STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to issue the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 as required for 2 (Residents 10 and 33) of 3 sampled residents. Findings:A.Record review of a facility-completed document titled, SNF Beneficiary Notification Review for Residents who received Medicare Part A services, revealed the following:Resident 10's Medicare Part A skilled services started on 8/2/25.Their last covered day of Part A services was 10/16/25.The facility initiated Resident 10's discharge from Part A services when benefit days were not exhausted.The same document also revealed that a NOMNC, Form CMS-10123 was not provided and should have been. B.Record review of a facility-completed document titled, SNF Beneficiary Notification Review for Residents who received Medicare Part A services, revealed the following:Resident 33's Medicare Part A skilled services started on 10/27/25.Their last covered day of Part A services was 11/12/25.The facility initiated Resident 33's discharge from Part A services when benefit days were not exhausted.The same document also revealed that a NOMNC, Form CMS-10123 was not provided and should have been.An interview with the Business Office Manager on 1/13/26 at 8:30 AM confirmed that Resident 10 and 33 did not receive the NOMNC, Form CMS-10123, and should have.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 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(B)Based on record review and interview, the facility failed to accurately code an active diagnosis 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 4) of 12 sampled residents. The facility census was 27.Findings Are: A record review of the facility policy MDS Assessment Coordinator dated November 2019 revealed each individual who completes a portion of the assessment must certify the accuracy of that portion of the MDS. A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated October 2025 revealed that active diagnoses are defined as Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. A record review of Resident 4's admission Record dated 1/12/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of acquired absence of right leg below knee. An interview on 1/11/2026 at 9:29 AM with Resident 4 revealed the resident's right lower leg had been amputated and the resident was unable to walk due to this. A record review of an Office Clinic Note Physician for Resident 4 dated 8/26/2025 revealed documentation of the resident having a history of a below the knee amputation. A record review of Resident 4's quarterly MDS dated [DATE] revealed no evidence of an active diagnosis related to their below the knee amputation. A record review of a hospital Discharge Summary for Resident 4 dated 10/9/2025 revealed the resident was evaluated by a physician; the documentation included that the resident had a history of a below the knee amputation to the right leg. A record review of Resident 4's quarterly MDS dated [DATE] revealed no evidence of an active diagnosis related to their below the knee amputation. An interview on 1/14/26 at 9:15 AM with the Director of Nursing confirmed that Resident 4's amputation was not included in their active diagnoses on their MDS's despite it affecting their daily activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E) Based on record review, observation, and interview; the facility failed to ensure the care plan was comprehensive for 3 (Residents 2, 4 and 18) of 12 sampled residents. The facility census was 27.A. A record review of Resident 2's face sheet revealed they were admitted on [DATE] and had diagnoses including hyponatremia (low sodium levels in the bloodstream), dementia (a progressive loss of memory, language, and other mental abilities), anxiety, and hypertension (high blood pressure). A record review of Resident 2's physician orders revealed they were taking the medication buspirone 5 milligrams (mg) twice daily for, negative statement to self, verbalizes sadness, related to anxiety disorder. A record review of Resident 2's physician orders revealed they were taking the medication citalopram 40 mg daily for, negative statement to self, verbalizes sadness, related to anxiety disorder. A record review of Resident 2's physician orders revealed they were taking the medication quetiapine 50 mg daily for, res displays extreme anxiety about surroundings and self, related to their dementia. A record review of Resident 2's progress notes revealed the following: - In a note dated 11/7/25 at 1:36 PM Resident 2 was verbally fighting with another resident and required redirection by a nurse. - In a note dated 11/12/25 2:23 AM Resident 2 was noted to be more anxious in the evenings and could not do any self-directed activity, with Resident 2 stating they did not know what to do with themself. Resident 2 also used the call light repeatedly and required redirection by staff. - In a note dated 11/17/25 at 8:53 PM Resident 2 was noted to have increased agitation with yelling. - In a note dated 12/2/25 at 8:33 PM Resident 2 had increased agitation and nervousness after supper and used their call light frequently. - In a note dated 12/3/25 at 8:56 PM Resident 2 continued to have increased confusion, anxiety, and agitation after supper, used the call light frequently, and expressed anger with staff. The note also revealed that staff spent time one to one with Resident 2, but it did not help. - In a note dated 12/20/25 9:10 PM Resident 2 was unable to verbalize to the staff what they wanted but stated they felt nervous. - In a note dated 12/22/25 10:49 PM Resident 2 stated they were miserable, and exhibited behaviors including raising the bed to the highest level and swinging the call light around. - In a note dated 12/31/25 8:33 PM Resident 2 used the call light repeatedly after being put to bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was noted by the nurse to have increased anxiety on other evenings as well. - In a note dated 1/10/26 at 9:52 PM Resident 2 used the call light repeatedly while in bed, then stated they were not sure what they wanted when a staff member responded. An interview on 1/14/26 at 8:17 AM with Registered Nurse-D (RN-D) revealed Resident 2 had dementia and obsessive-compulsive disorder. In addition, Resident 2 frequently yelled out during the night, and argued with their roommate. They required frequent redirection and reassurance from staff, preferred to be in a bed near the window, and wanted the divider curtain open to prevent feeling isolated or having anxiety from being in a small space. A record review of Resident 2's care plan revealed no mention of Resident 2's behaviors as described in the progress notes, or interventions related to dementia or anxiety. An interview on 1/14/2026 at 10:22 AM with the Director of Nursing (DON) confirmed the resident displayed the behaviors described in the progress notes. The interview also revealed the resident frequently woke up during the night and yelled out as if having a bad dream and that a light was left on to help assuage fear. Resident 2 also preferred to have personal items laid out on a bedside table in a particular way and had a specific routine that provided comfort to them. The interview also confirmed that Resident 2's care plan did not contain the goals or interventions to address anxiety or dementia diagnoses, or interventions for negative behaviors exhibited by Resident 2. B. A record review of the facility policy Care Plans, Comprehensive Person-Centered dated March 2022 revealed a policy statement of A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A record review of Resident 4's admission Record dated 1/12/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of acquired absence of right leg below knee. A record review of an Office Clinic Note Physician for Resident 4 dated 8/26/2025 revealed documentation of the resident having a history of a below the knee amputation. A record review of a hospital Discharge Summary for Resident 4 dated 10/9/2025 revealed the resident was evaluated by a physician; the documentation included that the resident had a history of a below the knee amputation to the right leg. An interview on 1/11/2026 at 9:29 AM with Resident 4 revealed the resident's right lower leg had been amputated and the resident was unable to walk due to this. The resident stated they would like to have a prosthesis so they could walk again but that they had not received one. A record review of Resident 4's undated Care Plan revealed the following sentence in the activity involvement problem section: (Resident 4) has had an amputation of part of their right leg. There were no goals or interventions in this section related to the amputation. Further review of the remainder of Resident 4's Care Plan revealed no other mention of their amputation or interventions in place related to the amputation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 1/14/26 at 9:15 AM with the DON revealed Resident 4 had expressed a recurring desire to obtain a prosthesis for their right leg. The DON stated that the resident was not a candidate for the prosthetic because they did not meet the physical strength criteria and because their skin was very fragile and small injuries, such as scratches, were difficult to heal on their lower extremities. The DON revealed that the facility did address the resident's desire for a prosthetic each time the resident brought it up and had the resident re-assessed to confirm their ineligibility, with the most recent time being within the last couple of months. The DON confirmed that the amputation did affect Resident 4's daily life and that this information was currently relevant and should have been in the care plan for staff reference. C. A record review of Resident 18's admission Record dated 1/14/2026 revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Major Depressive Disorder (MDD, 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). A record review of Resident 18's quarterly MDS dated [DATE] revealed the resident had a diagnosis of depression and was taking antidepressant medication. A record review of Resident 18's physician's orders revealed the resident was taking sertraline (an antidepressant) daily for major depressive disorder. The order had a start date of 11/1/2025. A record review of Resident 18's undated Care Plan revealed no evidence of the resident's MDD diagnosis or their need for interventions related to this diagnosis. An interview on 1/14/2026 at 10:44 AM with the DON confirmed there were no care plan interventions or goals related to their MDD diagnosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285250	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ponderosa Villa	755 First Street Crawford, NE 69339

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Licensure Reference Number 175 NAC 12-006.04(B)(ii) Based on record review and interview, the facility failed to ensure 3 of 5 sampled Nurse Aides (NA) completed the required 12 hours of ongoing training per year, including 4 hours of dementia care training, based on their date of hire. The facility census was 27.Findings Are: A record review of an untitled and undated, facility-provided, document revealed the following employee hire dates:-NA-A was hired on 6/7/2024,-NA-B was hired on 4/19/2024, and-NA-C was hired on 9/22/2023. A record review of a document titled NA-A's Training revealed that between 6/7/2024 and 6/7/2025, NA-A completed 7.5 hours of ongoing training, none of which were related to dementia care. A record review of a document titled NA-B's Training revealed that between 4/19/2024 and 4/19/2025, NA-B completed 9.5 hours of ongoing training, none of which were related to dementia care. A record review of a document titled NA-C's Training revealed that between 9/22/2024 and 9/22/2025, NA-C did not complete any ongoing training hours. An interview on 1/13/26 at 7:50 AM with the Administrator confirmed NA-A, NA-B, and NA-C had not completed the required amount of ongoing annual training hours.