STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS, Attorney General,	)	
Plaintiff,	)	**PETITION FOR DISCIPLINARY ACTION**
vs.	)	
MEGAN L. WIECK, N.H.A. AND N.H.A. PRECEPTOR,	)	
Defendant.	)	

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 38-176 (Reissue 2016) and 38-186 (Cum. Supp. 2020).

2. At all times relevant herein, the Defendant, Megan L. Wieck, has been the holder of a nursing home administrator license (#2700) and a nursing home administrator preceptor certificate (#408) issued by the Department of Health and Human Services Division of Public Health ("Department").

3. In November 2021, the Defendant applied for and was issued a license to administer more than one nursing home (#108) by the Department. The license remained active until Legacy Garden Rehabilitation & Living Center (LGR&LC) in Pender, Nebraska, closed in May 2022.

4. In May 2022, the Defendant applied for and was issued another license to administer more than one nursing home (#115) by the Department. The license remained

active until the Elms Health Care Center (EHCC) in Ponca, Nebraska, closed in November 2023.

5. The Department is the agency of the State of Nebraska authorized to enforce the laws of Nebraska regulating the practice of nursing home administration.

6. The Nebraska Board of Nursing Home Administrators considered the investigations into these matters and made disciplinary recommendations to the Attorney General, which recommendations have been considered. Such matters are privileged pursuant to Neb. Rev. Stat. §§ 38-1,105 and 38-1,106 (Reissue 2016).

7. On or about May 2021, the Defendant became employed as the Administrator at EHCC in Ponca, Nebraska, where she remained employed through June 2023.

8. From on or about November 2021, Defendant worked as a dual nursing home administrator at EHCC and LGR&LC in Pender, Nebraska, until the latter nursing home closed in mid-May 2022.

9. Thereafter, from on or about May 2022, the Defendant worked as a dual nursing home administrator at Hillcrest Care Center ("HCC") in Laurel, Nebraska, and EHCC, until she resigned from EHCC in late June 2023.

10. On or about March 10, 2025, the Defendant resigned from HCC, which then closed its doors in April 2025.

11. Pursuant to § 38-2404 of the Nursing Home Administrator Practice Act ("Act"), codified at Neb. Rev. Stat. §§ 38-2401 to 38-2426, "Administrator" or "Nursing Home Administrator" is defined as "any individual who meets the education and training requirements of section 38-2419 and is responsible for planning, organizing, directing,

and controlling the operation of a nursing home or an integrated system or who in fact performs such functions, whether or not such functions are shared by one or more other persons."

12. Section 38-2407 of the Act defines "Certified Preceptor" as "a person who is currently licensed by the State of Nebraska as a nursing home administrator, has three years of experience as a nursing home administrator, has practiced within the last two years in a nursing home, and is approved by the Department to supervise an administrator-in-training or a person in a mentoring program."

13. Pursuant to §38-2419(3) of the Act, an Administrator who is responsible for and overseeing the operations of a licensed facility or an integrated system is subject to disciplinary action against her license for any regulatory violations.

14. Pursuant to 175 NAC 12 section 006.02 (2024), as the Nursing Home Administrator, the Defendant is responsible for the overall management of the facility and must be responsible for and oversee the operation of a facility in compliance with Neb. Rev. Stat. § 38-2419. An administrator must:

> (A) Ensure compliance with statutes and regulations;
> (B) Plan, organize, and direct responsibilities delegated to the administrator by the licensee;
> (C) Maintain liaison, through meetings and period report, among the governing body, medical and nursing staff, and other professional and supervisory staff of the facility;
> (D) Protect and promote residents' health, safety and well-being;
> (G) Ensure the facility staff identify and review incidents and accidents, Resident complaints and concerns, patterns and trends in overall facility operation such as provisions of resident care and service and take action to alleviate problems and prevent reoccurrence.
> (H) Ensure that a report is made on any alleged abuse of a resident by a staff member, volunteer, family member, visitor, or any other person to Adult Protective Services or local law enforcement as directed in the Adult Protective Services Act... All alleged abuse must be investigated and residents protected from further abuse throughout the investigation.

(l) Ensure the establishment of a quality assurance/performance improvement committee and that the recommendations of the committee are addressed.

15. In December 2021, six months after becoming the Administrator at EHCC, the Defendant failed to ensure that appropriate and specific behavioral interventions were in place to protect residents from potential sexual abuse by a resident with a long history of adverse behaviors.

16. In December 2021, the Defendant failed to ensure an investigation into allegations of potential sexual abuse by a fellow resident with a long history of adverse behaviors was conducted and failed to ensure a completed investigation and report of investigative findings was submitted to the State Agency within the required time frame.

17. In June 2022, the long-term EHCC business manager, L.Z., retired. In August 2022, the Defendant hired A.F. for the dual position of Business Office Manager and Social Services Director. A.F. had no prior experience in financial management, but Defendant agreed to train and supervise A.F. in her business management job duties, which included billing and insurance claims, accounts receivable, accounts payable, payroll, and resident accounts.

18. On or about August 11, 2022, L.L. was admitted as a resident at EHCC. The Defendant failed to train and supervise A.F, the Business Manager. As a result, Medicare was not billed for L.L.'s care from August 11, 2022, through October 5, 2022, resulting in lost revenue from Medicare in the amount of $15,848. After his Medicare benefits expired, L.L. became a private pay patient until he qualified for Nebraska Medicaid on April 1, 2023. The Defendant failed to train and supervise A.F. on resident billing, and, as a result, EHCC did not bill L.L. for services rendered from October 5, 2022,

through March 31, 2023, resulting in a loss of income of over $20,000 to EHCC. The Defendant failed to train and supervise A.F. on Medicaid billing. Medicaid was not billed for LL's care until June 2023, resulting in additional loss of revenue to EHCC.

19. In October 2022, two EHCC residents eloped. An unannounced State survey visit to EHCC revealed the Defendant failed to ensure:

> (a) A Medical Director was on staff to coordinate medical care for facility residents;
> (b) The facility had a full time Director of Nursing;
> (c) A Quality Assessment and Assurance committee met quarterly, and the Director of Nursing and Medical Director participated as required;
> (d) Staff were checking wander alert door devices to ensure proper functioning;
> (e) The facility Elopement Evaluation quantitatively assessed all residents to accurately and consistently assess individual elopement risk;
> (f) The facility had wander alarm devices and straps available at all times in the event a resident became a risk for elopement; and
> (g) Facility had ongoing interventions in place to prevent resident elopements.

20. As a result of the State survey, EHCC received an immediate jeopardy tag and additional F-tags. The Owner of EHCC asked Defendant to submit to DHHS a timely request for an Informal Dispute Resolution. The Owner also asked Defendant five times between January 2023 and April 2023 to send requested facility documents to the attorney's office to prepare for the IDR process. Defendant never filed the IDR and never sent the requested documents to the attorney. CMS imposed a $9,750.00 civil money penalty on EHCC.

21. In December 2022, the Defendant hired G.F., as Dietary Manager, who did not hold the required credentials to serve as Director of Food and Nutrition Services and had no formal education in food service management. The Defendant failed to ensure

G.F. took and passed the required dietary management course necessary to become certified.

22. A dietary report dated April 13, 2023, prepared by the registered dietician consultant reported the EHCC kitchen was not being cleaned and maintained properly, a current menu was not posted in the kitchen, the posted menu was not being followed, no menus were posted for residents, meals cards were not being used, no substitution log, no alternatives were offered to residents, and large amounts of prepackaged foods were being served to residents.

23. The Defendant failed to monitor and supervise G.F., who did not follow physician-prescribed diets, failed to use proper handwashing and gloving techniques to prevent food contamination, and failed to clean and sanitize kitchen utensils. In April 2023, the State cited EHCC for multiple dietary deficiencies, including failing to provide residents with meals according to the food code and failure to ensure foods and/or menus met the dietary needs of residents.

24. Between June 2022 and June 2023, the Defendant failed to train and supervise A.K., the EHCC business manager, and EHCC's Medicare Quarterly Credit reports for five quarters, resulting in suspension of the provider agreement.

25. Between July 1, 2022, the Defendant failed to train and supervise A.K., the Business Manager, on Medicare Part A and Part B billing, resulting in no Medicare billing being submitted from July 1, 2022, through June 30, 2023.

26. The Defendant failed to train and supervise the EHCC Business Manager on how to follow up on Medicaid denials, resulting in cancellation of reimbursements.

27. Between January 2023 and June 2023, the Defendant failed to train and supervise the EHCC business manager, resulting in electric bills not being paid in full and late penalties totaling $1,133.40 being incurred:

2/16/23	Penalty	$234.44
3/26/23	Penalty	$152.45
4/17/23	Penalty	$166.52
5/16/23	Penalty	$318.81
6/16/23	Penalty	$261.18

28. Between March 2023 and June 2023, the Defendant failed to train and supervise the EHCC business manager on accounts payable, resulting in vendor invoices going unpaid. The garbage company cut off EHCC from collection; the consulting pharmacy cut off services for nonpayment; W.B. canceled EHCC's workers' compensation insurance due to an overdue audit; NCMIC canceled EHCC's insurance; G.S. sent EHCC to collections, A.H. threatened EHCC with legal action, and M., the medical records vendor, placed EHCC on suspension.

29. Between July 1, 2022, and June 30, 2023, the Defendant failed to train and supervise the EHCC business manager on the payment of federal unemployment insurance taxes, resulting in EHCC incurring $34,889.21 in penalties and interest:

9/30/22	Failure to file penalty	$1,898.85
9/30/22	Failure to pay penalty	$ 382.58
9/30/22	Failure to make proper tax deposit penalty	$1,895.78
9/30/22	Interest charges	$ 566.78
12/31/22	Failure to file penalty	$6,084.12

12/31/22	Failure to pay penalty	$ 811.22
12/31/22	Failure to make proper tax deposit penalty	$2,881.40
12/31/22	Interest charges	$1,230.91
3/31/22	Failure to file penalty	$8,506.50
3/31/23	Failure to pay penalty	$ 709.22
3/31/23	Failure to make proper tax deposit penalty	$4,725.83
3/31/23	Interest charges	$1,067.68
6/30/23	Failure to make a proper tax deposit penalty	$4,128.34

30. The Defendant failed to train and supervise the ECHH business manager, resulting in the Nebraska Department of Revenue (NDOR) assessing an income tax withholding penalty against EHCC in the amount of $1,320.00 and income tax withholding interest in the amount of $154.80 for the 2022 and 2023 tax periods. NDOR also increased EHCC's unemployment insurance rate from 0.2% to 5.4% due to untimely reporting.

31. By June 2023, the Defendant had charged $28,000.00 on the EHCC Owner's personal credit card for facility purchases and had failed to pay the account off in each month, resulting in accrued interest and late penalties.

32. By June 2023, the Defendant had charged or allowed EHCC staff to charge the entire credit limit on the EHCC business credit card and failed to make any payments.

33. After the Defendant resigned her position at EHCC in June 2023, she paid herself $6,540.63 for two full years of paid time off despite taking substantial time off while receiving her full salary.

34. While serving in the capacity as Administrator, the Defendant sent the EHCC Owner a photograph of her standing beside an aged and vulnerable male resident diagnosed with a neurocognitive disorder wearing the Defendant's short tennis skirt.

35. At all relevant times, HCC had an Abuse-Neglect-Exploitation policy that stated, "It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property . . . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur."

36. On or about January 16, 2025, the Defendant became aware of an allegation of resident abuse at HCC, failed to ensure an investigation was conducted, and failed to ensure the abuse allegation was reported to State agencies as required by law.

37. In 2022, HCC had a holiday pay policy that stated that all regular employees (those who have completed the orientation period) are eligible for 6 paid (non-working) holidays, or time and a half if they are called in to work on any of those six days (and/or Easter).

38. In 2024, HCC implemented a new policy approved by the Laurel City Council that added two more paid holidays (Christmas Eve and New Year's Eve) for permanent employees but excluded temporary/seasonal workers unless they actually worked on the designated holidays.

39. In May 2024, the Defendant notified the staff at HCC that paid holidays were being removed from the employee benefits package and advised that only upper management staff would receive paid holidays. When staff told Defendant that the 2022

and 2024 HCC employee handbooks provided for paid holidays for permanent staff, the Defendant dismissed them, and eight employees filed claims with the Nebraska Department of Labor.

40. In February 2024, the Nebraska Department of Labor issued citations against the City of Laurel for violation of the Wage Payment and Collection Act. In April 2025, the case was settled, and under the terms of the settlement agreement, the City of Laurel was forced to pay HCC permanent employees an undisclosed amount for unpaid holidays.

41. In March 2025, the Laurel City Council accepted the Defendant's resignation and severed her employment with HCC.

FIRST CAUSE OF ACTION

42. Paragraphs 1 through 41 are incorporated herein by reference.

43. Neb. Rev. Stat. § 38-178(6) (2024 Supp.) provides a professional license may be disciplined for the practice of the profession with gross incompetence or gross negligence.

44. The Defendant's conduct in (a) hiring unqualified employees for the positions as EHCC Business Manager and Dietary Manager; (b) failing to train and supervise both managers; and (c) failing to ensure allegations of resident abuse at EHCC and HCC were investigated fully and investigative findings promptly reported to State agencies constitutes gross incompetence and is grounds for discipline.

SECOND CAUSE OF ACTION

45. Paragraphs 1 through 41 are incorporated herein by reference.

46. Neb. Rev. Stat. § 38-178(24) (R.S. 2024 Supp.) provides a professional license may be disciplined for unprofessional conduct as set forth in §38-179.

47. Neb. Rev. Stat. § 38-179 (R.S. 2024 Supp.) defines unprofessional conduct as the failure to conform to the standards of acceptable and prevailing practice of a profession, regardless of whether a person, consumer, or entity is injured, including but not limited to ... (17) such other acts as may be defined by rules and regulations.

48. Title 172 NAC 106-014 (2020) governing the Practice of Nursing Home Administrators defines unprofessional conduct to include:

(1) (A) Failure to utilize appropriate judgment in administering safe nursing home practices;

(2) (B) Failure to exercise competence in carrying out nursing home administration.

(3) (C) Failure to follow policies or procedures implemented in the practice situation to safeguard patient or resident care;

(4) (D) Failure to safeguard the patient's or resident's dignity and right to privacy;

(5) (E) Violating the confidentiality of information or knowledge concerning the patient or resident;

. . .

(8) (H) Committing any act which endangers patient or resident welfare or safety;

(9) (I) Failure to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed professional;

. . . .

49. The Defendant's conduct, as set forth above, constitutes unprofessional conduct and is grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Chief Medical Officer set this matter for hearing, order appropriate disciplinary action pursuant to Neb. Rev. Stat. § 38-196 (Reissue 2016), and tax the costs of this action to the Defendant.

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Plaintiff,

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