes dementia management and care of the cognitively impaired and abuse, neglect and exploitation prevention. Record review of the facility policy dated 09-2024 titled Training revealed each employee must receive ongoing training to ensure competency and continued compliance with regulations and facility policy. This training must include 4 hours of dementia care if the licensee cares for residents with Alzheimer's Disease or Dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285117	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Center-Valhaven, LLC	300 West Meigs Street Valley, NE 68064

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(i)(ii)1 Based on interview and record review the facility failed to ensure nursing assistants had 12 hours of on-going training per year for 2 (Nurse Aide (NA) C, and D) of 2 sampled nursing assistant files. The facility census was 54. The findings are: Record review of NA C's employee file revealed a hire date of 07-22-2022, and a Course Completed History (CCH) dated 06-04-2025 revealed 10 hours of ongoing training was completed from 01-03-2024 to 08-06-2025. Record review of NA D's employee file revealed a hire date of 07-02-2024, and no documentation of on-going training. An interview with the Nurse Consultant (NC) conducted on 08-11-2025 at 2:30 PM confirmed NA C and NA D did not complete 12 hours of ongoing training annually. Record review of the facility policy dated 09-2024 titled Training revealed the facility must provide initial and ongoing training designed to meet the needs of the resident population. Ongoing training of nurse aides must consist of 12 hours per year on topics appropriate to the employee's job duties, including meeting the physical, psychosocial, and mental needs of the residents.