

**Department of Health and Human Services  
Division of Public Health, Licensure Unit  
Disciplinary Action Notices  
Issued Against Health Care Facilities and Services**

January 1, 2020 to January 31, 2020

<b>Facility Type Facility Name</b>	<b>Date of Disciplinary Action Notice</b>	<b>Type of Disciplinary Action</b>	<b>Terms of Disciplinary Action</b>	<b>Date of Certification Action Notice</b>	<b>Type of Certification Action</b>	<b>Terms of Cert Decision</b>	<b>Basis for Action</b>	<b>Informal Conf</b>	<b>No Appeal</b>	<b>No Appeal</b>
<b>Assisted Living</b>										
Edgewood Omaha Senior Living, LLC - Omaha	1/27/2020	Proh on Adm Probation	until corrected extended to 180 days				The facility failed to ensure background checks are completed on all staff and continued failure to ensure medications are kept secured when not in use.			
<b>Total: 1</b>								0	0	0
<b>Nursing Home</b>										
Belle Terrace - Tecumseh	1/16/2020	Fine Probation	\$1,000.00 90 days				The facility failed to provide sufficient staffing to meet the residents' needs including restorative services to prevent a decline in mobility and ambulation and response to residents.			
Parkview Home - Dodge	1/27/2020	Proh on Adm Probation	until corrected to continue				The facility failed to develop and implement an Emergency Preparedness Plan that included measures for failure of the heating and air conditioning systems. The facility continued to fail to provide a clean, safe and homelike environment by having portable heaters in the hallways. The facility continued to fail to ensure only authorized staff had access to medications.			
Premier Estates of Kenesaw, LLC - Kenesaw	1/8/2020	Proh on Adm Probation	until corrected extended to 180 days				The facility failed to 1) screen new employees for criminal background checks; 2) complete required PASARR screens on residents; 3) provide assistance with bathing; 4) provide enough staff to provide basic Activity of Daily Living (ADL) assistance to residents such as bathing, dining and restorative services; and 5) maintain accurate medical records. In addition, the following new deficient practices were found: 1) failure to update resident care plans to accurately reflect the residents needs for use of side rails and suicidal ideation; 2) failure to provide restorative nursing interventions to prevent a decline in range of motion for residents.			

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<b>Nursing Home</b>										
River City Nursing and Rehabilitation - Omaha	1/8/2020	Probation Proh on Adm	to continue to continue				The facility failed to ensure medications were administered to resident(s) per physician's orders resulting in hospitalization for the resident(s).			
<b>Total: 4</b>								0	0	0
<b>Grand Total: 5</b>								0	0	0