State of Nebraska
Office of Public Counsel/Ombudsman

PO Box 94604, State Capitol
Lincoln, Nebraska 68509
(402) 471-2035
Toll free - 800-742-7690
Fax (402) 471-4277
ombud@leg.ne.gov

1ST ANNUAL REPORT

NEB. REV. STAT. §83-104 REVIEW OF NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) STATE INSTITUTIONS

March 15, 2021

Jerall Moreland, Deputy Public Counsel/Ombudsman for Institutions
Julie L. Rogers, Public Counsel/Ombuds

TABLE OF CONTENTS

Attachments for Lincoln Regional Center

Attachments for Norfolk Regional Center

Attachments for Whitehall

Attachments for Hastings Regional Center

Attachments for YRTC-Lincoln

Attachments for YRTC-Geneva

Attachments for YRTC-Kearney

INTRODUCTION

Passed by the Nebraska Legislature in July 2020, Neb. Rev. Stat. §83-104 requires the Office of Public Counsel (also referred to as the Ombudsman's Office) to conduct an annual physical review of the following state institutions within the Nebraska Department of Health and Human Services (DHHS):

1. The Youth Rehabilitation and Treatment Center-Geneva;
2. The Youth Rehabilitation and Treatment Center-Kearney;
3. Any other facility operated and utilized as a Youth Rehabilitation and Treatment Center under state law;
4. The Hastings Regional Center;
5. The Lincoln Regional Center;
6. The Norfolk Regional Center; and
7. The Beatrice State Development Center.

Further, Neb. Rev. Stat. §83-104 requires the Office of Public Counsel (Ombudsman's Office) to report to the Legislature on or before March 15, 2021, for the 2020 calendar year[1] on the condition of such DHHS state institutions. This report summarizes the efforts of the Ombudsman's Office in its physical reviews of each institution, the collection of inspection reports regarding each facility, staffing information for each institution, and reports received by the Ombudsman's Office.

Background

Before the statutory requirement, facility visits to state institutions by the Ombudsman's office were generally initiated because of individual case complaints and reports made to the office or through identification of specific systems issues. The catalyst to this report requirement is one of the statutory responses to the crisis that unfolded at the YRTC-Geneva in August of 2019. This crisis necessitated the sudden relocation of the female youth being served there to YRTC-Kearney, a facility that served male youth up until that point, due to the seriously poor conditions of YRTC-Geneva. [2] In the year leading up to the crisis, the Ombudsman's Office received a total of three complaints regarding youth residing at YRTC-Geneva: two complaints in October 2018 about the school and one complaint in February 2019 about a youth's desire for a 60-day notice. No complaints were received about the conditions of the institution.

[1] Neb. Rev. Stat. §83-104 sets forth that beginning in 2021 after the initial March report, each annual report will be submitted on or before December 15 of each calendar year for the period of December 1 through November 30.
[2] "The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center, Special Report of Investigation" by the Office of the Public Counsel/Ombudsman and Office of Inspector General of Nebraska Child Welfare. https://nebraskalegislature.gov/pdf/reports/public_counsel/Geneva_Special_Report_2021.pdf

In January of 2020, the Nebraska Legislature's Health and Human Services Committee issued a report with several recommendations.[3] Recommendation number nine read, "Require an annual facilities review by the Ombudsman. The Legislature should consider requiring an annual review by the Ombudsman of all 24-hour residential facilities under DHHS's jurisdiction and a subsequent report to the Legislature on those reviews by the Ombudsman." Legislative Bill 1144 was introduced with such requirements in January of 2020, passed by the Nebraska Legislature on July 31, 2020, and approved by Governor Ricketts on August 11, 2020.

For the Nebraska Legislature to continue its role in guiding and facilitating the goal of improving not only the YRTC-system, but all state institutions under DHHS, the legislature has expressed its mandate for the Ombudsman's Office to enhance its jurisdictional authority by increasing its exposure at state institutions. This focused role will assist with changes that strengthen agency effectiveness and highlight the quality of care to those Nebraskans residing in our state institutions.

Annual Physical Review & Report Process

For the reporting period, the Ombudsman's Office conducted site visits, which included physical reviews, at each of the above-listed state institutions. Note, however, that due to the COVID pandemic, multiple visits to the facilities since March of 2020 were limited by the need to follow state guiding principles for the safety of those residing and working at each of the DHHS state institutions. During the majority of 2020, there were periods in which the office suspended all visits to state institutions that reported positive cases of COVID. During this time the office remained operational while adhering to CDC guidelines and limiting personal contact. When it was necessary to visit facilities, Ombudsman personnel wore personal protective masks and observed maximized social distancing. The office continued to receive information and updates from each facility regarding the impact and challenges the pandemic had on their operations, and delved into case complaints by alternative means such as the utilization of virtual tools.

The following is organized by institutions under "behavioral health" that are hospitals or other licensed facilities, and institutions under the Office of Juvenile Services, or Youth Rehabilitation and Treatment Centers (YRTCs). For this report, those listed under "behavioral health" are those that statutorily fall within the Divisions of Developmental Disabilities (Beatrice State Developmental Center) and Behavioral Health (Public Psychiatric Hospitals) which include the Lincoln, Norfolk, and Hastings Regional Centers. Within the Lincoln Regional Center's organization is the adolescent sex offender program at the Whitehall campus. During a majority of this reporting period, the Hastings Regional Center was operated as an adolescent residential substance abuse treatment facility, but in the fall of 2020, the program moved to the Whitehall campus. The Office of Juvenile Services is within the Division of Children and Family Services. Organizationally, this is different than how DHHS currently functions—all institutions serving

[3] "Report to the Nebraska Legislature on the Youth Rehabilitation and Treatment Centers" by the Health and Human Services Committee, January 22, 2020. https://nebraskalegislature.gov/pdf/reports/committee/health/yrtc_2020.pdf

adults are under one umbrella, and all institutions serving youth are under another, with both areas reporting to the DHHS chief operating officer.

This report provides summaries concerning observations and documentation reviews related to the internal and external conditions of each of the DHHS state institutions. The voluminous attachments include all inspection reports, federal compliance documentation, state licensing compliance, and staffing information for each institution and program as outlined in Neb. Rev. Stat. §83-104.

BEHAVIORAL HEALTH OVERVIEW

HOSPITAL OR LICENSED STATE INSTITUTIONS

Beatrice State Development Center (BSDC)

The Beatrice State Development Center (BSDC) is a state institution licensed as intermediate care facilities for individuals with intellectual or developmental disabilities operated under DHHS's Division of Developmental Disabilities. BSDC plays an important role in Nebraska's developmental disabilities system.

BSDC is a 24-hour state and federally funded residential treatment institution. BSDC is located in Beatrice, NE, and is divided into individually licensed Intermediate Care Facilities (ICF) for individuals within the larger campus area.

Several visits were made to this facility in 2020. Generally, the outside grounds of the campus are well kept. The campus is comprised of many buildings. The infrastructure required to provide services and housing for the residents at BSDC is significant. The campus has structures for individual's housing needs, dining, medical services, administrative services, religious functions, and recreation.

While most buildings on the campus are being utilized, a few appear to be no longer in use or limited to storage and sit vacantly. As should be expected, a campus as old as BSDC (over 130 years) has many buildings or structures on it that are dated, and in 2017, the campus went through a conditions analysis to determine the long-term structural needs of the facility. As a result, there are visible signs of several construction projects.

Remodeling projects were completed in living cottages and concrete work around campus was finished as well. Some of these projects are scheduled for completion in 2021. As for the interior design of cottages, depending on the building, the layout is essentially the same. Lake Street, Solar Cottage, and the State buildings each have their unique features. Most units have separate bedrooms, bathrooms, a kitchen, a common area for individuals, and a laundry room. General cleanliness of all the homes was observed and individual rooms were fairly organized and clean.

Based on the documentation provided to the Ombudsman's Office, surveys conducted at BSDC by the DHHS Public Health-Licensure Unit were made known. The reports cover regulatory and compliance issues. The survey findings are based on observations, interviews, and records review. These items and the actions taken by BSDC based on these findings are attached. (See Attachments B1 through B3.)

Generally, the facility's crisis stabilization unit is visited during Ombudsman's Office visits. The crisis stabilization unit provides an important program for individuals and other stakeholders. The purpose of the program is to intake unstable individuals from the community and prepare them for transitioning back to the community stabilized. The unit comprises of four different

wings and generally houses one to three individuals per wing, depending on the individual's needs.

Overall in 2020, a shift change was observed at BSDC during the COVID Pandemic which required staff to take temperature checks before facility entry to job posts. Like many institutions throughout the country, BSDC has staffing challenges and presents its share of staff injuries to this office (See Facility Staff Information Attachment B4), with these issues being compounded due to the number of staff COVID positive cases.

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. In regards to major construction projects, the projects are tracked on a summarized list. The information that can be obtained from access to this information can provide a comprehensive view of the condition of a facility.
3. Address issues identified in reports received by the Office of Public Counsel (See attachments B5 and B6), including staffing levels, retention rates, and turnover.

In 2020, the Ombudsman's Office received contact from staff and family members of residents. Two major complaints reported about BSDC pertained to how BSDC processed grievances, and the other reported issue concerned staffing levels at BSDC. Staffing is a challenge at BSDC and is an ongoing issue that the Ombudsman's Office is following closely.

Lincoln Regional Center (LRC)

The Lincoln Regional Center (LRC) is a 250 bed, Joint Commission-accredited state psychiatric hospital. DHHS's Division of Public Health licensure unit verifies LRC is licensed and meets statutory requirements as a Mental Health Substance Use Treatment Center and Psychiatric Hospital. (See Licenses, Attachment L1.)

Several visits were made to this facility. Generally, the outside grounds of the campus are well kept. The campus is comprised of several different buildings. The main patient buildings are building 3, 9, 10, and 14. There is also an administrative building and a building used predominantly for storage. The infrastructure required to provide services and housing for the residents of this psychiatric hospital is different than other state institutions in that most services can be provided to a patient without transportation out of their assigned building. The campus has structures for individual's housing needs, dining, medical services, administrative services, religious functions, and recreation.

Most buildings on the campus are being utilized, however, one building is no longer in use and is used for limited storage, but essentially sits vacant. It is my understanding that the building is

waiting to be demolished. As should be expected, a campus as old as LRC, which originally opened in 1870, has many buildings or structures that are dated.

Of note with this campus is the current situation it finds itself in. In September of 2019, the Joint Commission (J-Co), the accreditation body for Center for Medicare and Medicaid Services (CME) surveyed the Lincoln Regional Center (LRC) and found deficiencies in the physical structure of buildings 3, 5, and 10 that may pose as ligature risks. These buildings serve as behavioral health treatment and housing units for a diverse range of patients with mental health conditions. To address the deficiencies in the physical structure, a mitigation plan outlined the use of temporary staff to address the risks until the physical building modifications could be completed. The increase of staff was recognized during our visit. The changes in operations were noticeable and drove patients' complaints to our office.

LRC will continue to operate under their mitigation plan until the ligature plan is completed. The ligature plans involve renovations to the above-identified buildings to reduce possible patient safety risks as outlined, and to improve overall patient cares spaces. The construction project for the ligature plan was launched on January 11, 2021, and is currently scheduled to be completed in March 2022. (See Project letter, attachment L2)

Attached you will find facility staffing levels. Additionally, there were 63 patient assaults on staff in the calendar year 2020 for LRC main campus. (See Facility Staffing Information, Attachment L3)

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.
3. Ligature point renovation. The Ombudsman's Office will work to understand and address any major disruptions to patients and the impact the renovation will have on the facility's ability to intake needed patients for care as it undergoes this renovation.
4. Address issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment L4 and Occupancy Permits, Attachment L5), including staffing levels, retention rates, and turnover.

In 2020, the Ombudsman's Office received over 50 reports of complaint about LRC, mostly from the patients themselves, but some from staff and families as well. These complaints ranged from COVID concerns to operational changes due to the ligature mitigation plan to reasons of placement at LRC.

Norfolk Regional Center (NRC)

The Norfolk Regional Center (NRC) is a 120 bed, Joint Commission-accredited state psychiatric hospital. It is operated by DHHS.

The first thing you notice when visiting NRC is a large wire gate around the campus. The gate is approximately 15-20 ft. high with razor wire wrapped around the top. There are two main points of entry. The first for deliveries, transports, and emergency vehicles, the other for staff and public access. To gain entry, there is a voice button for identification. An NRC staff must buzz the public in for vehicle access to the building. Once you gain access inside the gated construction, there is a main public entry area with a phone. Visitors need to use this phone to gain entry inside the main area of the building. Essentially, comparing this campus to others across the state, one observes that it is easier to see a live body at a correctional facility or Veterans Home or other state institution for questions or help than it is at the NRC.

After gaining vehicle access to the parking grounds of the facility, there is a three-story brick hospital with several walk-out basements and egress points. Additionally, there are internal fences on both ends of the building to control independent yard access. The main building on the NRC campus, which houses all patient services, is dated over 50 years. The grounds are well kept. Other buildings located inside the fence seem to be utilized. Besides the main three-story building, there is a newer constructed maintenance building, paved lots for parking, a structure being used for covered parking and storage, a gazebo, and basketball courts outside the internal gates on the end of the main building.

The infrastructure of the main building allows for all patient services. The building has space for individual's housing needs, a cafeteria area, medical services, administrative services, religious functions, recreation, and other essential programming. Patient Living areas are Unit 1- West, Unit 2-West and East, Unit 3-West and East.

Based on the documents received from NRC, several surveys were conducted by the DHHS Public Health-Licensure Unit, about NRC. The reports cover regulatory and compliance issues. The survey findings based on observations, interviews, and records review are attached. (See Surveys, Attachment N1)

Attached you will find facility staffing levels. Additionally, there were 20 staff injuries related to assault staff in the calendar year 2020. (See Facility Staffing Information, Attachment N2)

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.

3. Address any issues identified in the Inspection reports received by the Office of Public Counsel (See Inspections Report, Attachment N3), including staffing levels, retention rates, and turnover.

In 2020, the Ombudsman's Office received over 50 reports of complaint related to LRC, mostly from the patients themselves, but some from friends and family members as well. These complaints ranged from COVID concerns to operational changes due to new leadership, to clinical team decisions to lack of staffing and access to legal law library.

Whitehall

The Whitehall Campus is located in the northeast quadrant of the city of Lincoln, Nebraska. It is licensed and accredited as part of the Lincoln Regional Center and considered an extension of the Lincoln Regional Center, a Joint Commission-accredited state psychiatric hospital. DHHS's Division of Public Health licensure unit verifies the Whitehall is licensed and meets statutory requirements as a Mental Health Substance Use Treatment Center. (See License, Attachment W1)

Whitehall, until recently, solely addressed the treatment needs of male adolescents who have sexually offended. In the fall of 2020, the Hastings Juvenile Chemical Dependency Program (JCDP) was relocated from the Hastings Regional Center to Whitehall. There are currently two distinct programming offerings on the Whitehall campus. With the addition of the JCDP, the immediate changes to facility operations were recognized in the fall of 2020.

In part, due to the functional changes of the facility, the Ombudsman's Office conducted several announced and unannounced visits to Whitehall. One of the visits, conducted on October 8, 2020, occurred about a week after the JCDP youth moved to Whitehall from the Hastings Regional Center. At that time, the census included eight sex offender treatment program youth and six JCDP youth. There were signs that the facility was working out the many logistics in combining two facility programs into one.

In regards to the layout of the campus, youth living quarters are determined by what programs the youth are participating in. Each youth has his bedroom in the living quarters. The insides of the youth cottages are dated. The youth rooms were generally clean and mostly neat. The recent carpet installation was a noticeable improvement in the youth cottages. Additionally, new lights in the youth cottages (Warner House and Community Life cottages) were noticed. The campus is comprised of several other structures. Some Administrative offices are located in the TAB building, with others located in the Knight House. There is a Whitehall Mansion on the campus with other buildings used by maintenance and a separate school building with a library for the use of both programs.

Generally, the outside grounds of the campus were well kept. There was a noticeable phone line connected to the building that could present a security concern. We discussed this with facility

administration and were told that the phone line is Windstream's and will be taken down during the CAT 6 voice/VOIP line project, which has begun.

Based on the documents provided by Whitehall, several surveys were conducted by DHHS's Public Health-Licensure Unit, on the Whitehall campus. The reports cover regulatory and compliance issues. The survey findings based on observations, interviews, and records review are attached (See Surveys, Attachment W2)

Attached you will find facility staffing levels. Additionally, there were 4 staff injuries related to assault staff in the calendar year 2020. (See Facility Staffing Information, Attachment W3)

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.
3. Ongoing progress on the following projects: Camera system and Windstream project.
4. Address any issues identified in reports received by the Office of Public Counsel (See Occupancy Permits, Attachment W4), including staffing levels, retention rates, and turnover.

Historically, reports of complaint from Whitehall are low in number. Generally, we see an issue or two brought to our attention. In 2020, after the move of the JCDP program to the Whitehall campus, the Ombudsman's Office did receive a related report of complaint about Whitehall, relating to the proper guidelines for securing a youth when acting out.

Hastings Regional Center

The Ombudsman's Office visited the Hastings Regional Center on various occasions throughout 2020. The campus is located on the west edge of Hastings. Through the better part of 2020, the Hastings Juvenile Chemical Dependency Program (JCDP) was operating on that campus. In the building the program was operating in at the time, the youth living area looked very dated. The facility was utilized to deliver residential substance abuse treatment for adolescent males (presently, as mentioned previously, administered in Lincoln on the Whitehall campus). Several buildings at HRC have been torn down, which has created open space on the campus. There were several construction projects throughout campus, which included the building of two new cottages, a building structure for a school and cafeteria, and an administration building. The grounds were busy and there were some trees on the ground waiting to be cleared on the south side of the campus. Several buildings were also going through demolition.

At the present time, the building where the JCDP was housed is not operating with any program in it. There are two brand new cottages at the HRC. The plan was formerly for these two cottages

to be used as living quarters for the chemical dependency program for boys in a college dorm-style setting and provide classification flexibility in housing placement. However, DHHS decided to repurpose the campus and the JCDP was relocated from HRC to Whitehall in October 2020.

At this time, the campus is being converted to house an all-female Youth Rehabilitation and Treatment Center (YRTC). The new cottages are currently going through renovations which include hardening of the walls, raising ceilings, and filming windows. The new cottages, even without the changes to who they will serve, probably would have eventually needed reinforcement to the structure. Additionally, some HRC staff that worked with the JCDP were assigned to YRTC-Kearney to create a seamless transition upon the female youth moving to the HRC campus, and will continue to work with them as the HRC becomes a YRTC.

DHHS, Division of Public Health licensure unit verified HRC was licensed and met statutory requirements as a Mental Health Substance Use Treatment Center and a Residential Child-Caring Agency while on the Hastings campus. The certificates are expired. (See Licenses, Attachment H1.)

The Ombudsman's Office was made aware of a risk assessment conducted on the HRC campus that evaluates the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of clients, staff, and other people visiting the facilities. (See Risk Assessments, Attachment H2.)

Attached you will find facility staffing Information. Additionally, there were zero assaults on staff in the calendar year 2020. (See Facility Staffing Information H3.)

Issues identified for review in 2021:

1. The transition of the HRC to a YRTC in order to serve female youth on campus under the Office of Juvenile Services.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.
3. Address any issues identified in the Inspection reports received by the Office of Public Counsel (See Inspections Report, Attachment H4), including staffing levels, retention rates, and turnover.

OFFICE OF JUVENILE SERVICES

YOUTH REHABILITATION AND TREATMENT CENTER (YRTC) SYSTEM

The Office of Juvenile Services within the Division of Children and Family Services at DHHS operates the Youth Rehabilitation and Treatment Centers (YRTCs), 24-hour state institutions to serve youth within Nebraska's juvenile justice system. As recently as 2019, there were two YRTCs: one for girls in Geneva and one for boys in Kearney. Currently, there are YRTCs in Kearney, Lincoln, Geneva (not operational as a YRTC currently), and soon-to-be Hastings.

Over the last 16 months, DHHS has implemented many initiatives throughout the YRTC system. The initiatives represent major changes incorporated into facilities operated by the Office of Juvenile Services. These initiatives indicated a fundamental shift in how care is delivered to youth. Some of these initiatives, such as repurposing of space and changes to gender placement at facilities, created necessary, albeit, unforeseen changes in facility operations, functioning, and building structure need throughout the system.

In regards to operational changes, the Ombudsman's Office observed, significant renovations to several of the state institutions. With more stability to the system, the hope is that a better understanding of the facility conditions and changes necessary to right the ship will become apparent in 2021.

The Ombudsman's Office experienced increased complaints in 2020 related to YRTC system changes. In 2020, the Ombudsman's Office received over 25 reports of complaints related to the YRTC system. The complaints were received from staff, youth and family members of youth. The issues ranged from youth placement to safety, and to communication concerns.

Based on the many changes to the system, the majority of the issues that were identified in the complaints were ongoing, in part, due to the functional and fundamental changes of the use of our Office of Juvenile Services state facilities. The Ombudsman's Office conducted several announced and unannounced visits to facilities across the YRTC system. In 2021, facilities operated by the Office of Juvenile Services are continuously being monitored and examined.

The following observations will provide a brief point in time view of the facility's operations under the Office of Juvenile Services in 2020: 1) YRTC-Lincoln, 2) YRTC-Geneva, 3) YRTC-Kearney, and 4) Hastings Regional Center -soon to become a YRTC for female youth (see above observations made under Behavior Health Overview).

YRTC - Lincoln

In 2019, the discussion between DHHS and Lancaster County was initiated to discuss facility space—utilizing a portion of the Lancaster County Youth Services Center as an additional YRTC. Shortly following, DHHS entered a 5-year contract with Lancaster County to lease space

within the same building as the Lancaster County Youth Services Center. The Lancaster County Youth Services center provides for the detention of youth being processed through the juvenile justice system, or youth who have been adjudicated and ordered by a criminal court to serve a specified period of time.

YRTC – Lincoln was established in 2020. With the addition of a newly created state facility, it became very important to the Ombudsman's Office to comprehend the new facility's mission and gain an understanding of general rules, responsibilities, and operations of the new YRTC. A request was made for YRTC-Lincoln policies. These were provided to the office promptly.

To continue data collection and understanding, the Ombudsman's Office began conducting announced and unannounced visits. Familiar with the Lancaster County Youth Services Center from previous Ombudsman cases, the facility design was not new. However, of interest was how the populations between the two facilities were sharing facility space for services such as school, recreation yards, cafeteria, and other essential service needs. (See Inspection reports, Attachment YLF 1.)

The housing unit where the youth reside at YRTC - Lincoln has two separate living pods—one for males and one for females. Each youth has a private room in the pod. The pods have a small common area for different uses for such things as phone calls, showers, and leisure activities. The pods are separated by a larger multi-purpose area designed for additional individual or group activities. Both the female and male pods share the larger multi-purpose area, which means the youth in each pod have opportunities for visual observations of each other.

As with the other YRTC's, YRTC - Lincoln will work toward American Correctional Association (ACA) accreditation. It is also understood that the facility will participate in the Performance-Based Standards (PbS) Project sponsored by the Council for Juvenile Correctional Administrators.

As of December 31, 2020, there were a total of 47 employees at the Lincoln Facility. Additionally, there was 19 youth to staff assaults. (See Facility Staffing Information, Attachment YLF 2.)

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.
3. Address any issues identified in the reports received by the Office of Public Counsel, including staffing levels, retention rates, and turnover.
4. Gain an understanding of the programming utilized at YRTC – Lincoln and the appropriate youth population best served in this new program.

YRTC – Geneva

On August 19, 2019, female youth from YRTC-Geneva were relocated to YRTC- Kearney after conditions on the Geneva campus was deemed insufficient and Geneva could not continue to care for the girls on this campus. The move to Kearney presented many challenges but was made due to the safety and well-being of the youth.

In 2020, the Ombudsman's Office conducted several visits on the Geneva campus. During this time, significant repair and refurbishing work on campus was observed. Of particular interest, the LaFleshe building formally used as living quarters for behavioral youth, was completely renovated in early 2020, and services were re-established at YRTC - Geneva for female youth who were going to be transitioned back into the community. YRTC - Geneva no longer has youth on its campus as the transition services were discontinued on the Geneva campus during the summer of 2020.

The YRTC - Geneva administration still exists on the campus at the writing of this report. These days, ever since the last half of 2020, the quietness of the campus is apparent—youth are not seen walking to classes or going to recreation. Instead, what is noticeable is a quiet campus comprised of many buildings sitting idle.

Buildings at YRTC - Geneva include four cottages that were used as youth living quarters, a chapel placed almost in the middle of the campus with an adjacent food service building, a maintenance building still being used by staff, and other buildings that were used for daycare, recreation, and training purposes. The building formerly used as the administration building is currently being used as a Medicaid call center.

Attached you will find facility staffing information. Additionally, there were zero assaults on staff in the calendar year 2020. (See Facility Staffing Information G1.)

Issues identified for review in 2021:

1. Determine when YRTC- Geneva Administration will no longer be housed on the Geneva campus and understand what the campus will be utilized for in the future.
2. Address any issues identified in reports received by the Office of Public Counsel (See email on construction work/remodeling in the Admins building that involved the Fire Marshall, Attachment G2, Fire Drill dated 8/5/2020, Attachment G3), including staffing levels, retention rates, and turnover.

YRTC - Kearney

YRTC - Kearney is located in Kearney, NE, and has been serving both male and female youth since August of 2019. It has gone through different operational models since the addition of females being served on its campus. Although a large campus, there is a significant amount of planning that is needed to maintain the operations of the two programs. In part due to the function changes of the facility, the Ombudsman's Office conducted several announced and unannounced visits on this campus.

Although, a non-state licensed facility, the YRTC- Kearney is accredited under the American Correctional Association (ACA). It also participates in Performance-Based Standards (PbS) project reviews sponsored by the Council for Juvenile Correctional Administrators and is currently under contract with the Missouri Youth Services Institute (MYSI) for assistance with implementing basic principles of the MYSI therapeutic and rehabilitative model approach.

Generally, the outside grounds of the campus are well kept. The campus is comprised of many buildings. The infrastructure required to provide services and housing for the youth is significant. The campus has structures for youth housing needs, cafeteria, medical services, administrative services, religious functions, and education and recreation areas. Dixon, the name of a building on campus, has generally been used for new intakes to the facility and for those youth who need to be separated for behavioral issues. With the addition of females, this has changed on many occasions as well. As for the interior design of each cottage, the layout is essentially the same for the male youth cottages. Those cottages have barrack-style living quarters on the second floor with a congregate restroom. The first level has three basic sections. Those sections being a game/rec area, bathroom area with showers, and a TV multi-purpose area. General cleanliness of the dorm areas was observed. Where the multi-use areas were utilized, at times they could be cluttered and somewhat organized but clean. Any issues were brought to the facility's attention and handled immediately.

YRTC - Kearney went through many operational changes in an attempt to work out the many logistics in combining two facility programs—serving males and females—on one campus. The changes led to the girls being placed at Morton Living Unit which allows for individual rooms. The facility also purchased two portable trailers for classroom use by the girls.

The Ombudsman's Office was made aware of a standards compliance reaccreditation audit conducted by the Commission on Accreditation for Corrections, July of 2020. (See the Standards Reaccreditation Audit, Attachment K1.)

Attached are the facility staffing levels and staff injuries by severity (See Facility Staffing Information, Attachment K2.)

Issues identified for review in 2021:

1. COVID plan, response, and impact to staff and individuals.
2. There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. Major construction projects

are tracked on a summarized list. The information that can be gleaned from a review of these systems will help provide a comprehensive view of the condition of the facility.

3. Address any issues identified in reports received by the Office of Public Counsel (See Food Establishment Inspection Report, Attachment K3), including staffing levels, retention rates, and turnover.

DHHS Public Health- Licensure Unit

C. Lake Street Surveys

Attachment B1

PLAN OF CORRECTION

Provider/Supplier Name:	Lake Street	Survey Date:
STREET ADDRESS, CITY, ZIP:	667 31st St, Apt 103, 104, 205, 206 Beatrice, NE 68310	8/6/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD16

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 0225	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. A work order was submitted to the Maintenance Department to repair/adjust the basement stair door that failed to close and latch within the door frame. The door had swollen from the humidity. The door was removed, planed down the edge, reinstalled and tested. It was confirmed on 8/14/20 that the door now closes and latches within the door frame.	8/14/2020
	2. A work order was submitted to the Maintenance Department to repair/adjust the upper level south stair door that failed to latch within the door frame. The door closer was adjusted and it was confirmed on 8/7/20 that the door will latch within the door frame.	8/7/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. A work order was submitted to the Maintenance Department to repair/adjust the basement stair door that failed to close and latch within the door frame. The door had swollen from the humidity. The door was removed, planed down the edge, reinstalled and tested. It was confirmed on 8/14/20 that the door now closes and latches within the door frame.	8/14/2020
	2. A work order was submitted to the Maintenance Department to repair/adjust the upper level south stair door that failed to latch within the door frame. The door closer was adjusted and it was confirmed on 8/7/20 that the door will latch within the door frame.	8/7/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	8/14/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	8/14/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020

K 0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 103 that failed to latch within the door frame. Increased the spring pressure on the the spring loaded hinges on the janitor closet door. It was confirmed on 8/14/20 that the janitor closet door in the hall of Unit 103 will latch within the door frame.	8/14/2020
	2. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 104 that failed to latch within the door frame. A missing screw in the strike plate was replaced and a loose screw was tightened. It was confirmed on 8/7/20 that the janitor closet door in the hall of Unit 104 will latch within the door frame.	8/7/2020
	3. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 205 that failed to latch within the door frame. Missing screws in the hinges of the door were replaced and loose screws were tightened. It was confirmed on 8/7/20 that the janitor closet door in the hall of Unit 205 will latch within the door frame.	8/7/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 103 that failed to latch within the door frame. Increased the spring pressure on the the spring loaded hinges on the janitor closet door. It was confirmed on 8/14/20 that the janitor closet door in the hall of Unit 103 will latch within the door frame.	8/14/2020
	2. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 104 that failed to latch within the door frame. A missing screw in the strike plate was replaced and a loose screw was tightened. It was confirmed on 8/7/20 that the janitor closet door in the hall of Unit 104 will latch within the door frame.	8/7/2020
	3. A work order was submitted to the Maintenance Department to repair/adjust the janitor closet door equipped with a closing device in the hall of Unit 205 that failed to latch within the door frame. Missing screws in the hinges of the door were replaced and loose screws were tightened. It was confirmed on 8/7/20 that the janitor closet door in the hall of Unit 205 will latch within the door frame.	8/7/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	8/14/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020
	3. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	8/14/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020

	3. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

BSTA27- TRANSITION APARTMENTS
#27
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 8/17/2020 8:00 AM | **REGULAR** | **WO# BSTA272066**

NOT TO EXCEED $6.00 | **STATUS COMPLETED**

AGENCY

Name		**Contact**	Mike Bakderson
Address	3000 LINCOLN BLVD. BEATRICE, NE 68310	**Phone/E-mail**	
		Phone	
		Fax	

BASIC | **DATE CREATED 8/5/2020 7:52 AM**

K0325

Interior Repair Fire Marshal - 311 Lake East Apts.: Door leading to the basement (inside east entrance) will not close with positive latch. This door is equipped with a door closer.

ASSIGNMENT

Assigned To	Robertson, Steve	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email	steve.robertson@nebraska.gov	**Start Time**	
		PO#	

COMPLETION

Work Completed	9/14/2020 1:56 PM
Repair Category/Code	Doors And Lock Systems Repaired/replaced door

The door is a wood door and had swelled from the humidity. We removed the door, planed down the edge, reinstalled and tested. the door is now latching fine. Work completed on Friday, August 14th, 2020.

REQUIRED SIGNATURE

Name (print)

Signature

Signed

DETAIL

CATEGORY	DESCRIPTION	QUANTITY	RATE	AMOUNT
Labor	Robertson, Steve - Regular	1	[redacted]	
Labor	Wieden, Dan - Regular	1		

KB321

BSTA27- TRANSITION APARTMENTS
#27
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 8/17/2020 8:00 AM
NOT TO EXCEED $0.00

REGULAR

WO# BSTA272067
STATUS COMPLETED

AGENCY

Name
Address 3000 LINCOLN BLVD.
BEATRICE, NE
68310

Contact [redacted]
Phone/E-mail
Phone
Fax

BASIC

DATE CREATED 8/5/2020 7:55 AM

Interior Repair Fire Marshal - Apts. #103: South janitor closet door will not close with positive latch. This door is equipped with a door closer. - The door closers on the bedroom doors are not attached to the door. To meet the fire code, we need to either remove all the door closer equipment or remove the fire rating tag attached to the door.

ASSIGNMENT

Assigned To [redacted]
Mobile
Email

Skill General Maintenance
Appointment N/A
Start Time
PO#

COMPLETION

Work Completed 8/14/2020 1:39 PM
Repair Category/Code Doors And Lock Systems
Repaired/replaced door

Unused door closers and accompanying hardware removed from the bedroom doors on Friday, August 8th, 2020. Increased the spring pressure on the spring loaded hinges on the south housekeeping closet so the door would latch on Friday, August 14th, 2020.

REQUIRED SIGNATURE

Name (print)
Signature
Signed

DETAIL

CATEGORY	DESCRIPTION	QUANTITY	RATE	AMOUNT
Labor	[redacted]	[redacted]		
Labor				

K0321

BSTA27- TRANSITION APARTMENTS
#27
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 8/17/2020 8:00 AM | REGULAR | WO# BSTA272068

NOT TO EXCEED $0.00 | STATUS COMPLETED

AGENCY

Name		Contact	Mike Balderson
Address	3000 LINCOLN BLVD. BEATRICE, NE 68310	Phone/E-mail	
		Phone	
		Fax	

BASIC DATE CREATED 8/5/2020 7:56 AM

Interior Repair Fire Marshal - Apt. #104: North janitor closet door will not close with positive latch. This door is equipped with a door closer.

ASSIGNMENT

Assigned To	[redacted]	Skill	General Maintenance
Mobile		Appointment	N/A
Email		Start Time	
		PO#	

COMPLETION

Work Completed	8/14/2020 1:45 PM
Repair Category/Code	Doors And Lock Systems Repaired/replaced door

The strike plate had a missing screw and a loose screw. I lightened the loose screw and replaced the missing screw on Friday, August 7th, 2020.

REQUIRED SIGNATURE

Name (print)

Signature

Signed

DETAIL

CATEGORY	DESCRIPTION	QUANTITY	RATE	AMOUNT
Labor	[redacted]			

BSTA27- TRANSITION APARTMENTS
#27
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 8/17/2020 8:00 AM | **REGULAR** | **WO# BSTA272089**

NOT TO EXCEED $0.00 | **STATUS COMPLETED**

AGENCY

Name		**Contact**	[redacted]
Address	3000 LINCOLN BLVD. BEATRICE, NE 68310	**Phone/E-mail**	
		Phone	
		Fax	

BASIC **DATE CREATED 8/5/2020 7:58 AM**

K0325

Interior Repair Fire Marshal - Apt. #205: South stairwell door at the top of the stairs will not close with positive latch. This door is equipped with a door closer. - South janitor closet door will not close with positive latch. This door is equipped with a door closer. K0321

ASSIGNMENT

Assigned To	[redacted]	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email		**Start Time**	
		PO#	

COMPLETION

Work Completed	8/14/2020 1:52 PM
Repair Category/Code	Doors And Lock Systems Repaired/replaced door

I adjusted the door closer on the south stairway door so that it would latch on Friday, August 7th, 2020. The hinges on the south janitor closet had missing and loose screws. I tightened/replaced the screws on Friday, August 7th, 2020.

REQUIRED SIGNATURE

Name (print)

Signature

Signed

DETAIL

CATEGORY	DESCRIPTION	QUANTITY	RATE	AMOUNT
Labor	[redacted]			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	867 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Lake Street ICF-ID is a two story Type II (000) construction that was approved on 2013 and is fully sprinkled with a fire alarm. The facility has 24 skilled certified beds. At the time of the survey the census was 16. 42 CFR 483.470 The facility was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0225	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures 2012 EXISTING (Prompt) Interior stairs used as a primary means of escape shall be enclosed with fire barriers in accordance with Section 8.3 having a minimum 1/2-hour fire resistance rating. Stairs shall comply with 7.2.2.5.3. The entire primary means of escape shall be arranged so that it is not necessary for the occupants to pass through a portion of a lower story unless that route is separated from all spaces on that story by construction having not less than a 1/2-hour fire resistance rating. In	K0225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrischek | TITLE: ICFA | (X6) DATE: 8/18/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
K0225	Continued From page 1 buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction shall be protected to afford the required fire resistance rating of the supported wall. 1. Stairs that connect a story at street level to only one other story shall be permitted to be open to the story that is not at street level. 2. In Prompt Evacuation Capability facilities, stair enclosures shall not be required in buildings of three or fewer stories protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception shall be permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is separated from all spaces on that floor by construction having a 1/2-hour fire resistance rating. 3. In Prompt Evacuation Capability facilities, stair enclosures shall not be required in buildings of two or fewer stories with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. The requirement found at section 33.2.2.3.3, 33.2.3.4.6 or 33.2.3.4.3.7 are not permitted to be used in this instance. 4. In Prompt Evacuation Capability facilities, of three or fewer stories protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs shall be permitted to be open at the topmost story only. The entire primary means of escape of which the stairs are a part shall be separated from all portions of lower stories. Stairs shall comply with 7.2.2 unless otherwise specified in Chapter 33. Winders complying with	K0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
K0225	Continued From page 2 7.2.2.2.4 shall be permitted. Exterior stairs shall be protected against blockage caused by fire within the building. 33.2.2.4, 33.2.2.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure fire rated stair doors latched within the doorframe. This deficient practice would allow the stairwells to be filled with smoke, fire and gasses during an emergency, which would delay egress. The facility has the capacity for 24 beds with a census of 16 on the day of survey. Findings are: Observations on 8-5-20 at 1:26 pm and 1:58 pm revealed: 1. The basement stair door failed to close and latch within the doorframe. 2. The upper level south stair door failed to latch within the door frame. During an interview on 8-5-20 at 1:26 pm and 1:58 pm, Facility Staff A confirmed the stair doors failed to latch within the frame.	K0225		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	567 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
K0321	Continued From page 3 rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that hazard area doors would close and latch within the doorframes. This deficient practice would allow the exit corridors to fill with smoke, fire and gasses during an emergency, which would delay egress. The facility has the capacity for 24 beds with a census of 16 on the day of survey. Findings are: Observations on 8-5-20 between 1:39 pm and	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
K0321	Continued From page 4 1:52 pm revealed: 1. Janitor closet door equipped with closing device, in the hall of Unit 103 failed to latch within the doorframe. 2. Janitor closet door equipped with closing device in the hall of Unit 104 failed to latch within the doorframe. 3. Janitor closet door equipped with closing device in the hall of Unit 205 failed to latch within the doorframe. During an interview on 8-5-20 between 1:39 pm and 1:52 pm, Facility Staff A confirmed the janitor closet doors failed to latch within the doorframe.	K0321		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G115	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
E 000	Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrichek
TITLE: ICFA
(X6) DATE: 8/18/2020

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.

PLAN OF CORRECTION

Provider/Supplier Name:	Lake Street	Survey Date
STREET ADDRESS, CITY, ZIP:	667 31st St, Apt 103, 104, 205, 206 Beatrice, NE 68310	8/6/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD16

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 436	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	For Client 2, a Vision Examination dated 2/10/2020, Annual Nursiing Evaluation dated 4/1/2020, Adaptive Equipment List dated 5/13/2020 and Individual Support Plan (ISP) dated 5/13/2020 revealed that Client 2 utilized corrective lenses, but refused.	9/18/2020
	A baseline will be implemented to establish Client 2's ability to wear their prescriptive eye glasses and reason(s) for refusal. Upon review of the baseline data, QIDP A will develop a formal habilitation program in order to provide training for Client 2 to wear their prescriptive eye glasses to make an informed choice and enhance their vision.	9/18/2020
	The QDDPs will complete a review of all other individuals in the Lake Street ICF to identify and address any other issues relating to furnishing, maintaining or use of adaptive equipment.	9/18/2020
	A monitoring system (internal observation) will be developed to ensure availability and informed choice of eye glasses to enhance vision.	9/18/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A baseline will be implemented to establish Client 2's ability to wear their prescriptive eye glasses and reason(s) for refusal. Upon review of the baseline data, QIDP A will develop a formal habilitation program in order to provide training for Client 2 to wear their prescriptive eye glasses to make an informed choice and enhance their vision.	9/18/2020
	The QDDPs will complete a review of all other individuals in the Lake Street ICF to identify and address any other issues relating to furnishing, maintaining or use of adaptive equipment.	9/18/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	A monitoring system (internal observation) will be developed to ensure availability and informed choice of eye glasses to enhance vision.	9/18/2020

	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator is the responsible person for monitoring and to ensure compliance.	9/18/2020
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 316T ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: . Based on record review, interview and observation, the facility failed to ensure training for 1 of 1 client (Client 2) who refused to wear their prescribed corrective lenses. This deficient practice had the potential to affect all clients who utilized adaptive or supportive equipment. Facility census was 16 at the time of the survey. Findings: Record review of Client 2's 2/10/2020 Vision Examination, 4/1/2020 Annual Nursing Evaluation, 5/13/2020 Adaptive Equipment list, and 5/13/2020 Individual Support Plan (ISP) revealed Client 2 utilized corrective lenses. Observations throughout the survey (8/3/2020 from 4:25pm-6:25pm, 8/5/2020 from 11:25am-12:05am, and 8/6/2020 from 9:30am-9:55am) identified Client 2 failed to wear their prescriptive eye glasses and when asked, Client 2 stated they did not have glasses to wear. Interview with Client 2's Coverage Qualified Intellectual Disability Professional (QIDP) A, on 8/6/2020 at 11:00am confirmed Client 2 refused	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbanchek | TITLE: ICFA | (X6) DATE: 8/18/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
W 436	Continued From page 1 to wear their glasses and had no training in place to address the refusal.	W 436		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	867 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
E 000	Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulbrechek
TITLE: ICFA
(X6) DATE: 8/18/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
E 000	Initial Comments Representatives of the DHHS, Division of Public Health conducted a Recertification survey on 8/3/2020-8/6/2020 in order to determine compliance with Federal regulations at Appendix Z, Emergency Preparedness. The facility was found to be in compliance with regulations. Facility census was 16 at the time of the survey.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ubruschek | TITLE: ICFA | (X6) DATE: 8/18/2020

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.

Fralin, Russell

From: Urbaschek, Dawn
Sent: Thursday, December 10, 2020 5:07 PM
To: Schmidt, Joan
Cc: Fralin, Russell; Balderson, Mike; Harrison, Corina
Subject: FW: Lake Street Revisit 2567
Attachments: Lake Street ICF ID Revisit EP 2567 8-26-2020.pdf; Lake Street ICF ID Revisit 2567 8-26-2020.pdf

Copies for review.

Thank you,

Dawn Urbaschek | *ICF/DD Manager*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-239-0993
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Brandt, Sharon K[redacted]
Sent: Thursday, December 10, 2020 3:53 PM
To: Urbaschek, Dawn <[redacted]
Subject: Lake Street Revisit 2567

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Good Afternoon Dawn Urbaschek:

RE: Lake Street ICF, Beatrice

On August 26, 2020 we conducted an onsite revisit to verify that the facility had achieved and maintained compliance with the deficiencies cited at the August 5, 2020 survey. The attached CMS 2567 shows your facility was found to be in substantial compliance at this time.

The Centers for Medicare and Medicaid Services (CMS) has been notified of the results of our revisit.

If you have any further questions, please contact our office.

Thank you,

Sharon Brandt, C.L.S.S.Y.B.
[redacted]

Nebraska State Fire Marshal Agency
246 S. 14th Street | Lincoln, NE 68508
Office | 402-471-9475

Sharon.brandt[redacted]
sfm.nebraska.gov | Facebook
Arson Hotline 1-888-WY-ARSON

Your Opinion Matters!
Please take a very brief survey regarding Life Safety Code Surveys at Health Care Facilities
CLICK HERE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	R 08/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
{E 000}	Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING	R 08/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE STREET ICF/ID	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310

(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
{K 000}	INITIAL COMMENTS 42 CFR 483.470 A revisit survey was conducted at Lake Street ICF/ID on 8/26/20 for all previous deficiencies cited on 8/5/20. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies" of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DHHS Public Health – Licensure Unit

C. Solar Cottage Surveys

Attachment B2

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, [redacted]

COMPANY:

DATE: January 8, 2020

FAX NUMBER: 402.742.2326

TOTAL PAGES INCLUDING COVER: 3

PHONE NUMBER:

PHONE NUMBER: [redacted]

☐ URGENT ✓ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received for Greg Penner and the Solar Cottage ICF at the Beatrice State Developmental Center.

The EPoc Plans of Correction are being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	Solar Cottages	Survey Date
STREET ADDRESS, CITY, ZIP:	753,743, 723, 715 Solar Drive Beatrice NE 68310	12/17/2019
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 249		
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	For Client 3, the IDT will meet to assess, discuss, recommend and develop intervention strategies to ensure active engagement during waking/training hours and adjust supports as needed. The IDT will ensure Client 3 has focused training on the basic skills of making a choice, grasping and picking up items as included in the ISP dated 7/3/19.	
	Solar Cottage ICF staff will be in-serviced on intervention strategies to ensure active engagement during waking/training hours.	
	For all individuals residing within Solar Cottages ICF, an IDT assessment will be completed to ensure active engagement during waking/training hours is occurring and adjust supports as needed to ensure compliance.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 3, the IDT will meet to assess, discuss, recommend and develop intervention strategies to ensure active engagement during waking/training hours and adjust supports as needed. The IDT will ensure Client 3 has focused training on the basic skills of making a choice, grasping and picking up items as included in the ISP dated 7/3/19.	
	Solar Cottage ICF staff will be in-serviced on intervention strategies to ensure active engagement during waking/training hours.	
	For all individuals residing within Solar Cottages ICF, an IDT assessment will be completed to ensure active engagement during waking/training hours is occurring and adjust supports as needed to ensure compliance.	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	A monitoring system will be implemented to ensure active engagement is maintained through observation and audits.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator will be responsible to monitor and ensure compliance.	

E 018		
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	As stated in the facility policy titled "Emergency Preparedness and Planning" dated 5/20/19, the facility will ensure for all future emergencies and/or testing exercises that the Individual Supported Evacuation Tracking Log will be filled out completely to include client departure and arrival times, transportation, relocation destination, and on-duty staff assigned to specific clients.	
	Solar Cottage ICF staff at the Beatrice State Developmental Center will be in-serviced on the importance of completing the Individual Supported Evacuation Tracking Log in it's entirety. An in-service will be assigned in EDC-LINK for all staff to view and acknowledge.	
	The Individual Supported Evacuation Tracking Log will be reviewed during the emergency and/or testing exercise debriefing by the Incident Command Team to ensure it is filled out completely.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	As stated in the facility policy titled "Emergency Preparedness and Planning" dated 5/20/19, the facility will ensure for all future emergencies and/or testing exercises that the Individual Supported Evacuation Tracking Log will be filled out completely to include client departure and arrival times, transportation, relocation destination, and on-duty staff assigned to specific clients.	
	Solar Cottage ICF staff at the Beatrice State Developmental Center will be in-serviced on the importance of completing the Individual Supported Evacuation Tracking Log in it's entirety. An in-service will be assigned in EDC-LINK for all staff to view and acknowledge.	
	The Individual Supported Evacuation Tracking Log will be reviewed during the emergency and/or testing exercise debriefing by the Incident Command Team to ensure it is filled out completely.	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	Solar Cottage ICF staff at the Beatrice State Developmental Center will be in-serviced on the importance of completing the Individual Supported Evacuation Tracking Log in it's entirety. An in-service will be assigned in EDC-LINK for all staff to view and acknowledge.	
	The Individual Supported Evacuation Tracking Log will be reviewed during the emergency and/or testing exercise debriefing by the Incident Command Team to ensure it is filled out completely.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator will be responsible to monitor and ensure compliance.	

	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3082 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client training programs were implemented as outlined in the Individual Support Plans (ISPs) for 1 of 6 clients in the sample (Client 3). This failure had the potential to affect all clients residing at the facility. Facility census was 67 at the time of the survey. FINDINGS: Review of Client 3's ISP, dated 7/3/19, revealed it included three programs which focused on the training of the basic skills of making a choice, grasping and the picking up of items. All three of these training programs specified the schedule and frequency for implementation of training procedures "should be practiced whenever there is a functional or situational reason to do so". Observations during the survey identified Client 3 to sleep (eyes closed with their head down, leaning forward or to the side) a significant period of time during scheduled daily activities.	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | ICFA | 1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3066 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 249	Continued From page 1 Observations found staff failed to wake Client 3 or engage Client 3 in a manner that interrupted the sleeping and reengaged Client 3 in the activities taking place. Specifically: 1) Observations on 12/10/19 from 3:00pm -3:40pm identified Client 3 to attending Music Group in the Chapel. From 3:05pm - 3:40pm, Client 3 was observed to have their eyes closed and head leaning forward and tilted to the right. Client 3 did not open their eyes or lift their head during these 35 minutes. Staff A, seated directly to the right of Client 3, did not attempt to wake Client 3 during this time. 2) Observations on 12/11/19 from 12:13pm - 12:40pm identified Client 3 to be in the "Pay It Forward" home room. Client 3 was observed to have their eyes closed and head leaning to the right. Staff B went over to Client 3 and asked "would you like to help" and moved Client 3 to an area where a painting activity was taking place. Staff B spoke to Client 3 about what Staff B was painting but did not physical engage Client 3 in the activity. Client 3 remained with their eyes closed and their head leaning to the right until 12:40pm when another staff escorted Client 3 to lunch. 3) Observations on 12/11/19 from 4:15pm - 4:45pm identified Client 3 to be at home (753 Solar) in the living room, sitting in front of the television (TV). The TV was on, but Client 3 was observed to have their eyes closed, with their head leaning forward. At 4:14pm Staff C entered the living room and asked Client 3 if they wanted to help Staff C make the evening meal. Client 3 looked up at Staff C as Staff C took Client 3 in to the kitchen area. At	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 249	Continued From page 2 4:18pm, Client 3 was observed to be in the kitchen area with their eyes closed and their head hanging forward. Staff D and Client 3's Qualified Intellectual Disability Professional (QIDP) were observed to verbally interact with Client 3 during this time and were unsuccessful in waking Client 3. At 4:45pm, Client 3 was taken to their bedroom to rest prior to the evening meal. 4) Observations on 12/12/19 from 11:30am - 12:00pm identified Client 3 to be the Pay It Forward home room. Client 3 was at observed to have their eyes open and seated next to Staff E. Staff E was gluing items on to small white paper sacks. At 11:33am Client 3 was observed to repeatedly blink their eyes and began to yawn. Client 3 was observed to have their eye closed and their head leaning to the right within 18 seconds of yawning. Both Staff E and Staff F tried to "wake" Client 3 by talking directly to Client 3, rubbing Client 3's arm and putting an item in Client 3's hand. From 11:34am - 12:00pm, Client 3 was observed have their eyes closed with their head leaning to the right. Interviews with Staff E and Staff F (during the 12/12/19 observation in the Pay It Forward home room) confirmed Client 3 was sleepy on most days and was every difficult to keep awake when sleepy. Staff E stated Client 3 could sleep "through anything". Staff F stated it was common to have Client 3 sleep through lift transfers in a sling and personal cares. When interviewed on 12/16/19 at 2:30pm, Client 3's QIDP confirmed Client 3 was sleepy or slept much of the time Client 3 was in their wheelchair.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 249	Continued From page 3 The QIPD stated Client 3 was new to the 753 Solar home and staff were still learning how to keep Client 3 awake. The QIDP confirmed when Client 3 was sleepy or sleeping during scheduled activities times, staff would not be able to implement training programs in accordance with the programs' procedures.	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities;	E 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ICFA | 1/8/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
E 018	Continued From page 1 transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement policy and procedure for tracking of clients and on-duty staff during 1 of 1	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
E 018	Continued From page 2 full scale emergency exercises. This failure has the potential to affect all clients residing at the facility and all staff employed by the facility. The facility census was 67 at the time of survey. Findings: Review of the facility's policy titled, "Emergency Preparedness and Planning," (dated 05/20/2019) the policy revealed during an emergency and/or testing exercises, the facility will document names of clients and on-duty staff, vehicle transportation, transfer locations, and medical needs. Review of the facility's Emergency Preparedness documents titled, "Incident Action Plan (IAP)" and "Individual Supported Evacuation Tracking Log," (dated 11/04/2019) failed to identify client departure and arrival time, transportation, relocation destination, and on-duty staff assigned to specific clients. Interview on 12/16/2019 at 2:15 pm, the Administrator verified the evacuation tracking log was incomplete and failed to document the necessary emergency tracking information for clients and on-duty staff.	E 018		

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

received 1-3-2020

January 3, 2020

Greg Penner
Administrator
Solar Cottages Icf
3052 3056 3060 Pet Blv 753 743 723 715 Solar
Beatrice, NE 68310

Dear Mr. Penner:

The enclosed report documents a finding of noncompliance with the ICF certification regulations for Solar Cottages Intermediate Care Facility For Intellectually Disabled following the survey at your facility completed on December 17, 2019 by representatives of the Nebraska Department of Health and Human Services Division of Public Health.

The violations found must be corrected to avoid disciplinary action against the facility's license. Therefore, a written statement of compliance must be submitted to the Department within 10 working days of receipt of this letter. The statement of compliance must include for each deficiency cited:

1) Action(s) that will be taken to correct the deficiency;
2) The procedure for implementing the corrective action(s);
3) How the facility will monitor its corrective actions/performance to ensure that the violation is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent;
4) Identify person(s) by position, not individual name, who will be responsible for monitoring and ensuring that compliance is achieved and continues;
5) A realistic date by which each violation will be corrected (which should be within 45 days of the exit of the survey); and
6) Signature of the administrator or other authorized official and date.

If you fail to submit and implement a statement of compliance, the Department may initiate disciplinary action against the facility license.

If you have any questions regarding this correspondence, contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: mark.luger@nebraska.gov

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS AcuteCare Facilities

FROM: Russell Fralin, [redacted]

COMPANY:

DATE: January 31, 2020

FAX NUMBER: 402.742.8319

TOTAL PAGES INCLUDING COVER: 9

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received for Greg Penner and the Solar Cottage ICF at the Beatrice State Developmental Center.

The EPoc Plans of Correction are being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 763 743 723 715 SOLAR BEATRICE, NE 68310

(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
E 000	Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 1/31/20

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 06 - SOLAR 3052 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 716 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3052 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 12 skilled certified beds. At the time of the survey the census was 9.	K 000		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility allowed storage to obstruct access to the electrical disconnect boxes. This deficient practice could cause a delay and injury when turning off the power during an electrical emergency. The facility has the capacity for 12 beds with a census of 9 on the day of survey. Findings are: Observations on 1-13-20 at 1:33 pm revealed,	K0511		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 06 - SOLAR 3052 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0511	Continued From page 1 contractor ladder stored in front of panel boxes in the Electrical room. During an interview on 1-13-20 at 12:33 pm, Maintenance Staff A confirmed the items stored in front of the panel boxes. NFPA Standard: 2011 NFPA 70, 65.26 Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. 2011 NFPA 70,65.32 Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (6?2 ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 65.34(A). In all cases, the work space shall permit at least a 90 degree opening of doors or hinged panels.	K0511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 07 - SOLAR 3056 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3056 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 10 skilled certified beds. At the time of the survey the census was 9. 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 08 - SOLAR 3060 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0321	Continued From page 2 as storage and was over 50 square feet and that the facility failed to provide a self-closing device on the door.	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 08 - SOLAR 3060 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3060 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 10 skilled certified beds. At the time of the survey the census was 8.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 08 - SOLAR 3060 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 783 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0321	Continued From page 1 closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that a self-closing device was installed on a room used as storage. This deficient practice would allow smoke, fire and gasses to escape the hazard room and enter the exit corridor, which would delay egress. The facility has the capacity for 10 beds with a census of 8 on the day of survey. Findings are: Observations on 1-13-20 at 1:20 pm revealed the office near the dining room was used as a storage room and the door failed to provide a self-closing device. During an interview on 1-13-20 at 1:20 pm, Maintenance Staff confirmed the office was used	K0321		

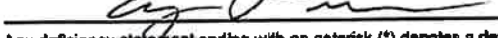
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 05 - SOLAR 715 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 715 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 10. 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE



ICF-A | 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 04 - SOLAR 723 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 723 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 11.	K 000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the snow and ice was removed from the sidewalks, so that egress from the exit would not impede it to full instant use in the case of fire or other emergency. The facility has a capacity of 16 and a census of 11 patients at the time of the survey. Findings are: Observations on 1-13-20 at 12:53 pm revealed, the	K0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 04 - SOLAR 723 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0211	Continued From page 1 sidewalks from 2 of 2 exit door on the north and south patios were covered with snow and ice. During an interview on 1-13-20 at 12:53 pm, Administration Staff A confirmed the snow and ice covered sidewalk. NFPA Standard: 2012 NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K0211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 03 - SOLAR 743 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 743 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 9.	K 000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the snow and ice was removed from the sidewalks, so that egress from the exit would not impede it to full instant use in the case of fire or other emergency. The facility has a capacity of 16 and a census of 9 patients at the time of the survey. Findings are: Observations on 1-13-20 at 12:35 pm revealed, the	K0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CFA | 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 03 - SOLAR 743 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 783 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0211	Continued From page 1 sidewalks from 2 of 2 exit door from the north and south patios were covered with snow and ice. During an interview on 1-13-20 at 12:35 pm, Administration Staff A confirmed the snow and ice covered sidewalk. NFPA Standard: 2012 NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K0211		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 02 - SOLAR 753 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3066 3080 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 753 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 9.	K 000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the snow and ice was removed from the sidewalks, so that egress from the exit would not impede it to full instant use in the case of fire or other emergency. The facility has a capacity of 16 and a census of 9 patients at the time of the survey. Findings are: Observations on 1-13-20 at 12:15 pm revealed, the	K0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CFA | 1/31/20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING 02 - SOLAR 753 B. WING _____	01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
K0211	Continued From page 1 sidewalks from 2 of 2 exit door on the north and south patios were covered with snow and ice. During an interview on 1-13-20 at 12:15 pm, Administration Staff A confirmed the snow and ice covered sidewalk. NFPA Standard: 2012 NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K0211		

PLAN OF CORRECTION

Provider/Supplier Name:	Solar Cottages	Survey Date
STREET ADDRESS, CITY, ZIP:	3052 3056 3060 Pet Blv 753 743 723 715 Solar	1/13/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	GWJI21

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K 0211		1/13/2020
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 723 Solar (422) so that egress would not be impeded.	1/13/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 723 Solar (422) so that egress would not be impeded.	1/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
K 0211	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	1/13/2020
	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 743 Solar (420) so that egress would not be impeded.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 743 Solar (420) so that egress would not be impeded.	1/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
K 0211	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	1/13/2020
	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 753 Solar (418) so that egress would not be impeded.	1/13/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	BSDC Maintenance was contacted to remove all snow and ice from the sidewalks leading to the north and south patios and exit doors of 753 Solar (418) so that egress would not be impeded.	1/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
K 0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	1/13/2020
	The Safety Coordinator immediately removed the contractor's ladder from in-front of the electrical panel boxes in the mechanical room of 3052 Peterson (416).	1/13/2020

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator immediately removed the contractor's ladder from in-front of the electrical panel boxes in the mechanical room of 3052 Peterson (416).	1/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Safety Coordinator immediately removed the contractor's ladder from in-front of the electrical panel boxes in the mechanical room. The BSDC Facility Maintenance Manager and outside contractors were notified of the deficiency.	1/13/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/13/2020
K 0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	1/30/2020
	Observations on 1/13/20 revealed the office near the dining room at 3060 Peterson Blvd. (413) was being used as a storage room and the door failed to provide a self closing device. The home was requested to remove all items from the room and to store in the storage shed outside. All stored items were removed from this office and completed on 1//30/20.	1/30/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observations on 1/13/20 revealed the office near the dining room at 3060 Peterson Blvd. (413) was being used as a storage room and the door failed to provide a self closing device. The home was requested to remove all items from the room and to store in the storage shed outside. All stored items were removed from this office and completed on 1//30/20.	1/30/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/30/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	1/30/2020
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

January 24, 2020

Greg Penner
Solar Cottages
3052, 3056, 3060 Pet BLV 753 743 723 715 Solar
Beatrice, NE 68310

RE: Solar Cottages ICF #ICFDD17

Dear Mr. Penner:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On January 13, 2020, DHHS representatives conducted surveys to determine whether your facility was in compliance with Federal Condition of Participation requirements, State Licensure regulations, and Life Safety Code Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. Enclosed you will find the CMS-2567's documenting the results of that survey. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations and Title 175 NAC 17Regulations Governing Licensure of Intermediate Care Facilities for Individuals with Intellectual Disabilities.

PLAN OF CORRECTION (POC)

A POC for each deficiency cited must be submitted to DHHS.AcuteCareFacilities@nebraska.gov **NO LATER THAN 10 calendar days after receipt of the CMS-2567's**. Failure to submit an acceptable POC timely may result in the imposition of Disciplinary Action.

An acceptable POC must include:

- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiencies cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction;
- **PROVIDE THE DATE WHEN CORRECTION ACTION WILL BE COMPLETED.** Correction dates should be no later than forty-five calendar days from the exit date of the survey or **February 21, 2020.**

NOTE: Remember to attach copies of any auditing tools; education; revised or new policies/processes.

SIGNATURE ON FIRST PAGE OF THE 2567's: The first page must be signed by the provider/supplier representative and faxed to 402-742-8319.

We will notify you whether your plan of correction is or is not acceptable via email. Subsequently, if your plan of correction is **not accepted, you must submit an addendum to your plan of correction within ten (10) calendar days of the notification.**

We thank you and your staff for your cooperation and assistance during the survey. If you have any questions regarding this correspondence, please contact this office.

Sincerely,

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: mark.luger@nebraska.gov

ML/ti

Fralin, Russell

From:	Penner, Greg
Sent:	Friday, March 20, 2020 4:24 PM
To:	Harrison, Corina; Fralin, Russell; Bratt, Julie
Subject:	Fwd: Solar Cottages Revisit Survey with Complaint 3-18-2020
Attachments:	Solar Cottages Revisit 3-18-20.pdf; Solar Cottage Revisit 3-18-2020.pdf; Solar Cottage Revisit W tags 3-18-2020.pdf; Solar Cottages Finding Letter 3-18-20.pdf; Solar Cottages Complaint 3-18-2020.pdf

FYI

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: DHHS DDBH Facilities [redacted]
Date: 3/20/20 9:16 AM (GMT-06:00)
To: "Penner, Greg" [redacted]
Cc: "Luger, Mark" [redacted]
Subject: Solar Cottages Revisit Survey with Complaint 3-18-2020

***PLEASE NOTE**: We are moving toward a more paperless system. As a result, your survey information is being emailed to you. You are being sent a survey letter, and a copy of the survey report form (CMS-2567). We hope our conversion to utilize less paper is a convenient process for you, don't hesitate to contact one of the staff assistants if you have any questions. THANK YOU!*

Good Morning, Mr. Penner:

PLEASE NOTE: The individual to whom this is addressed is to confirm receipt to sender.

Attached is a copy of the results from the Revisit survey with complaints recently completed at your facility.

Your opinion is important to us and we would like your feedback regarding the survey process. Please complete an evaluation about this survey by clicking on the link below:

[redacted]

Sincerely,

Tiffany Isley [redacted]
PUBLIC HEALTH
Nebraska Department of Health and Human Services
OFFICE: 402-471-9[redacted]
[redacted]**cebook | Twitter | LinkedIn**

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 20, 2020

Greg Penner, Administrator
Solar Cottages Icf
3052 3056 3060 Pet Blv 753 743 723 715 Solar
Beatrice, NE 68310

Dear Mr. Penner:

After reviewing the findings of the onsite revisit survey conducted for Solar Cottages on March 16-18,2020 by representatives of this Department, we are pleased to inform you that your facility is in substantial compliance.

The enclosed form indicates the survey results. Please retain for your files.

The surveyors wish to thank you and your staff for your cooperation If you have any questions, please contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 20, 2020

Greg Penner, Administrator
Solar Cottages Icf
3052 3056 3060 Pet Blvd. 753 743 723 715 Solar
Beatrice, NE 68310

Dear Mr. Penner:

An unannounced visit was made to Solar Cottages ICF on March 16-18, 2020, by representatives of this Department. The purpose of the visit was to investigate a complaint on non-compliance with regulatory requirements received by our office.

The following are the general allegations of non-compliance and conclusions:

ALLEGATION:
The facility fails to ensure systems are in place to protect clients from clients with adverse behaviors.
The facility fails to ensure staff safely transfer clients via mechanical lifts.

FINDINGS:
The facility had systems and processes in place to protect clients from clients with adverse behaviors. Facility staff could identify processes and supports in place. Observations revealed staff were able to implement supports. At the time of the investigation, the facility was found to be in compliance with the regulations.

The facility had systems and processes in place to safely transfer clients via mechanical lifts. Facility staff could identify processes and supports in place. Observations revealed staff were able to implement supports. At the time of the investigation, the facility was found to be in compliance with the regulations.

These findings are related to regulations under the Licensure Unit's regulatory authority. Since each division has unique statutory and regulatory obligations and guidelines, it may be possible that your facility will receive additional findings from other divisions who have also participated in the investigation/assessment of these same or similar allegations.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	R 03/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 000	INITIAL COMMENTS Representatives of the DHHS, Division of Public Health conducted a revisit on 3/16/2020 through 3/18/2020 to the 12/17/19 Certification survey to determine compliance with the federal regulations at 42 CFR 483, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The facility census was 66 at the time of the revisit. The facility was found to be in compliance with these regulations.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	R 03/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3062 3066 3080 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
E 000	Initial Comments Representatives of the DHHS, Division of Public Health conducted a revisit on 3/16/2020 through 3/18/2020 to the 12/17/19 Certification survey in order to determine compliance with Federal regulations at Appendix Z, Emergency Preparedness. The facility census was 66 at the time of the revisit. The previously cited deficiencies were corrected and the facility was found to be in compliance with regulations.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD17	A. BUILDING _____ B. WING _____	C 03/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES ICF	3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310

(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
W 000	**INITIAL COMMENTS** Representatives of the DHHS, Division of Public Health conducted a Complaint Investigation on 3/16/2020 through 3/18/2020 to the 12/17/19 Certification survey to determine compliance. The facility census was 66 at the time of the revisit. The facility was found to be in compliance with these regulations.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 25, 2020

Greg Penner, Administrator
Solar Cottages
3052,3054,3056,3060 Pet Blv 753,743,723,715 Sol Dr
Beatrice, NE 68310

Dear Mr. Penner:

An unannounced visit was made to Solar Cottages on September 21, 2020-September 23, 2020, by a representative of this Department. The purpose of the visit was to investigate a complaint on non-compliance with regulatory requirements received by our office.

The following are the general allegation(s) of non-compliance and conclusions:

ALLEGATIONS:

1) The facility fails to protect clients from staff abuse.

2) The facility failed to ensure sufficient staffing to meet client needs.

FINDINGS:

1) The facility had systems and policies in place to respond to and address staff to client abuse, neglect, and mistreatment. At the time of the onsite survey investigation, the facility was found to be in compliance with the regulation.

2) The facility had systems and policies in place to provide the necessary and appropriate supervision to meet client needs. At the time of the onsite survey investigation, the facility was found to be in compliance with the regulation.

These findings are related to regulations under the Licensure Unit's regulatory authority. Since each division has unique statutory and regulatory obligations and guidelines, it may be possible that your facility will receive additional findings from other divisions who have also participated in the investigation/assessment of these same or similar allegations.

Sincerely,

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES	3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR BEATRICE, NE 68310

(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
W 000	INITIAL COMMENTS A representative of the DHHS, Division of Public Health conducted a Complaint Investigation from 9/21/2020 through 9/23/2020 to determine compliance with the Federal regulations at 42 CFR 483, Subpart I, section 483.410-483.480, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The facility was found to be in compliance with these regulations. The facility census was 64 at the time of the investigation.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DHHS Public Health – Licensure Unit

C. State Building Surveys

Attachment B3

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 4, 2020

Ms. Dawn Urbaschek, Administrator
400 State Building
3104, 3070, 3071 State Ave
Beatrice, NE 68310

Dear Ms. Urbaschek:

An unannounced visit was made to 400 State Building on March 3, 2020, by representatives of this Department. The purpose of the visit was to investigate a complaint on non-compliance with regulatory requirements received by our office.

The following are the general allegation of non-compliance and conclusions:

ALLEGATION:
The facility fails to ensure residents are free from abuse.

FINDINGS:
Observations and interviews revealed no evidence of staff to client abuse during the recertification survey. Record review and interview revealed the facility had systems and policies in place to address and prevent abuse, neglect, and mistreatment of clients by staff. Record review and interviews revealed the facility implemented its policies, investigated staff to client abuse allegations, and implemented safeguards to protect clients which met the requirements necessary according the regulatory standards. At the time of the onsite survey investigation, the facility was found to be in compliance with the regulation.

These findings are related to regulations under the Licensure Unit's regulatory authority. Since each division has unique statutory and regulatory obligations and guidelines, it may be possible that your facility will receive additional findings from other divisions who have also participated in the investigation/assessment of these same or similar allegations.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 000	**INITIAL COMMENTS** Representatives of the DHHS, Division of Public Health conducted a Complaint Investigation, from 3/3/2020 through 3/3/2020, to determine compliance with the Federal regulations at 42 CFR 483, Subpart I, section 483.410-483.480, Conditions of Participation for Intermediate Care Facilities for individuals with Intellectual Disabilities. The facility was found to be in compliance with these regulations.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS AcuteCare Facilities

FROM: Russell Fralin, [redacted]

COMPANY:

DATE: March 5, 2020

FAX NUMBER: [redacted]

TOTAL PAGES INCLUDING COVER: 10

PHONE NUMBER:

PHONE NUMBER: [redacted]

☐ URGENT ✓ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received for Dawn Urbaschek and the State Building ICF at the Beatrice State Developmental Center to include those for Public Health, as well as the Fire Marshal.

The EPoc Plans of Correction are being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	400 State Building	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 State Ave Beatrice, NE 68310	2/11/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	4SE121

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
3070 State		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to replace the faulty door closer leading to the laundry room from the dining areas on 3070 State Avenue. GT Fire and Security completed the installation of the door closer on 2/21/20.	2/21/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	GT Fire and Security completed the installation of the door closer on 2/21/20.	2/21/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/21/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/21/2020
400 State		
K0200	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. A work order was submitted to the Maintenance Department to remove all EXIT buttons and magnets from the exit doors on 402 State, 404 State, 406 State and 408 State. It was confirmed that all EXIT buttons and magnets were removed on 2/20/20.	2/20/2020
	2. A work order was submitted to the Maintenance Department to remove the slide lock on one of the two bathroom doors between rooms 3 and 4 on 408 State. It was confirmed that the east slide lock was removed on 2/11/20.	2/11/2020

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. A work order was submitted to the Maintenance Department to remove all EXIT buttons and magnets from the exit doors on 402 State, 404 State, 406 State and 408 State. It was confirmed that all EXIT buttons and magnets were removed on 2/20/20.	2/20/2020
	2. A work order was submitted to the Maintenance Department to remove the slide lock on one of the two bathroom doors between rooms 3 and 4 on 408 State. It was confirmed that the east slide lock was removed on 2/11/20.	2/11/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
K0222	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to remove the delayed egress signage on the exit door of 406 State due to the magnetic lock supporting the delayed egress has been removed. It was confirmed on 2/20/20 that the signage was removed from the door.	2/20/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department to remove the delayed egress signage on the exit door of 406 State due to the magnetic lock supporting the delayed egress has been removed. It was confirmed on 2/20/20 that the signage was removed from the door.	2/20/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020

K0291	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to repair or remove the emergency light in the hall on the 1st floor near the nursing office area. It was confirmed on 2/20/20 that the emergency light was removed. This building is on generator back-up power therefore, the emergency light was no longer required.	2/20/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department to repair or remove the emergency light in the hall on the 1st floor near the nursing office area. It was confirmed on 2/20/20 that the emergency light was removed. This building is on generator back-up power therefore, the emergency light was no longer required.	2/20/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/20/2020
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. The chair that was holding the conference room door open was immediately removed by the Safety Coordinator. Signage "Do Not Block or Prop Door Open" was placed on the door.	2/10/2020
	2. The entry rug was moved immediately by the Safety Coordinator to allow the hallway door to close and latch properly.	2/10/2020
	3. The chair holding the medication room door open on 402 State was removed immediately by the Safety Coordinator. The staff assigned to 402 State along with Shift Supervisors and Home Managers were notified of the deficiency.	2/10/2020
	4. A work order was submitted to the Maintenance Department to install a door closer on the southwest office on the 2nd floor of State Building that was being utilized as a storage area. On 2/11/20, it was confirmed that a door closer was installed on the door.	2/11/2020
	5. A work order was submitted to the Maintenance Department to repair/adjust the laundry room door on 406 State that would not close completely with positive latch. On 2/11/20, it was confirmed that the door will close and latch properly.	2/11/2020

	6. A work order was submitted to the Maintenance Department to install a door closer on room #5 on 408 State that was being used as a storage area. It was confirmed on 2/11/20 that a door closer has been installed and the door will close with positive latch.	2/11/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. The chair that was holding the conference room door open was immediately removed by the Safety Coordinator. Signage "Do Not Block or Prop Door Open" was placed on the door.	2/10/2020
	2. The entry rug was moved immediately by the Safety Coordinator to allow the hallway door to close and latch properly.	2/10/2020
	3. The chair holding the medication room door open on 402 State was removed immediately by the Safety Coordinator. The staff assigned to 402 State along with Shift Supervisors and Home Managers were notified of the deficiency.	2/10/2020
	4. A work order was submitted to the Maintenance Department to install a door closer on the southwest office on the 2nd floor of State Building that was being utilized as a storage area. On 2/11/20, it was confirmed that a door closer was installed on the door.	2/11/2020
	5. A work order was submitted to the Maintenance Department to repair/adjust the laundry room door on 406 State that would not close completely with positive latch. On 2/11/20, it was confirmed that the door will close and latch properly.	2/11/2020
	6. A work order was submitted to the Maintenance Department on to install a door closer on room #5 on 408 State that was being used as a storage area. It was confirmed on 2/11/20 that a door closer has been installed and the door will close with positive latch.	2/11/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	1. The Facility Maintenance Manager along with the Home Manager and Shift Supervisors will monitor and ensure compliance.	2/10/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/10/2020
	3. The Facility Maintenance Manager along with the Home Manager and Shift Supervisors will monitor and ensure compliance.	2/10/2020
	4. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	5. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	6. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	1. The Facility Maintenance Manager along with the Home Manager and Shift Supervisors will monitor and ensure compliance.	2/10/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/10/2020

	3. The Facility Maintenance Manager along with the Home Manager and Shift Supervisors will monitor and ensure compliance.	2/10/2020
	4. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	5. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
	6. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/2020
K0353	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to have the foreign material removed from the sprinkler head in the 1st floor conference room of 3104 State (400) building. It was confirmed on 2/28/20 that the sprinkler heads were cleaned of all foreign materials.	2/28/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department to have the foreign material removed from the sprinkler head in the 1st floor conference room of 3104 State (400) building. It was confirmed on 2/28/20 that the sprinkler heads were cleaned of all foreign materials.	2/28/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020
200 Sheridan		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. A work order was submitted to the Maintenance Department to repair/adjust the 2nd floor shower room door that failed to close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	2. A work order was submitted to the Maintenance Department to install an additional or heavier spring that would ensure the fire rated door leading to the non-sprinkled north crawl space would close and secure properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020

	3. A work order was submitted to the Maintenance Department to install an additional or heavier spring that would ensure the fire rated door leading to the non-sprinkled south crawl space would close and secure properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. A work order was submitted to the Maintenance Department to repair/adjust the 2nd floor shower room door that failed to close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	2. A work order was submitted to the Maintenance Department to install an additional or heavier spring that would ensure the fire rated door leading to the non-sprinkled north crawl space would close and secure properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	3. A work order was submitted to the Maintenance Department to install an additional or heavier spring that would ensure the fire rated door leading to the non-sprinkled south crawl space would close and secure properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	3. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	1. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	3. The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
Carstens Center		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to adjust/repair the northwest gymnasium mechanical room door to ensure that the door will close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	A work order was submitted to the Maintenance Department to adjust/repair the northwest gymnasium mechanical room door to ensure that the door will close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
Chapel		
K0300	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to have maintenance staff inspect and sign off on the inspection tag for the fire extinguisher in the south mechanical room. It was confirmed on 2/28/20 that the inspection tag was signed off for January and February of 2020.	2/28/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department to have maintenance staff inspect and sign off on the inspection tag for the fire extinguisher in the south mechanical room. It was confirmed on 2/28/20 that the inspection tag was signed off for January and February of 2020.	2/28/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020

K0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	The Safety Coordinator removed all items that were being stored in front of the electrical panel boxes. Red tape was also placed on the floor in front of the electrical panels to ensure no items will be blocking access to the electrical panels. It was confirmed on 2/28/20 that electrical panel boxes were not obstructed.	2/28/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator removed all items that were being stored in front of the electrical panel boxes. Red tape was also placed on the floor in front of the electrical panels to ensure no items will be blocking access to the electrical panels. It was confirmed on 2/28/20 that electrical panel boxes were not obstructed.	2/28/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/28/2020
D Building		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to adjust/repair the Kiln room door to ensure that the door will close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department to adjust/repair the Kiln room door to ensure that the door will close and latch properly. It was confirmed on 2/26/20 that the door will close and latch properly.	2/26/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020

	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
K0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	The Safety Coordinator removed all items that were being stored in front of the electrical panel boxes. Red tape was also placed on the floor in front of the electrical panels to ensure no items will be blocking access to the electrical panels. It was confirmed on 2/21/20 that the electrical panel boxes were not obstructed.	2/21/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator removed all items that were being stored in front of the electrical panel boxes. Red tape was also placed on the floor in front of the electrical panels to ensure no items will be blocking access to the electrical panels. It was confirmed on 2/21/20 that the electrical panel boxes were not obstructed.	2/21/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/21/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/21/2020
Admin Building		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department to install a door closer on the south computer lab door located in the basement of the Administration Building. It was confirmed on 2/26/20 that a door closer has been installed and the door will close with positive latch.	2/26/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	A work order was submitted to the Maintenance Department to install a door closer on the south computer lab door located in the basement of the Administration Building. It was confirmed on 2/26/20 that a door closer has been installed and the door will close with positive latch.	2/26/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/26/2020
K0353	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	A work order was submitted to the Maintenance Department requesting that the ceiling tiles that were removed by contractors be replaced/installed. It was confirmed on 3/2/20 that the ceiling tiles have been replaced as requested.	3/2/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department requesting that the ceiling tiles that were removed by contractors be replaced/installed. It was confirmed on 3/2/20 that the ceiling tiles have been replaced as requested.	3/2/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	3/2/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	3/2/2020
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 12 - 3070 STATE AVENUE B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 3070 State is a single story building of Type V construction that was built in 1970 and is fully sprinkled. The facility has 10 certified beds. At the time of the survey the census was 8 residents. 400 State Building - 3070 State was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbochek | TITLE: ICFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 12 - 3070 STATE AVENUE B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 1 rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosure for hazardous areas to separate them from the rest of the facility. This deficient practice would allow fire and smoke to migrate out of the hazard areas into the exit corridor which could delay egress. The facility census was 8. Findings are: Observation on 2-10-20 at 2:58 pm revealed:	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 12 - 3070 STATE AVENUE B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 2 1. The south fire rated door leading to the mechanical room and laundry hall equipped with a self-closing device failed to close and latch within the doorframe. During an interview on 2-10-20 at 2:58 pm, Facility Staff A confirmed the self-closure was broken.	K0321		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	**INITIAL COMMENTS** 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - F Building/Main is a two story building of Type III construction that was approved in 2002 and is fully sprinkled. The facility has 36 certified beds. At the time of the survey the census was 10 residents. 400 State Building - Main was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0200	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Escape Requirements - Other 2012 EXISTING (Prompt and Slow) List in the REMARKS section any LSC Section 33.2 Means of Escape requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K0200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrschek | TITLE: FCFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0200	Continued From page 1 failed to assure that exit buttons were removed from the exit doors and failed to assure that slide locks were not used. This deficient practice would delay egress in the event of an emergency. The facility census was 10. Findings are: Observations on 2-10-20 at 1:54 pm and 2:24 pm revealed: 1. Four of four living units provided exit buttons at the exits, the magnetically locked function had been removed from the door. 2. A slide lock on 2 of 2 doors for the restroom between rooms 3 and 4 in Unit 408. During an interview on 2-10-20 at 1:54 pm and 2:24 pm, Facility Staff A confirmed the exit buttons and the slide locks.	K0200		
K0222	Egress Doors CFR(s): NFPA 101 Egress Doors 2012 EXISTING (Prompt and Slow) Doors in means of egress shall be as follows: 1. Doors complying with 7.2.1 shall be permitted. 2. Doors within individual rooms and suites of rooms shall be permitted to be swinging or sliding. 3. No door in any means of egress, other than those complying with (4) or (5), shall be locked against egress when the building is occupied. 4. Delayed-egress locks in accordance with 7.2.1.6.1 shall be permitted. 5. Access-controlled egress doors in accordance with 7.2.1.6.2 shall be permitted. 6. Revolving doors complying with 7.2.1.10 shall be permitted.	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0222	Continued From page 2 Corridor doors must be provided with positive latching hardware and roller latches are not permitted. Lockups are not permitted by regulation. 33.3.2.2.2, 33.3.2.11.2, 42 CFR 483.470 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the magnetically locked exit door signage was appropriate. This deficient practice would cause confusion and delay egress during an emergency. The facility census was 10. Findings are: Observations on 2-10-20 at 2:38 pm revealed, delayed egress signage on the exit door for unit 406, the magnetic lock had been removed and not functional. During an interview on 2-10-20 at 2:38 pm, Facility Staff A confirmed the exit door had delayed egress signage posted on the door and the magnet was not functional.	K0222		
K0291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting 2012 EXISTING (Prompt and Slow) Emergency lighting in accordance with 7.9 shall be provided in facilities with prompt or slow evacuation capability having more than 25 rooms, unless each room has a direct exit to the outside of the building at finished ground level. 33.3.2.9 This STANDARD is not met as evidenced by: Based on observation and interview the facility	K0291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0291	Continued From page 3 failed to maintain emergency light in the basement stairway. The deficient practice would not ensure operation of the light upon loss of normal power that could delay egress during an emergency. The facility census was 10. Findings are: Observation on 2-10-20 at 2:02 pm revealed the emergency light in the hall on first floor near Nurse Office, failed to operate when the test button was depressed. During an interview on 2-10-20 at 2:02 pm, Facility Staff A confirmed the nonfunctioning emergency light.	K0291		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt and Slow) Rooms containing high-pressure boilers, refrigerating machinery, transformers, or other service equipment subject to possible explosion shall not be located under or adjacent to exits. All such rooms shall be effectively separated from other parts of the building as specified in section 8.7. Hazardous areas shall be separated with construction of a minimum of 1-hour fire resistance with openings protected with self-closing fire doors or have an automatic extinguishment system and smoke partition in accordance with 8.4. Hazardous areas shall include but not be limited to the following: boiler or heating rooms, laundries, repair shop, spaces storing combustibles in quantities deemed hazardous. 33.3.3.2.2	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 4 33.3.3.2.1, 33.3.3.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosure for hazardous areas to separate them from the rest of the facility. This deficient practice would allow fire and smoke to migrate out of the hazard areas into the exit corridor which could delay egress. The facility census was 7. Findings are: Observation on 2-10-20 between 1:56 pm and 2:46 pm revealed: General Area 1. The fire rated Conference Room door equipped with a self-closing device was held open with a chair. 2. A rug obstructed the fire rated door next to the Conference Room, which was equipped with a self-closing device failed to latch within the doorframe. Unit 402 3. The Medication room door equipped with a self-closing device, was held open with a chair. Unit 406 4. The south west Office, was used as a storage room and the facility failed to provide a self-closing device on the door. 5. The Laundry Room door equipped with a self-closing device, failed to latch within the doorframe. Unit 408 6. Room 5, was used as a storage room and the facility failed to provide a self-closing device on the door. During an interview on 2-10-20 between 1:56 pm	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 5 and 2:46 pm, Facility Staff A confirmed the findings.	K0321		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt and Slow) Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system was last checked _____ b) Who provided system test _____ c) Water system supply source_____ 33.3.3.5.1, 9.7.5, 9.7.7, 9.7.8, NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that fire sprinklers were free of foreign material. This deficient practice would affect the operating temperature of the fire sprinklers and increased the potential that the sprinkler system would fail to activate as designed during a fire. The facility census was 7. Findings are: Observation on 2-10-20 1:58 pm revealed: 1. Sprinkler to the left of the Conference Room door was covered in foreign material. During an interview on 2-10-20 1:58 pm Facility	K0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0353	Continued From page 6 Staff A confirmed the foreign matter covering the sprinkler.	K0353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	**INITIAL COMMENTS** 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 200 Sheridan is a two story building of Type II construction that was approved in 2002 and is fully sprinkled. 400 State Building - 200 Sheridan was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Vabnchek
TITLE: ICFA
(X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 1 between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous would latch within the doorframe. This deficient practice would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 2-10-20 between 1:43 am and 2:43 pm revealed: 1. 2nd floor Staff Shower Room door equipped with a self-closing device failed to close and latch within the doorframe. 2. The fire rated door to the non-sprinkled north crawl space failed to provide a self-closing device	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 2 and failed to close within the frame. 3. The fire rated door to the non-sprinkled south crawl space failed to provide a self-closing device and the failed to close within the frame. During an interview on 2-10-20 between 1:43 pm and 2:42 pm, Facility Staff A confirmed the findings	K0321		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 05 - CHAPEL NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 13, Assembly Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Chapel is a single story building of Type V construction that was approved in 2002 and is not sprinkled. 400 State Building - Chapel was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012	K 000		
K0300	Protection - Other CFR(s): NFPA 101 Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct monthly inspections of the fire extinguisher. This condition increased the potential that a fire extinguisher would fail to operate during a fire.	K0300		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulbrecht | TITLE: TCFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 05 - CHAPEL NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0300	Continued From page 1 Findings are: Record review on 2-10-20 at 11:20 am, revealed the inspection tag for fire extinguisher in the south Mechanical Room was last inspected on 1/19. During an interview on 2-10-20 at 11:20 am, Facility Staff A acknowledged the fire extinguisher had not been inspected. NFPA Standard: 2010, NFPA 10, 7.2.1.2* Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.	K0300		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that electrical panel boxes were not obstructed. This deficient practice would delay maintenance of the electrical system in the building. Findings are: Observations on 2-10-20 at 11:25 am revealed, several items stored in front of the panel boxes in the south Mechanical Room. During an interview on 2-10-20 at 3:05 pm and 3:10	K0511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 05 - CHAPEL NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0511	Continued From page 2 pm, Facility Staff A confirmed the items obstructing the panel boxes.	K0511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 13, Assembly Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Carstens is a single story building of Type II construction that was approved in 2002 and is fully sprinkled. 400 State Building - Carstens was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Wilroschek | TITLE: TCFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 1 between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous area would close and latch. These deficient practices would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 2-10-20 at 12:02 pm revealed: 1. The north Gym Mechanical room door equipped with self-closing device failed to close and latch within the doorframe. During an interview on 2-10-20 at 12:42 pm, Facility Staff A confirmed the door failed to latch	K0321		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 2 within the doorframe.	K0321		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - D Building is a three story building of Type II construction that was approved in 2002 and is fully sprinkled. 400 State Building - D Building was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrich | TITLE: ICFIA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 1 between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosure for hazardous areas to separate them from the rest of the facility. This deficient practice would allow fire and smoke to migrate out of the hazard areas, which could delay egress. Findings are: Observation on 2-10-20 between 1:43 pm and 2:11 pm revealed: 1. The 1-hour fire rated door to the Kiln Room failed to close and latch into the doorframe. During an interview on 2-10-20 at 1:43 pm and 2:11	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE RFATRICF, NF 68310

(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
K0321	Continued From page 2 pm, Facility Staff A confirmed the closure on the door was not operating.	K0321		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide clear space in front of electrical panels. This deficient practice could cause a delay and injury when turning off the power during an electrical emergency. Findings are: Observations on 2-10-20 at 1:14 pm revealed, the electrical panel box D located in on the third floor electrical room was obstructed with plastic tubs labeled Dry Mop and Rags. During an interview on 2-10-20 at 1:14 pm, Facility Staff A confirmed the items in front of the electrical panel box.	K0511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE PATRICK, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Administration is a two story building of Type II construction that was approved in 2002 and is fully sprinkled. 400 State Building - Administration was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrschek | TITLE: ICFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3184, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 1 between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous area was self-closing. This deficient practice would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 2-10-20 at 2:50 pm revealed: 1. The 1 ½ hour fire rated door to the basement Computer Lab failed to provide a self-closing device. During an interview on 2-10-20 at 2:50 pm, Facility Staff A confirmed the self-closing device had been	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0321	Continued From page 2 removed.	K0321		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2).	K0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0353	Continued From page 3 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that ceilings were free of	K0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0353	Continued From page 4 penetrations. This deficient practice would not allow the sprinkler system to activate as it was designed and fire would spread throughout the egress corridor. Findings are: Observation on 2-10-20 at 2:40 pm revealed: 1. The ceiling grid in the tunnel corridor had several open penetrations where ceiling tiles were missing. During an interview on 2-10-20 at 2:40 pm, Facility Staff A confirmed the missing ceiling tiles.	K0353		

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER
FACSIMILE TRANSMITTAL SHEET

TO: DHHS AcuteCare Facilities

FROM: Russell Fralin [redacted]

COMPANY:

DATE: March 5, 2020

FAX NUMBER: [redacted]

TOTAL PAGES INCLUDING COVER: 10

PHONE NUMBER:

PHONE NUMBER: [redacted]

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received for Dawn Urbaschek and the State Building ICF at the Beatrice State Developmental Center to include those for Public Health, as well as the Fire Marshal.

The EPoc Plans of Correction are being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	400 State Building	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 State Ave Beatrice, NE 68310	2/11/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	4SE111

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W197	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	For Client 2: Client 2 was discharged from the Beatrice State Developmental Center (BSDC) on 2/21/20.	2/21/2020
	For Client 3: During a recent Public Health survey on 2/3/20, it revealed that Client 3 actively and independently participated in their environment requiring little to no staff interventions related to daily living and developmental skills. Observations revealed that Client 3 is independent or capable of demonstrating developmental and daily living skills with the focus of the facility's services directed at behavioral or mental health needs. Review of Client 3's Individual Support Plan (ISP) dated 6/27/19 identified the individual as an effective verbal communicator who communicated wants, needs and thoughts using long complex grammatically correct statements; to possess strengths/skills in several areas of independent living skills; is able to withdraw, secure, carry and spend small amounts of money; and completed custodial, recycling and vehicle detailing work, earning $305.90 over the last 30 days.	3/27/2020
	Client 3's records include a letter dated 5/24/19 from the Facility Administrator to an attorney regarding Client 3's arrest and pending charges. The letter identified that Client 3 had been at the facility's Crisis Stabilization Unit (CSU) from 10/31/18-4/1/19 and could be readmitted on 5/28/19. The letter described the services provided as "treatment and habilitative care in the CSU, which has been designed to provide behavioral, psychiatric and medical interventions to Nebraskans who have been determined to be developmental disabled and who, by reason of mental health crisis, drug abuse, or other circumstances are struggling in their community placement".	3/27/2020
	On February 27, 2020, the QIDP received a letter addressed to Client 3 from Dawn Sybrant, Interim Program Manager with DHHS Medicaid and Long-Term Care as notification that Medicaid funding for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) services will be terminated as Client 3 no longer meets the level of need criteria for ICF/DD services. A Notice of Action letter states that Client 3's Medicaid funding for ICF/DD services will be discontinued after April 27, 2020. The Notice of Action letter reason for the decision states "review of the 2/14/20, BSDC 400 State Building recertification survey found you do not need ICF/DD services as you do not have developmental needs requiring continuous active treatment services".	3/27/2020

	BSDC facility administration is working with the DHHS Department of Developmental Disabilities in regards to options for funding.	3/27/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	On February 27, 2020, the QIDP received a letter addressed to Client 3 from Dawn Sybrant, Interim Program Manager with DHHS Medicaid and Long-Term Care as notification that Medicaid funding for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) services will be terminated as Client 3 no longer meets the level of need criteria for ICF/DD services. A Notice of Action letter states that Client 3's Medicaid funding for ICF/DD services will be discontinued after April 27, 2020. The Notice of Action letter reason for the decision states "review of the 2/14/20, BSDC 400 State Building recertification survey found you do not need ICF/DD services as you do not have developmental needs requiring continuous active treatment services".	3/27/2020
	BSDC facility administration is working with the DHHS Department of Developmental Disabilities in regards to options for funding.	3/27/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	BSDC facility administration is working with the DHHS Department of Developmental Disabilities in regards to options for funding.	3/27/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator is the responsible person for monitoring and to ensure compliance.	3/27/2020
W249	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	For Client 1, staff will be re-inserviced on appropriate training techniques and implementation of the Individual Support Plan (ISP) program "Dining Etiquette" dated 11/27/19, to ensure staff are offering napkins or prompting Client 1 to wipe face whenever eating or drinking; to have a napkin available at every meal or snack and to occur at every given opportunity as appropriate.	3/27/2020
	For all other individuals residing within the State Building ICF, staff will be re-inserviced on mealtime programs as outlined in the Individual Support Plan (ISP).	3/27/2020
	A monitoring system will be developed to ensure implementation of the ISP and mealtime programs will be completed by Compliance Specialists, QDDPs, Home Managers and DTSS.	3/27/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	For Client 1, staff will be re-inserviced on appropriate training techniques and implementation of the Individual Support Plan (ISP) program "Dining Etiquette" dated 11/27/19, to ensure staff are offering napkins or prompting Client 1 to wipe face whenever eating or drinking; to have a napkin available at every meal or snack and to occur at every given opportunity as appropriate.	3/27/2020
	For all other individuals residing within the State Building ICF, staff will be re-inserviced on mealtime programs as outlined in the Individual Support Plan (ISP).	3/27/2020
	A monitoring system will be developed to ensure implementation of the ISP and mealtime programs will be completed by Compliance Specialists, QDDPs, Home Managers and DTSS.	3/27/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	A monitoring system will be developed to ensure implementation of the ISP and mealtime programs will be completed by Compliance Specialists, QDDPs, Home Managers and DTSS.	3/27/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator will be the responsible person for monitoring and to ensure compliance.	3/27/2020
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	ACTIVE TREATMENT CFR(s): 483.440(a)(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews the facility failed to ensure that 2 of 4 sampled clients admitted to the facility had developmental needs requiring continuous active treatment services. This had the potential to affect all clients residing at the facility. The facility census was 18 at the time of the recertification survey. Findings: A. Client 2 1) Observations on 2/3/2020 (4:50pm-6:25pm), 2/4/2020 (11:40am-12:26pm), and 2/5/2020 (7:15am-7:45am) revealed Client 2 actively and independently participated in their environment and required little to no staff interventions related to daily living and developmental skills. These observations identified Client 2: a. Verbally communicated clearly and effectively their wants and needs and asked direct and appropriate questions to direct support staff and the surveyor.	W 197		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbanchek | TITLE: ICFA | (X6) DATE: 3-5-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 1 b. Independently prepared meals and snacks using the stove, oven, microwave, and toaster: (1) breakfast- cooked oatmeal and mixed with banana and honey; made toast and prepared coffee, milk, and juice; (2) lunch-assisted staff to cook a grilled cheese sandwich, and prepared their own vegetables and drinks; (3) supper-prepared 3 baked burritos, a bowl of blue berries, and drinks. Client 2 independently took food temperatures and verified said temperatures with staff to ensure food was safe to eat. Client 2 asked staff for assistance in use of the stove and oven for correct cooking temperatures and due to fear of hot surfaces. Client 2 was knowledgeable about and utilized oven mitts to prevent burns from hot pots and pans. c. Client 2 ate independently. Client 2 took single bites, adequate in size, chewed bite before swallowing, and either paused or set fork down on the plate between bites. The client took sips of their drink(s) between bites. The client did not talk with food in their mouth. Client 2 had no episodes of gagging or coughing that would indicate choking or difficulties with drinking or feeding themselves. d. Possessed the basic developmental skills of toileting, maintaining privacy, dressing, grooming, and personal hygiene cares needed for independence. e. Independently completed laundry and clothes care tasks. f. Used leisure time appropriately by making personal phone calls, prepared game console and played video games, took naps in their bedroom,	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 2 completed personal shopping in the community (with 2 staff), played cards/board games, and watched television (game shows and news channels). Client 2 was able to have conversations regarding current news events with direct support staff and the surveyor. g. Was able to read, tell time, and had writing skills. Client 2 would request they be provided "quiet time" between work activities and leisure time in order for the client to write letters to their attorney, a local judge presiding over a case involving Client 2, local politician(s), and the surveyor. h. Possessed basic telephone and computer skills, including accessing internet websites for music entertainment during meal and leisure times. i. Observations revealed the facility provided Client 2 with two to one staffing supervision levels at all times during waking hours from 6:00am to 11:00pm. Constant visual supervision and 15-minute checks were provided when Client 2 utilized the bathroom, slept in their room, and leisure time on the living unit. During transitions from the living unit, when completing janitorial job tasks, and when in the community staff were positioned directly on either side of Client 2 due to behavioral risks. j. During observations o n 2/4/2020 (11:40am-12:26pm) and 2/5/2020 (7:15am-7:45am) Client 2 displayed and engaged in verbal and physical aggression toward direct support staff, supervisory staff, and the surveyor which included:	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 3 (1) Yelling and screaming in a loud voice (2) Verbally threatening to do staff bodily harm (3) Using profanity, racist comments, name calling, belittling and derogatory remarks (4) Invading direct care staffs personal space, lunging at staff in an intimidating manner (flaying arms out at their sides and posturing by thrusting chest forward), and threatening physical harm (5) Punching a table and walls with a closed fist while yelling and cursing at direct support staff (6) Flipped over then shoved an eight foot (wood and metal) table across the day room. This caused three chairs to be flipped over and miscellaneous items on the table (paper, pens, hand sanitizer, Kleenex, etc.) to be strewn in the day room and hallway. (7) Kicked and tipped over a love seat then shoved the loveseat toward the supervisor who was sitting in the living-room area. 2) Record review of the following documents identified Client 2 (admitted to the facility on 11/22/19) was independent and required no training programs for basic skill acquisition to address daily living skill developmental deficits. The facility's provision of active treatment services was focused on the client's behavioral and mental health needs. a. Review of the "Assessment Admission/Discharge" (dated 11/26/19) identified Client 2 was independent in the following skills: feeding, drinking, grooming, dressing, bathing, mobility/ambulation, and receptive/expressive communication. The client was able to: read survival words and simple printed material,	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 4 instructions, tell time (and associated events related to time periods), perform errands, and make small purchases with cash money, writing checks, or use of a debit card. b. Client 2's Individual Support Plan (ISP, dated 11/22/19 (admission) and subsequent meetings dated 11/26/19 and 12/19/19) identified that Client 2 was an emergency placement at the facility due to aggressive behaviors, property damage, significant safety concerns, and law enforcement involvement in the community. On 11/25/19 (three days after admission) Client 2 was placed in emergency protective custody (EPC) with law enforcement and transferred from the facility to the Lincoln Crisis Center due to significant safety concerns, threats, maladaptive behaviors, and for mental health evaluation. Client 2's ISP identified the client was able to verbally communicate wants and needs. Client 2 independently groomed (used a disposable razor for shaving), dressed, toileted, completed laundry/clothing care, bathed/showered, read, walked/ambulated, utilized money/debit card/write checks, and could tell time. Client 2 independently fed themselves, made/prepared their own meals, completed table setting steps, cleaned-up after meal, expressed food preferences and dislikes, and assisted staff with meal planning. The client independently participated in recreational activities which included playing X-box, lifting weights, free-style rapping, writing music, watching sports, and playing basketball, cards, and the drums. Client 2 independently navigated a computer, phones, and electronic devices. Client 2 was knowledgeable about and could independently	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 5 take their medications. The ISP documented that Client 2 identified they were most proud of being a published author, political advocate, being athletic, and completing custodial jobs and cleaning cars with great detail. The ISP included no evidence that the facility had implemented active treatment training and teaching of daily living skills (as identified above) for Client 2. Further review of the ISPs identified Client 2 had skill maintenance programs for medication administration, money management, and bedroom cleaning/maintenance, even though Client 2 was independent in these skills. The ISP identified the facility developed six behavior programs to address Client 2's behaviors which included a goal to increase pro-social communication and goals to decrease property destruction, verbal aggression, physical aggression, and suicidal and homicidal ideations. The ISP identified multiple rights restrictions specific to behavioral, safety, and suicidal/homicidal precautions including: psychotropic medications (Prazosin and Quietiapine), 2:1 supervision, 15-minute visual checks, all sharps locked unless in use, limited access to fire starting materials/lighters, scheduled phone calls to guardian, no access to internet, no horror or rated 'R' movies, and a crisis safety plan addressing physical and mechanical restraints. c. Review of the "Annual Independent Living Skills Assessment Summary" (dated 12/19/19) identified Client 2 was independent in all areas of self-help skills including toileting, personal hygiene, hand	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 6TATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 6 washing, bathing, applying lotion, oral hygiene, grooming, dressing/undressing, eating, being appropriate while eating, and mealtime activities. Client 2 was independent in areas of home living skills including dining, meal preparation, meal-time clean up, clothing care (washing, drying, and putting away items), and household care chores. The assessment identified the client needed minimal verbal prompting when utilizing the stove/oven or completing tasks such as vacuuming, mopping, emptying garbage, and cleaning windows/mirrors. The social developmental skills section of the assessment identified Client 2 enjoyed being around and socializing with others. Client 2 had skills to engage with other when socializing and human sexuality needs. The client was independent in all areas of safety skills, medication administration, and cognitive skills of money management, utilization of numbers (dates, social security numbers, etc.), time concepts, reading, writing, and identification of colors. Client 2 was independent in recreation/leisure, community integration, and shopping skills. The assessment identified Client 2's independent living skills needed to addresss teaching the client how to take responsibility for their aggressive behaviors and in appropriate social actions. d. Review of the "Transition Planning: Individual Risks, Protections, Supports and Services" (dated 12/19/19) identified Client 2 was capable of recognizing hazardous environments, independently ambulated and transferred in/out of vehicles, and independently completed all daily living skills. This assessment identified Client 2 required no direct occupational, physical,	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 7	W 197		

recreation, and/or specialty healthcare therapies. Client 2 was employed and paid by the facility for completing custodial jobs. Client 2 had two to one staffing (6:30am - 11:00pm and when off of the living unit) for training/safety needs, and for staff to be immediately available to provide needed redirection and intervention for behavioral risks. Client 2 had a BSP, safety plan, and crisis intervention plan to address the client's verbal and physical aggressions, property destruction, elopements, and suicidal and homicidal ideations/attempts. This document identified that these behavioral plans, "sometimes they are not successful in protecting me and others when I am aggressive."

e. Review of the "Nutritional Evaluation" (dated 12/17/19) identified Client 2 ate independently. Client 2 was able to express food preferences and dislikes. Client 2 preferred to and independently prepared their own meals. The client assisted with meal planning, food preparation, table setting and clearing. Client 2 was diagnosed with GERD (Gastroesophageal reflux disease).

f. Review of the "BSP Post Admission Report," (dated 12/19/19) identified that from 11/22/19 - 12/15/19 Client 2 had no incidents of property destruction, did not engage in suicidal and homicidal ideations, and no attempts to elope. This report identified that Client 2 was independent in daily living skills to be successful in community placement. The BSP was implemented to provide supports so that Client 2 would be able to manage their behaviors and mental health symptoms and decrease targeted aggressive behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 8 g. Review of the "Evaluation and Management" (admission history and physical, dated 12/31/19) identified Client 2 was diagnosed with autism spectrum disorder (history of developmental disability), mood disorder, personality history, and GERD. The physician identified that Client 2 had a full scale IQ of 86. (This IQ diagnosis was identified in 7/29/15 comprehensive IQ evaluation assessment received as collateral documentation at the time of Client 2's admission.) h. Review of the "Annual Dental Examination" (dated 12/11/19) revealed that the dentist identified Client 2 was independent and had "Very good oral care. [Client 2] does floss. Periodontal health very good." i. Review of Client 2's "Admission Psychological Assessment" (dated 12/6/19) identified the following diagnoses: Autism spectrum disorder (by history and without intellectual impairment), generalized anxiety disorder, post-traumatic stress disorder, and paranoid personality disorder. The facility's Psychologist identified in this assessment that based on the cognitive and psychological testing results that Client 2 "would not and does not meet the criteria for an intellectual disability"; but due to the identified Autism spectrum disorder (by history) deemed Client 2 eligible for developmental disability services. j. Review of the documents completed by the facility's Psychiatrist titled "Evaluation and Management" (dated 12/19/19, 12/26/19, 1/9/2020, and 1/24/2020) revealed Client 2 was prescribed psychotropic medications Prazosin and	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 9 Quietiapine for behavior management. These documents identified Client 2's diagnoses to be Autism spectrum disorder (by history and without intellectual impairment), paranoid personality disorder, post-traumatic stress disorder, and generalized anxiety disorder. 3) Record review of General Event Reports (GERs) and associated documents identified Client 2's involvement in incidents of physical aggression to staff and law enforcement involvement. a. Review of a GER and Preliminary Event Review (PERs) revealed an incident occurred on 11/25/19 in which Client 2 was transferred to the Mental Health Crisis Center in Lincoln. According to the GER and PER, due to safety concerns, threats made to staff and Client 2's unwillingness to participate in medication changes or medication beyond their current regimen, the Clinical Services Administrator contacted the Nebraska State Patrol (NSP). Client 2 was determined to be a risk to themselves and others and the NSP initiated emergency protective custody and transported Client 2 to the Mental Health Crisis Center. b. Review of a GER and T-Logs (electronic communication log) revealed an incident occurred on 2/10/2020 in which Client 2 physically attacked staff. According to the GER and T-Log, a supervisor was delivering a message to Client 2 from nursing staff and the subject of law enforcement surfaced within the conversation. Client 2 shoved the supervisor and tried to break the supervisor's phone. Client 2 grasped the supervisor's throat and lunged forward, hitting the	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 10 supervisor with closed fists. Client 2 continued to aggress toward the supervisor, requiring three staff to physically intervene with Client 2's aggression. 4) Interviews with Client 2 and facility staff verified Client 2 was independent in or capable of demonstrating developmental and daily living skills and resided at the facility due to behavioral or mental health needs. a. During interviews on 2/3/2020 at 5:10pm (in the presence of Staff F and J) and 2/5/2020 at 7:18am (in the presence of Staff B and I) Client 2 confirmed that the facility was the fifth placement they had been in since May 2019. Client 2 identified they had to go to court because of an incident at one of the former service providers. Client 2 reported they were taken by law enforcement to a local crisis center after being admitted to the facility because they were being aggressive. Client 2 reported they were independent in cleaning their bedroom and the living unit, laundry tasks, showering/bathing, personal hygiene, shaving, eating, drinking, tooth brushing and flossing, dressing, and grooming. Client 2 reported they earned pay for janitorial work and were able to independently utilize money/debit card to purchase personal items. Client 2 identified they were able to communicate verbally, in writing, and on the phone with facility staff, their attorney, guardian, and other politicians. Client 2 verified they had written a book in 2015 about being autistic.	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3184, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 11	W 197		

Client 2 confirmed they were independent in meal preparations, cooking, serving, and clean-up after the meal. Client 2 reported being able to follow recipes and menus provided by the facility. Client 2 verified they know how to use the microwave, toaster, stove, and oven.

Client 2 reported they planned their recreation and leisure time and didn't like staff telling them what to do. Client 2 liked to go the facility's gym to play basketball and lift weights, play video games against staff, watch television, play cards, call family members, complete personal errands, and/or hang out on the living unit.

Client 2 verified they had training programs for behaviors and medication administration programs. Client 2 revealed their medication program was to check off the electronic medication sheet. Client 2 admitted to refusing to participate in the program because the client already knew how to take their medications. According to Client 2 they could independently take their medications and knew the names of medications, dosage, the rationale for use, times, and how to take the medications.

b. Interview with Staff F on 2/4/2020 at 4:52 pm and 2/5/2020 at 3:20pm, confirmed Client 2 was independent and did an excellent job with completing personal hygiene, grooming, showering, toileting, dressing/undressing, brush and floss teeth, shaving, and eating/drinking. Staff F added that Client 2 would shower up to three times per day because the client cared about their appearance. Client 2 independently used an electric razor to shave their head daily. Client 2 was capable of doing all steps to preparing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 12 cooking their meals independently, but did occasionally ask for staff assistance with the stove/oven. Client 2 was capable of doing janitorial work independently and wanted to get a job in the community doing such. Client 2 completed medication administration and knew their meds, but wanted staff to deliver and provide Client 2 their medications. Client 2 could communicate their wants and needs verbally and in writing. Staff F verified they had read a 400 page book that Client 2 authored and published. Staff F verified that Client 2 had behavior support plans to address verbal and physical aggression, elopement, and suicidal thoughts. According to Staff F, Client 2 had a hard time controlling their anger and rage which caused the client to yell and scream, get in staffs face, use lots of curse words, threaten to harm staff and property, and elope. Staff F reported that Client 2 repeatedly stated they wanted a reason to sue the facility for 2.1 million dollars as Client 2 had tried to sue the State of Nebraska Corrections Department. According to Staff F, Client 2 tried to bait staff into arguments by using verbal aggression and threats so the client could get a reaction from staff and a reason for Client 2 to become violent. Staff F revealed during incidents of aggression Client 2 would repeatedly talk about being in prison for four years and that Client 2 knew how beat up staff. Staff F did not know why Client 2 was at the facility, except the client was provided structure. Staff F identified that Client 2 was not like some of the other clients that needed assistance with their daily living skills. c. Interview with Staff I on 2/6/2020 at 10:13am confirmed Client 2 was at the facility instead of jail	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 13 or the regional center. Staff I verified Client 2 was independent in showering, toileting, personal hygiene, dressing/undressing, brushing teeth, grooming/shaving, eating, and drinking. Client 2 had skills to complete steps for meal preparation, cooking, serving, eating, and completing clean-up. Staff I identified Client 2 independently made their own oatmeal and coffee each morning and got their own snacks and drinks. Client 2 communicated independently verbally and in writing. Client 2 wrote several letters per week to various providers, politicians, judges, and the facility. Staff I verified Client 2 had programs addressing medication administration and behavior and safety plans. According to Staff I, Client 2 knew their medications, why they were prescribed, could independently take them, and how document on the facility's electronic MAR (medication administration record). Staff I reported Client 2 was at the facility for their anger management issues. According to Staff I, Client 2 yelled, screamed, threatened harm, made insulting remarks, got face to face with staff and screamed, and was physically aggressive toward staff. Client 2's behaviors were unpredictable and aggressive. Staff I reported they believed based on Client 2's behaviors and skills that the client had more mental health needs than developmental disability needs. d. Interview with Staff A on 2/6/2020 at 11:38am, identified Client 2 was at the facility due to behavioral problems in community based services which resulted in Client 2 being in legal trouble. Staff A confirmed Client 2 was independent with skills for showering, toileting, personal hygiene, dressing/undressing, brushing teeth,	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 14 grooming/shaving, eating, drinking, and taking their medications. Client 2 was able to cook independently with a few staff prompts. Client 2 was able to speak their mind and communicate verbally and in writing. Staff A identified that Client 2 had programs for medication administration, money management, and behavior and safety plans. However, Client 2 refused to participate in the medication program and told staff it was their job to get the client's medications and complete the documentation. Staff A verified Client 2 knew their medications and how to take them. Staff A confirmed Client 2 was verbally aggressive, destroyed property, physically aggressive, and eloped one time from the facility but not off of the campus. Staff A reported Client 2 displayed verbal aggression and threatened staff daily. Client 2 would posture and get nose to nose with staff while screaming and using profanity. Client 2 punched walls, and threw chairs/furniture and items from tables. Staff A verified that Client 2 was sent to a local crisis center due their aggressions and for evaluation a couple of days after being admitted to the facility. When asked what active treatment skills were being taught to Client 2, Staff A replied that Client 2 was not being taught active treatment skills. Staff A reported Client 2 did not belong at the facility, as the client did not need the facility's help for skill acquisition of basic daily living skills. According to Staff A, the facility did not have the supports to meet Client 2's specific behavioral or mental health needs. e. Interview with Staff B on 2/6/2020 at 12:51pm, confirmed Client 2 had programs to address bedroom maintenance/cleaning, medication administration, money management, and	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 15	W 197		

behavior/safety plans to address the clients verbal and physical aggressions. Staff B verified Client 2 did very well with cleaning and room maintenance, knew how to take their medications, and how to use money. Staff B confirmed Client 2 was independent in laundry tasks, eating, drinking, toileting, showering, dressing/undressing, gave themselves haircuts, shaving, and tooth brushing/flossing. Client 2 had meal preparation skills, cooked well, used the stove/oven and microwave. But Client 2 acted like they couldn't cook so that staff would cook for the client. Staff B verified Client 2 cooked their own breakfast and lunch each day. Staff B verified that Client 2's behavior/safety plans were to address Client 2's verbal (screaming and yelling) and physical aggression, threatening harm to others/staff, getting face to face with staff and posturing, belittling, property destruction (flipping tables and throwing objects) and inappropriate social skills (cursing and eloping). Staff B reported Client 2 knew right from wrong and had no remorse for their behaviors. According to Staff B, Client 2 refused facility supports and teaching of new skills to deal with their anger management and behaviors. Staff B stated, "We can't teach if he won't accept our help." Staff B reported they did not know what else the facility could do to help address Client 2's aggressive behaviors and mental health needs. Staff B identified that Client 2 would benefit from supports or treatment at another facility better equipped to meet Client 2's aggressive and mental health needs.

f. Interview with Client 2's Qualified Intellectual Disabilities Professional (QIDP-B) on 2/10/2020 at 1:17pm, confirmed Client 2's ISP included: (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 16 maintenance programs for medication administration, money management, and bedroom cleaning' and (b) six programs to address Client 2's social communication, verbal aggression, physical aggression, property destruction, and suicidal and homicidal ideations. QIDP-B verified Client 2 was independent in grooming/shaving, tooth brushing/oral cares, shower/bathing, toileting, dressing/undressing, eating/drinking, communicating wants and needs, and basic meal preparations skills. QIDP-B reported Client 2 was not confident using the stove and needed minimal verbal prompting when doing meal preparations. Staff also provided prompting to Client 2 to complete clean up tasks after meals as Client 2 usually refused. QIDP-B reported Client 2 was very independent and capable of completing day to day living activities and tasks. QIDP-B confirmed that Client 2 did not have an intellectual disabilities diagnosis, however, the clients Autism diagnosis qualified them for services. The facility was the fifth placement for Client 2 since being approved in May 2019 for developmental disabilities services. Currently Client 2 was involved in a court case regarding a behavioral/assaultive incident toward a staff and their vehicle at the previous community based provider where Client 2 received services. When asked why Client 2 was receiving services at the ICF/ID facility, QIDP-B replied that Client 2 needed help with their mental health, aggressions, and the facility provided a more structured environment. QIDP-B verified that Client 2 received mental health services and 1:1 therapies with a facility psychologist. QIDP-B identified that Client 2 and	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 17 their guardian refused medication changes for mental health stabilization and treatment as recommended by the facility's physicians. Additionally, Client 2 was not open to learning new coping mechanisms to address their aggressions. According to QIDP-B, if Client 2 could get their mental health and aggression stabilized they could have an independent life in the community. When asked if Client 2 belonged and was in need of ICF/ID level care, QIDP-B replied "No." B. Client 3 1) Observations on 2/3/2020 (5:00pm-6:00pm), 2/4/2020 (11:30am-11:50am), 2/5/2020 (8:13am-8:15am and 9:03am-9:45am), 2/6/2020 (1:00pm-1:45pm) and 2/7/2020 (7:45am - 8:20am) revealed Client 3 to actively and independently participate in their environment requiring little to no staff interventions related to daily living and developmental skills. Observations identified Client 3: a. Verbally communicated clearly and effectively with direct support staff, peers and the surveyor. b. Possessed the basic developmental skills (eating/drinking, toileting, dressing, grooming/hygiene) needed for i independence and privacy. c. Used leisure time appropriately d. Independently made coffee, set the table, cleaned kitchen areas, and loaded the dishwasher e. Used a microwave to reheat food and read/interpreted food preparation directions f. Was able to read, identify numbers and possessed rudimentary writing skills g. Accurately conversed on current events with	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 18 direct support staff, peers and the surveyor h. Possessed rudimentary computer skills i. Wore a watch and accurately identified the time Observations identified the facility provided Client 3 with supervision levels ranging from constant visual supervision to staff positioned directly at Client 3's side due to the potential for behaviors. 2) Review of Client 3's records identified Client 3 as independent or capable of demonstrating developmental and daily living skills, with the focus of facility's services directed at behavioral or mental health needs. Specifically: a. Review of Client 3's Individual Support Plan (ISP) dated 6/27/19 identified Client 3: - As an effective verbal communicator who communicated wants, needs and thoughts using long complex grammatically correct statements. - To possess strengths/abilities in several areas of independent living skills. Client 3 independently used the restroom in familiar areas and was capable of demonstrating many independent living skills. - As able to withdraw, secure, carry and spend small amounts of money. - Completed custodial, recycling and vehicle detailing work, earning $305.90 over the last 30 days. - Had three skill training programs: to document	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 19 the taking of their medications on their electronic medication administration record (MAR) located in Therap (an electronic records system), to follow a task analysis for keeping their money ledger current, and a program to complete a task analysis of their grooming/hygiene routine. - Had a Behavior Support Program (BSP) to address coping skills, participation in daily routine and pro-social behaviors while working to decrease verbal aggression, physical aggression, self-injurious behaviors, disrespectful bounderies and comments, arguing and lying. -With many rights restrictions specific to behavioral, safety and suicidal/homicidal precautions identified in Client 3's Individualized Safety Plan and Mental Health Behavioral Crisis Intervention Plan (MHBCIP) b. Review of Client 3's Independent Living Skills Assessment (updated 6/27/19) identified Client 3 could complete the basic skills of toileting, bathing, eating, hygiene/grooming, and oral hygiene. Client 3 needed verbal prompts to gather items/materials or to ensure Client 3 performed the task/skill. This assessment was updated from an 11/10/18 Independent Living Skills Assessment competed at the time of Client 3's first admission to the facility. According to the 6/27/19 update, Client 3 skill levels were unchanged from the original 11/10/18 assessment. c. Review of Client 3's transitional planning document dated 2/3/2020 identified Client 3 did not currently require services or supports related to speech and language, physical therapy or	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 20 occupational therapy. d. Client 3's Psychological Assessment dated 6/18/19 identified the following diagnoses: Mild Intellectual Disabilities, Neurodevelopmental Disorder associated with prenatal alcohol exposure, Posttraumatic Stress Disorder and Conduct Disorder, Unspecified Onset, callous/lack of empathy type. e. Client 3's 5/28/19 MHBCIP outlined a plan to address Client 3's "target program behaviors" of physical and verbal aggression, self-injurious behaviors and suicidal/homicidal precautions. Behaviors included physical violence in various forms, along with the use of sharp or blunt objects to harm others. The plan also included the use of physical restraint as needed. f. Client 3's 12/16/19 Individualized Safety Plan addressed safety concerns related to behaviors of physical and verbal aggression, self-injurious behaviors and suicidal/homicidal ideation. The safety plan outlined supervision levels based on the occurrence of behaviors and identified the following restrictions: - Increased staff ratios for off campus activities - Use of vehicle safety locks and devices to prevent removal of seat belts during transportation - Restricted access to sharps (knives, scissor, razors, or any items easily converted to a weapon) - On-person and area searches related to access to sharps - Limited and supervised access to phone calls and computers.	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3184, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 21 g. Client 3's record included a 5/24/19 letter from the facility administrator to an attorney regarding Client 3's arrest and pending charges. The letter identified Client 3 had been at the facility's Crisis Stabilization Unit (CSU) from 10/31/19-4/1/19 and could be readmitted to the facility on 5/28/19. The facility's letter described the services provided as "treatment and habilitative care in the CSU, which has been designed to provide behavioral, psychiatric and medical interventions to Nebraskanswho have been determined to be developmentally disabled and who, by reason of mental health crisis, drug abuse, or other circumstances are struggling in their community placements." h. Client 3's record included a 9/20/19 Order of Probation resulting from Client 3's conviction of Assault in the Third Degree, a Class I Misdemeanor committed on or about 5/12/19. Further review of the document identified Client 3 was to complete a probation period of 12 months. One of the conditions of this probation was for Client 3 to "follow all programming terms at Beatrice Statement Developmental Center." The facility licensed and certified as 400 State Building operates the CSU and is located at Beatrice State Developmental Center. 3) Interviews with Client 3 and facility staff confirmed Client 3 as independent in or capable of demonstrating developmental and daily living skills and resided at the facility due to behavioral or mental health needs. Specifically: a) Client 3 (interviewed 2/11/2020 at 11:10am in	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 22 the presence of Staff N) confirmed they had been in jail prior to returning to the facility. Client 3 stated they were sent to the facility to do their probation as they "attacked someone" by punching them in the face. Client 3 reported it was a staff person they punched while living in a group home operated by a community provider. Client 3 reported they were independent in eating/drinking, communication, using the bathroom, dressing and grooming. According to Client 3, they knew how to shower and take care of their dentures, but often choose not to complete the tasks as they were "tired" or "not in the mood". Client 3 reported they could make their own meals in the microwave or crock pot and was learning to cook on a stove top. Client 3 reported they took Risperdal and Depakote stating these were the medications they "needed the most" as these medications were for behaviors. According to Client 3, they saw a facility psychologist one time per week to learn how to talk about and express feelings and emotions. Client 3 reported they could get rather upset and "go overboard" in how they reacted. Client 3 confirmed training programs were in place for their behaviors, hygiene, medication administration and money skills. According to Client 3, they had already learned how to take their medication and documented the taking of the medication in their MAR. Client 3 stated they knew how to do all the things listed in the hygiene program and the program was a checklist to make sure hygiene tasks were completed. Client 3 reported they could do most to of the tasks in the	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 23 money program and had a program to help with behaviors. Client 3 reported they were to remain at the facility until they completed their probation at which time their interdisciplinary team would see if they could find an "EFH" (extended family home) that would take Client 3. b) Interview with Staff N (on 2/5/2020 at 9:10pm during an observation of Client 3 cleaning at Bear Creek) confirmed Client 3 required little to no assistance to complete the custodial tasks. Staff N stated their presence was due to Client 3's required supervision levels and to redirect Client 3 should Client 3 rush through the task and miss a step in the cleaning process. c) Interview with Staff I (on 2/6/2020 at 11:05am) confirmed Client 3 was independent in eating/drinking, communication, toileting, dressing, and denture care. According to Staff I, Client 3 would lie about taking a shower, but knew how to shower and possessed grooming/hygiene skills. Staff I reported Client 3's readmission to the facility was due to behaviors that resulted in jail. Staff I reported Client 3's behaviors were anger based and lead to physical aggression. d) Interview with Staff H (on 2/10/2020 at 12:30pm) confirmed Client 3 readmission to the facility due to anger issues, particularly directed at women. Staff H reported Client 3 was ordered to complete their probation at the facility. According to Staff H, Client 3 was independent in eating/drinking, communication, toileting, dressing, denture care and grooming/hygiene.	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 24	W 197		

Staff H reported Client 3 does not always shower, but had the skills to do so. Staff H reported Client 3 completes both their medication and money programs without staff assistance. Staff H stated Client 3 had a BSP as Client 3's behaviors all came from anger.

e) Interview with Staff G (on 2/11/2020 at 11:59am) confirmed Client 3 was at the facility instead of jail. According to Staff G, Client 3's needs were related to anger issues, primarily physical aggression and verbal threats. Staff G (a female staff) confirmed they had been "attacked" by Client 3 and Client 3 targets women when angry. Staff G reported Client 3 is at the facility to work on anger management, coping skills, medication administration and money skills. Staff G confirmed Client 3 was independent in eating/drinking, communication, bathing/showering, dressing, denture care and groom/hygiene, but would refuse to complete denture care or lie regarding the completion of showers.

f) Interview with Client 3's Qualified Intellectual Disabilities Professional (QIDP), on 2/10/2020 at 2:15pm, confirmed Client 3's ISP included: a BSP with multiple goals specific to target behaviors, a medication administration program in which Client 3 was maintaining progress, a grooming program designed as a task analysis to assess completion of skills and a money program for which Client 3 needed assistance to keep a ledger.

The QIDP confirmed Client 3 was independent in eating/drinking, communication, toileting, dressing and denture care. The QIDP reported Client 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 25 needed supervision to ensure they completed grooming and hygiene tasks and would lie about showering. According to Client 3's QIDP, Client 3 returned to the facility as they were in jail, having been arrested after attacking a staff person at their community based group home. The QIDP stated Client 3's probation continued through October 2020 and was to take place at the facility. The QIDP stated Client 3 had behavioral and mental health needs which required higher levels of staff supervision. Interview with the facility Administrator on 2/11/2020 at 1:30pm confirmed: 1) Client 2 was admitted to the facility as an emergency placement due to Client 2's aggression in a community based program. The Administrator identified that Client 2 required a structured environment and enhanced supervision (2:1) to address Client 2's aggressive behaviors and mental health needs. According to the Administrator, Client 2 was independent in their daily living skills, medication administration, and required little to no staff intervention for cooking and personal shopping. The Administrator verified that Client 2's plan at the facility's "Crisis Stabilization Unit" (CSU) was established to address Client 2's socially inappropriate behaviors and communications, mental health needs, and medication oversight. 2) Client 3 was readmitted to the facility based on an emergency situation. This readmission occurred after Client 3's arrest and jailing for	W 197		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 197	Continued From page 26 attacking staff at Client 3's community based group home. The administrator reported the community based provider did not have the supports or treatment in place which Client 3 required. According to the administrator, Client 3 required structure and extra supervision provided by CSU to address Client 3's behavioral needs. The Administrator reported admission to the facility's CSU was authorized by the State of Nebraska Department of Developmental Disabilities. According to the Administrator, the Department had a screening process, with referrals coming from Service Coordination. The Administrator reported that although each client situation were different, the goal of the CSU was to have clients transition thought the program within a 90 - 120 day time frame. (Note: Client 3 was readmitted to the facility on 5/28/19 with a plan to stay into October 2020 for the completion of their probation; well beyond the 90-120 day time frame.)	W 197		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 249	Continued From page 27 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure mealtime programs were implemented as outlined in the Individual Support Plan (ISP) for 1 of 2 clients in the sample. This failure had the potential to affect all clients residing at the facility. Facility census was 18 at the time of the survey. FINDINGS: Review of Client 1's ISP, dated 11/12/2019, revealed it included a program which focused on using a napkin to wipe Client 1's face during meal or snack time when eating or drinking. The training program specified the frequency for implementation "should occur at every given opportunity as appropriate." Observations identified staff did not implement "Dining Etiquette" ISP program, dated 11/27/2019 during 3 of 4 meals. Observation on 2/3/2020 from 5:19pm - 5:46pm identified Staff C did not offer a napkin or prompt Client 1 to wipe Client 1's face during or after the meal. Observation on 2/4/2020 from 12:33pm - 1:00pm identified Staff D did not offer a napkin or prompt Client 1 to wipe Client 1's face during or after the meal. Observation on 2/5/2020 from 11:55am - 12:54pm identified Staff E and Staff D did not offer a napkin	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
W 249	Continued From page 28 or prompt Client 1 to wipe Client 1's face during or after the meal, during which Client 1 was observed to have saliva dripping of their face multiple times. Interviews with Staff D on 2/6/2020 at 12:55pm and Staff E on 2/11/2020 at 10:36am revealed staff were not able to identify a program that was to be implemented during meal and snack times without checking Client 1's record. Interview on 2/11/2020 at 11:37am with Qualified Intellectual Disabilities Professional (QIDP) A confirmed: 1) Staff should be offering napkins and prompting Client 1 to wipe Client 1's face whenever eating or taking a drink, 2) Client 1 should have a napkin available at every meal or snack, and 3) Client 1's program was not implemented correctly a majority of the time based on surveyor observations.	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
E 000	Initial Comments Representatives of the DHHS, Division of Public Health conducted a Recertification survey on 2/3/2020 - 2/11/2020 in order to determine compliance with Federal regulations at Appendix Z, Emergency Preparedness. The facility was found to be in compliance with regulations.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbaschek | TITLE: ICFA | (X6) DATE: 3-5-20

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.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

February 26, 2020

Dawn Urbaschek
400 State Building
3104, 3070, 3071 State Ave
Beatrice, NE 68310

Dear Ms. Urbaschek:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On February 3 - 11, 2020, DHHS representatives conducted surveys to determine whether your facility was in compliance with Federal Condition of Participation requirements, State Licensure regulations, and Life Safety Code Requirements for Critical Access Hospitals. Enclosed you will find the CMS-2567's documenting the results of that survey. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations and 175 NAC Chapter 17 Regulations Governing **Licensure of Intermediate Care Facilities for Individuals with Intellectual Disabilities.**

PLAN OF CORRECTION (POC)

A POC for each deficiency cited must be submitted to DHHS.AcuteCareFacilities@nebraska.gov NO LATER THAN 10 calendar days after receipt of the CMS-2567's. Failure to submit an acceptable POC timely may result in the imposition of Disciplinary Action.

An acceptable POC must include:

- **The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiencies cited;**
- **The procedure for implementing the acceptable plan of correction for the specific deficiency cited;**
- **The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;**
- **The title of the person responsible for implementing the acceptable plan of correction;**
- **PROVIDE THE DATE WHEN CORRECTION ACTION WILL BE COMPLETED.** Correction dates should be no later than forty-five calendar days from the exit date of the survey or **March 27, 2020.**

NOTE: Remember to attach copies of any auditing tools; education; revised or new policies/processes.

SIGNATURE ON FIRST PAGE OF THE 2567's: The first page must be signed by the provider/supplier representative and faxed to [redacted]

We will notify you whether your plan of correction is or is not acceptable via email. Subsequently, if your plan of correction is not accepted, you must submit an addendum to your plan of correction within ten (10) calendar days of the notification.

We thank you and your staff for your cooperation and assistance during the survey. If you have any questions regarding this correspondence, please contact this office.

Sincerely,

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 3071 State is a single story building of Type V construction that was built in 1970 and is fully sprinkled. The facility has 12 certified beds. At the time of the survey the census was 0 residents. 400 State Building - 3071 State was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K0345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
K0345	Continued From page 1 failed to assure that all fire alarm devices were labeled. This deficient practice increased the potential that the fire alarm would fail to detect smoke from a fire, which would affect all occupants in all smoke compartments. The facility census was 0 on the day of survey. Findings are: Observations on 2-28-20 at 1:00 pm revealed, the smoke detector in the Laundry Room failed to be labeled or identified. During an interview on 2-28-20, at 1:00 pm, Facility Staff A confirmed the smoke detector failed to be identified.	K0345		

PLAN OF CORRECTION

Provider/Supplier Name:	400 State Building	Survey Date
STREET ADDRESS, CITY, ZIP:	3071 State Ave Beatrice, NE 68310	2/11/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	4SE111

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K0345	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	At the conclusion of the State Fire Marshal's walk through inspection, the Safety Coordinator contacted GT Fire and Security to acquire information pertaining to the correct numbering of smoke detectors on 3071 State / 411. On February 14, 2020, it was determined that this smoke detector should be labeled as #3 to coincide with the inspection report. The Safety Coordinator placed the appropriate #3 label on the smoke head in the laundry room of 3071 State / 411 on February 14, 2020.	2/14/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	At the conclusion of the State Fire Marshal's walk through inspection, the Safety Coordinator contacted GT Fire and Security to acquire information pertaining to the correct numbering of smoke detectors on 3071 State / 411. On February 14, 2020, it was determined that this smoke detector should be labeled as #3 to coincide with the inspection report. The Safety Coordinator placed the appropriate #3 label on the smoke head in the laundry room of 3071 State / 411 on February 14, 2020.	2/14/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/14/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/14/2020
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

****
*** FAX TX REPORT ***
****

TRANSMISSION OK

JOB NO.	0503
DESTINATION ADDRESS	[redacted]
SUBADDRESS	
DESTINATION ID	
ST. TIME	09/10 13:26
TX/RX TIME	01'09
PGS.	3
RESULT	OK

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER
FACSIMILE TRANSMITTAL SHEET

TO: DHHS.DDBHFacilities@nebraska.gov FROM: Russell Fralin, [redacted]

COMPANY: DATE: September 10, 2020

FAX NUMBER: [redacted] TOTAL PAGES INCLUDING COVER:

PHONE NUMBER: PHONE NUMBER: [redacted]

☐ URGENT ✓ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front page(s) for the 2567's received for State Building ICF at the Beatrice State Developmental Center for the Public Health survey.

The EPoc Plans of Correction are being emailed per the instructions in the letter received.

Please advise if further information is needed.

Thank You

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER
FACSIMILE TRANSMITTAL SHEET

TO: DHHS.DDBHFacilities@nebraska.gov

FROM: Russell Fralin, [redacted]

COMPANY:

DATE: September 10, 2020

FAX NUMBER: [redacted]

TOTAL PAGES INCLUDING COVER:

PHONE NUMBER:

PHONE NUMBER: [redacted]

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front page(s) for the 2567's received for State Building ICF at the Beatrice State Developmental Center for the Public Health survey.

The EPoc Plans of Correction are being emailed per the instructions in the letter received.

Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	400 State	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 State Ave Beatrice, NE 68310	8/31/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W197	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	For Client 5: During a recent Public Health survey on 8/27/20, it revealed that Client 5 actively and independently participates in their environment requiring little to no staff inteventions related to daily living and developmental skills. Observations identified Client 5 verbally communicated clearly and effectively with direct support staff and the surveyor, possessed basic developmental skills (eating/drinking, dressing, toileting, grooming/hygiene) needed for independence and privacy; used leisure time appropriately; independently set the table; retrieving items from the cupboard; used a microwave to reheat food and put items in the dishwasher; was able to read and identify numbers and accurately conversed on current events with direct support staff.	10/15/2020
	Review of Client 5's records identified Client 5 as independent or capable of demonstrating developmental and daily living skills with the focus of the facility's services directed at behavioral or mental health needs. Review of Client 5's Individual Support Plan (ISP) dated 2/21/20 identified Client 5 as an effective verbal communicator and expressed wants and needs using long complex utterances; receptive and linguistic language skill, as well as cognitive linguistic skills, all fall within normal limits based on informal assessment; possessed strengths/abilities in all areas of independent living skills; independently utilized the restroom in familiar areas, washed hands, bathed and ate/drank; capable of demonstrating other independent living skills, occassionally needing verbal reminders to ensure completion or thoroughness; able to make small puchases, make change, identify coins/bills and made $150.92 in the past 30 days.	10/15/2020
	Client 5's records included a 5/2/2020 assessment by a psychiatrist, stating Client 5 "does not meet eligibility for the Nebraska Developmental Waiver due to not having a developmental disability as defined by Nebraska Statute". This is based on the fact there is no evidence of a developmental disability present before the age of 22. The Facility Administrator met with the ICF/DD Manager, informed of the outcome of Level of Care Review and instructed to begin the referral process to community based services.	10/15/2020

	Initiating in accordance to W Tags, the Beatrice State Developmental Center (BSDC) Administration met with Service Coordination, Community Based Services and Behavioral Health to discuss options for Client 5 to find and secure alternative, less restrictive living arrangements on 9/4/2020. Once identified, a 60 day transition period will begin with a tentative discharge date of November 2, 2020.	10/15/2020
	For all indivdiuals residing in the State Building ICF, the Comprehensive Functional Assessment (CFA) has been reviewed to determine specific developmental deficits requiring active treatment essential for privacy and independence (including, but not limited to: toileting, personal hygiene, dental hygiene, eating, bathing, dressing, grooming, and communication of basic needs). Should any review indicate that an individual did not meet the requirement for the provision of active treatment, findings were submitted to the Facility Administrator. Facility Administrator discussed with Director, Deputy Director of Developmental Disabilities and any others applicable to the situations to develop plans for referral out of BSDC. Information was shared with the ICF Administrator, QDDP and Service Coordinator.	10/15/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Client 5's records included a 5/2/2020 assessment by a psychiatrist, stating Client 5 "does not meet eligibility for the Nebraska Developmental Waiver due to not having a developmental disability as defined by Nebraska Statute". This is based on the fact there is no evidence of a developmental disability present before the age of 22. The Facility Administrator met with the ICF/DD Manager, informed of the outcome of Level of Care Review and instructed to begin the referral process to community based services.	10/15/2020
	Initiating in accordance to W Tags, the Beatrice State Developmental Center (BSDC) Administration met with Service Coordination, Community Based Services and Behavioral Health to discuss options for Client 5 to find and secure alternative, less restrictive living arrangements on 9/4/2020. Once identified, a 60 day transition period will begin with a tentative discharge date of November 2, 2020.	10/15/2020
	For all indivdiuals residing in the State Building ICF, the Comprehensive Functional Assessment (CFA) has been reviewed to determine specific developmental deficits requiring active treatment essential for privacy and independence (including, but not limited to: toileting, personal hygiene, dental hygiene, eating, bathing, dressing, grooming, and communication of basic needs). Should any review indicate that an individual did not meet the requirement for the provision of active treatment, findings were submitted to the Facility Administrator. Facility Administrator discussed with Director, Deputy Director of Developmental Disabilities and any others applicable to the situations to develop plans for referral out of BSDC. Information was shared with the ICF Administrator, QDDP and Service Coordinator.	10/15/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	

	DHHS Executive Medical Officer will review all referrals prior to admission to the Beatrice State Developmental Center (BSDC). The DHHS Executive Medical Officer will determine if the referral to BSDC is appropriate for ICF/DD Level of Care.	10/15/2020
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator is the responsible person for monitoring and to ensure compliance.	10/15/2020
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	ACTIVE TREATMENT CFR(s): 483.440(a)(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. This STANDARD is not met as evidenced by: . Based on observations, record review, and interviews the facility failed to ensure that 1 of 4 sampled clients (Client 5) admitted to the facility had developmental needs requiring continuous active treatment services. This failure had the potential to affect all clients residing at the facility. Facility census was 16 at the time of the revisit to the 2/11/2020 recertification survey. FINDINGS: 1) Observations on 8/27/2020 from 11:32am - 12:10pm, 2:40pm -3:00pm, 5:40pm - 6:30pm and 8/28/2020 from 8:37am - 9:55am revealed Client 5 to actively and independently participate in their environment requiring little to no staff interventions related to daily living and developmental skills. Observations identified Client 5: a. Verbally communicated clearly and effectively with direct support staff and the surveyor. b. Possessed basic developmental skills (eating/drinking, dressing, toileting grooming/hygiene) needed for independence and privacy.	{W 197}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn C. Ulrschek | TITLE: ICFA | (X6) DATE: 9-10-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 1 c. Used leisure time appropriately d. Independently set the table, retrieving items from the cupboard e. Used a microwave to reheat food and put items in the dishwasher f. Was able to read and identify numbers g. Accurately conversed on current events with direct support staff Observations identified the facility provided Client 5 with supervision levels ranging from constant visual supervision to time alone in Client 5's bedroom, with periodic checks by staff. 2) Review of Client 5's records identified Client 5 as independent or capable of demonstrating developmental and daily living skills, with the focus of facility's services directed at behavioral or mental health needs. Specifically: a. Review of Client 5's Individual Support Plan (ISP) dated 2/21/2020 identified Client 5: - As an effective verbal communicator and expressed wants and needs using long complex utterances. Client 5's receptive and expressive language skills, as well as cognitive linguistic skills, all fall within normal limits based on informal assessment. - Possessed strengths/abilities in all areas of independent living skills. Client 5 independently utilized the restroom in familiar areas, washed hands, bathed and ate/drank. Client 5 was capable of demonstrating other independent living skills, occasionally needing verbal reminders to ensure completion or thoroughness.	{W 197}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 2 - As able to make small purchases, make change, identify coins and bill and made $150.92 in the past 30 days (from admission to annual ISP.) - Had skill training programs to complete the task analysis (TA) for: 1) taking medications independently, 2) reading and identifying correct serving sizes and track daily caloric intake, 3) independent meal preparation, 4) arriving to scheduled activities, work and appointment on time independently and 5) increasing the time worked independently. - Had a Behavior Support Program (BSP) to address inappropriate verbal/gestural behavior, physical aggression, property destruction, elopement, stealing, self-injurious behavior, suicidal/homicidal ideations and lying. Behaviors were being address through pro-social replacement behaviors. b. Review of Client 5's Independent Living Skills Assessment (updated 2/12/2020) identified Client 5 could complete the basic skills of toileting, bathing, eating, hygiene/grooming, dressing and oral hygiene independently or with a verbal prompt from staff to gather items/materials or to ensure completion of the task/skill. c. Review of Client 5's transitional planning document dated 2/11/2020 identified Client 5 did not currently require services or supports related to speech and language, physical therapy or occupational therapy. d. Client 5's Psychological Assessment dated 2/26/2020 identified the following diagnoses: Unspecified Neurodevelopmental Disorder,	{W 197}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 3 Antisocial Personality Disorder, Bipolar I Disorder, by history, Post-traumatic Stress Disorder by history, R/O Alcohol use disorder. e. Client 5's 1/21/20 Mental Health/Behavior Crisis Intervention Plan (MHBCIP) outlined a plan to address Client 5's "target problem behaviors" of Lying, Inappropriate verbal/gestural behavior, Physical aggression, Elopement, Stealing, Self-injurious behaviors and Suicidal/homicidal ideations. The plan also included the use of physical restraint as needed. f. Client 5's 7/29/2020 Individualized Safety Plan addressed safety concerns related to behaviors of lying, stealing, elopement, inappropriate verbal and gestural behaviors, physical and verbal aggression, self-injurious behaviors and suicidal/homicidal ideation. The safety plan outlined supervision levels based on the occurrence of behaviors and identified the following restrictions: - Increased staff ratios for various activities - Use of vehicle safety locks and devices to prevent removal of seat belts during transportation - Restricted access to sharps (knives, scissor, razors, or any items easily converted to a weapon) -Restricted access to fire starting materials - On-person and area searches - Limited and supervised access to phone calls and computers. g. Client 5's records included a 5/2/2020 assessment by a psychiatrist, stating Client 5 "does not meet eligibility for the Nebraska Developmental Waiver due to not having a	{W 197}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 4 developmental disability as defined by Nebraska Statue. This is based on the fact there is no evidence of a developmental disability present before the age of 22 ..." 3) Interviews with Client 5 and facility staff confirmed Client 5 as independent in or capable of demonstrating developmental and daily living skills and/or did not need to be at the facility. Specifically: a) Client 5 (interviewed 8/31/2020 at 11:10am in the presence of Staff O) confirmed they were independent in eating/drinking, communication, dressing and grooming. According to Client 5, staff were helping Client 5 in learning to cooking and on working skills. Client 5 stated they did not need to be at the facility and wanted to move to Omaha. Client 5 reported they needed to find an apartment and contact "the Omaha Housing Authority." Client 5 also stated they need to "look into Section 8 and sign up for food stamps". b) Interview with Staff N (on 8/31/2020 at 10:30am) confirmed Client 5 required no assistance to complete their vacuuming job. Staff N stated Client 5 was independent in preparing and eating their packed lunch. Staff N reported that when starting to work with Client 5 approximately 2 weeks ago, it was Client 5 who showed Staff N how to complete Client 5's auto detailing job. c) Interview with Staff L (on 8/27/2020 at 4:23pm) confirmed Client 5 had the skills to complete all self-care needs and Client 5 put a lot of importance on their appearance. Staff L reported	{W 197}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 5 Client 5 was very "manipulative and clever" and behaviors and safety concerns were the reasons Client 5 was at the facility. d) Interview with Client 5's Qualified Intellectual Disabilities Professional (QIDP) C on 8/31/2020 at 12;15pm, confirmed Client 5's ISP included: a BSP with multiple goals specific to target behaviors and skill training program for: medication administration, arriving on schedule, increasing work time, measurement of portion sizes and caloric intake and meal preparation. QIDP C confirmed Client 5 was independent in eating/drinking, communication, toileting, dressing, oral hygiene and grooming. QIDP C reported Client 5 sometimes needed supervision to ensure they completed these skills. QIDP C stated, based on the regulatory requirement for active treatment, they "did not think" Client 5 needed to be at the facility. e) Interview with the facility Administrator on 8/31/2020 at 1:00pm confirmed the facility had received an assessment from a psychiatrist stating that Client 5 did not meet eligibility requirements for services through the State of Nebraska Department of Developmental Disabilities. (A copy of this assessment was obtained from the facility and referenced above.) According to the Administrator, based on this assessment, Client 5 would not remain at the facility. The Administrator confirmed a meeting was scheduled on 9/4/2020 and parties within the State of Nebraska Department of Health and Human Services were to discuss options for Client 5 and how the facility would transition	{W 197}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 08/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310

(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
{W 197}	Continued From page 6 Client 5's services.	{W 197}		

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 3, 2020

Dawn Urbaschek, Administrator
400 State Building
3104, 3070, 3071 State Ave
Beatrice, NE 68310

Dear Ms. Urbaschek:

On August 27-31, 2020, DHHS representatives conducted an onsite revisit to verify that your facility had achieved and maintained compliance with the deficiencies cited during a survey conducted on 2/11/2020. During the revisit survey, the original cited deficiency W-0249 was found to be in compliance, however, the facility was found to be out of compliance with W-0197 and was cited as you will see on the enclosed CMS-2567.

PLAN OF CORRECTION (POC)

A POC for each deficiency cited must be submitted to DHHS.DDBHFacilities@nebraska.gov **NO LATER THAN 10 calendar days** after receipt of the CMS-2567. Failure to submit an acceptable POC timely may result in the imposition of Disciplinary Action.

An acceptable POC must include:

- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction;
- **PROVIDE THE DATE WHEN CORRECTION ACTION WILL BE COMPLETED.** Correction dates should be no later than forty-five calendar days from the exit date of the survey or October 15, 2020.

NOTE: Remember to attach copies of any auditing tools; education; revised or new policies/procedures.

SIGNATURE ON FIRST PAGE OF THE 2567's: The first page must be signed by the facility Administrator or representative.

We will notify you whether your plan of correction is or is not acceptable via email.

We thank you and your staff for your cooperation and assistance during the survey. If you have any questions regarding this correspondence, please contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

2020 Facility Staff Information

Staff levels

Staff Injuries

Staff planning

Attachment B4

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Per your request

2 messages

Skirry, Sarah [redacted]
To: "Moreland, Jerall" [redacted]

Tue, Feb 23, 2021 at 4:40 PM

Hello Jerall,

Please find below the responses to your email earlier this month:

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020: **88 Long-term / 27 Crisis**
2. The number of positions vacant as of December 31, 2020: **32 Long-term / 8 Crisis**
3. The number of positions needed in your HR staffing plan for FY21: **Approximately 138**
4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020: **115**
5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020: **8.4% Long-term / 14.8% Crisis**
6. The number of vacant positions as of December 31, 2020 – **same #2**

B. The number of assaults on staff for calendar year 2020 - See attachment

C. Please provide a copy of the most recent inspections or audit reports for calendar year 2020. To include, but not limited to reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, etc. – See attachments

If you have any further questions please don't hesitate to reach out.

Thank you,

Sarah

Sarah Skirry | *Legislative Coordinator*

OFFICE OF LEGISLATIVE SERVICES

Nebraska Department of Health and Human Services

OFFICE: [redacted] CELL: [redacted]

DHHS.ne.gov | Facebook | Twitter | LinkedIn

7 attachments

B. 2020 Staff Injuries Due To Individual Aggression - Behaviors.pdf
299K

C. All 2020 FIRE DRILLS COMPLETED (dates and times) - 4TH QTR..pdf
38K

C. All ICF Licensure Renewal 2020.pdf
1328K

C. Lake Street Surveys FM-PH 2020.pdf
1460K

C. Solar Cottage Surveys FM-PH 2020.pdf
2741K

C. State Building Surveys FM-PH 2020.pdf
6499K

Staffing plan.pdf
508K

Jerall Moreland [redacted] Wed, Feb 24, 2021 at 1:31 PM
To: "Skirry, Sarah" [redacted]

Thanks for the information, Sarah- Have a great Week.

Jerall
[Quoted text hidden]
--
Jerall Moreland, Deputy Ombudsman for Institutions
Nebraska Legislature- Ombudsman's Office
[redacted]

D/L	1/7/2020	1800 Hrs.	DT Crisis	402 State	Individual was in crisis state. She was hitting, kicking and biting. Individual lowered herself to the ground and continued to hit and kick injuring staff's right abdominal area.	Redirection using coping skills.	Minor Clinic / Hospital	F
D/L	1/20/2020	1834 Hrs.	DT Crisis	406 State	Individual was in behaviors Crisis staff was redirecting the individual when he grabbed staff and fell to the floor. When staff went to stand, individual bit staff's right wrist / forearm.	Watch proximity of appendages to escalated individuals.	Emergency Room	M
D/L	1/21/2020	0815 Hrs.	DTSS Crisis	406 State	Individual threw a radio that hit staff on the left side - back of his head. No information provided.	No information provided.	Emergency Room	M
D/L	1/21/2020	1130 Hrs.	Home Manager Crisis	406 State	Staff was assisting with a behavior. Individual escalated and exhibited physical aggression and property destruction. Staff was blocking and redirecting so the individual did not harm himself, others or additional property. The individual punched staff in the stomach.	Be mindful of body positioning. Review de-escalation and verbal communication techniques to continue to try.	Minor Clinic / Hospital	M
D/L	1/24/2020	1745 Hrs.	DT Crisis	406 State	Individual was having a behavior. Staff was attempting to stay visual with the individual when the individual spit in staff's face. Individual then swung at staff scratching staff's face in 3 places. Individual also bit staff's left elbow.	Better body positioning and blocking.	Emergency Room	M
D/L	1/24/2020	1715 Hrs.	DT Crisis	406 State	Individual was having an escalated behavior. Individual attacked staff. Staff attempted to redirect individual when individual lowered himself to the floor. Individual continued to attack staff so staff attempted to limit individual's extremities when individual bit the top of staff's right hand.	Better body positioning and blocking.	Emergency Room	M
D/L	2/2/2020	1745 Hrs.	DT Crisis	406 State Ind. Bedroom	Escalated individual became physically aggressive toward staff. Staff placed individual in a physical hold. Individual got a hand free and squeezed and twisted staff's right arm and shoulder.	Attempt further de-escalation techniques.	Emergency Room	M
D/L	2/2/2020	1745 Hrs.	DT Crisis	406 State Ind. Bedroom	Individual was escalated. He was placed in a physical hold. Individual dropped to the floor and his knee landed hard on staff's left hand.	Use better body mechanics	Emergency Room	M

D/L	2/2/2020	1730 Hrs.	DTSS Crisis	406 State Ind. Bedroom	Individual was escalated. Individual attacked staff grabbing staff's face and arms. Individual than pulled staff to the floor injuring staff's knees, right upper arm, left forearm, left side and hand and left forehead.	Use better body mechanics	Emergency Room	M
D/L	2/2/2020	1745 Hrs.	DT Crisis	406 State Ind. Bedroom	While individual was in crisis, staff attempted a side body hug. Individual was very combative and pulled staff down to the floor. Staff fell and hit her left knee with the weight of four (4) people on her knee.	Use better body mechanics	No Medical Treatment	M
D/L	2/9/2020	0730 Hrs.	DT Crisis	406 State	Staff was dealing with a behavior on 406 State when he received multiple scratches / bites including red drainage and abrasions (discolorations) on his left forearm and hand / right tricep, forearm and hand.	Better redirection and body blocking.	Emergency Room	M
D/L	2/10/2020	1415 Hrs.	DT Crisis	406 State Safe Room	Individual was in behavior. Individual was sitting on the floor when he kicked staff in the back of her right knee.	Better body positioning.	No Medical Treatment	M
D/L	2/12/2020	1230 Hrs.	DT Crisis	"D" Building Safe Room	Individual was in behavior. Individual was kicking, hitting and spitting at staff. Individual lowered herself to the floor and continued hitting and kicking. Individual kicked staff's left ribs.	Better redirection and body blocking.	Emergency Room	F
D/L	2/18/2020	1030 Hrs.	ATP Manager	"D" Building Safe Room	Individual was attempting to leave the safe area. Staff stepped in front of individual to body block her from leaving. Individual kicked staff in the left knee.	Staff followed the individuals' safety plan. Staff should be aware of their surroundings and be aware that the individual will kick.	No Medical Treatment	F
D/L	2/18/2020	1027 Hrs.	DT Crisis	"D" Building Safe Room	Individual was aggressive toward staff. Staff attempted to intervene, limiting individual's extremities. Individual kneed staff 4-5 times in the lower back and scratched staff's right hand.	I would suggest that staff utilize de-escalation techniques that don't involve physical interaction with supported individuals.	Minor Clinic / Hospital	F
D/L	2/21/2020	2230 Hrs.	DTSS Crisis	3104 State 1ST Floor Near Entry Door	Individual eloped from 404 State. Staff attempted to body block and cue individual to return to the home. Individual became physically aggressive, punched staff repeatedly in the face, left side jaw and choked. Staff attempted to block and apply physical hold when her right arm hit against the wall and floor.	No information provided.	Emergency Room	M
D/L	2/21/2020	2250 Hrs.	DT Crisis	3104 State 404	Individual started assaulting DTSS. Staff joined in putting individual in a hold. Staff and the individual fell, staff landed on her back, shoulder and left knee. Individual fell on top of staff landing on her right rib and shoulder area.	No information provided.	No Medical Treatment	M

D/L	3/10/2020	1530 Hrs.	DT 311 Lake	Chapel	Staff was attempting to redirect individual due to individual was hitting herself. While staff was holding individual's hand to stop her from hitting herself, individual bit staff's right hand.	Staff should be more attentive when individual is manic.	No Medical Treatment	F
D/L	3/10/2020	1700 Hrs.	DT Crisis	3104 State "F" Bldg. 1st Floor Hallway	Individual was in crisis behavior when he hit staff twice and attempted to bite. Another staff escorted individual backwards when he lunged forward and bit staff on her upper right arm above the elbow. Individual also punched staff in the right side of the head and right shoulder area twice.	Staff followed plans, prompted coping skills and used proper body positioning. Several staff involved. Attempt a hold potentially due to area was limited.	No Medical Treatment	M
D/L	3/10/2020	1720 Hrs.	QDDP Crisis	3104 State "F" Bldg. 1st Floor Hallway	Staff was on the first floor of "F" building talking to staff and going to clock-out. Staff was standing next to the wall when an individual was being escorted through the hallway. Individual stopped and punched staff between the eyes / forehead. Staff's head jerked back and hit the wall as well.	Maintain body positioning / space between individual and staff. It was unknown that individual was there when staff came downstairs. Staff escorting need to position themselves between individual and others.	No Medical Treatment	M
D/L	3/13/2020	0745 Hrs.	DT Crisis	3104 State 402 State	While individual was in a behavior, she bit staff's right arm above the wrist.	Staff is not seeking to go see doctor at this time.	No Medical Treatment	F
D/L	3/15/2020	2030 Hrs.	DTSS Crisis	3104 State 406 State	Individual attacked staff and then grabbed staff's hoodie and dropped himself to the ground taking staff with him injuring staff's lower back area.	More efficient body blocking and redirection.	No Medical Treatment	M
D/L	3/20/2020	2040 Hrs.	DTSS SOLAR	3056 PETERSON	Staff was assisting with a behavior that an individual was having on 3056 Peterson. While this staff was supporting the individual, she kicked staff directly in the right knee.	More staffing to help deal with major behaviors.	No Medical Treatment	F
D.L.	3/31/2020	2010 Hrs.	DT Crisis	3104 State 408 State	Individual wanted a big glass to drink out of but due to his safety plan individual is only allowed 1 - 8oz. and 1 - 14 oz. Individual had behavior, staff intervened and got her right wrist bent backwards.	Staff needed to help when he (Lyle) was called for.	Emergency Room	M
D/L B.C.	4/3/2020	1115 Hrs.	DT Crisis	"D" Building Safe Room	Individual was in a behavior. Staff were escorting individual into the safe area where she bit staff's right arm.	Offer BST support.	No Medical Treatment	F
D/L B.M.	5/29/2020	1402 Hrs.	DT Crisis	402 State	When an individual went to kick staff in the knee, staff stepped back to avoid the kick and her right knee buckled.	Use better body mechanics.	Minor Clinic / Hospital	F
D/L S.L.	6/5/2020	1215 Hrs.	DT Crisis	402 State Safe Room	Individual was in escalated behavior and hit and kicked staff in the stomach multiple times.	Better use of the bean bag protocol.	Emergency Room	F

D/L M.H.	7/1/2020	2122 Hrs.	DT Crisis	408 State Hallway	Individual hit staff on her forearms, jerking staff's upper back. Staff was redirecting the individual back to his bedroom when the individual slammed the bedroom door on staff's foot jerking her lower back.	Use better body mechanics.	No Medical Treatment	M
D/L T.D.	7/5/2020	1700 Hrs.	DT Crisis	406 State	Individual bit his tongue at lunch and had been in and out of behavior all day. Individual was bleeding from the mouth and spitting on staff. Staff also received a little scratch on his right thumb during a behavioral episode.	Individual spit blood mixed with saliva on staff.	No Medical Treatment	M
D/L B.C.	7/5/2020	1700 Hrs.	DT Crisis	406 State	Individual bit his tongue at lunch and had been in and out of behavior all day. Individual was bleeding from the mouth and spitting contacting staff's face, arm, chest, neck, etc.	Individual spit in staff's face, blood mixed with saliva. Have face shields.	No Medical Treatment	M
D/L E.B.	7/8/2020	2000 Hrs.	DT Crisis	402 State Kitchen Area	Individual was having an escalated behavior and grabbing at staff. Staff was redirecting the individual out of the kitchen area when the individual hit staff in the head. Staff and individual fell down to the floor with staff landing on her left knee.	Better body positioning.	No Medical Treatment	F
D/L D.C.	7/17/2020	1400	DT Crisis	406 State	Individual was upset and started hitting staff in the face. Staff attempted to block. Individual grabbed PPE mask that staff was wearing and pulled. The mask caught staff's ear (ripped earing) then grabbed staff by the hair and pulled hurting staff's neck.	Better body blocking and re-direction.	No Medical Treatment	M
D/L T.B.	7/18/2020	1520 Hrs.	DT Crisis	406 State	Individual was having an escalated behavior. Staff encouraged individual to use his coping skills. Individual would not listen and verbally threatened staff. Individual suddenly attacked staff. Staff attempted to hold individual when the individual bit staff's left forearm (breaking skin) and also scratched staff's inner elbow on left arm.	No recommendations provided.	Emergency Room	M
D/L C.L.	7/27/2020	1020 Hrs.	DT Crisis	3RD Floor "D" Building	Individual was fluid seeking (behavior). Staff escorted individual to safe area. Individual lowered himself to the mat on the floor. Individual took staff down with him, landing on staff's right leg. Staff's leg hit the ground and individual rolled onto staff's leg.	Not provided.	No Medical Treatment	M

D/L L.D.	7/28/2020	1845 Hrs.	DT Crisis	406 State	Individual came out of his bathroom and started aggressing toward staff. Individual scratched staff's face several times, punched staff in the face and attempted to bite staff.	Better redirection.	Emergency Room	M
D/L J.F.	7/28/2020	1955 Hrs.	DTSS Crisis	406 State	Individual was fluid seeking (behavior) and became physically aggressive toward staff, hitting staff in the arms and back. Staff attempted to put individual in a Mandt hold and redirect individual back to his bedroom when staff hit his back on the individual's wardrobe.	Better body mechanics	No Medical Treatment	M
D/L G.O.	7/30/2020	0105 Hrs.	DT Solar North	3052 Peterson Ind. Bedroom	Individual began to self-injure himself during a behavioral incident. Staff attempted to redirect and block the individual from hurting himself. Individual scratched staff's hands and arms and hit staff in the chest.	No recommendations provided.	No Medical Treatment	M
D/L L.V.	9/28/2020	0845 Hrs.	DT Crisis	408 State Hallway	Staff attempted to block individual from hitting another staff. Individual grabbed staff by the hair and bit the top of staff's head.	Staff to be aware of the surroundings when redirecting an individual with physically aggressive behavior,	Minor Clinic / Hospital	M
D/L B.C.	11/26/2020	0745 Hrs.	DT Crisis	408 State Ind. Bedroom	Individual was in behavior and fluid seeking. Staff redirected individual as he was trying to hit, kick and bite. Individual bit staff on her right thumb.	Be more aware of hand position when individual is having a behavior.	Emergency Room	M
D/L K.P.	12/12/2020	1510 Hrs.	DT Crisis	3071 State / 411 East living room.	Individual was demanding fast food which he could not have. Individual became upset and punched the television. Staff went to move individual away from the television when individual punched staff in the left jaw and neck area causing staff's head to whip back fast enough to hurt her neck and cause a migraine.	Client was in behavior and hit staff in the face. Staff should use better body mechanics.	No Medical Treatment	M
D/L J.K.	12/15/2020	1200 Hrs.	ATPS	3071 State / 411 East living room.	Staff was redirecting individual to his bedroom when individual grabbed staff's left pinky finger possibly dislocated or broke finger.	None provided.	No Medical Treatment	M

Stats as of 02/11/2021

Home	IDD Level	Age	Wheelchair	Acuity			
				Braden Risk	Enteral Feeding	PNM Risk	Health Risk
3070 State Ave - 412	Severe	48				moderate	moderate
3070 State Ave - 412	Moderate	40				low	moderate
3070 State Ave - 412	Mild	55				moderate	moderate
3070 State Ave - 412	Severe	43				high	moderate
3070 State Ave - 412	Moderate	59				moderate	high
3070 State Ave - 412	Severe	37				moderate	moderate
3070 State Ave - 412	Mild	67	yes	mild	high		high
3070 State Ave - 412	Moderate	59				low	moderate
	Average age	**51**					
412 # of individuals			**8**				
Solar Cottages North							
3060 Peterson Blvd. - 413	Severe	29				high	moderate
3060 Peterson Blvd. - 413	Profound	65				high	moderate
3060 Peterson Blvd. - 413	Severe	37				high	moderate
3060 Peterson Blvd. - 413	Mild	33				moderate	moderate
3060 Peterson Blvd. - 413	Moderate	65				moderate	moderate
3060 Peterson Blvd. - 413	Severe	40				moderate	moderate
3060 Peterson Blvd. - 413	Mild	49				moderate	moderate
413 # of individuals	**Average age**	**45.4**	**7**				
3056 Peterson Blvd. - 414	Mild	63				moderate	high
3056 Peterson Blvd. - 414	Profound	83	yes	mild		high	high
3056 Peterson Blvd. - 414	Profound	64				low	moderate
3056 Peterson Blvd. - 414	Mild	66				moderate	high
3056 Peterson Blvd. - 414	Profound	61				moderate	moderate
3056 Peterson Blvd. - 414	Severe	64				moderate	moderate
3056 Peterson Blvd. - 414	Profound	63				moderate	moderate
3056 Peterson Blvd. - 414	Profound	54				high	moderate
3056 Peterson Blvd. - 414	Profound	53	yes	mild		moderate	high
3056 Peterson Blvd. - 414	Moderate	71				low	moderate
414 # of individuals	**Average age**	**64.2**	**10**				
3052 Peterson Blvd. - 416	Profound	58	yes			moderate	moderate
3052 Peterson Blvd. - 416	Profound	73	yes			moderate	high
3052 Peterson Blvd. - 416	Mild	72	yes			moderate	high
3052 Peterson Blvd. - 416	Profound	51				moderate	high
3052 Peterson Blvd. - 416	Profound	67				moderate	high
3052 Peterson Blvd. - 416	Profound	62				moderate	moderate
3052 Peterson Blvd. - 416	Profound	55				moderate	moderate
3052 Peterson Blvd. - 416	Profound	65				moderate	high
	Average age	**62.9**	**8**				
416 # of individuals							
Solar Cottages ICF South							

Regulation Minimum:

- Severe/Profound: 1 to 3.2 = 0.31
- Moderate: 1 to 4 = 0.25
- Mild: 1 to 6.4 = 0.16

Safety Plan:

- No Safety Plan = 0.0
- Routine = 0.5
- Enhanced = 0.75
- One to One = 1.0
- Two to One = 3.0

MHBCIP:

- Yes = 1.0
- No = 0.0

Medical Risk:

- Medical Complex Score of 1 = 1.0

NOTE

- Total # of FTE's to operate with calculated minimum staffing= 100.23*14=1403.22/10=140(-2 for outliers)=138

Determination of staffing numbers may not be determined just by ratios of staff to individual BSDC has to take into consideration acuity for medically and behaviorally complex individuals. Weights and formula helps determine BSDC staff minimums.

Home	Calculated Minimums*	Outliers
CSU	5	Staffing for crisis is one to one with a float
		• 1 safety plans requires 1 to 1 when in community • 1 safety plan requires 1 to 1 supervision if alarm is not functioning • 1 safety plan requires 1 to 1 supervision when exhibiting precursors, safety concerns or target behaviors

Crisis stabilization unit has a current census of four residents with an average age of 25.

723 Solar - 422	Severe	77	yes	mild		high	moderate
723 Solar - 422	Profound	70	yes	moderate	high		high
723 Solar - 422	Profound	59	yes	high	high	high	high
723 Solar - 422	Profound	54				moderate	moderate
422 # of individuals	**Average age**	**64.5**	**9**				
715 Solar - 424	Severe	66				moderate	low
715 Solar - 424	Mild	71	yes	high	high	high	high
715 Solar - 424	Severe	36				moderate	moderate
715 Solar - 424	Severe	67	yes			moderate	moderate
715 Solar - 424	Moderate	64	yes	mild		moderate	high
715 Solar - 424	Mild	57				low	moderate
715 Solar - 424	Profound	63				moderate	moderate
715 Solar - 424	Moderate	56	yes	high	high	moderate	high
715 Solar - 424	Severe	60	yes	mild		moderate	high
	Average age	**60**	**9**				
424 # of individuals							
Lake Street ICF							
Lake Street Homes - 103	Mild	52	yes	mild		moderate	high
Lake Street Homes - 103	Mild	61				moderate	low
Lake Street Homes - 103	Mild	54				low	moderate
Lake Street Homes - 104	Moderate	47				low	low
Lake Street Homes - 104	Moderate	70				moderate	moderate
Lake Street Homes - 104	Severe	58				low	moderate
Lake Street Homes - 104	Moderate	61				low	moderate
Lake Street Homes - 205	Mild	61				moderate	moderate
Lake Street Homes - 205	Moderate	59				low	moderate
Lake Street Homes - 205	Moderate	59				low	moderate
Lake Street Homes - 205	Mild	42				low	moderate
Lake Street Homes - 206	Mild	56				low	low
Lake Street Homes - 206	Mild	34				low	high
Lake Street Homes - 206	Moderate	41				low	moderate
Lake Street Homes - 206	Moderate	56				low	low
	Average age	**54.1**	15				

753 Solar - 418	Profound	59	yes as needed			moderate	high
753 Solar - 418	Profound	63	yes	mild	high		high
753 Solar - 418	Profound	68	yes	high		high	high
753 Solar - 418	Profound	64	yes	moderate		moderate	high
753 Solar - 418	Profound	65	yes	mild	high		high
753 Solar - 418	Profound	58	yes			high	high
753 Solar - 418	Profound	49	yes	high		high	high
753 Solar - 418	Profound	61	yes	mild	high		high
418 # of individuals	**Average age**	**60.9**	**8**				
743 Solar - 420	Profound	63	yes	moderate		high	high
743 Solar - 420	Profound	63	yes	mild		high	high
743 Solar - 420	Profound	62	yes	mild		high	high
743 Solar - 420	Profound	73				high	high
743 Solar - 420	Profound	60	yes			moderate	moderate
743 Solar - 420	Profound	60				moderate	moderate
743 Solar - 420	Profound	67	yes	mild		moderate	high
743 Solar - 420	Profound	56	yes		high		high
743 Solar - 420	Profound	63	yes	mild		high	moderate
420 # of individuals	**Average age**	**63**	**9**				
723 Solar - 422	Profound	71	yes	mild		high	high
723 Solar - 422	Profound	60	yes	moderate		high	high
723 Solar - 422	Severe	55	yes	moderate		high	moderate
723 Solar - 422	Profound	57	yes	mild		moderate	moderate
723 Solar - 422	Profound	69				high	high

2020

ICF Licensure Renewals

Attachment B5

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 16, 2020

Mark Luger
Public Health/Health Licensure & Investigations-Licensure
Behavioral Health & DD Facilities & Services
Nebraska State Office Building -1st Floor
P.O. Box 94986
301 Centennial Mall
Lincoln, NE 68509-4986

Dear Mr. Luger:

Attached are the Intermediate Care Facilities for Persons with Intellectual Disabilities Licensure Renewal Applications for 400 State Building ICF, Lake Street ICF, Sheridan Cottages ICF and Solar Cottages ICF.

Accompanying each application are the Nebraska State Fire Marshal Occupancy Permits for the ICF.

If you need additional information, please do not hesitate to contact me.

Corina Harrison, Facility Administrator
Beatrice State Developmental Center
3000 Lincoln Blvd.
Beatrice, NE 68310

ICF	Beds to License	Fee	Coding
Solar Cottages ICF	79	1,750.00	25050131.522100.421
Lake Street ICF	24	1,550.00	25050150.522100.310
400 State Building ICF	58	1,750.00	25050129.522100.404
Sheridan Cottages ICF	8	1,550.00	25050133.522100.441
		$6,600.00	Total Approved
**requesting 12 post remodel*			

DHHS
NEBRASKA

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Expiration Date 3/31/2021

Intermediate Care Facilities for the Mentally Retarded Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

400 State Building
3104, 3070, 3071 STATE AVE
BEATRICE, NE 68310

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o: DAWN URBASCHEK, ICF/DD MANAGER
400 STATE BUILDING
3000 LINCOLN BLVD
BEATRICE NE 68310

LICENSE NO: ICFDD07
TELEPHONE NUMBER: [redacted]
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: DAWN URBASCHEK

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [redacted]

4. TOTAL NUMBER OF BEDS TO BE LICENSED: ___ 58 _____

OWNERSHIP INFORMATION

6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA, DEPT OF HEALTH & HUMAN SERVS
(Legal Name of Individual or Business Organization)

MAILING ADDRESS: P O BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

_____ Sole Proprietorship
_____ Partnership
_____ Limited Partnership
_____ Corporation
_____ Limited Liability Company
_____ Governmental (XXX State, _____ District, _____ County, _____ City or Municipal)
_____ Other (Please Specify) Non-profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by
(1) the owner, if the applicant is an individual or partnership,
(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Corina Harrison, Facility Administrator	[signature]	3/16/2020
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404875

Name of Facility:	**BSDC -400 Building-Apts 402,404, 406, 408**
Type of Facility:	**ICF/MR**
Location:	**3104 State St & 3071 State St Beatrice**
Maximum Occupancy:	**36 Beds**
Date Issued:	**2/13/2019**

Inspected By: **8725 Susen Lindner**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404876

Name of Facility:	**BSDC - 400 Building 3070 State Ave**
Type of Facility:	**ICF/MR**
Location:	**3070 State Avenue Beatrice**
Maximum Occupancy:	**10 Beds**
Date Issued:	**2/13/2019**

Inspected By: **8725 Susen Lindner**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404878

Name of Facility:	**BSDC - 400 Building 3071 State Ave**
Type of Facility:	**ICF/MR**
Location:	**3071 State Avenue Beatrice**
Maximum Occupancy:	**12 Beds**
Date Issued:	**2/13/2019**

Inspected By: **8725 Susen Lindner**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

DHHS
NEBRASKA

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Expiration Date 3/31/2021

Intermediate Care Facilities for the Mentally Retarded Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

LAKE STREE ICF/ID
667 31ST ST, APT 103, 104, 205, 206
BEATRICE, NE 68310

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o: DAWN URBASCHEK, ICF/DD MANAGER
LAKE STREET ICF/ID
3000 LINCOLN BLVD
BEATRICE NE 68310

LICENSE NO: ICFDD16
TELEPHONE NUMBER: ([redacted]
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: DAWN URBASCHEK

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [redacted]

4. TOTAL NUMBER OF BEDS TO BE LICENSED: ___ 24 ___

OWNERSHIP INFORMATION

6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA, DEPT OF HEALTH & HUMAN SERVS
(Legal Name of Individual or Business Organization)

MAILING ADDRESS: P O BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

_____ Sole Proprietorship
_____ Partnership
_____ Limited Partnership
_____ Corporation
_____ Limited Liability Company
_____ Governmental (XXx State, _____ District, _____ County, _____ City or Municipal)
_____ Other (Please Specify) Non-profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by
(1) the owner, if the applicant is an individual or partnership,
(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Corina Harrison, Facility Administrator — AUTHORIZED REPRESENTATIVE - TYPE OR PRINT
SIGNATURE — 3/16/2020 DATE

AUTHORIZED REPRESENTATIVE - TYPE OR PRINT
SIGNATURE
DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 405055

Name of Facility:	**BSDC Lake Street Complex Apts 103, 104, 205, 206**
Type of Facility:	**ICF/MR**
Location:	**667 31st Street Beatrice**
Maximum Occupancy:	**24 Beds**
Date Issued:	**6/27/2019**

Inspected By: **8725 Susen Lindner**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

DHHS

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Expiration Date 3/31/2021

Intermediate Care Facilities for the Mentally Retarded Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

Sheridan Cottages
3054 PETERSON BLVD
BEATRICE, NE 68310

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o: GREG PENNER, ICF/DD MANAGER
SHERIDAN COTTAGES
3000 LINCOLN BLVD
BEATRICE NE 68310

LICENSE NO: ICFDD11
TELEPHONE NUMBER: [redacted]
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: GREG PENNER

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [redacted]

4. TOTAL NUMBER OF BEDS TO BE LICENSED: ___ 8 (requesting 12 beds post remodel)

OWNERSHIP INFORMATION

6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA, DEPT OF HEALTH & HUMAN SERVS
(Legal Name of Individual or Business Organization)

MAILING ADDRESS: P.O BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

_____ Sole Proprietorship
_____ Partnership
_____ Limited Partnership
_____ Corporation
_____ Limited Liability Company
_____ Governmental (XXx State, _____ District, _____ County, _____ City or Municipal)
_____ Other (Please Specify) Non-profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by
(1) the owner, if the applicant is an individual or partnership,
(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Corina Harrison, Facility Administrator	[signature]	3/16/2020
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 405009

Name of Facility:	**BSDC - Sheridan Cottages, 3054**
Type of Facility:	**ICF/MR**
Location:	**3054 Peterson Blvd Beatrice**
Maximum Occupancy:	**8 Beds**
Date Issued:	**5/31/2019**

Inspected By: **8725 Susen Lindner**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

DHHS
NEBRASKA

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Licensure Unit

Expiration Date 3/31/2021

Intermediate Care Facilities for the Mentally Retarded Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

Solar Cottages ICF
3052 3056 3060 PET BLV 753 743 723 715 SOLAR
BEATRICE, NE 68310

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT:

c/o GREG PENNER, ICF/DD MANAGER
SOLAR COTTAGES ICF/ID
3000 LINCOLN BLVD
BEATRICE, NE 68310

LICENSE NO: ICFDD17
TELEPHONE NUMBER: [redacted]
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: GREG PENNER

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: [redacted]

4. TOTAL NUMBER OF BEDS TO BE LICENSED: 79

OWNERSHIP INFORMATION

6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA-DHHS
(Legal Name of Individual or Business Organization)

MAILING ADDRESS: PO BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

_____ Sole Proprietorship
_____ Partnership
_____ Limited Partnership
_____ Corporation
_____ Limited Liability Company
_____ Governmental (XXx State, _____ District, _____ County, _____ City or Municipal)
_____ Other (Please Specify) Non-profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application are true and correct and I/we hereby apply for a renewal license.

PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by
(1) the owner, if the applicant is an individual or partnership,
(2) two of its members, if the applicant is a limited liability company,
(3) two of its officers, if the applicant is a corporation, or
(4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.

Corina Harrison, Facility Administrator	[signature]	3/16/2020
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10270

Name of Facility:	**Solar Cottages ICF 715**
Type of Facility:	**ICF/MR**
Location:	**715 Solar Dr, Beatrice**
Maximum Occupancy:	**14 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10269

Name of Facility:	**Solar Cottage ICF 723**
Type of Facility:	**ICF/MR**
Location:	**723 Solar Dr, Beatrice**
Maximum Occupancy:	**14 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10268

Name of Facility:	**Solar Cottage ICF 743**
Type of Facility:	**ICF/MR**
Location:	**743 Solar Dr, Beatrice**
Maximum Occupancy:	**14 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10267

Name of Facility:	**Solar Cottage ICF 753**
Type of Facility:	**ICF/MR**
Location:	**753 Solar Dr, Beatrice**
Maximum Occupancy:	**16 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10265

Name of Facility:	**Solar Cottage ICF 3052**
Type of Facility:	**ICF/MR**
Location:	**3052 Peterson Blvd, Beatrice**
Maximum Occupancy:	**12 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10264

Name of Facility:	**Solar Cottage IFC 3056**
Type of Facility:	**ICF/MR**
Location:	**3056 Peterson Blvd, Beatrice**
Maximum Occupancy:	**12 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10266

Name of Facility:	**Solar Cottage ICF 3060**
Type of Facility:	**ICF/MR**
Location:	**3060 Peterson Blvd, Beatrice**
Maximum Occupancy:	**10 Beds Persons**
Date Issued:	**2/20/2020**

Inspected By: **Susen Lindner**
Deputy State Fire Marshal

Approved By: Chris B Gruell
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 18, 2020

Mark Luger, Progam Manager II
DHHS Public Health – Licensure Unit
Office of DD and Behavioral Health
P.O. Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986

Dear Mr. Luger,

Please accept this letter as a request to move 3054 Peterson Blvd. and the 8 licensed beds to the Solar Cottages ICF/IDD. We stipulate that by moving the only home attached to the Sheridan Cottage ICF/IDD to the Solar Cottages ICF/IDD, that the ICF/IDD identified as Sheridan Cottages will no longer exist.

This will increase the licensed beds in the Solar Cottages ICF/IDD from 79 to 87. We would like this merger to become official on June 29, 2020.

If you ha[redacted]

Greg Penner, ICF/DD Manager
Solar Cottages ICF/IDD
[redacted]

Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall So, P O Box 94986
Lincoln, NE 68509-4986

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

Solar Cottages

MEETS STATUTORY REQUIREMENTS AS
INTERMEDIATE CARE FAC/MR

Services

Lic # ICFDD14

Gary J. Anthone, MD

SEAL

EXPIRES
3/31/2021

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

Cut on heavy line and place on license.

Solar Cottages
3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR, BEATRICE, NE 68310

This is to verify that your INTERMEDIATE CARE FAC/MR is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

2019- 2020

4th Quarter Fire Drill Times

Attachment B6

2019 - 2020 FIRE DRILL TIMES - 4TH QTR. 2020

Building	Chapel 3065 Carstens Drive	Carstens Center 3000 Carstens Drive	West Wing 834 Sheridan	Admin. 843 Wallman	"D" Bldg. 941 Sheridan	South Apts. 3020 Lake St,	East Apts. 667 31st St.
1st Shift							
2019 - 2020	12/31/2019 1309 Hrs. 03/27/2020 1104 Hrs. 06/30/2020 1106 Hrs. 09/23/2020 1003 Hrs.	12/26/2019 1002 Hrs. 03/24/2020 1410 Hrs. 06/26/2020 0846 Hrs. 09/22/2020 1310 Hrs.	12/18/2019 1129 Hrs. 03/31/2020 1513 Hrs. 06/29/2020 1039 Hrs. 09/17/2020 1329 Hrs.	10/17/2019 1346 Hrs. 01/31/2020 1245 hrs. 06/30/2020 0953 Hrs. 08/28/2020 1103 Hrs.	08/16/2019 0951 Hrs. 11/19/2019 1407 Hrs. 02/18/2020 1306 Hrs. 09/01/2020 1116 Hrs.	VACANT 3RD QTR 2019 VACANT 4TH QTR 2019 VACANT 1ST QTR 2020 VACANT 2ND QTR 2020 VACANT 3RD QTR 2020	03/07/2020 1203 Hrs. 06/06/2020 0902 Hrs. 09/06/2020 1305 Hrs. 12/31/2020 1324 Hrs.
2nd Shift							
2019 - 2020							01/03/2020 1923 Hrs. 04/04/2020 1625 Hrs. 07/06/2020 1815 Hrs. 10/05/2020 1721 Hrs.
3rd Shift							
2019 - 2020							02/19/2020 0527 Hrs. 05/18/2020 0436 Hrs. 08/18/2020 2302 Hrs. 4TH Qtr 2020 COVID
Follow up needed							
Follow up Completed							
Building	**402** 3104 State	**404** 3104 State	**406** 3104 State	**408** 3104 State	**411** 3071 State	**412** 3070 State	**413** 3060 Peterson
1st Shift							
2019 - 2020	02/09/2020 1241 Hrs. 05/08/2020 1041 Hrs. 08/15/2020 1146 Hrs. 12/30/2020 1127 Hrs.	02/09/2020 1241 Hrs. 05/08/2020 1041 Hrs. 08/15/2020 1146 Hrs. 12/30/2020 VACANT	02/09/2020 1241 Hrs. 05/08/2020 1041 Hrs. 08/15/2020 1146 Hrs. 12/20/2020 VACANT	02/09/2020 1241 Hrs. 05/08/2020 1041 Hrs. 08/15/2020 VACANT 12/30/2020 1127 Hrs.	02/24/2020 VACANT 05/24/2020 VACANT 08/24/2020 VACANT 12/30/2020 1143 Hrs.	02/22/2020 1013 Hrs. 05/20/2020 1209 Hrs. 08/23/2020 1311 Hrs. 12/30/2020 1153 Hrs.	02/08/2020 0928 Hrs. 05/07/2020 1121 Hrs. 08/08/2020 1034 Hrs. 11/07/2020 1325 Hrs.
2nd Shift							
2019 - 2020	03/12/2020 2026 Hrs. 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH QTR 2020 COVID	03/12/2020 VACANT 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH QTR 2020 COVID	03/12/2020 2026 Hrs. 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH Qtr 2020 COVID	03/12/2020 2026 Hrs. 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH Qtr 2020 COVID	03/17/2020 VACANT 06/17/2020 VACANT 09/17/2020 VACANT 12/30/2020 1546 Hrs.	01/06/2020 2032 Hrs. 04/06/2020 1723 Hrs. 07/07/2020 1824 Hrs. 10/06/2020 1610 Hrs.	01/15/2020 1934 Hrs. 04/17/2020 2035 Hrs. 07/20/2020 1622 Hrs. 10/20/2020 1719 Hrs.

3rd Shift							
2019 - 2020	01/13/2020 0541 Hrs. 04/14/2020 0445 Hrs. 07/14/2020 2247 Hrs. 10/22/2020 0616 Hrs.	01/13/2020 0541 Hrs. 04/14/2020 0445 Hrs. 07/14/2020 2247 Hrs. 10/22/2020 0616 Hrs.	01/13/2020 0541 Hrs. 04/14/2020 0445 Hrs. 07/14/2020 2247 Hrs. 10/22/2020 VACANT	01/13/2020 0541 Hrs. 04/14/2020 0445 Hrs. 07/14/2020 2247 Hrs. 10/22/2020 0616 Hrs.	01/10/2020 VACANT 04/10/2020 VACANT 07/10/2020 VACANT 10/15/2020 0618 Hrs.	03/11/2020 0529 Hrs. 06/11/2020 0434 Hrs. 09/15/2020 2250 Hrs. 12/31/2020 0547 Hrs.	03/13/2020 0531 Hrs. 06/11/2020 0434 Hrs. 09/13/2020 2255 Hrs. 12/31/2020 0559 Hrs.
Follow up needed							
Follow up Completed							
Building	**414** 3056 Peterson	**415** 3054 Peterson	**416** 3052 Peterson	**418** 753 Solar	**420** 743 Solar	**422** 723 Solar	**424** 715 Solar
1st Shift							
2019 - 2020	01/11/2020 1446 Hrs. 04/10/2020 1243 Hrs. 07/10/2020 1142 Hrs. 10/16/2020 1344 Hrs.	03/06/2020 VACANT 06/06/2020 VACANT 09/06/2020 VACANT 12/06/2020 VACANT	03/07/2020 1303 Hrs. 06/05/2020 0904 Hrs. 09/04/2020 1407 Hrs. 12/30/2020 1207 Hrs.	01/10/2020 1312 Hrs. 04/11/2020 1114 Hrs. 07/11/2020 1015 Hrs. 10/17/2020 1417 Hrs.	03/20/2020 1410 Hrs. 06/18/2020 0850 Hrs. 09/18/2020 1315 Hrs. 12/30/2020 1231 Hrs.	02/15/2020 1223 Hrs. 05/15/2020 1324 Hrs. 08/23/2020 1432 Hrs. 4TH QTR 2020 COVID	03/21/2020 1219 Hrs. 06/24/2020 0835 Hrs. 09/21/2020 0934 Hrs. 12/30/2020 1247 Hrs.
2nd Shift							
2019 - 2020	02/20/2020 2051 Hrs. 05/08/2020 1607 Hrs. 08/06/2020 1709 Hrs. 11/05/2020 1910 Hrs.	01/23/2020 VACANT 04/23/2020 VACANT 07/23/2020 VACANT 10/23/2020 VACANT	01/07/2020 2036 Hrs. 04/08/2020 1928 Hrs. 07/08/2020 1604 Hrs. 10/07/2020 1706 Hrs.	02/04/2020 1910 Hrs. 05/04/2020 1810 Hrs. 08/05/2020 1714 Hrs. 12/30/2020 1553 Hrs.	01/08/2020 2043 Hrs. 04/09/2020 1946 Hrs. 07/09/2020 1632 Hrs. 10/13/2020 1734 Hrs.	01/25/2020 1606 Hrs. 04/22/2020 1706 Hrs. 07/22/2020 1907 Hrs. 10/23/2020 1806 Hrs.	01/14/2020 1957 Hrs. 04/15/2020 2056 Hrs. 07/16/2020 1618 Hrs. 10/19/2020 1719 Hrs.
3rd Shift							
2018 - 2020	03/03/2020 0619 Hrs. 06/04/2020 2356 Hrs. 09/04/2020 2254 Hrs. 12/31/2020 0609 Hrs.	02/21/2020 VACANT 05/21/2020 VACANT 08/21/2020 VACANT 11/21/2020 VACANT	02/12/2020 0455 Hrs. 05/11/2020 0636 Hrs. 08/10/2020 2252 Hrs. 12/31/2020 0618 Hrs.	03/02/2020 0521 Hrs. 06/02/2020 2359 Hrs. 09/01/2020 2249 Hrs. 12/31/2020 0630 Hrs.	02/21/2020 0456 Hrs. 05/22/2020 0059 Hrs. 08/20/2020 2257 Hrs. 12/31/2020 0636 Hrs.	03/09/2020 0518 Hrs. 06/08/2020 2356 Hrs. 09/11/2020 2258 Hrs. 4TH QTR 2020 COVID	02/14/2020 0439 Hrs. 05/12/2020 0636 Hrs. 08/11/2020 2258 Hrs. 12/31/2020 0645 Hrs.
Follow up needed							
Color Code	**Blue** **4th Qtr.** **2019**	**Red** **1st Qtr.** **2020**	**Green** **2nd Qtr.** **2020**	**Purple** **3rd Qtr.** **2020**	**Orange** **4th Qtr.** **2020**		

Lincoln Regional Center

Licenses verification

Attachment L1

Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall So, P O Box 94986
Lincoln, NE 68509-4986

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

Lincoln Regional Center

MEETS STATUTORY REQUIREMENTS AS
PSYCHIATRIC HOSPITAL
Lic # 500004

EXPIRES
12/31/2021

SEAL

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

Cut on heavy line and place on license.

Lincoln Regional Center
ADDRESS: 801 W PROSPECTOR, LINCOLN, NE 68522

This is to verify that your PSYCHIATRIC HOSPITAL is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall So, P O Box 94986
Lincoln, NE 68509-4986

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

Lincoln Regional Center

MEETS STATUTORY REQUIREMENTS AS
MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER

Services
MENTAL HEALTH TREATMENT

Lic # MHSU030

Gary J. Anthone, MD

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

EXPIRES
9/30/2021

SEAL

Cut on heavy line and place on license.

Lincoln Regional Center

FOLSOM & PROSPECTOR, BUILDING 14, LINCOLN, NE 68509

This is to verify that your MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

DHHS Letter

Regarding launch of Litigature project

Attachment L2

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

DATE: January 20, 2021

TO: Jerall Moreland, Ombudsman's Office

As a key partner in the behavioral health system, the Division of Behavioral Health (DBH) wants to thank you for your participation in the stakeholder sessions held the week before Christmas. I wanted to provide a summary for you. This communication highlights:

1) Lincoln Regional Center (LRC) ligature point renovation, and
2) 2021 strategic planning sessions.

During the September 2019 Joint Commission survey for the LRC, specific risks related to ligature points were identified. Ligature risks are related to suicide prevention in hospital settings to reduce deaths by suicide while serving the most vulnerable patients. The LRC submitted and was subsequently approved to implement an interim risk mitigation plan. This plan required the LRC to implement increased staffing and patient safety monitoring processes until a permanent resolution could be implemented. In order to implement risk mitigation of the ligature points identified, the LRC must undergo renovations in the three hospital units on the LRC campus. These hospital units serve male and female patients who are court ordered for competency evaluation and restoration or who are mental health board committed to inpatient care and unable to be served by psychiatric hospitals in the community. This construction project launched on January 11, 2021 and is currently scheduled to be completed in March 2022.

The LRC has thoroughly explored various options to ensure the most efficient and least disruptive approach to completing this renovation project. The selected approach allows for the construction to be done the most quickly (one building at a time) while also allowing for the most flexibility in capacity management. We feel this puts the LRC in the best position to continue to meet the needs of the larger behavioral health system. Our team continues to manage capacity for admissions, quarantine and isolation related to COVID-19. This is a complex project and we appreciate the importance of staying in communication.

The initial phase of construction is focused on renovations in Building 10. To accommodate this, the female patients have been moved from Building 10 to Building 3. The men's acute psychiatric program has moved from Building 3 to Building 5. The male forensic program will remain in Building 5.

The LRC is expecting little to no disruption in the capacity for female patients during the renovation project. Female patients will continue to be treated in a building physically separate from our male patients. The LRC is projecting a slight reduction of overall male bed capacity (approximately 10 beds) during the course of renovation.

We want to assure you that the LRC will continue to closely monitor the wait list and prioritize admissions according to statutory requirements. The LRC will offer additional support, such

as consultation provided to community providers who are serving mental health board committed patients awaiting transfer to the LRC, and will work with community providers, DHHS Divisions and Regional Behavioral Health Authorities to explore other innovative alternatives for patients, whenever appropriate.

Additionally, we will meet with the State Court Administrator on a regular basis to answer questions and explore solutions to ensure patients needing competency evaluation and/or restoration continue to be served. With the passing of LB686, outpatient competency restoration will be implemented effective July 1, 2021. This will allow patients needing competency restoration to be served in the community and, when the Court deems appropriate, will likely divert some patients from being admitted to the LRC. This enhancement to the system brings Nebraska into alignment with best practices. Nebraska has been working with the GAINS Center for Behavioral Health and Justice Transformation and state and local key partners to develop and execute an implementation plan for outpatient competency restoration to be readily available on July 1, 2021. Additionally, this will help to ensure that the LRC capacity is more readily available for patients requiring inpatient service at the LRC.

This increased flexibility with outpatient restoration is just one example of how Nebraska's behavioral health system continues to evolve. The DBH strives to lead efforts that will ensure Nebraska becomes the national leader in behavioral healthcare.

In support of the DBH's 2021-2024 strategic planning efforts, it is an opportune time to assess the rehabilitation and treatment continuum at the front door and back door of the LRC. The role of the LRC within the behavioral health continuum of care will also be discussed. The LRC plays a critical role in ensuring Nebraska's most vulnerable citizens receive necessary treatment services that support recovery.

In order to complete this important strategic analysis, the DBH will be bringing together a group of key stakeholders in February 2021. These key stakeholders will include representatives from other DHHS Divisions, Regional Behavioral Health Authorities, community based hospitals and other behavioral health service providers, the Courts and other advocates. The DBH will be working with leaders across these agencies and systems to identify the most appropriate participants.

We will begin your requested updates via a call on January 28th at 2:00CST. You will be receiving a calendar invite with call in information from Peter Snyder. If this time does not work for you, or if you have any questions, please contact Pete Snyder at [redacted]. We look forward to partnering with you all in these planning efforts.

Larry W. Kahl
Chief Operating Officer
Department of Health and Human Services

Sheri Dawson, RN, BS
Director
Division of Behavioral Health
Department of Health and Human Services

Facility Staff Information

Staffing Levels

Number of Assaults on Staff

Attachment L3

Nebraska Department of Health and Human Services (NEDHHS) - LRC Data
as of 1/1/2021

Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
A19211	ACCOUNTANT I	1	0	1	0%	0%
S19112	ACCOUNTING CLERK II	1	0	1	0%	0%
H77023	ACTIVITY SPECIALIST	17	0	17	0%	0%
V77024	ACTIVITY SUPERVISOR	2	1	3	33%	0%
A09121	ADMINISTRATIVE ASSISTANT I	1	0	1	0%	0%
V09122	ADMINISTRATIVE ASSISTANT II	0	1	1	100%	0%
H75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	7	0	7	0%	0%
V75016	ASSOCIATE DIRECTOR OF NURSING (NEW)	5	0	5	0%	14%
I79510	BARBER/BEAUTICIAN	0	1	1	100%	
V09213	BUSINESS MANAGER III	1	0	1	0%	0%
C72342	CERTIFIED MASTER SOCIAL WORKER	9	2	11	18%	9%
V72343	CERTIFIED MASTER SOCIAL WORKER SUPERVISOR	0	1	1	100%	50%
C72792	CHEMICAL DEPENDENCY COUNSELOR	1	0	1	0%	0%
H75321	CLINICAL NURSE TRAINER (NEW)	1	0	1	0%	0%
V72460	CLINICAL PROGRAM MANAGER	3	0	3	0%	0%
K76410	COMPLIANCE SPECIALIST	5	0	5	0%	0%
M82122	CUSTODIAL LEADER	1	0	1	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	8	1	9	11%	25%
I74110	DENTAL ASSISTANT	1	0	1	0%	0%
D74150	DENTIST	1	0	1	0%	0%
C73210	DHHS PROGRAM SPECIALIST	1	0	1	0%	0%
V73210	DHHS PROGRAM SPECIALIST	1	0	1	0%	0%
G73280	DHHS QUALITY ASSURANCE COORDINATOR	1	0	1	0%	0%
S09130	DHHS SCHEDULING COORDINATOR	3	0	3	0%	0%
G75017	DIRECTOR OF NURSING (NEW)	1	0	1	0%	0%
N00750	FACILITY OPERATING OFFICER	2	0	2	0%	25%
M80121	FOOD SERVICE AIDE	3	0	3	0%	0%
M80123	FOOD SERVICE COOK	23	1	24	4%	18%
R80123	FOOD SERVICE COOK	0	1	1	100%	
V80312	FOOD SERVICE DIRECTOR II	1	0	1	0%	0%
M80124	FOOD SERVICE LEADER	0	1	1	100%	50%
V80220	FOOD SERVICE SUPERVISOR	2	0	2	0%	0%
V02202	HEALTH INFORMATION MANAGER	1	0	1	0%	0%
S02201	HEALTH INFORMATION TECHNICIAN	10	0	10	0%	0%
H76311	HUMAN SERVICES TREATMENT SPECIALIST I	6	1	7	14%	20%
A37740	LIBRARIAN/AGENCY	0	1	1	100%	
I75013	LICENSED PRACTICAL NURSE (NEW)	8	8	16	50%	27%
R75013	LICENSED PRACTICAL NURSE (NEW)	0	1	1	100%	
C72341	MASTER SOCIAL WORKER	4	0	4	0%	18%
H72431	MENTAL HEALTH PRACTITIONER I	6	0	6	0%	20%
H72432	MENTAL HEALTH PRACTITIONER II	11	4	15	27%	27%
V72433	MENTAL HLTH PRACTITIONER SUPERVISOR	2	0	2	0%	0%
P76142	MENTAL HLTH SECURITY SPECIALIST II	201	35	236	15%	22%
R76142	MENTAL HLTH SECURITY SPECIALIST II	22	19	41	46%	29%
V76154	MENTAL HLTH SECURITY UNIT SUPERVISOR	19	0	19	0%	8%
D75350	NURSE PRACTITIONER	5	1	6	17%	14%
H77312	OCCUPATIONAL THERAPIST	3	0	3	0%	0%
S01113	OFFICE CLERK III	2	1	3	33%	40%
V03351	OFFICE SERVICES MANAGER I	1	0	1	0%	0%
R74731	PHARMACIST	0	2	2	100%	
N74740	PHARMACIST/CLINICAL	3	0	3	0%	0%
I74712	PHARMACY INVENTORY TECHNICIAN	1	0	1	0%	0%
N74732	PHARMACY MANAGER	1	0	1	0%	0%
I74711	PHARMACY TECHNICIAN	3	0	3	0%	0%
D75420	PHYSICIAN	1	0	1	0%	0%
G11900	PRINCIPAL	1	0	1	0%	0%
N74213	PSYCHIATRIC DIRECTOR	0	1	1	100%	
G76700	PSYCHIATRIC FACILTY RISK MNGMT ADMIN	0	1	1	100%	
D74211	PSYCHIATRIST	1	0	1	0%	0%
N74211	PSYCHIATRIST	2	3	5	60%	0%
N74823	PSYCHOLOGIST/LICENSED	7	2	9	22%	17%
N74822	PSYCHOLOGIST/PROV LICENSED	1	0	1	0%	0%
N74825	PSYCHOLOGY DIRECTOR	1	0	1	0%	
H75014	REGISTERED NURSE (NEW)	18	20	38	53%	21%
R75014	REGISTERED NURSE (NEW)	3	9	12	75%	0%
C79920	RELIGIOUS COORDINATOR	1	0	1	0%	0%
V82330	SAFETY COORDINATOR	1	0	1	0%	0%
A82310	SAFETY SPECIALIST	4	0	4	0%	0%
S01841	STAFF ASSISTANT I	3	1	4	25%	17%
S01842	STAFF ASSISTANT II	4	0	4	0%	17%
A13252	STATISTICAL ANALYST II	1	0	1	0%	0%
V13253	STATISTICAL ANALYST III	1	0	1	0%	0%
S05211	SUPPLY WORKER I	1	0	1	0%	0%
S01511	SWITCHBOARD OPERATOR/RECEPTIONIST	4	0	4	0%	0%
T11360	TEACHER (SCATA CONTRACT)	3	0	3	0%	0%
A11122	TRAINING SPECIALIST I	2	0	2	0%	0%
C72481	YOUTH COUNSELOR I	2	0	2	0%	0%
P76752	YOUTH SECURITY SPECIALIST II	21	1	22	5%	24%
V76753	YOUTH SECURITY SUPERVISOR	9	0	9	0%	9%
		505	**121**	**626**	**19%**	**19%**

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Ombudsman's Contact

Snyder, Peter [redacted]
To: "Moreland, Jerall" <[redacted]>

Wed, Feb 17, 2021 at 10:57 AM

In addition to the information in the spreadsheet I sent you last week for item #6 this is the additional information:

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020

   505

2. The number of positions vacant as of December 31, 2020

   121

3. The number of positions needed in your HR staffing plan for FY21

   626

4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020

   505

5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020

   19%

6. The number of vacant positions as of December 31, 2020

   121

B. The number of assaults on staff for calendar year 2020

63

Please let me know if you have any additional questions regarding this information.

Thanks,

Peter Snyder, M.Ed.; C.T.R.S.

Hospital Operating Officer- Lincoln Regional Center

Nebraska Department of Health and Human Services

OFFICE- [redacted]

MOBILE- [redacted]

DHHS.ne.gov | Facebook | Twitter | LinkedIn

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Ombudsman's Contact

Snyder, Peter <Pete[redacted]> Mon, Feb 8, 2021 at 4:56 PM
To: "Moreland, Jerall[redacted]
Cc: "Vogel, Barbara"[redacted]

There were 63 patient assaults on staff in calendar year 2020 for LRC main campus. There were 67 patient assaults on staff in calendar year 2020 if we include the Whitehall campus.

We are working on making sure we have all the other information sent to you this week.

Thanks,

Peter Snyder, M.Ed.; C.T.R.S.

Hospital Operating Officer- Lincoln Regional Center

Nebraska Department of Health and Human Services

OFFICE[redacted]

MOBILE- [redacted]

DHHS.ne.gov | Facebook | Twitter | LinkedIn

[Quoted text hidden]

LRC Inspection Documentation

Fire Extinguisher

Elevator Safety

Sprinkler

Alarm

Attachment L4

Fire Extinguisher

Inspection Certificate

For

Lincoln Regional Center
801 W Prospector Pl
Lincoln, NE 68522

This Inspection was performed in accordance with applicable Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Inspection Date
Sep 29, 2020

Building: Lincoln Regional Center
Contact: Kurt -
Title: -

Company: General Fire & Safety
Contact: Ron Fox
Title: Fire Extinguisher Technician

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center
Address: 801 W Prospector Pl
Address:
City/State/Zip: Lincoln, NE 68522
Country: United States of America

Contact: Kurt -
Phone: [redacted]
Fax:
Mobile:
Email:

Inspection Performed By

Company: General Fire & Safety
Address: 2431 Fairfield Street
Address:
City/State/Zip: Lincoln, NE 68521
Country: United States of America

Inspector: Ron Fox
Phone: [redacted]
Fax:
Mobile: [redacted]
Email: [redacted]

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Fire	115	100.00%	115	100.00%	115	100.00%	0	0%
Totals	**115**	**100%**	**115**	**100.00 %**	**115**	**100.00 %**	**0**	**0%**

Certification

Company: General Fire & Safety
Inspector: Ron Fox

Signed:

Building: Lincoln Regional Center
Contact: Kurt -

Signed:

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln Regional Center

The Inspection & Testing section lists all of the items inspected in your building. Items are grouped by Passed or Failed/Other. Items are listed by Category. Each item includes the services performed, and the time & date at which testing occurred.

Device Type	Location	ScanID : S/N	Service	Date Time
		Passed		
Fire				
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 1st-Breakroom	ZX419353 ZX419353	Inspected	09/11/20 8:32:33 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 1st-Life Skills	57605862 XP-448275	Inspected	09/11/20 8:39:41 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 1st-Lobby-Elev	BP992371 BP992371	Inspected	09/11/20 8:35:35 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 1st-North	V70728 V70728	Inspected	09/11/20 8:30:05 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 1st-South	RH-009537 RH-009537	Inspected	09/11/20 8:44:50 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 2nd-East Hall	XB936969 XB936969	Inspected	09/11/20 9:01:29 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 2nd-Kitchen	AK346456 AK346456	Inspected	09/11/20 8:52:28 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 2nd-North	AZ497627 AZ497627	Inspected	09/11/20 8:58:20 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 2nd-South	XB947621 XB947621	Inspected	09/11/20 9:09:35 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 2nd-Tech Station	Y574063 Y574063	Inspected	09/11/20 8:49:43 AM
Fire Extinguisher, 6 Ltr, Class K	Building 10 LL-Canteen	A-35483507 A-35483507	Inspected	09/11/20 9:24:35 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 10 LL-Elev	WK692500 WK692500	Inspected	09/11/20 9:12:19 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 10 LL-Elev Mech Room	BE740174 BE740174	Inspected	09/11/20 9:21:42 AM
Fire Extinguisher, 20 Lbs, B.C.	Building 10 LL-Generator Room	XH732457 XH732457	Inspected	09/11/20 9:18:00 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 10 LL-Kitchen Office	A92847699 A92847699	Inspected	09/11/20 9:28:15 AM
Fire Extinguisher, 6 Ltr, Class K	Building 10 LL-Kitchen-East Door	A-35483510 A-35483510	Inspected	09/11/20 9:30:55 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 10 LL-Mech Room	XL808783 XL808783	Inspected	09/11/20 9:15:39 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 10 Penthouse	XS139166 XS139166	Inspected	09/11/20 9:05:06 AM
Fire Extinguisher, 5 Lbs,	Building 14 1st-Hall-Rm 121	ZP736971	Hydro Test	09/29/20 2:53:12 PM

Device Type	Location	ScanID : S/N	Service	Date Time
A.B.C.		ZP736971		
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 1st-Hall-Rm 138	ZP736943 ZP736943	Hydro Test	09/29/20 2:52:10 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 1st-Hall-Rm 148a	AZ497634 AZ497634	Inspected	09/09/20 9:34:04 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 1st-Hall-Rm 153	YF864122 YF864122	Inspected	09/09/20 9:32:43 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 1st-Hall-Rm 189	SP535641 SP535641	Inspected	09/09/20 9:28:48 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 2nd-Hall-Rm 212	XA51018 XA51018	Inspected	09/09/20 9:51:51 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 2nd-Hall-Rm 240	V69213 V69213	Inspected	09/09/20 9:46:07 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 2nd-Hall-Rm 252	YC301458 YC301458	Inspected	09/09/20 9:44:36 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 2nd-Hall-Rm 281	ZU118735 ZU118735	Hydro Test	09/29/20 3:23:36 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 2nd-Hall-Rm 290	XG-467364 XG-467364	Inspected	09/09/20 9:39:31 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 2nd-Rm 217	XM79553 XM79553	Inspected	09/09/20 9:49:32 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 2nd-Rm 230	AK349954 AK349954	Inspected	09/09/20 9:47:57 AM
Fire Extinguisher, 6 Ltr, Class K	Building 14 2nd-Rm 271-Kitchen	AC817615 AC817615	Inspected	09/09/20 9:42:48 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 3rd-Hall-Middle Stairs	ZP736936 ZP736936	Hydro Test	09/29/20 3:27:06 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 3rd-Hall-Rm 319	ZP724320 ZP724320	Hydro Test	09/29/20 3:26:10 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 3rd-Hall-Rm 331	ZP736994 ZP736994	Hydro Test	09/29/20 3:28:26 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 3rd-Hall-Rm 359	ZZ-182844 ZZ-182844	Inspected	09/09/20 9:55:05 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 3rd-Office-Rm 348	C98789954 C98789954	Inspected	09/09/20 9:57:46 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 LL-Elev Mech Rm-Rm 039	K884527 K884527	Inspected	09/09/20 9:17:53 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Hall-Rm 029	ZP724348 ZP724348	Hydro Test	09/29/20 3:42:02 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Hall-Rm 041	ZP724373 ZP724373	Hydro Test	09/29/20 3:43:16 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Hall-Rm 056	ZP715804 ZP715804	Hydro Test	09/29/20 3:35:24 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Mech Rm 014	BS730257 BS730257	Inspected	09/09/20 9:10:39 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Hall	ZW989049 ZW989049	Hydro Test	09/29/20 2:47:40 PM
Fire Extinguisher, 6 Ltr, Class K	Building 14 LL-NW Mech Room-Spare	AB110001 AB110001	Inspected	09/25/20 11:15:19 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	57605861 WT-363452	Inspected	09/25/20 11:19:28 AM
Fire Extinguisher, 10 Lbs,	Building 14 LL-NW Mech	RC-057831	Inspected	09/25/20 11:21:41 AM

Device Type	Location	ScanID : S/N	Service	Date Time
A.B.C.	Room-Spare	RC-057831		
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	XL914520 XL914520	Inspected	09/25/20 11:17:26 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	WU105507 WU105507	Inspected	09/25/20 11:24:45 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	AU800350 AU800350	Inspected	09/25/20 11:27:49 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	AV616821 AV616821	Inspected	09/25/20 11:28:12 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-NW Mech Room-Spare	AW981212 AW981212	Inspected	09/25/20 11:30:30 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Rm 029	VZ498987 VZ498987	Inspected	09/09/20 9:12:41 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Rm 056-Storage	ZP724307 ZP724307	Hydro Test	09/29/20 3:36:42 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Rm 056b	XL938807 XL938807	Inspected	09/09/20 9:23:00 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Rm 062-Storage	ZP724331 ZP724331	Hydro Test	09/29/20 3:40:47 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LL-Shop-Rm 054	AW981252 AW981252	Inspected	09/09/20 9:20:44 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 14 LLNW Mech Room-Spare	AT713959 AT713959	Inspected	09/25/20 11:24:53 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 1st-By Elevator	A40076392 A40076392	Inspected	09/11/20 10:36:18 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 1st-East	BS798461 BS798461	Inspected	09/11/20 10:33:44 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 3 1st-Kitchen	W-425773 W-425773	Inspected	09/11/20 10:31:02 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 1st-West	AU371289 AU371289	Inspected	09/11/20 10:27:53 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 2nd-By Elevator	BN438136 BN438136	Inspected	09/11/20 10:39:29 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 2nd-East	BN438033 BN438033	Inspected	09/11/20 10:42:54 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 2nd-Kitchen	AW981794 AW981794	Inspected	09/11/20 10:45:21 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 2nd-West	S758439 S758439	Inspected	09/11/20 10:48:55 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 LL-East	BV748715 BV748715	Inspected	09/11/20 10:08:49 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 LL-Elevator Mech Room	AK346420 AK346420	Inspected	09/11/20 10:13:43 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 3 LL-Maintenance Shop	BF-142204 BF-142204	Inspected	09/11/20 10:06:03 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 LL-Rec Room-Kitchen	YB784137 YB784137	Inspected	09/11/20 10:20:00 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 LL-Rec Room-West Wall	BK191555 BK191555	Inspected	09/11/20 10:16:49 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 3 LL-Rm 008-Mech Room	AT-018360 AT-018360	Inspected	09/11/20 10:23:06 AM
Fire Extinguisher, 5 Lbs,	Building 3 LL-Rm 028	SJ-230292	Inspected	09/11/20 10:10:46 AM

Device Type	Location	ScanID : S/N	Service	Date Time
A.B.C.		SJ-230292		
Fire Extinguisher, 5 Lbs, A.B.C.	Building 3 LL-West	AZ499964 AZ499964	Inspected	09/11/20 10:25:41 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-Lobby	XL938806 XL938806	Inspected	09/09/20 2:53:01 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-Rec Room-RT Office	XB816431 XB816431	Inspected	09/09/20 3:09:04 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-S2-Tech Station	XL914486 XL914486	Inspected	09/09/20 2:44:28 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 LL-Gym Storage	XF876503 XF876503	Inspected	09/09/20 2:03:04 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 LL-West Electrical Room	XS048693 XS048693	Inspected	09/09/20 2:59:20 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-Canteen-Breakroom	ZP737022 ZP737022	Hydro Test	09/28/20 3:48:17 PM
Fire Extinguisher, 6 Ltr, Class K	Building 5 1st-Canteen-Kitchen	A-35484808 A-35484808	Hydro Test	09/28/20 3:38:39 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-H.I.M. Office	ZT900966 ZT900966	Inspected	09/09/20 1:56:39 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 5 1st-Kitchen	ZP896214 ZP896214	Hydro Test	09/28/20 3:48:52 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-Rec Room	AW981247 AW981247	Inspected	09/09/20 2:08:28 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 5 1st-Rec Room-Library	RX-783016 RX-783016	Inspected	09/09/20 2:11:53 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-S1-Fire Exit	VS-479556 VS-479556	Inspected	09/09/20 2:25:07 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-S1-Tech Room	SJ-230294 SJ-230294	Inspected	09/09/20 2:23:27 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-S2-Fire Exit	AT713834 AT713834	Inspected	09/09/20 2:41:32 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-S3-Fire Exit	AY719620 AY719620	Inspected	09/09/20 2:27:26 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 1st-Security Office	RH-020799 RH-020799	Inspected	09/09/20 1:57:52 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 2nd-S3-Tech Station	WU095774 WU095774	Inspected	09/09/20 2:31:44 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 2nd-S4-Fire Exit	AW981253 AW981253	Inspected	09/09/20 2:39:48 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 2nd-S4-Tech Station	RH-020810 RH-020810	Inspected	09/09/20 2:36:44 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 2nd-S5-Tech Station	R988783 R988783	Inspected	09/09/20 2:51:18 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 2nd-South Elev Mech Room	AT713841 AT713841	Inspected	09/09/20 2:33:42 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 5 Annex-Hall	ZP896220 ZP896220	Hydro Test	09/28/20 3:49:20 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 Annex-Mech Room	WA-658121 WA-658121	Inspected	09/09/20 3:15:03 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 LL-East Elec Room	AY696880 AY696880	Inspected	09/09/20 3:00:55 PM
Fire Extinguisher, 5 Lbs,	Building 5 LL-Elev Mech Room	RH-009547	Inspected	09/09/20 3:03:13 PM

Device Type	Location	ScanID : S/N	Service	Date Time
A.B.C.		RH-009547		
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 LL-Gym-Work Out Room	VP-622356 VP-622356	Inspected	09/09/20 2:05:45 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 5 LL-Mech Room	AZ621013 AZ621013	Inspected	09/09/20 2:56:14 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Building 7 LL-Elev Mech Room	BR334948 BR334948	Inspected	09/09/20 11:16:48 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 7 LL-Loading Dock	XS122493 XS122493	Inspected	09/09/20 11:14:25 AM
Fire Extinguisher, 10 Lbs, Carbon Dioxide	Building 9 Basement Mech Room	X863229 X863229	Inspected	09/09/20 11:13:22 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 9 Basement-Stairs	BN340978 BN340978	Inspected	09/09/20 10:58:42 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 9 East Hall	AK379543 AK379543	Inspected	09/09/20 10:54:17 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 9 East Hall	AK347330 AK347330	Inspected	09/09/20 10:56:35 AM
Fire Extinguisher, 5 Lbs, A.B.C.	Building 9 South Lobby	M613495 M613495	Inspected	09/09/20 10:47:01 AM
Fire Extinguisher, 20 Lbs, A.B.C.	Maintenance/Grounds Boiler Room-South Wall	ZR267659 ZR267659	Hydro Test	09/28/20 3:17:40 PM
Fire Extinguisher, 5 Lbs, A.B.C.	Maintenance/Grounds Carpenter Shop-North	ZP715802 ZP715802	Hydro Test	09/28/20 3:23:03 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds Carpenter Shop-South	AH-333035 AH-333035	Inspected	09/28/20 3:18:27 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds Cave	BF-142219 BF-142219	Inspected	09/28/20 3:19:08 PM
Fire Extinguisher, 20 Lbs, B.C.	Maintenance/Grounds Gas Pump	V897464 V897464	Inspected	09/09/20 11:41:42 AM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds Grounds Shop-Entry	K901376 K901376	Inspected	09/28/20 3:20:16 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds Shop	YU18673 YU18673	Inspected	09/09/20 12:01:01 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds Shop	ZP896247 ZP896247	Hydro Test	09/28/20 3:26:01 PM
Fire Extinguisher, 10 Lbs, A.B.C.	Maintenance/Grounds West Shed-Entry	ZP896238 ZP896238	Hydro Test	09/28/20 3:23:55 PM

Service Summary

Generated by: BuildingReports.com

Building: Lincoln Regional Center

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Fire Extinguisher, 10 Lbs, A.B.C.	Hydro Test	5
Fire Extinguisher, 10 Lbs, A.B.C.	Inspected	20
Fire Extinguisher, 10 Lbs, Carbon Dioxide	Inspected	1
Fire Extinguisher, 20 Lbs, A.B.C.	Hydro Test	1
Fire Extinguisher, 20 Lbs, B.C.	Inspected	2
Fire Extinguisher, 5 Lbs, A.B.C.	Hydro Test	13
Fire Extinguisher, 5 Lbs, A.B.C.	Inspected	68
Fire Extinguisher, 6 Ltr, Class K	Hydro Test	1
Fire Extinguisher, 6 Ltr, Class K	Inspected	4
Total		**115**
Grand Total		**115**

Fire Extinguisher Maintenance Report

Generated by: BuildingReports.com

Building: Lincoln Regional Center

This report provides details on the Hydrostatic Test and Maintenance/Breakdown dates for fire extinguishers. Items that will need either of these services at any time in the next two years are displayed. Items are grouped together by year for budgeting purposes.

ScanID	Location	Serial #	Hydro	Breakdown	Mfr Date
Due in 2021					
Breakdown/Maintenance					
Fire Extinguisher, A.B.C., 10 Lbs					
A92847699	Building 10 LL-Kitchen Office	A92847699	09/09/27	09/11/21	09/09/15
				Total Fire Extinguisher, A.B.C., 10 Lbs:	1
Hydrostatic Test					
Fire Extinguisher, A.B.C., 5 Lbs					
VP-622356	Building 5 LL-Gym-Work Out Room	VP-622356	09/09/21	09/09/27	09/09/09
				Total Fire Extinguisher, A.B.C., 5 Lbs:	1
Fire Extinguisher, Class K, 6 Ltr					
AB110001	Building 14 LL-NW Mech Room-Spare	AB110001	09/09/21		09/09/06
				Total Fire Extinguisher, Class K, 6 Ltr:	1
Due in 2022					
Breakdown/Maintenance					
Fire Extinguisher, A.B.C., 5 Lbs					
WK692500	Building 10 LL-Elev	WK692500	09/09/28	09/11/22	09/09/04
				Total Fire Extinguisher, A.B.C., 5 Lbs:	1
Hydrostatic Test					
Fire Extinguisher, A.B.C., 10 Lbs					
K884527	Building 14 LL-Elev Mech Rm-Rm 039	K884527	09/09/22	09/09/28	09/09/10
				Total Fire Extinguisher, A.B.C., 10 Lbs:	1
Fire Extinguisher, A.B.C., 5 Lbs					
V69213	Building 14 2nd-Hall-Rm 240	V69213	09/09/22	09/09/28	09/09/10
S758439	Building 3 2nd-West	S758439	09/09/22	09/11/28	09/09/10
				Total Fire Extinguisher, A.B.C., 5 Lbs:	2
Fire Extinguisher, B.C., 20 Lbs					
V897464	Maintenance/Grounds Gas Pump	V897464	09/09/22	09/09/28	09/09/10
				Total Fire Extinguisher, B.C., 20 Lbs:	1
Fire Extinguisher, Class K, 6 Ltr					
AC817615	Building 14 2nd-Rm 271-Kitchen	AC817615	09/09/22		09/09/12
				Total Fire Extinguisher, Class K, 6 Ltr:	1

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln Regional Center

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Fire Extinguisher	Fire	100.00%	115

Type	Qty	Model #	Description	Manufacture Date
New (under 90 days)				
Amerex				
Fire Extinguisher	1	AB402-08	A.B.C.	09/09/2020
In Service - 3 Years to 5 Years				
Amerex				
Fire Extinguisher	1	AB456-17	A.B.C.	09/09/2017
In Service - 5 Years to 10 Years				
Amerex				
Fire Extinguisher	1	AB402-15	A.B.C.	09/09/2015
Fire Extinguisher	1	AB456-15	A.B.C.	09/09/2015
Sentry				
Fire Extinguisher	1	X-K01-3	Class K	09/09/2015
Fire Extinguisher	2	X-K01-3	Class K	09/09/2014
Amerex				
Fire Extinguisher	2	AB500-13	A.B.C.	09/09/2013
Sentry				
Fire Extinguisher	1	XA05	A.B.C.	09/09/2013
Fire Extinguisher	4	XAA05-1	A.B.C.	09/09/2013
Amerex				
Fire Extinguisher	1	AB456-13	A.B.C.	09/09/2013
Fire Extinguisher	7	AB500-12	A.B.C.	09/09/2012
Kidde				
Fire Extinguisher	1	PRO 5	A.B.C.	09/09/2012
Sentry				
Fire Extinguisher	1	XAA05	A.B.C.	09/09/2012
Fire Extinguisher	4	XAA05-1	A.B.C.	09/09/2012
Amerex				
Fire Extinguisher	1	AB456-12	A.B.C.	09/09/2012

Badger				
Fire Extinguisher	2	ADV-10	A.B.C.	09/09/2012
Buckeye				
Fire Extinguisher	1	10HISA80ABC	A.B.C.	09/09/2012
Fire Extinguisher	1	10SHISA80ABC	A.B.C.	09/09/2012
Amerex				
Fire Extinguisher	1	AB260-12	Class K	09/09/2012
Fire Extinguisher	1	A402-99	A.B.C.	09/09/2011
Fire Extinguisher	2	AB402-11	A.B.C.	09/09/2011
Sentry				
Fire Extinguisher	2	XAA05	A.B.C.	09/09/2011
Fire Extinguisher	6	XAA05-1	A.B.C.	09/09/2011
Buckeye				
Fire Extinguisher	1	10HISA80ABC	A.B.C.	09/09/2011
Sentry				
Fire Extinguisher	1	XAA10S	A.B.C.	09/09/2011
In Service - 10 Years to 15 Years				
Sentry				
Fire Extinguisher	1	XA05	A.B.C.	09/09/2010
Fire Extinguisher	2	XAA05	A.B.C.	09/09/2010
Fire Extinguisher	1	XAA10S	A.B.C.	09/09/2010
Amerex				
Fire Extinguisher	1		B.C.	09/09/2010
Sentry				
Fire Extinguisher	1	PRO 5	A.B.C.	09/09/2009
Fire Extinguisher	1	XAA05	A.B.C.	09/09/2009
Buckeye				
Fire Extinguisher	1	10HISA80ABC	A.B.C.	09/09/2009
Sentry				
Fire Extinguisher	11	XA05	A.B.C.	09/09/2008
Fire Extinguisher	2	XAA05	A.B.C.	09/09/2008
Fire Extinguisher	4	XA10T	A.B.C.	09/09/2008
Fire Extinguisher	1	XAA20	A.B.C.	09/09/2008
Fire Extinguisher	1	XA05	A.B.C.	09/09/2007
Fire Extinguisher	1	XAA05	A.B.C.	09/09/2007
Fire Extinguisher	1	XA10H	A.B.C.	09/09/2007
Buckeye				
Fire Extinguisher	1	5HI SA	A.B.C.	09/09/2006
Sentry				
Fire Extinguisher	1	XA05	A.B.C.	09/09/2006
Fire Extinguisher	5	XAA05	A.B.C.	09/09/2006
Amerex				
Fire Extinguisher	1	AB456-06	A.B.C.	09/09/2006
Fire Extinguisher	1	AB260	Class K	09/09/2006

In Service - 15 Years to 25 Years				
Sentry				
Fire Extinguisher	2	XA05	A.B.C.	09/09/2005
Fire Extinguisher	9	XAA05	A.B.C.	09/09/2005
Badger				
Fire Extinguisher	1	10MB-8H-05	A.B.C.	09/09/2005
Buckeye				
Fire Extinguisher	1	10HI	A.B.C.	09/09/2005
Sentry				
Fire Extinguisher	1	XA10H	A.B.C.	09/09/2005
Fire Extinguisher	2	XA10T	A.B.C.	09/09/2005
Amerex				
Fire Extinguisher	1	A408-05	B.C.	09/09/2005
Fire Extinguisher	1	AB500-04	A.B.C.	09/09/2004
Sentry				
Fire Extinguisher	1	XAA05	A.B.C.	09/09/2004
Amerex				
Fire Extinguisher	1	AB402-03	A.B.C.	09/09/2003
Sentry				
Fire Extinguisher	1	XAA05	A.B.C.	09/09/2003
Amerex				
Fire Extinguisher	3	AB500-01	A.B.C.	09/09/2001
Fire Extinguisher	1	A330	Carbon Dioxide	09/09/2001
Badger				
Fire Extinguisher	1	10MB8H00	A.B.C.	09/09/2000
Amerex				
Fire Extinguisher	3	A402-99	A.B.C.	09/09/1999
Badger				
Fire Extinguisher	1	10MB8H99	A.B.C.	09/09/1999

Elevator Safety

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Lincoln Regional Ctr **Building Address:** #3

Elevator No.: **State ID Number:** 4076 **Elevator Type:** **Elevator Use:** **# of Landings:**

Last Annual Insp. Date: 5-8-2019 **Elevator Speed:** **Elevator Capacity:** **Code Year:** **Manufacturer:**

	ELEVATORS — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	X			
	2 Must make car and floor sill's level.	1.3.1.1	X			
	3 Must make emergency light operable.	1.5.1(b)	X			
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	X			
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	X			
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	X			
	7 Must provide ample, guarded, machine room lighting.	2.3.1	X			
	8 Must provide sufficient heating/cooling for equipment	2.6.1	X			
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	X			
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	X			
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	X			
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	X			Tested April 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			X	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1			X	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	X			
	16 Must make car top inspection station operable.	3.3.1	X			
	17 Must make car top light and GFCI outlet operable.	3.2.1	X			
	18 Must make hoist way venting clear and louvers operable.	3.11.1			X	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)			X	
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1			X	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	X			
	22 Must maintain monthly fire service testing log in control room.	6.1.1	X			
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	X			
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	X			
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	X			
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	X			
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	X			
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	X			
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	X			
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	X			
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	X			
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	X			
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3				
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4				
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6				
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1				
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1				
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)				
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1				

Inspector Name: **Inspector Signature:** Carol B Bonka **Date:** 08-25-2020

Building Contact Name: Tony **Contact Signature:**

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Lincoln Regional Ctr Building Address: # 5

Elevator No.: State ID Number: 4071 Elevator Type: Hydro Elevator Use: Pass # of Landings: 2

Last Annual Insp. Date: 5-8-2019 Elevator Speed: Elevator Capacity: Code Year: Manufacturer: TKE

	ELEVATORS — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	☒	☐	☐	
	2 Must make car and floor sill's level.	1.3.1.1	☒	☐	☐	
	3 Must make emergency light operable.	1.5.1(b)	☒	☐	☐	
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	☒	☐	☐	
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	☒	☐	☐	
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	☒	☐	☐	
	7 Must provide ample, guarded, machine room lighting.	2.3.1	☒	☐	☐	
	8 Must provide sufficient heating/cooling for equipment	2.6.1	☒	☐	☐	
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	☒	☐	☐	
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	☒	☐	☐	
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	☒	☐	☐	
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	☒	☐	☐	April 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)	☐	☐	☒	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	☐	☐	☒	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	☒	☐	☐	
	16 Must make car top inspection station operable.	3.3.1	☒	☐	☐	
	17 Must make car top light and GFCI outlet operable.	3.2.1	☒	☐	☐	
	18 Must make hoist way venting clear and louvers operable.	3.11.1	☐	☐	☒	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)	☐	☐	☒	
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1	☐	☐	☒	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	☒	☐	☐	
	22 Must maintain monthly fire service testing log in control room.	6.1.1	☒	☐	☐	
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	☒	☐	☐	
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	☒	☐	☐	
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	☒	☐	☐	
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	☒	☐	☐	
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	☒	☐	☐	
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	☒	☐	☐	
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	☒	☐	☐	
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	☒	☐	☐	
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	☒	☐	☐	
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	☒	☐	☐	
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3	☐	☐	☐	
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4	☐	☐	☐	
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6	☐	☐	☐	
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1	☐	☐	☐	
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1	☐	☐	☐	
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)	☐	☐	☐	
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1	☐	☐	☐	

Inspector Name: Inspector Signature: Chris B Bonds Date: 08-25-2020

Building Contact Name: Tom Contact Signature:

Shaw N

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Wineolm Regional Cit **Building Address:** #5

Elevator No.: **State ID Number:** 6403 **Elevator Type:** Hyd or O **Elevator Use:** Pass **# of Landings:** 2

Last Annual Insp. Date: 5-8-20 **Elevator Speed:** **Elevator Capacity:** **Code Year:** **Manufacturer:** TRE

	ELEVATORS — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	X			
	2 Must make car and floor sill's level.	1.3.1.1	X			
	3 Must make emergency light operable.	1.5.1(b)	X			
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	X			
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	X			
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	X			
	7 Must provide ample, guarded, machine room lighting.	2.3.1	X			
	8 Must provide sufficient heating/cooling for equipment	2.6.1	X			
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	X			
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	X			
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	X			
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	X			TESTED April 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			X	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1			X	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	X			
	16 Must make car top inspection station operable.	3.3.1	X			
	17 Must make car top light and GFCI outlet operable.	3.2.1	X			
	18 Must make hoist way venting clear and louvers operable.	3.11.1			X	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)			X	
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1			X	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	X			
	22 Must maintain monthly fire service testing log in control room.	6.1.1	X			
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	X			
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	X			
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	X			
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	X			
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	X			
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	X			
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	X			
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	X			
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	X			
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	X			
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3				
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4				
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6				
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1				
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1				
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)				
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1				

Inspector Name: **Inspector Signature:** Carol B. Bonds **Date:** 08-25-2020

Building Contact Name: Tom **Contact Signature:**

JFF

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Lincoln Regional Ctr **Building Address:** Bldg 10

Elevator No.: 2 **State ID Number:** 7183 **Elevator Type:** **Elevator Use:** Pass **# of Landings:** 3

Last Annual Insp. Date: 5-8-2019 **Elevator Speed:** **Elevator Capacity:** **Code Year:** **Manufacturer:** TKE

	ELEVATORS — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	☒	☐	☐	
	2 Must make car and floor sill's level.	1.3.1.1	☒	☐	☐	
	3 Must make emergency light operable.	1.5.1(b)	☒	☐	☐	
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	☒	☐	☐	
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	☐	☐	☒	
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	☒	☐	☐	
	7 Must provide ample, guarded, machine room lighting.	2.3.1	☒	☐	☐	
	8 Must provide sufficient heating/cooling for equipment	2.6.1	☒	☐	☐	
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	☒	☐	☐	
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	☒	☐	☐	
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	☒	☐	☐	
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	☒	☐	☐	TESTED Apr. 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)	☐	☐	☒	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	☐	☐	☒	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	☒	☐	☐	
	16 Must make car top inspection station operable.	3.3.1	☒	☐	☐	
	17 Must make car top light and GFCI outlet operable.	3.2.1	☒	☐	☐	
	18 Must make hoist way venting clear and louvers operable.	3.11.1	☐	☐	☒	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)	☒	☐	☐	
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1	☐	☐	☒	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	☒	☐	☐	
	22 Must maintain monthly fire service testing log in control room.	6.1.1	☒	☐	☐	
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	☒	☐	☐	
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	☒	☐	☐	
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	☒	☐	☐	
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	☒	☐	☐	
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	☒	☐	☐	
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	☒	☐	☐	
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	☒	☐	☐	
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	☒	☐	☐	
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	☒	☐	☐	
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	☒	☐	☐	
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3	☐	☐	☐	
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4	☐	☐	☐	
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6	☐	☐	☐	
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1	☐	☐	☐	
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1	☐	☐	☐	
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)	☐	☐	☐	
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1	☐	☐	☐	

Inspector Name: **Inspector Signature:** Carol B Bonds **Date:** 08-25-2020

Building Contact Name: JFF **Contact Signature:**

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Lincoln Regional Ctr **Building Address:** Bldg 10

Elevator No.: #1 **State ID Number:** 1182 **Elevator Type:** Hydro **Elevator Use:** Pass **# of Landings:** 3

Last Annual Insp. Date: 5-8-2019 **Elevator Speed:** **Elevator Capacity:** **Code Year:** **Manufacturer:** TKE

	ELEVATORS Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	X			
	2 Must make car and floor sill's level.	1.3.1.1	X			
	3 Must make emergency light operable.	1.5.1(b)	X			
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	X			
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1				
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	X			
	7 Must provide ample, guarded, machine room lighting.	2.3.1	X			
	8 Must provide sufficient heating/cooling for equipment	2.6.1	X			
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	X			
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	X			
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	X			
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	X			Tested April 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			X	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1			X	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	X			
	16 Must make car top inspection station operable.	3.3.1	X			
	17 Must make car top light and GFCI outlet operable.	3.2.1	X			
	18 Must make hoist way venting clear and louvers operable.	3.11.1	X		X	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)	X			
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1			X	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	X			
	22 Must maintain monthly fire service testing log in control room.	6.1.1	X			
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	X			
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	X			
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	X			
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	X			
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	X			
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	X			
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	X			
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	X			
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	X			
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	X			
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3				
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4				
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6				
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1				
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1				
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)				
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1				

Inspector Name: **Inspector Signature:** Chad B Bonka **Date:** 08-25-2020

Building Contact Name: Jeff **Contact Signature:**

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
sfm.Conveyances@nebraska.gov Office:
402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Lincoln Regional Ctr **Building Address:** Bldg #14

Elevator No.: **State ID Number:** 10054 **Elevator Type:** **Elevator Use:** **# of Landings:**

Last Annual Insp. Date: 5-8-2019 **Elevator Speed:** **Elevator Capacity:** **Code Year:** **Manufacturer:**

	ELEVATORS — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
IN CAR	1 Must make door reopening device operable.	1.1.1	☒	☐	☐	
	2 Must make car and floor sill's level.	1.3.1.1	☒	☐	☐	
	3 Must make emergency light operable.	1.5.1(b)	☒	☐	☐	
	4 Must make emergency Alarm Bell/Phone operable.	1.6.1	☒	☐	☐	
	5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	☒	☐	☐	
MACHINE ROOM	6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	☒	☐	☐	
	7 Must provide ample, guarded, machine room lighting.	2.3.1	☒	☐	☐	
	8 Must provide sufficient heating/cooling for equipment	2.6.1	☒	☐	☐	
	9 Must provide lockable mainline and lighting disconnects.	2.11.1	☒	☐	☐	
	10 Must have fire extinguisher adjacent to controls/machine areas	2.7	☒	☐	☐	
	11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	☒	☐	☐	
	12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	☒	☐	☐	TESTED April 2020
	13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)	☐	☐	☒	
	14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	☐	☐	☒	
CAR TOP	15 Must make car top stop switch operable.	3.1.1	☒	☐	☐	
	16 Must make car top inspection station operable.	3.3.1	☒	☐	☐	
	17 Must make car top light and GFCI outlet operable.	3.2.1	☒	☐	☐	
	18 Must make hoist way venting clear and louvers operable.	3.11.1	☒	☐	☐	
	19 Check that a standard railing is provided where required.	3.4.3.1 (b)	☒	☐	☐	
	20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1	☐	☐	☒	
Fire	21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	☒	☐	☐	
	22 Must maintain monthly fire service testing log in control room.	6.1.1	☒	☐	☐	
HOISTWAY	23 Must maintain door closing foot pound pressure within limits.	1.8.1	☒	☐	☐	
	24 Must properly adjust door equipment on car & hall doors.	3.17.1	☒	☐	☐	
	25 Must maintain door gibs and retainers if provided to code.	1.7.1	☒	☐	☐	
	26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	☒	☐	☐	
PIT AREA	27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	☒	☐	☐	
	28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	☒	☐	☐	
	29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	☒	☐	☐	
	30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	☒	☐	☐	
	31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	☒	☐	☐	
	32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	☒	☐	☐	
	ESCALATORS					
	33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3	☐	☐	☐	
	34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4	☐	☐	☐	
	35 Must keep safety decals or signs in good shape for passengers to read.	7.6	☐	☐	☐	
	36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1	☐	☐	☐	
	37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1	☐	☐	☐	
	38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)	☐	☐	☐	
	39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1	☐	☐	☐	

Inspector Name: **Inspector Signature:** Donald B Brooks **Date:** 08-25-2020

Building Contact Name: **Contact Signature:**

Sprinkler system

Sprinkler Inspection Certificate

For

Lincoln regional center B 3
801 west prospector
Lincoln, Ne 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 7, 2020

Building: Lincoln regional center B 3
Contact: Kurt Anderson
Title: Na

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 3	**Contact:** Kurt Anderson
Address: 801 west prospector	**Phone:** Na
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** [redacted]
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** [redacted]
Country: United States of America	**Email:** j[redacted]

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Dec 7, 2020

Building: Lincoln regional center B 3

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Tamper Switch	5	5	0	5	5
Waterflow Switch	4	4	0	4	4

EC 02.03.05 EP 09

Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10

All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Supervisory Signal	5	5	0	5	5

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Control Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 17

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 3
Inspector: Jerad Baxter	Contact: Kurt Anderson
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Tamper Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Tamper Switch	Basement Center room 008	30561921	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 008	30561922	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 008	59342398	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 008	59342401	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	1st Center rom 116	59342404	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 5

EC 02.03.05 EP 02	Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Waterflow Switch	Basement Center room 008	30561918	1		06/08-P	09/08-P	12/07-P
Waterflow Switch	Basement Center room 008	59342402	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Center rom 116	59342405	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	2nd Center rom 216	59342406	1	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 4							

EC 02.03.05 EP 09	Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. Auxiliary and low-point drains in preaction or deluge systems shall be operated after each system operation and before the onset of freezing conditions (and thereafter as needed). (2011 ed.) (NFPA 25 13.2.5; 13.4.4.3.2)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Drain	Basement Center room 008	59342396	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Supervisory Signal	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Supervisory Signal	Basement Center room 008	30561920	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center room 008	30561923	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center room 008	59342400	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	1st Center rom 116	59342403	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	2nd Center rom 216	59342408	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 5

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Control Valve	2nd Center rom 216	59342407	1	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)	

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Post Indicator Valve	Garden Center outside Sw side	59342397	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Annual	1
Drain	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	4
Total		**17**
Grand Total		**17**

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Post Indicator Valve	Valve	5.88%	1
Waterflow Switch	Alarm	23.53%	4
Supervisory Signal	Alarm	29.41%	5
Tamper Switch	Alarm	29.41%	5
Drain	Device	5.88%	1
Control Valve	Valve	5.88%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 90 Days - 1 Year					
Control Valve	1		Butterfly		03/02/2020
Drain	1		Main		03/02/2020
Post Indicator Valve	1				03/02/2020
Supervisory Signal	5				03/02/2020
Tamper Switch	2				03/02/2020
Tamper Switch	3		Control Valve	Supervisory	03/02/2020
Waterflow Switch	2			Alarm	03/02/2020
Waterflow Switch	2		Vane	Alarm	03/02/2020

Sprinkler Inspection Certificate

For

Lincoln regional center B 5
801 west prospector pl
lincoln, ne 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 7, 2020

Building: Lincoln regional center B 5
Contact: tiffany na
Title: administrative assistant

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 5	**Contact:** tiffany na
Address: 801 west prospector pl	**Phone:** (402) 471-4444
Address:	**Fax:**
City/State/Zip: lincoln, ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** [redacted]
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** [redacted]
Country: United States of America	**Email:** [redacted]

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Dec 7, 2020

Building: Lincoln regional center B 5

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Tamper Switch	5	5	0	7	7
Waterflow Switch	5	5	0	7	7

EC 02.03.05 EP 09

Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10

All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Supervisory Signal	5	5	0	7	7

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Control Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 24

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 5
Inspector: Jerad Baxter	Contact: tiffany na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Tamper Switch	5	5	0	7	7

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Tamper Switch	Basement Boiler	59342377	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Boiler	59342378	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	1st Closet closet by reception center	59342382	1-s-2	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	1st Closet room 133a	59342386	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342388	1	03/02-P	06/08-P	09/08-P	
Tamper Switch	2nd Closet s4 housekeeping cliset	59342390	1	03/02-P	06/08-P	09/08-P	
Tamper Switch	2nd Closet s5 west stairwell	59342395	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 7

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Waterflow Switch	5	5	0	7	7

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Waterflow Switch	Basement Boiler	59342380	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Closet room 133a	59342384	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Closet room 133a S2	68605364	1		06/08-P	09/08-P	12/07-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	03/02-P	06/08-P	09/08-P	
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	03/02-P	06/08-P	09/08-P	
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 7

EC 02.03.05 EP 09	Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. Auxiliary and low-point drains in preaction or deluge systems shall be operated after each system operation and before the onset of freezing conditions (and thereafter as needed). (2011 ed.) (NFPA 25 13.2.5; 13.4.4.3.2)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Drain	Basement Boiler	59342375	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Supervisory Signal	5	5	0	7	7

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Supervisory Signal	Basement Boiler	59342376	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Boiler	59342379	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	1st Closet closet by reception center	59342381	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	03/02-P	06/08-P	09/08-P	
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	03/02-P	06/08-P	09/08-P	
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 7

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Control Valve	1st Closet room 133a S2	68605365	1		06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)	

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Post Indicator Valve	Garden outside ne of entrance	59342356	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Annual	1
Drain	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	5
Total		**18**
	Untested	
Supervisory Signal		2
Tamper Switch		2
Waterflow Switch		2
Total		**6**
Grand Total		**24**

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Supervisory Signal	Alarm	29.17%	7
Tamper Switch	Alarm	29.17%	7
Waterflow Switch	Alarm	29.17%	7
Post Indicator Valve	Valve	4.17%	1
Drain	Device	4.17%	1
Control Valve	Valve	4.17%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 90 Days - 1 Year					
Control Valve	1				03/02/2020
Drain	1		Main		03/02/2020
Post Indicator Valve	1				03/02/2020
Supervisory Signal	7				03/02/2020
Tamper Switch	6				03/02/2020
Tamper Switch	1		Control Valve	Supervisory	03/02/2020
Waterflow Switch	3				03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020

Zone Address Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Zone Address Report lists all of the devices and items that have an individual address, or are grouped together under a common zone. The device type, location and description are included for your reference. For more information on the device, use the link provided under ScanID.

Address	Device Type	Location	Type	ScanID
Control Panel 1				
Zone/Address: s-2				
	Tamper Switch	1st Closet closet by reception center		59342382
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

Notes & Recommendations

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Notes & Recommendations Report details additional inspection notes made by the Inspectors during the course of the building inspection. Notes are grouped by SystemID.

Note	Device Type	Location	Comment	ScanID
1	Waterflow Switch	2nd Closet s4 housekeeping cliset		59342391
	Did not test due to COVID			

Sprinkler Inspection Certificate

For

Lincoln regional center B 10
800 west prospector
Lincoln, Ne 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 7, 2020

Building: Lincoln regional center B 10
Contact: Kurt Na
Title: Maintance manager

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 10	**Contact:** Kurt Na
Address: 800 west prospector	**Phone:** Na
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** [redacted]
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** [redacted]
Country: United States of America	**Email:** [redacted]

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Dec 7, 2020

Building: Lincoln regional center B 10

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Tamper Switch	7	7	0	7	7
Waterflow Switch	3	3	0	3	3

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Supervisory Signal	6	6	0	6	6

LS 02.01.35 EP 14 All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Total Device Count: 18

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 10
Inspector: Jerad Baxter	Contact: Kurt Na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 10

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Tamper Switch	Basement Center room 013	59342343	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 013	59342344	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 013	59342345	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 013	59342349	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center room 013	59342350	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	1st Center room 147	59342409	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	2nd East room 234	59342340	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Waterflow Switch	Basement Center room 013	59342347	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Center room 147	59342411	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	2nd East room 234	59342339	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 3

EC 02.03.05 EP 09	Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. Auxiliary and low-point drains in preaction or deluge systems shall be operated after each system operation and before the onset of freezing conditions (and thereafter as needed). (2011 ed.) (NFPA 25 13.2.5; 13.4.4.3.2)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Drain	Basement Center room 013	59342353	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Supervisory Signal	Basement Center room 013	59342342	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center room 013	59342346	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center room 013	59342348	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center room 013	59342351	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	1st Center room 147	59342410	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	2nd East room 234	59342341	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 6

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Post Indicator Valve	Basement Center room 013	59342352	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 10

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Drain	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	6
Tamper Switch	Annual	7
Waterflow Switch	Annual	3
Total		**18**
Grand Total		**18**

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 10

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Waterflow Switch	Alarm	16.67%	3
Tamper Switch	Alarm	38.89%	7
Supervisory Signal	Alarm	33.33%	6
Post Indicator Valve	Valve	5.56%	1
Drain	Device	5.56%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 90 Days - 1 Year					
Drain	1		Main		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	6				03/02/2020
Tamper Switch	2				03/02/2020
Tamper Switch	1			Supervisory	03/02/2020
Tamper Switch	3		Control Valve	Supervisory	03/02/2020
Tamper Switch	1		OS&Y	Supervisory	03/02/2020
Waterflow Switch	3		Vane	Alarm	03/02/2020

Sprinkler Inspection Certificate

For

Lincoln regional center B 14
801 west prospector
Lincoln, Ne 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 7, 2020

Building: Lincoln regional center B 14
Contact: Kurt Na
Title: Maintance manager

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 14	**Contact:** Kurt Na
Address: 801 west prospector	**Phone:** 479-5452
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** [redacted]
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** [redacted]
Country: United States of America	**Email:** [redacted]

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Dec 7, 2020

Building: Lincoln regional center B 14

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Tamper Switch	9	9	0	9	9
Waterflow Switch	5	5	0	5	5

EC 02.03.05 EP 09

Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

EC 02.03.05 EP 10

Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.34 EP 10

All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Supervisory Signal	11	11	0	11	11

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2020)	Total Quantity
Backflow Prevention	0	0	0	1	1
Check Valve	1	1	0	1	1
Control Valve	2	2	0	2	2
Post Indicator Valve	1	1	0	1	1

Total Device Count: 32

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 14
Inspector: Jerad Baxter	Contact: Kurt Na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Tamper Switch	9	9	0	9	9

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Tamper Switch	Basement Room 42	59342430	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Room 42	59342432	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Room 42	59342437	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Room 42	59342438	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center Room 039	59342335	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement Center Room 039	59342338	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	1st Center Room 135 above ceiling	59342412	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	3rd Center Room 340	59342419	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	3rd Center Room 340	59342421	1-3rd floor	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 9

EC 02.03.05 EP 02	Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Waterflow Switch	Basement Room 42	59342427	1		06/08-P	09/08-P	12/07-P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	3rd Center Room 340	59342423	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 5

EC 02.03.05 EP 09	Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. Auxiliary and low-point drains in preaction or deluge systems shall be operated after each system operation and before the onset of freezing conditions (and thereafter as needed). (2011 ed.) (NFPA 25 13.2.5; 13.4.4.3.2)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Drain	Basement Room 42	59342426	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

EC 02.03.05 EP 10

Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Fire department connections shall be inspected quarterly to verify the following: Connections are visible and accessible, couplings or swivels are not damaged and rotate smoothly, plugs or caps are in place and undamaged, gaskets are in place and in good condition, identification signs are in place, the check valve is not leaking, the automatic drain valve is in place and operating properly and the clapper is in place and operating properly. (2011 ed.) (NFPA 25 13.7.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Fire Dep't Connection	Basement Room 42	59342433	0		06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Supervisory Signal	11	11	0	11	11

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Supervisory Signal	Basement Room 42	59342429	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Room 42	59342431	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Room 42	59342436	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Room 42	59342439	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center Room 039	59342336	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Basement Center Room 039	59342337	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	3rd Center Room 340	59342418	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	Penthouse Elevator room	59342424	1	03/02-P	06/08-P	09/08-P	12/07-P

Device Total: 11

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

All backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. (2011 ed.) (NFPA 25 13.6.2.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Backflow Prevention	0	0	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Backflow Prevention	Basement Room 42	59342428	0	03/02-P	06/08-P		
Device Total: 1							

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Check Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Check Valve	Basement Room 42	59342434	1	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Control Valve	2nd Center Room 247 above ceiling	59342416	1	03/02-P	06/08-P	09/08-P	12/07-P
Control Valve	Penthouse Elevator room	59342425	1	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 2							

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Post Indicator Valve	Garden South In yard south of building	59342435	0	03/02-P	06/08-P	09/08-P	12/07-P
Device Total: 1							

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Check Valve	Annual	1
Control Valve	Annual	2
Drain	Annual	1
Fire Dep't Connection	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	11
Tamper Switch	Annual	9
Waterflow Switch	Annual	5
Total		**31**
	Untested	
Backflow Prevention		1
Total		**1**
Grand Total		**32**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

This section lists out all the devices and components that have been associated with a Wet Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane			50	4	1	☑	59342417

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Backflow Prevention	Valve	3.12%	1
Post Indicator Valve	Valve	3.12%	1
Tamper Switch	Alarm	28.12%	9
Supervisory Signal	Alarm	34.38%	11
Control Valve	Valve	6.25%	2
Waterflow Switch	Alarm	15.62%	5
Drain	Device	3.12%	1
Fire Dep't Connection	Hose	3.12%	1
Check Valve	Valve	3.12%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 90 Days - 1 Year					
Backflow Prevention	1				03/02/2020
Check Valve	1		Grooved		03/02/2020
Control Valve	2		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Fire Dep't Connection	1		Wall		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	9				03/02/2020
Supervisory Signal	2		Pressure		03/02/2020
Tamper Switch	2				03/02/2020
Tamper Switch	7		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Waterflow Switch	1		Vane	Alarm	03/02/2020

Zone Address Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Zone Address Report lists all of the devices and items that have an individual address, or are grouped together under a common zone. The device type, location and description are included for your reference. For more information on the device, use the link provided under ScanID.

Address	Device Type	Location	Type	ScanID
Control Panel 1				
Zone/Address: 3rd floor				
	Tamper Switch	3rd Center Room 340	Control Valve	59342421
	Waterflow Switch	3rd Center Room 340	Vane	59342422

Alarm system

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg # 3- Lincoln Regional Center

Property Address: 801 West Prospector PL.
Lincoln, NE 68506

Inspection Date: 8/21/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg # 3- Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	[redacted]
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	[redacted]
Monitoring Acct Number	Customer Provided
Phone Line one or IP	Customer Supplied

Phone Line two or IP	Customer Supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	AFP 1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-10-2020	8-10-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators	✓	✓	
Remote power panels	✓	✓	

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-10-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	8-10-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg. # 5- Lincoln Regional Center

Property Address: 801 West Prospector PL.
Lincoln, NE 68506

Inspection Date: 8/18/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 5- Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	[redacted]
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied
Phone Line one or IP	Customer Supplied

Phone Line two or IP	Customer Supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	AFP 1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-10-2020	8-10-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators	✓	✓	
Remote power panels	✓	✓	

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-10-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	8-10-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg. # 9 - Lincoln Regional Center

Property Address: 801 West Prospector PL. Lincoln, NE 68522

Inspection Date: 8/14/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 9 - Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	[redacted]
Main Account Email	
Authority Having Juristiction	Nebraska state fire marshall
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln, NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	kurt.anderson@nebraska.gov
Monitoring Acct Number	[redacted]
Phone Line one or IP	Customer supplied

Phone Line two or IP	customer supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	In FACP

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	AFP1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	9am	10am
BLDG management	9am	10am
BLDG occupants	9am	10am
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision			
Local annunciator			
Remote annunciators			
Remote power panels	✓	✓	

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal		✓		NA
Alarm restoration		✓		NA
Trouble signal		✓		NA
Trouble restoration		✓		NA
Supervisory signal		✓		NA
Supervisory restoration		✓		NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg. # 10 - Lincoln Regional Center

Property Address: 801 West Prospector PL. Lincoln, NE 68522

Inspection Date: 8/18/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 10 - Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	(402) 479-5453
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln, NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied
Phone Line one or IP	Customer supplied

Phone Line two or IP	Customer supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	AFP 1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-12-2020	8-12-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators	✓	✓	
Remote power panels	✓	✓	

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-12-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	8-12-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL.
Power Plant, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg. # 11 - Lincoln Regional Center

Property Address: 801 West Prospector PL. Power Plant
Lincoln, NE 68522

Inspection Date: 8/21/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 11 - Lincoln Regional Center
Shipping Street	801 West Prospector PL. Power Plant
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	[redacted]
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln, NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied

Phone Line one or IP	Customer supplied
Phone Line two or IP	Customer supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	AFP 1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-10-2020	8-10-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators			

Remote power panels

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-10-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	8-10-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC Bldg. # 14 - Lincoln Regional Center

Property Address: 801 West Prospector PL. Lincoln, NE 68522

Inspection Date: 8/21/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 14 - Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	[redacted]
Main Account Email	kurt.anderson@nebraska.gov
Authority Having Juristiction	Nebraska State Fire Marshal
AHJ Phone Number	
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln, NE 68508
Monitoring Org Phone	[redacted]
Monitoring Org Email	
Monitoring Acct Number	Customer supplied
Phone Line one or IP	Customer supplied

Phone Line two or IP	Customer supplied
Means Of Transmission	Pots

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	Notifier 1010
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-10-2020	8-10-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators	✓	✓	
Remote power panels	✓	✓	

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries	✓	✓	

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-10-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	
Phone:	
Date:	8-10-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC ANNEX #5 - Lincoln Regional Center
Address: 801 West Prospector Plaza, Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Horn Strobe	Strobe
Passed	8	5
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	8	5

This inspection was performed on 8/11/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe			Main Entrance	Passed		8/18/2020 10:06 AM
2	Horn Strobe			Outside Rm 1	Passed		8/18/2020 10:06 AM
3	Horn Strobe			Outside Rm 4	Passed		8/18/2020 10:05 AM
4	Strobe			Bathroom by rm 4	Passed		8/18/2020 10:05 AM
5	Strobe			Women’s Bathroom	Passed		8/18/2020 10:04 AM
6	Horn Strobe			Outside Women’s RR	Passed		8/18/2020 10:04 AM
7	Horn Strobe			Outside Room 7	Passed		8/18/2020 10:04 AM
8	Strobe			Rm 9	Passed		8/18/2020 10:03 AM
9	Horn Strobe			Outside Room 14	Passed		8/18/2020 10:03 AM
10	Horn Strobe			Outside Room 12	Passed		8/18/2020 10:02 AM
11	Strobe			Rm 16	Passed		8/18/2020 10:02 AM
12	Strobe			Rm 15	Passed		8/18/2020 10:02 AM
13	Horn Strobe			Outside horn strobe south side	Passed		8/18/2020 10:01 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC ANNEX #5 - Lincoln Regional Center
Address: 801 West Prospector Plaza, Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	
Passed	
Mitigated	
New - Passed	
Failed	
Removed	
Not Inspected	
Total	

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Main Entrance
Model	-
Voltage/Current	120VAC
s/Communication	Yes Passed

This inspection was performed on 8/11/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Silent Knight			Main Entrance	Passed		8/18/2020 10:07 AM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V8AH	Silent Knight		9-27-19	1st Floor Main Entrance	Passed	
1	12V8AH	Silent Knight		9-27-2029	1st Floor Main Entrance	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Silent Knight		120VAC	Main Entrance	1st Floor	Passed	24 hr 5min	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC ANNEX #5 - Lincoln Regional Center
Address: 801 West Prospector Plaza, Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Heat Detector	Manual Pull Station	Smoke Detector
Passed	1	2	30
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	1	2	30

This inspection was performed on 8/11/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	zone 1 002	silent knight	SD505-APS	Main entrance	Passed		8/18/2020 9:46 AM
2	Smoke Detector	zone 1 005	silent knight	SD505-APS	Hall outside rm 2	Passed		8/18/2020 10:00 AM
3	Smoke Detector	zone 1 030	silent knight	SD505-APS	Hall outside rm 4	Passed		8/18/2020 10:00 AM
4	Smoke Detector	zone 1 032	silent knight	SD505-APS	rm 3	Passed		8/18/2020 9:59 AM
5	Smoke Detector	zone 1 031	silent knight	SD505-APS	RM 4	Passed		8/18/2020 9:59 AM
6	Smoke Detector	zone 1 03	silent knight	SD505-APS	RM 2	Passed		8/18/2020 9:58 AM
7	Smoke Detector	zone 1 04	silent knight	SD505-APS	RM 1	Passed		8/18/2020 9:58 AM
8	Smoke Detector	zone 1 23	silent knight	SD505-APS	Hall by Women's RR	Passed		8/18/2020 9:57 AM
9	Smoke Detector	zone 1 028	silent knight	SD505-APS	Men's RR	Passed		8/18/2020 9:57 AM
10	Smoke Detector	zone 1 022	silent knight	SD505-APS	By Rm 114	Passed		8/18/2020 9:57 AM
11	Smoke Detector	zone 1 019	silent knight	SD505-APS	By Rm 15	Passed		8/18/2020 9:56 AM
12	Heat Detector	Zone 1 024	Silent knight	SD505-AHS	Rm 9	Passed		8/18/2020 9:56 AM
13	Smoke Detector	zone 1 029	silent knight	SD505-APS	Women's RR	Passed		8/18/2020 9:55 AM
14	Smoke Detector	zone 1 032	silent knight	SD505-APS	RM 5	Passed		8/18/2020 9:54 AM
15	Smoke Detector	zone 1 008	silent knight	SD505-APS	By Rm 7	Passed		8/18/2020 9:54 AM
16	Smoke Detector	zone 1 009	silent knight	SD505-APS	Rm 7	Passed		8/18/2020 9:54 AM
17	Smoke Detector	zone 1 006	silent knight	SD505-APS	Rm 6	Passed		8/18/2020 9:53 AM
18	Smoke Detector	zone 1 013	silent knight	SD505-APS	outside rm 13	Passed		8/18/2020 9:53 AM
19	Smoke Detector	zone 1 015	silent knight	SD505-APS	rm 13	Passed		8/18/2020 9:52 AM
20	Smoke Detector	zone 1 020	silent knight	SD505-APS	rm 15	Passed		8/18/2020 9:52 AM
21	Smoke Detector	zone 1 012	silent knight	SD505-APS	rm 11	Passed		8/18/2020 9:52 AM
22	Smoke Detector	zone 1 010	silent knight	SD505-APS	rm 8	Passed		8/18/2020 9:51 AM
23	Smoke Detector	zone 1 007	silent knight	SD505-APS	rm 5	Passed		8/18/2020 9:51 AM
24	Smoke Detector	zone 1 25	silent knight	SD505-APS	custodial closet	Passed		8/18/2020 9:50 AM
25	Smoke Detector	zone 1 27	silent knight	SD505-APS	Electrical Rm	Passed		8/18/2020 9:50 AM
26	Smoke Detector	zone 1 26	silent knight	SD505-APS	IT Room	Passed		8/18/2020 9:49 AM
27	Smoke Detector	zone 1 21	silent knight	SD505-APS	RM 116	Passed		8/18/2020 9:49 AM
28	Smoke Detector	zone 1 011	silent knight	SD505-APS	RM Office 122	Passed		8/18/2020 9:49 AM
29	Smoke Detector	zone 1 014	silent knight	SD505-APS	RM Office 120	Passed		8/18/2020 9:48 AM
30	Smoke Detector	zone 1 017	silent knight	SD505-APS	Conference Rm	Passed		8/18/2020 9:48 AM
31	Smoke Detector	zone 1 016	silent knight	SD505-APS	Conference Rm	Passed		8/18/2020 9:47 AM
32	Manual Pull Station	M33	Silent Knight	SD500-PS	East	Passed		8/18/2020 9:47 AM
33	Manual Pull Station	M34	Silent Knight	SD500-PS	West	Passed		8/18/2020 9:46 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC ANNEX #5 - Lincoln Regional Center
Address: 801 West Prospector Plaza, Lincoln, NE 68522

TJC - Fire Alarm 2020 Annual Inspection Summary

Result Totals

Devices	
Passed	
Mitigated	
New - Passed	
Failed	
Removed	
Not Inspected	
Total	

This inspection was performed on 8/11/2020 in accordance with applicable requirements.

NFPA 72, 2010 Edition

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Protex Central
1239 N Minnesota Ave, Hastings, NE, 68901
Office: (800) 274-0888 Fax: (402) 463-6057

NFPA72 2010 Testing and Inspection Form

Property: LRC ANNEX #5 - Lincoln Regional Center

Property Address: 801 West Prospector Plaza
Lincoln, NE 68522

Inspection Date: 8/18/2020

1. PROPERTY INFORMATION

Account Name or Property Name	LRC ANNEX #5 - Lincoln Regional Center
Shipping Street	801 West Prospector Plaza
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	[redacted]
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	[redacted]
Description of property	Hospital
Scope of this instance of inspection	Full 100%

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	[redacted]
Monitoring Organization	Midwest Alarm Services
Address	141 M Street Lincoln, NE
Monitoring Org Phone	[redacted]
Monitoring Org Email	kurt.anderson@nebraska.gov
Monitoring Acct Number	Customer Supplied
Phone Line one or IP	Customer supplied

Phone Line two or IP	Customer supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maintenance

4. DESCRIPTION OF SYSTEM OR SERVICE

4.1 Control unit Make and Model	Silent knight
4.2 Software firmware revision	NA

4.3 System Power

The description Of Primary Power is included in the List of devices on Panels as well as the Disconnecting means location.

4.3.2 Secondary Power

The description of secondary power is included in the listing of devices and capacity is also incuded

5. AND 7. NOTIFICATIONS MADE BEFORE AND AFTER TESTING

NOTIFICATION MADE PRIOR AND AFTER TESTING

Description	Time in Testing	Time off testing
Monitoring Org	8-11-2020	8-11-2020
BLDG management		
BLDG occupants		
AHJ		
Other If applicable		

6. TESTING RESULTS

6.1 Control Unit and Related Equipment

6.1 CONTROL UNIT AND RELATED EQUIPMENT

Description	Visual Inspection	Functional test	Comments
Control unit	✓	✓	
Lamps/LEDs/LCDs	✓	✓	
Fuses	✓		
Trouble signals	✓	✓	
Disconnect switches	✓	✓	
Ground-fault monitoring	✓	✓	
Supervision	✓	✓	
Local annunciator	✓	✓	
Remote annunciators			
Remote power panels			

6.2 SECONDARY POWER

6.2 Secondary Power

Description	Visual Inspection	Functional test	Comments
Battery Condition	✓	✓	
Load voltage	✓	✓	
Discharge test	✓	✓	
Charger test	✓	✓	
Remote panel batteries			

6.3 Alarm And Supervisory Alarm Initiating Device

Attach supplementary device test sheets for all initiating devices.

6.4 Notification Appliances

Attach supplementary appliance test sheets for all notification appliances.

6.5 Interface Equipment

Attach supplementary interface component test sheets for all interface components. Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 SUPERVISING STATION MONITORING

6.6 Supervising Station Monitoring

Description	Yes	No	Time	Comments
Alarm signal	✓			
Alarm restoration	✓			
Trouble signal	✓			
Trouble restoration	✓			
Supervisory signal	✓			
Supervisory restoration	✓			

6.7 PUBLIC EMERGENCY ALARM REPORTING SYSTEM

6.7 Public Emergency Alarm Reporting System

Description	Yes	No	Time	Comments
Alarm signal				NA
Alarm restoration				NA
Trouble signal				NA
Trouble restoration				NA
Supervisory signal				NA
Supervisory restoration				NA

8. SYSTEM RESTORED TO NORMAL OPERATION

8. SYSTEM RESTORED TO NORMAL OPERATION

Date and time Restored to Normal operation.	8-11-2020

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	[redacted]
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Tiffany Fitzpatrick
Title:	Maintenance
Phone:	
Date:	8-11-2020

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	4	3	15	111
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	4	3	15	111

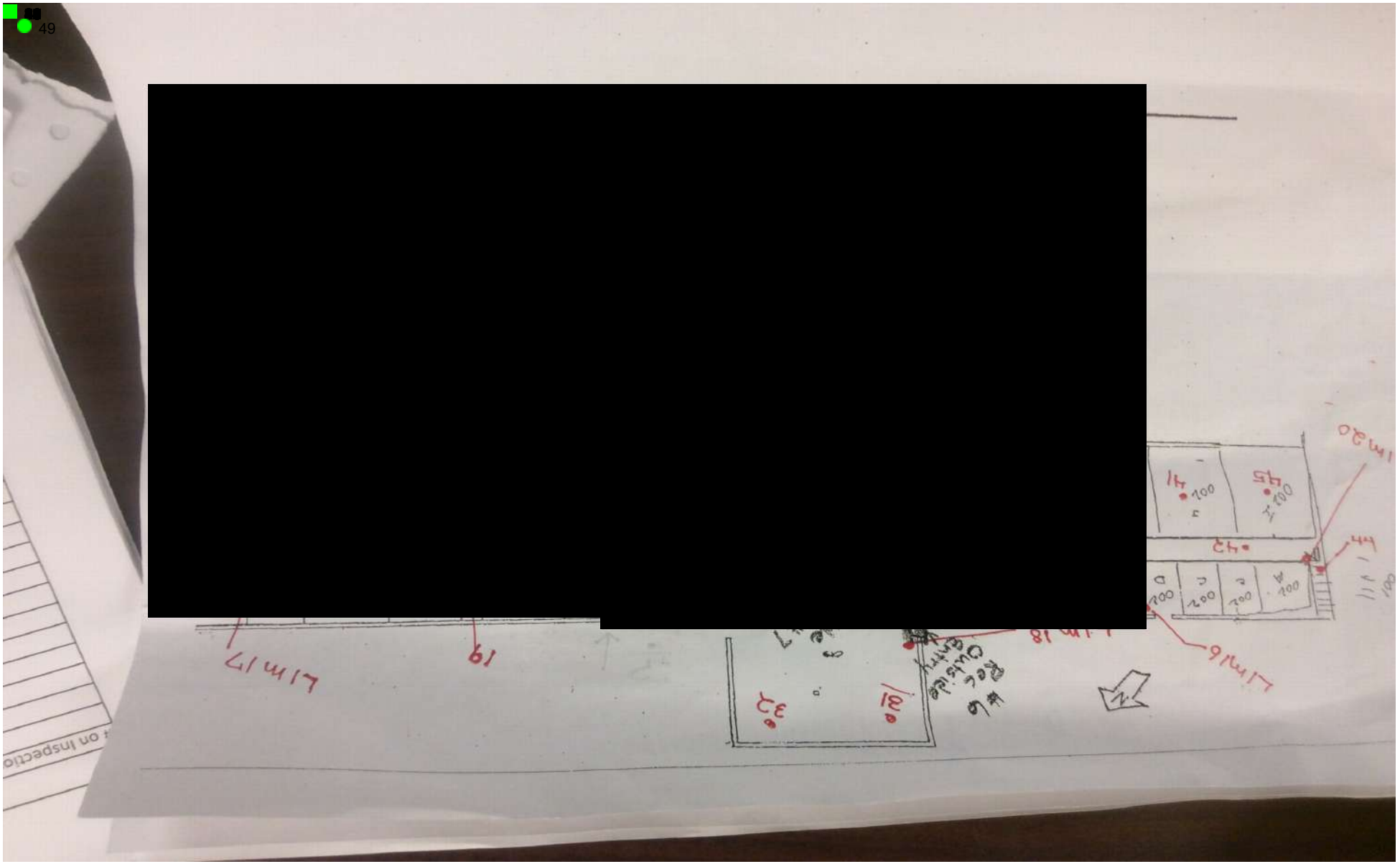
This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

BASEMENT TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D27	Notifier	FSP-851	031A	Passed		8/24/2020 12:01 PM
2	Manual Pull Station	L1M17	Notifier		east Exit 032	Passed		8/24/2020 12:01 PM
3	Smoke Detector	L1D24	Notifier	FSP-851	030	Passed		8/24/2020 12:01 PM
4	Smoke Detector	L1D22	Notifier	FSP-851	Hall by rm 30	Passed		8/24/2020 12:01 PM
5	Smoke Detector	L1D23	Notifier	FSP-851	029	Passed		8/24/2020 12:01 PM
6	Smoke Detector	L1D26	Notifier	FSP-851	031	Passed		8/24/2020 12:00 PM
7	Smoke Detector	L1D19	Notifier	FSP-851	Hall by 28	Passed		8/24/2020 12:00 PM
8	Smoke Detector	L1D21	Notifier	FSP-851	Hall by 27	Passed		8/24/2020 12:00 PM
9	Smoke Detector	L1D18	Notifier	FSP-851	Hall by 25	Passed		8/24/2020 12:00 PM
10	Smoke Detector	L1D16	Notifier	FSP-851	Hall by 23	Passed		8/24/2020 12:00 PM
11	Smoke Detector	L1D13	Notifier	FSP-851	Rm 22	Passed		8/24/2020 12:00 PM
12	Smoke Detector	L1D17	Notifier	FSP-851	Rm 024	Passed		8/24/2020 12:00 PM
13	Smoke Detector	L1D12	Notifier	FSP-851	Pharmacy Entrance	Passed		8/24/2020 11:59 AM
14	Smoke Detector	L1D11	Notifier	FSP-851	Hall by Rm 020	Passed		8/24/2020 12:00 PM
15	Smoke Detector	L1D28	Notifier	FSP-851	Hall by Rm 005	Passed		8/24/2020 11:59 AM
16	Smoke Detector	L1D32	Notifier	FSP-851	Day rm 019	Passed		8/24/2020 11:59 AM
17	Smoke Detector	L1D30	Notifier	FSP-851	Day rm 019 SE	Passed		8/24/2020 11:59 AM
18	Smoke Detector	L1D31	Notifier	FSP-851	Day rm 019 NW	Passed		8/24/2020 11:59 AM
19	Smoke Detector	L1D29	Notifier	FSP-851	Day rm 019 SW	Passed		8/24/2020 11:59 AM
20	Smoke Detector	L1D34	Notifier	FSP-851	Hall by 006	Passed		8/24/2020 11:59 AM
21	Smoke Detector	L1D35	Notifier	FSP-851	Hall by Mech 002	Passed		8/24/2020 11:59 AM
22	Smoke Detector	L1D10	Notifier	FSP-851	Day rm 017	Passed		8/24/2020 11:59 AM
23	Smoke Detector	L1D33	Notifier	FSP-851	Rm 006	Passed		8/24/2020 11:59 AM
24	Smoke Detector	L1D38	Notifier	FSP-851	Rm 002L	Passed		8/24/2020 11:59 AM
25	Smoke Detector	L1D40	Notifier	FSP-851	Rm 002K	Passed		8/24/2020 11:59 AM
26	Smoke Detector	L1D39	Notifier	FSP-851	Hall by rm 002E	Passed		8/24/2020 11:59 AM
27	Smoke Detector	L1D42	Notifier	FSP-851	Hall by rm 002J	Passed		8/24/2020 11:58 AM
28	Smoke Detector	L1D41	Notifier	FSP-851	Hall by rm 002J	Passed		8/24/2020 11:58 AM
29	Smoke Detector	L1D45	Notifier	FSP-851	Hall by rm 002I	Passed		8/24/2020 11:58 AM
30	Smoke Detector	L1D05	Notifier	FSP-851	Hall by rm 14	Passed		8/24/2020 11:58 AM
31	Smoke Detector	L1D81	Notifier	FSP-851	005 rec Room	Passed		8/24/2020 11:58 AM
32	Smoke Detector	L1D08	Notifier	FSP-851	Elevator Lobby	Passed		8/24/2020 11:58 AM
33	Heat Detector	L1D09	Notifier		Elevator Pit	Passed		8/24/2020 11:58 AM
34	Smoke Detector	L1D15	Notifier	FSP-851	Elevator Equipment rm	Passed		8/24/2020 11:58 AM
35	Heat Detector	L1D14	Notifier		Elevator Equipment Rm	Passed		8/24/2020 11:58 AM
36	Smoke Detector	L1D06	Notifier	FSP-851	Storage 015A	Passed		8/24/2020 11:58 AM
37	Smoke Detector	L1D25	Notifier	FSP-851	Basement Stairs E	Passed		8/24/2020 11:58 AM
38	Smoke Detector	L1D44	Notifier	FSP-851	Basement Stairs W	Passed		8/24/2020 11:57 AM
39	Smoke Detector	L1D07	Notifier	FSP-851	Basement Stairs Center	Passed		8/24/2020 11:57 AM
40	Smoke Detector	L1D37	Notifier	FSP-851	Above Hall ceiling West	Passed		8/24/2020 11:57 AM

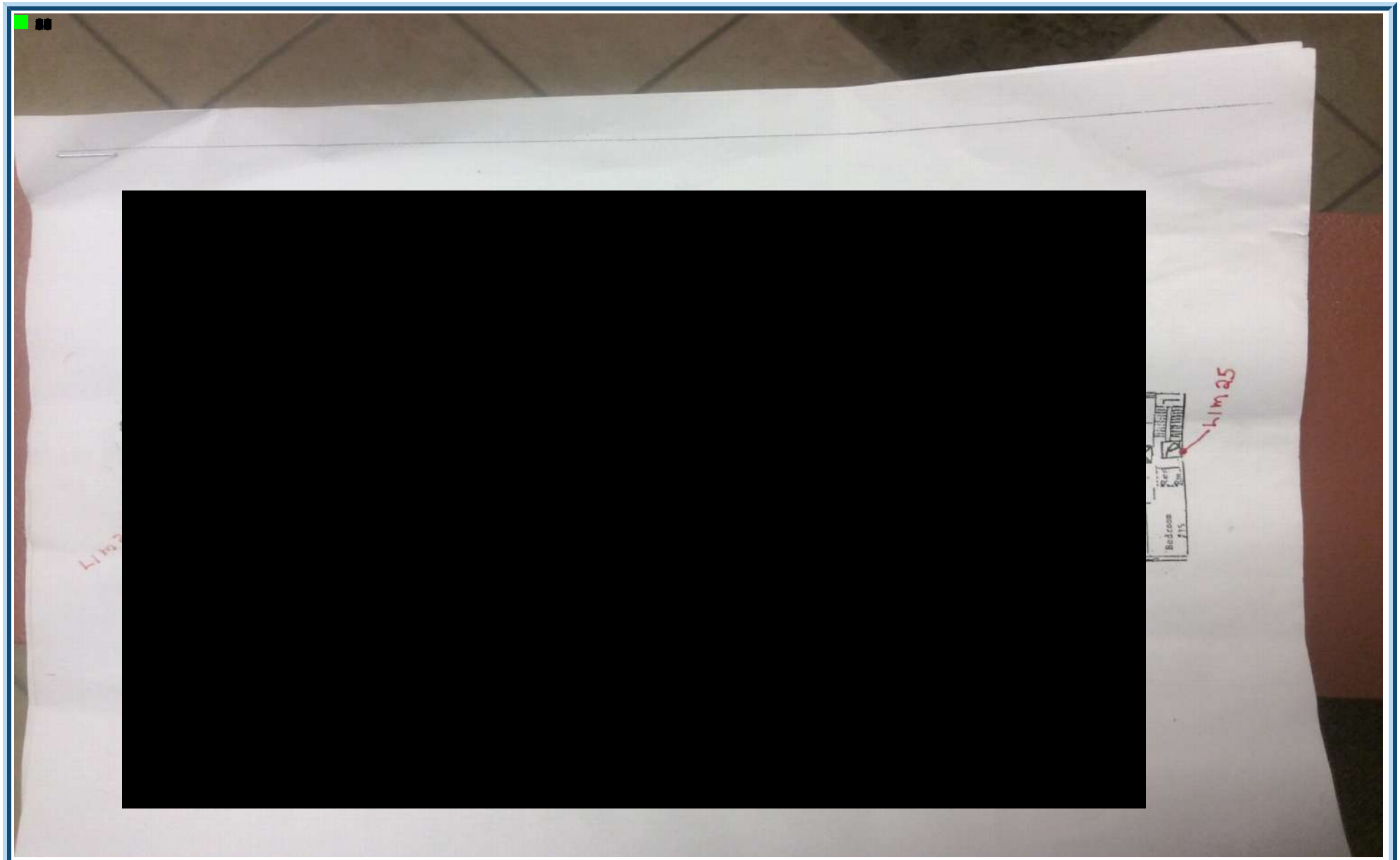
Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L1D43	Notifier	FSP-851	Above Hall ceiling West	Passed		8/24/2020 11:57 AM
42	Duct Detector	L1D01	Innovair		Return air	Passed		8/24/2020 11:57 AM
43	Duct Detector	L1D02	Innovair		AHU-1	Passed		8/24/2020 11:57 AM
44	Duct Detector	L1D03	Innovair		AHU-2	Passed		8/24/2020 11:57 AM
45	Duct Detector	L1D36	Innovair		Rm 002H	Passed		8/24/2020 11:56 AM
46	Manual Pull Station	L1M18	Notifier		Dayroom 019	Passed		8/24/2020 11:56 AM
47	Manual Pull Station	L1M20	Notifier		West Exit	Passed		8/24/2020 11:56 AM
48	Manual Pull Station	L1M11	Notifier		Elevator Lobby	Passed		8/24/2020 11:56 AM
49	Manual Pull Station	L1M16	Notifier		North Exit	Passed		8/24/2020 11:56 AM
49	Smoke Detector	L1D04	Notifier	FSP851	By tunnel doors	Passed		8/24/2020 11:56 AM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

1st FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D50	Notifier	FSP-851	Elevator Lobby	Passed		8/12/2020 9:24 AM
2	Smoke Detector	L1D51	Notifier	FSP-851	Elevator Lobby	Passed		8/12/2020 9:25 AM
3	Smoke Detector	L1D52	Notifier	FSP-851	Mail Rm	Passed		8/12/2020 10:50 AM
4	Smoke Detector	L1D48	Notifier	FSP-851	Reception office	Passed		8/12/2020 10:49 AM
5	Smoke Detector	L1D46	Notifier	FSP-851	Main Entrance	Passed		8/12/2020 10:48 AM
6	Smoke Detector	L1D67	Notifier	FSP-851	Hall by 160	Passed		8/12/2020 10:47 AM
7	Smoke Detector	L1D66	Notifier	FSP-851	Hall by 154	Passed		8/12/2020 10:46 AM
8	Smoke Detector	L1D65	Notifier	FSP-851	Hall by 153	Passed		8/12/2020 10:46 AM
9	Smoke Detector	L1D61	Notifier	FSP-851	152C	Passed		8/12/2020 10:45 AM
10	Smoke Detector	L1D60	Notifier	FSP-851	147	Passed		8/12/2020 10:44 AM
11	Smoke Detector	L1D64	Notifier	FSP-851	Tech station	Passed		8/12/2020 10:43 AM
12	Smoke Detector	L1D59	Notifier	FSP-851	Dayroom 152C	Passed		8/12/2020 10:42 AM
13	Smoke Detector	L1D57	Notifier	FSP-851	Hall by 144	Passed		8/12/2020 10:41 AM
14	Smoke Detector	L1D55	Notifier	FSP-851	Dining Rm	Passed		8/12/2020 10:40 AM
15	Smoke Detector	L1D56	Notifier	FSP-851	Dining Rm	Passed		8/12/2020 10:40 AM
16	Smoke Detector	L1D54	Notifier	FSP-851	Nurse 139	Passed		8/12/2020 10:39 AM
17	Smoke Detector	L1D82	Notifier	FSP-851	Rm 144	Passed		8/12/2020 10:39 AM
18	Smoke Detector	L1D69	Notifier	FSP-851	Hall by 116	Passed		8/12/2020 10:38 AM
19	Smoke Detector	L1D53	Notifier	FSP-851	main med rm	Passed		8/12/2020 10:38 AM
20	Smoke Detector	L1D71	Notifier	FSP-851	wiring closet	Passed		8/12/2020 9:55 AM
21	Smoke Detector	L1D72	Notifier	FSP-851	114	Passed		8/12/2020 9:54 AM
22	Smoke Detector	L1D70	Notifier	FSP-851	Dayroom 108	Passed		8/12/2020 9:54 AM
23	Smoke Detector	L1D73	Notifier	FSP-851	113	Passed		8/12/2020 9:53 AM
24	Smoke Detector	L1D77	Notifier	FSP-851	Day Rm 108C	Passed		8/12/2020 9:52 AM
25	Smoke Detector	L1D76	Notifier	FSP-851	Hall by 111	Passed		8/12/2020 9:52 AM
26	Smoke Detector	L1D74	Notifier	FSP-851	Day Rm 108C	Passed		8/12/2020 9:52 AM
27	Smoke Detector	L1D75	Notifier	FSP-851	110	Passed		8/12/2020 9:47 AM
28	Smoke Detector	L1D80	Notifier	FSP-851	Hall by 102	Passed		8/12/2020 9:46 AM
29	Smoke Detector	L1D47	Notifier	FSP-851	Main lobby	Passed		8/12/2020 9:43 AM
30	Smoke Detector	L1D58	Notifier	FSP-851	Hall by Dayroom 152C	Passed		8/12/2020 9:42 AM
31	Smoke Detector	L1D63	Notifier	FSP-851	Hall by 145	Passed		8/12/2020 9:36 AM
32	Smoke Detector	L1D78	Notifier	FSP-851	Hall by 109	Passed		8/12/2020 9:34 AM
33	Smoke Detector	L1D79	Notifier	FSP-851	Hall by 104	Passed		8/12/2020 9:34 AM
34	Manual Pull Station	L1M21	Notifier		Main Entrance	Passed		8/12/2020 9:33 AM
35	Manual Pull Station	L1M25	Notifier		East Stairs	Passed		8/12/2020 9:33 AM
37	Manual Pull Station	L1M35	Notifier		Tech 110	Passed		8/12/2020 9:32 AM
38	Manual Pull Station	L1M28	Notifier		West Stairs	Passed		8/12/2020 9:31 AM
39	Manual Pull Station	L1M22	Notifier		Elevator Lobby	Passed		8/12/2020 9:32 AM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

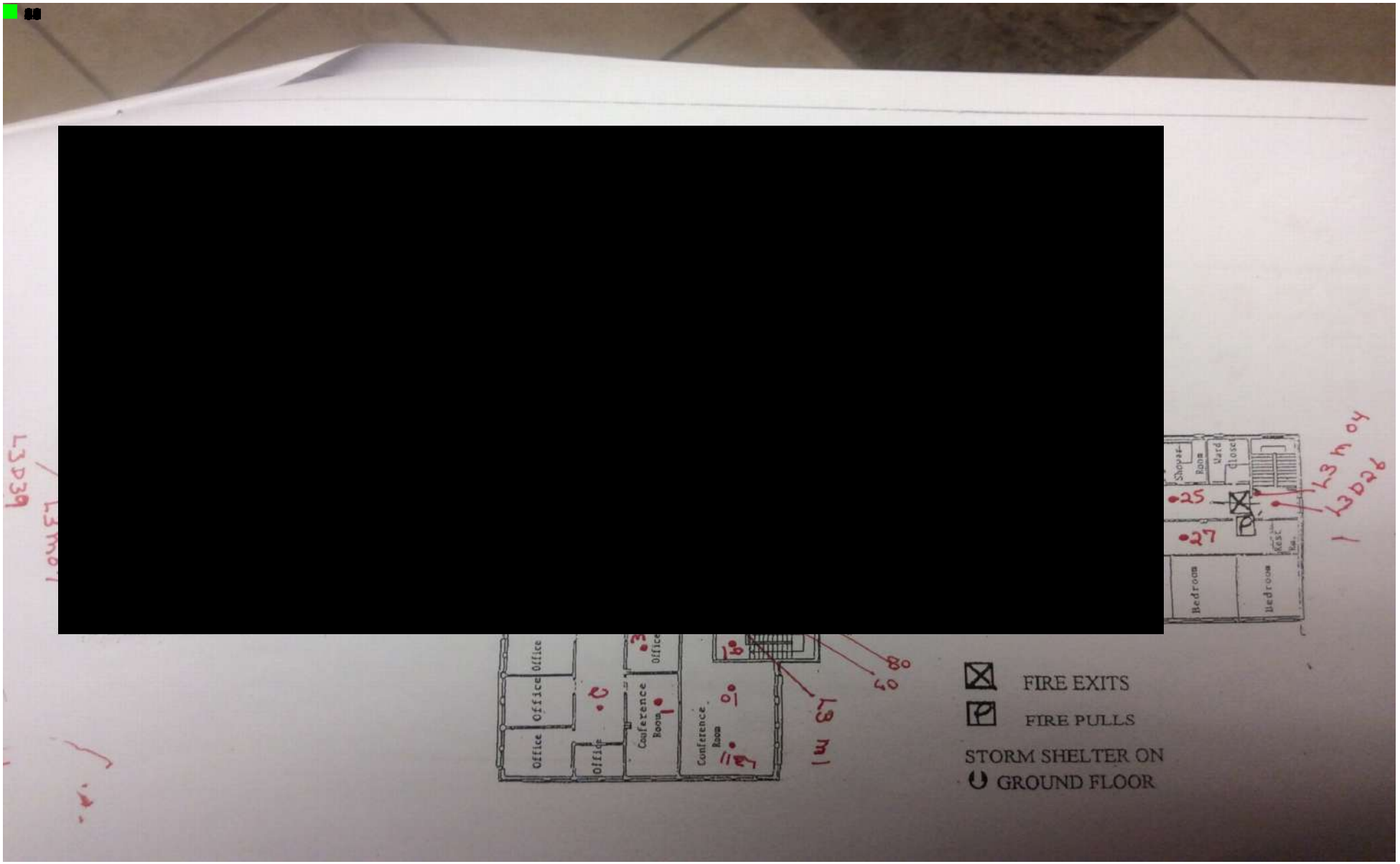
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D07	Notifier	FSP-851	Top of Shaft	Passed		8/24/2020 11:55 AM
2	Heat Detector	L3D08	Notifier		Top of Shaft	Passed		8/24/2020 11:55 AM
3	Smoke Detector	L3D06	Notifier	FSP-851	Elevator lobby	Passed		8/24/2020 11:55 AM
4	Smoke Detector	L3D09	Notifier	FSP-851	Top of Stairs	Passed		8/24/2020 11:55 AM
5	Smoke Detector	L3D27	Notifier	FSP-851	Hall by 250	Passed		8/24/2020 11:55 AM
6	Smoke Detector	L3D25	Notifier	FSP-851	Hall by 245	Passed		8/24/2020 11:56 AM
7	Smoke Detector	L3D24	Notifier	FSP-851	Hall by 249	Passed		8/24/2020 11:55 AM
8	Smoke Detector	L3D23	Notifier	FSP-851	241	Passed		8/24/2020 11:55 AM
9	Smoke Detector	L3D26	Notifier	FSP-851	Top of stairs E	Passed		8/24/2020 11:55 AM
10	Smoke Detector	L3D22	Notifier	FSP-851	Hall by 238	Passed		8/24/2020 11:55 AM
11	Smoke Detector	L3D19	Notifier	FSP-851	Day rm 232	Passed		8/24/2020 11:55 AM
12	Smoke Detector	L3D21	Notifier	FSP-851	237	Passed		8/24/2020 11:55 AM
13	Smoke Detector	L3D18	Notifier	FSP-851	236	Passed		8/24/2020 11:55 AM
14	Smoke Detector	L3D17	Notifier	FSP-851	242C	Passed		8/24/2020 11:54 AM
15	Smoke Detector	L3D12	Notifier	FSP-851	235	Passed		8/24/2020 11:54 AM
16	Smoke Detector	L3D14	Notifier	FSP-851	Dining Rm	Passed		8/24/2020 11:54 AM
17	Smoke Detector	L3D13	Notifier	FSP-851	230	Passed		8/24/2020 11:55 AM
18	Smoke Detector	L3D28	Notifier	FSP-851	Hall by 216	Passed		8/24/2020 11:54 AM
19	Smoke Detector	L3D29	Notifier	FSP-851	Hall by 214	Passed		8/24/2020 11:54 AM
20	Smoke Detector	L3D30	Notifier	FSP-851	214	Passed		8/24/2020 11:54 AM
21	Smoke Detector	L3D31	Notifier	FSP-851	213	Passed		8/24/2020 11:54 AM
22	Smoke Detector	L3D33	Notifier	FSP-851	208C	Passed		8/24/2020 11:54 AM
23	Smoke Detector	L3D32	Notifier	FSP-851	Hall by 211	Passed		8/24/2020 11:53 AM
24	Smoke Detector	L3D36	Notifier	FSP-851	Hall by 205	Passed		8/24/2020 11:53 AM
25	Smoke Detector	L3D37	Notifier	FSP-851	outside 204	Passed		8/24/2020 11:53 AM
26	Smoke Detector	L3D39	Notifier	FSP-851	Top of Stairs W	Passed		8/24/2020 11:53 AM
27	Smoke Detector	L3D05	Notifier	FSP-851	Elevator lobby	Passed		8/24/2020 11:53 AM
28	Smoke Detector	L3D04	Notifier	FSP-851	Hall by 220	Passed		8/24/2020 11:53 AM
29	Smoke Detector	L3D01	Notifier	FSP-851	228	Passed		8/24/2020 11:53 AM
30	Smoke Detector	L3D02	Notifier	FSP-851	Hall by 223	Passed		8/24/2020 11:53 AM
31	Smoke Detector	L3D03	Notifier	FSP-851	227	Passed		8/24/2020 11:53 AM
32	Smoke Detector	L3D10	Notifier	FSP-851	226	Passed		8/24/2020 11:53 AM
33	Smoke Detector	L3D11	Notifier	FSP-851	226	Passed		8/24/2020 11:53 AM
34	Smoke Detector	L3D15	Notifier	FSP-851	Dining Rm 233	Passed		8/24/2020 11:52 AM
35	Smoke Detector	L3D16	Notifier	FSP-851	Hall by 235	Passed		8/24/2020 11:52 AM
36	Smoke Detector	L3D20	Notifier	FSP-851	Hall by Dayroom 237	Passed		8/24/2020 11:52 AM
37	Smoke Detector	L3D34	Notifier	FSP-851	Hall by Dayroom 208C	Passed		8/24/2020 11:52 AM
38	Smoke Detector	L3D35	Notifier	FSP-851	Tech Station 210	Passed		8/24/2020 11:52 AM
39	Smoke Detector	L3D38	Notifier	FSP-851	Hall by 202	Passed		8/24/2020 11:52 AM
40	Manual Pull Station	L3M10	Notifier		210	Passed		8/24/2020 11:52 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Manual Pull Station	L3M01	Notifier		Elevator Lobby	Passed		8/24/2020 11:52 AM
42	Manual Pull Station	L3M09	Notifier		Tech 241	Passed		8/24/2020 11:52 AM
43	Manual Pull Station	L3M04	Notifier		East Stairs	Passed		8/24/2020 11:52 AM
44	Manual Pull Station	L3M07	Notifier		West Stairs	Passed		8/24/2020 11:51 AM
45	Smoke Detector	L3D40	Notifier	FSP-851	239	Passed		8/24/2020 11:51 AM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

2nd FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Horn Strobe	Strobe
Passed	32	26
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	32	26

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe			Main entrance	Passed	Ceiling	8/18/2020 11:35 AM
2	Horn Strobe		P2W	Main Entrance	Passed		8/18/2020 11:34 AM
3	Horn Strobe		P2W	Main Hall	Passed		8/18/2020 11:34 AM
4	Strobe			Men's RR	Passed	Ceiling	8/18/2020 11:33 AM
5	Strobe			Women's RR	Passed	Ceiling	8/18/2020 11:33 AM
6	Horn Strobe		P2W	Him	Passed		8/18/2020 11:33 AM
7	Horn Strobe		P2W	Cafeteria	Passed		8/18/2020 11:32 AM
8	Horn Strobe		P2W	Gym Stairs entrance	Passed		8/18/2020 11:31 AM
9	Horn Strobe		P2W	Hall outside RT	Passed		8/18/2020 11:31 AM
10	Strobe		SW	RT	Passed		8/18/2020 11:30 AM
11	Horn Strobe		P2W	OT	Passed		8/18/2020 11:30 AM
12	Strobe		SW	Canteen	Passed		8/18/2020 11:30 AM
13	Horn Strobe		P2W	Outside S2	Passed		8/18/2020 11:29 AM
14	Horn Strobe		P2W	S2 Main Area	Passed		8/18/2020 11:29 AM
15	Strobe			S-2 restroom	Passed	Ceiling	8/18/2020 11:28 AM
16	Strobe			S-2 restroom	Passed	Ceiling	8/18/2020 11:28 AM
17	Strobe		SW	S-2 Confrence rm	Passed		8/18/2020 11:28 AM
18	Horn Strobe		P2W	S2 Hall	Passed		8/18/2020 11:27 AM
19	Horn Strobe		P2W	S2 Hall Main	Passed		8/18/2020 11:26 AM
20	Horn Strobe		P2W	S1 Main Area	Passed		8/18/2020 11:26 AM
21	Strobe		SW	S-2 laundry bath	Passed		8/18/2020 11:26 AM
22	Strobe		SW	S-1 laundry bath	Passed		8/18/2020 11:25 AM
23	Horn Strobe		P2W	S1 Main Hall	Passed		8/18/2020 11:25 AM
24	Strobe			S-1 restroom	Passed	Ceiling	8/18/2020 11:24 AM
25	Strobe			S-1 restroom	Passed	Ceiling	8/18/2020 11:24 AM
26	Strobe		SW	S-1 nurse station	Passed		8/18/2020 11:23 AM
27	Strobe		SW	S-1 nurse office	Passed		8/18/2020 11:23 AM
28	Horn Strobe		P2W	S1 Main Hall	Passed		8/18/2020 11:22 AM
29	Strobe		SW	S-2 nurse station	Passed		8/18/2020 11:22 AM
30	Strobe		SW	S-2 nurse office	Passed		8/18/2020 11:21 AM
31	Strobe		SW	S- 1 Confrence rm	Passed		8/18/2020 11:21 AM

2nd Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P2W	Elevator lobby	Passed		8/18/2020 11:45 AM
2	Strobe		SW	Hall outside S-5 entrance	Passed		8/18/2020 11:44 AM
3	Horn Strobe		P2W	S-4 Main Area	Passed		8/18/2020 11:44 AM
4	Strobe		SW	S-4 Tech RR	Passed		8/18/2020 11:44 AM
5	Strobe		SW	S-4 RR	Passed		8/18/2020 11:43 AM
6	Strobe		SW	S-4 RR	Passed		8/18/2020 11:43 AM
7	Horn Strobe		P2W	S-4 Conference rm	Passed		8/18/2020 11:42 AM
8	Horn Strobe		P2W	S-4 Main Hall	Passed		8/18/2020 11:42 AM
9	Horn Strobe		P2W	S-3Main Area	Passed		8/18/2020 11:41 AM
10	Strobe		SW	S-4 Tech RR	Passed		8/18/2020 11:40 AM
11	Strobe			S-3 RR	Passed		8/18/2020 11:40 AM
12	Strobe			S-3 RR	Passed		8/18/2020 11:39 AM
13	Horn Strobe		P2W	S-3 conference rm	Passed		8/18/2020 11:39 AM
14	Horn Strobe		P2W	S-3 Main Hall	Passed		8/18/2020 11:38 AM
15	Horn Strobe		P2W	Hall to S-5	Passed		8/18/2020 11:38 AM
16	Horn Strobe		P2W	S-5 Entrance	Passed		8/18/2020 11:37 AM
17	Horn Strobe		P2W	S-5 Main Hall	Passed		8/18/2020 11:37 AM
18	Horn Strobe		P2W	S-5 Main Area	Passed		8/18/2020 11:37 AM
19	Horn Strobe		P2W	S-5 Office Hall	Passed		8/18/2020 11:36 AM
20	Horn Strobe		P2W	S-5 conference rm	Passed		8/18/2020 11:36 AM
21	Strobe			S-5 RR	Passed		8/18/2020 11:35 AM

Basement TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SW	North ELE Lobby	Passed		8/18/2020 11:48 AM
2	Horn Strobe		P2W	Basement Mech Ent	Passed		8/18/2020 11:47 AM
3	Horn Strobe		P2W	Basement Mech	Passed		8/18/2020 11:47 AM
4	Horn Strobe		P2W	Basement Mech outside elevator rm	Passed		8/18/2020 11:46 AM
5	Horn Strobe		P2W	Gym	Passed		8/18/2020 11:46 AM
6	Horn Strobe		PC2R	weight arm	Passed		8/18/2020 11:46 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP2 Tampers Waterflows 2020 Annual Inspection Summary

Result Totals

Devices	Control Valve Switch	PIV	Standpipe Water Flow	Water Flow Vane Switch
Passed	4	1	4	1
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	4	1	4	1

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

BASEMENT TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Control Valve Switch	L1M01	rm 008	Passed			8/24/2020 11:50 AM
2	Standpipe Water Flow	L1M05	Rm 008	Passed			8/24/2020 11:50 AM
3	Control Valve Switch	L1M04	rm 08	Passed			8/24/2020 11:50 AM
4	Control Valve Switch	L1M01	Craft Rm	Passed			8/24/2020 11:50 AM
5	Standpipe Water Flow	L1M32	Rm 008	Passed			8/24/2020 11:50 AM

1st FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M26	116	Passed			8/24/2020 11:50 AM
2	Water Flow Vane Switch	L1M32	116	Passed			8/24/2020 11:51 AM
3	PIV	L1M02	Outside	Passed			8/24/2020 11:51 AM

2nd FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Control Valve Switch	L3M06	Riser Rm 216	Passed			8/24/2020 11:51 AM
2	Standpipe Water Flow	L3M05	Riser rm 216	Passed			8/24/2020 11:51 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Horn	Horn Strobe	Strobe
Passed	4	23	64
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	4	23	64

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

BASEMENT TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P1224MCW	Outside Room 031	Passed		8/12/2020 11:17 AM
2	Horn Strobe		P1224MCW	Outside Room 023	Passed		8/12/2020 11:17 AM
3	Strobe			022	Passed		8/12/2020 11:16 AM
4	Strobe			022	Passed		8/12/2020 11:16 AM
5	Horn Strobe		P1224MCW	Outside Room 020	Passed		8/12/2020 11:15 AM
6	Horn Strobe		P1224MCW	Rm 019	Passed		8/12/2020 11:14 AM
7	Horn Strobe		P1224MCW	Rm 019	Passed		8/12/2020 11:14 AM
8	Strobe		S1224MCW	019	Passed		8/12/2020 11:13 AM
9	Strobe		S1224MCW	019	Passed		8/12/2020 11:12 AM
10	Horn Strobe		P1224MCW	Outside Rm 018	Passed		8/12/2020 11:04 AM
11	Strobe		S1224MCW	Outside 018	Passed		8/12/2020 11:02 AM
12	Strobe		S1224MCW	Outside 006	Passed		8/12/2020 11:02 AM
13	Strobe		S1224MCW	006	Passed		8/12/2020 11:01 AM
14	Strobe		S1224MCW	006 RR	Passed		8/12/2020 11:01 AM
15	Horn Strobe		P1224MCW	Outside Rm 002G	Passed		8/12/2020 10:59 AM
16	Horn Strobe		P1224MCW	Outside Rm 002B	Passed		8/12/2020 10:59 AM
17	Strobe		S1224MCW	002I	Passed		8/12/2020 10:58 AM
18	Strobe		S1224MCW	002J	Passed		8/12/2020 10:58 AM
19	Strobe		S1224MCW	002K	Passed		8/12/2020 10:57 AM
20	Strobe		S1224MCW	002L	Passed		8/12/2020 10:57 AM
21	Horn Strobe		P1224MCW	Outside Rm 014	Passed		8/12/2020 10:56 AM
22	Strobe		S1224MCW	014	Passed		8/12/2020 10:56 AM
23	Strobe		S1224MCW	012	Passed		8/12/2020 10:55 AM
24	Horn			Boiler Mech Rm	Passed		8/12/2020 10:54 AM

1st FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P1224MCW	Lobby	Passed		8/24/2020 12:04 PM
3	Strobe		S1224MCW	136	Passed		8/24/2020 12:04 PM
4	Strobe		S1224MCW	131	Passed		8/24/2020 12:04 PM
5	Strobe		S1224MCW	127	Passed		8/24/2020 12:04 PM
6	Strobe		S1224MCW	128	Passed		8/24/2020 12:04 PM
7	Strobe		S1224MCW	125	Passed		8/24/2020 12:04 PM
8	Strobe		S1224MCW	Outside Rm 142	Passed		8/24/2020 12:04 PM
9	Horn Strobe		P1224MCW	outside rm 124	Passed		8/24/2020 12:03 PM
10	Horn Strobe		P1224MCW	Dining Rm	Passed		8/24/2020 12:03 PM
11	Strobe		S1224MCW	Rm 120	Passed		8/24/2020 12:03 PM
11	Strobe		S1224MCW	Rm 120	Passed		8/24/2020 12:03 PM
12	Strobe		S1224MCW	Rm 142	Passed		8/24/2020 12:03 PM
13	Strobe		S1224MCW	Rm 142	Passed		8/24/2020 12:03 PM
14	Strobe		S1224MCW	Outside Rm 116	Passed		8/24/2020 12:03 PM
15	Strobe		S1224MCW	Rm 114	Passed		8/24/2020 12:03 PM
16	Horn Strobe		P1224MCW	Outside Rm 114	Passed		8/24/2020 12:03 PM
17	Strobe		S1224MCW	Kitchen 140	Passed		8/24/2020 12:03 PM
18	Strobe		S1224MCW	108C	Passed		8/24/2020 12:03 PM
19	Strobe		S1224MCW	110	Passed		8/24/2020 12:03 PM
20	Strobe		SC2415W	106	Passed	Ceiling	8/24/2020 12:03 PM
21	Horn Strobe		P1224MCW	108	Passed		8/24/2020 12:03 PM
22	Strobe		SC2415W	104	Passed	Ceiling	8/24/2020 12:03 PM
23	Strobe		S1224MCW	101A	Passed		8/24/2020 12:02 PM
24	Strobe		S1224MCW	108A	Passed		8/24/2020 12:02 PM
25	Strobe		S1224MCW	108B	Passed		8/24/2020 12:02 PM
26	Horn Strobe		P1224MCW	Outside 147	Passed		8/24/2020 12:02 PM
27	Strobe		S1224MCW	152C	Passed		8/24/2020 12:02 PM
28	Strobe		S1224MCW	152B	Passed		8/24/2020 12:02 PM
29	Strobe		S1224MCW	152A	Passed		8/24/2020 12:02 PM
30	Strobe		S1224MCW	151	Passed		8/24/2020 12:02 PM
31	Strobe		SC2415W	155	Passed	Ceiling	8/24/2020 12:02 PM
32	Strobe		SC2415W	157	Passed	Ceiling	8/24/2020 12:02 PM
33	Strobe		S1224MCW	162	Passed		8/24/2020 12:02 PM
34	Horn Strobe		P1224MCW	Outside 157	Passed		8/24/2020 12:01 PM
35	Horn			Outside 152A	Passed		8/24/2020 12:01 PM

2nd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		S1224MCW	254	Passed		8/24/2020 1:02 PM
2	Horn Strobe		P1224MCW	242	Passed		8/24/2020 1:02 PM
3	Strobe		SC2415W	247	Passed		8/24/2020 1:02 PM
4	Strobe		SC2415W	245	Passed		8/24/2020 1:02 PM
5	Horn			242	Passed		8/24/2020 12:16 PM
6	Strobe		S1224MCW	242A	Passed		8/24/2020 12:16 PM
7	Strobe		S1224MCW	241	Passed		8/24/2020 12:16 PM
8	Strobe		S1224MCW	242B	Passed		8/24/2020 12:16 PM
9	Horn Strobe		P1224MCW	242C	Passed		8/24/2020 12:16 PM
10	Strobe		S1224MCW	242C	Passed		8/24/2020 12:16 PM
11	Strobe		S1224MCW	236	Passed		8/24/2020 12:16 PM
12	Strobe		S1224MCW	Dining rm	Passed		8/24/2020 12:16 PM
13	Strobe		S1224MCW	Dining rm	Passed		8/24/2020 12:15 PM
14	Horn Strobe		P1224MCW	Dining Rm	Passed		8/12/2020 11:33 AM
15	Strobe		S1224MCW	Dining rm Staff RR	Passed		8/12/2020 11:29 AM
16	Strobe		S1224MCW	Outside 216	Passed		8/12/2020 11:29 AM
17	Strobe		S1224MCW	231	Passed		8/12/2020 11:29 AM
18	Horn Strobe		P1224MCW	Outside 213	Passed		8/12/2020 11:28 AM
19	Strobe		S1224MCW	214	Passed		8/12/2020 11:28 AM
20	Strobe		S1224MCW	208 C	Passed		8/12/2020 11:27 AM
21	Strobe		S1224MCW	210	Passed		8/12/2020 11:27 AM
22	Strobe		S1224MCW	208B	Passed		8/12/2020 11:26 AM
23	Horn			208	Passed		8/12/2020 11:26 AM
24	Strobe		SC2415W	206	Passed		8/12/2020 11:25 AM
25	Strobe		S1224MCW	208A	Passed		8/12/2020 11:25 AM
26	Strobe		SC2415W	204	Passed		8/12/2020 11:24 AM
27	Horn Strobe		P1224MCW	Outside 204	Passed		8/12/2020 11:21 AM
28	Strobe		S1224MCW	201 rr	Passed		8/12/2020 11:20 AM
29	Strobe		S1224MCW	220	Passed		8/12/2020 11:20 AM
30	Horn Strobe		P1224MCW	220	Passed		8/12/2020 11:19 AM
31	Strobe		S1224MCW	228	Passed		8/12/2020 11:19 AM
32	Horn Strobe		P1224MCW	212	Passed		8/12/2020 11:18 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Account: LRC Bldg # 3- Lincoln Regional Center

Assistant Inspector:

Address: 801 West Prospector PL., Lincoln, NE 68506

Scope: Full 100%

Frequency: 2020 Annual Account

Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	-	-
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	3	3
Total	3	3

Supercomponent Information	
Type	2 - FACP
Location	1st FLOOR Main Entrance
Model	AFP1010
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

BASEMENT TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24S8	L1M12	005	Not Inspected		
2	Annuciator	Notifier			By Elevator	Not Inspected		

1st FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Dining Rm	Not Inspected		
2	FACP	Notifier	AFP1010		Main Entrance	Not Inspected		
3	Power Supply	Notifier	FCPS-24S8	L1M24	Rm 144	Not Inspected		

2nd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Dining Room	Not Inspected		
2	Power Supply	Notifier	FCPS-24S8	L3M03	235	Not Inspected		

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V8AH			9-11-19	BASEMENT 005	Not Inspected	Left
1	12V8AH			9-11-19	BASEMENT 005	Not Inspected	Right
2	12V26AH	Notifier	AFP1010	12-12-18	1st FLOOR Main Entrance	Not Inspected	Left
2	12V26AH	Notifier	AFP1010	12-12-18	1st FLOOR Main Entrance	Not Inspected	Right
3	12V8AH			1-30-20	1st FLOOR Rm 144	Not Inspected	Left
3	12V8AH			1-30-2020	1st FLOOR Rm 144	Not Inspected	Right
2	12V8AH	Notifier	FCPS-24S8	9-11-19	2nd FLOOR 235	Not Inspected	Left
2	12V8AH	Notifier	FCPS-24S8	9-11-2019	2nd FLOOR 235	Not Inspected	Right

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1	L1M12	Power Supply	Notifier	FCPS-24S8		005	BASEMENT	Not Inspected		
2		Annuciator	Notifier			By Elevator	BASEMENT	Not Inspected		
1		Annuciator	Notifier			Dining Rm	1st FLOOR	Not Inspected		
2		FACP	Notifier	AFP1010	120	Main Entrance	1st FLOOR	Not Inspected	24hr 5min	
3	L1M24	Power Supply	Notifier	FCPS-24S8	120	Rm 144	1st FLOOR	Not Inspected		
1		Annuciator	Notifier			Dining Room	2nd FLOOR	Not Inspected		
2	L3M03	Power Supply	Notifier	FCPS-24S8	120	235	2nd FLOOR	Not Inspected	24/5	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP19 Shutdown 2020 Annual Inspection Summary

Result Totals

Devices	Fan	Relays
Passed	-	22
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	4	-
Total	4	22

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

BASEMENT TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder Hall by Rm 020	Passed		8/24/2020 1:28 PM
2	Relays				Door Holder Hall by Rm 020	Passed		8/24/2020 1:28 PM
3	Relays				Door Holder Hall by Rm 002H	Passed		8/24/2020 1:28 PM
4	Fan	L1M06			Fan control	Not Inspected		
5	Fan	L1M07			Damper relay	Not Inspected		
6	Fan	L1M08			AHU 1 Fan control	Not Inspected		
7	Fan	L1M09			AHU 2 Fan control	Not Inspected		
8	Relays	L1M11	Primary Recall		Elevator Mech Rm	Passed		8/24/2020 1:28 PM
9	Relays	L1M12	Alt. Recall		Elevator Mech Rm	Passed		8/24/2020 1:28 PM
10	Relays	L1M13	Shunt		Elevator Mech Rm	Passed		8/24/2020 1:28 PM
11	Relays	L1M14	Flash hat		Elevator Mech Rm	Passed		8/24/2020 1:28 PM
12	Relays	L1M30			Damper by Rm 25	Passed		8/24/2020 1:28 PM
13	Relays	L1M31			Damper by Rm 030	Passed		8/24/2020 1:28 PM
14	Relays	L1M33			Damper by Rm 028	Passed		8/24/2020 1:28 PM

1st FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 152 East	Passed		8/24/2020 1:29 PM
2	Relays				Door Holder 142 East	Passed		8/24/2020 1:29 PM
3	Relays				Door Holder 108 West	Passed		8/24/2020 1:29 PM
4	Relays				Door Holder 121 West	Passed		8/24/2020 1:29 PM
5	Relays	L1M23			Damper Rm 144	Passed		8/24/2020 1:28 PM
6	Relays	L1M29			Damper Rm 117	Passed		8/24/2020 1:28 PM

2nd FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 2 east 242	Passed		8/24/2020 1:30 PM
2	Relays				Door Holder 2 east 233	Passed		8/24/2020 1:30 PM
3	Relays				Door Holder 2 West 208	Passed		8/24/2020 1:29 PM
4	Relays				Door Holder 2 West 233	Passed		8/24/2020 1:29 PM
5	Relays	L3M02			Damper by rm 235	Passed		8/24/2020 1:29 PM
6	Relays	L3M08			Damper by rm 214	Passed		8/24/2020 1:29 PM

Supercomponent Results

Number	Type	Zone/address	Make	Model	Location	Layout	Result	Comments
4	Fan	L1M06			Fan control	BASEMENT	Not Inspected	
5	Fan	L1M07			Damper relay	BASEMENT	Not Inspected	
6	Fan	L1M08			AHU 1 Fan control	BASEMENT	Not Inspected	
7	Fan	L1M09			AHU 2 Fan control	BASEMENT	Not Inspected	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	18	59	17	238
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	1	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	18	59	18	238

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D65	notifier	SDX-551	gym stairs	Passed		8/11/2020 9:51 AM
2	Smoke Detector	L1D41	notifier	SDX-551	tunnel stairs	Passed		8/11/2020 9:19 AM
3	Smoke Detector	L1D44	notifier	SDX-551	elevator lobby	Passed		8/11/2020 9:18 AM
4	Smoke Detector	L1D45	notifier	SDX-551	Hall by office door	Passed		8/10/2020 9:33 AM
5	Smoke Detector	L1D47	notifier	SDX-551	Hall by reception	Passed		8/10/2020 9:46 AM
6	Smoke Detector	L1D48	notifier	SDX-551	Hall by med rm	Passed		8/10/2020 9:51 AM
7	Heat Detector	L1D49	notifier	FDX-551	mop closet	Passed		8/10/2020 9:35 AM
8	Heat Detector	L1D50	notifier	FDX-551	medication rm	Passed		8/10/2020 9:32 AM
9	Smoke Detector	L1D52	notifier	SDX-551	reception center	Passed		8/11/2020 12:22 PM
10	Heat Detector	L1D54	notifier	FDX-551	reception center	Passed		8/11/2020 12:22 PM
11	Heat Detector	L1D55	notifier	FDX-551	reception center	Passed		8/11/2020 12:23 PM
12	Smoke Detector	L1D56	notifier	SDX-551	medical records	Passed		8/10/2020 9:35 AM
13	Smoke Detector	L1D57	notifier	SDX-551	medical records	Passed		8/10/2020 9:36 AM
14	Smoke Detector	L1D58	notifier	SDX-551	Hall s stairs	Passed		8/10/2020 9:37 AM
15	Smoke Detector	L1D53	notifier	SDX-551	Hall by reception	Passed		8/10/2020 9:34 AM
16	Heat Detector	L1D62	notifier	FDX-551	conf. rm	Passed		8/10/2020 9:38 AM
17	Smoke Detector	L1D59	notifier	SDX-551	Hall by dish rm	Passed		8/10/2020 9:38 AM
18	Heat Detector	L1D61	notifier	FDX-551	dish rm	Passed		8/10/2020 12:02 PM
19	Heat Detector	L1D60	notifier	FDX-551	cooking Area	Passed		8/10/2020 12:03 PM
20	Heat Detector	L1D63	notifier	FDX-551	dining rm	Passed		8/10/2020 9:39 AM
21	Heat Detector	L1D64	notifier	FDX-551	dining rm	Passed		8/10/2020 9:40 AM
22	Smoke Detector	L1D42	notifier	SDX-551	Hall by delivery	Passed		8/11/2020 12:23 PM
23	Heat Detector	L1D43	notifier	FDX-551	janitor closet	Passed		8/10/2020 9:46 AM
24	Smoke Detector	L1D37	notifier	SDX-551	Hall by O.T	Passed		8/10/2020 9:47 AM
25	Smoke Detector	L1D30	notifier	SDX-551	Hall by canteen	Passed		8/10/2020 9:49 AM
26	Heat Detector	L1D31	notifier	FDX-551	by t.r. office	Passed		8/10/2020 9:50 AM
27	Heat Detector	L1D33	notifier	FDX-551	T.R.	Passed		8/11/2020 12:24 PM
28	Heat Detector	L1D38	notifier	FDX-551	O.T.	Passed		8/10/2020 9:50 AM
29	Heat Detector	L1D35	notifier	FDX-551	T.R. storage rm	Passed		8/10/2020 9:52 AM
30	Heat Detector	L1D28	notifier	FDX-551	canteen	Passed		8/10/2020 9:53 AM
31	Heat Detector	L1D25	notifier	FDX-551	canteen cooking Area	Passed		8/10/2020 9:55 AM
32	Heat Detector	L1D26	notifier	FDX-551	laundry rm	Passed		8/10/2020 9:54 AM
33	Smoke Detector	L1D27	notifier	SDX-551	Hall by canteen kit	Passed		8/10/2020 9:56 AM
34	Smoke Detector	L3D18	notifier	SDX-551	Hall by housekeeping storage	Passed		8/10/2020 9:57 AM
35	Heat Detector	L3D50	notifier	FDX-551	laundry shoot	Passed		8/10/2020 9:58 AM
36	Heat Detector	L3D61	notifier	FDX-551	laundry shoot	Passed		8/10/2020 10:00 AM
37	Smoke Detector	L3D17	notifier	SDX-551	south end of hall	Passed		8/10/2020 10:01 AM
38	Smoke Detector	L3D16	notifier	SDX-551	big yard corridor	Passed		8/10/2020 10:02 AM
39	Smoke Detector	L4D04	notifier	SDX-551	stairwell	Passed		8/10/2020 10:10 AM
40	Smoke Detector	L4D05	notifier	SDX-551	stairwell	Passed		8/10/2020 10:04 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L3D21	notifier	SDX-551	s-1 day Room	Passed		8/10/2020 11:27 AM
42	Smoke Detector	L3D22	notifier	SDX-551	s-1 day Room	Passed		8/10/2020 11:31 AM
43	Heat Detector	L3D19	notifier	FDX-551	S-1 Custodial Closet	Passed		8/10/2020 11:28 AM
44	Smoke Detector	L3D20	notifier	SDX-551	s-1 coat closet by tech	Passed		8/10/2020 11:22 AM
45	Smoke Detector	L3D23	notifier	SDX-551	s-1 program mgr. off.	Passed		8/10/2020 11:26 AM
46	Smoke Detector	L3D24	notifier	SDX-551	s-1 day Room	Passed		8/11/2020 1:58 PM
47	Smoke Detector	L3D25	notifier	SDX-551	s-1 day Room	Passed		8/10/2020 11:25 AM
48	Smoke Detector	L3D27	notifier	SDX-551	s-1 tech office	Passed		8/11/2020 1:22 PM
49	Heat Detector	L3D28	notifier	FDX-551	S-1 Hall by Room 28	Passed		8/10/2020 11:21 AM
50	Smoke Detector	L3D29	notifier	SDX-551	s-1 laundry Room	Passed		8/10/2020 11:29 AM
51	Smoke Detector	L3D31	notifier	SDX-551	s-1 Hall by Room 1	Passed		8/11/2020 1:59 PM
52	Smoke Detector	L3D32	notifier	SDX-551	s-1 hall by Room 4	Passed		8/10/2020 11:19 AM
53	Smoke Detector	L3D34	notifier	SDX-551	s-1 hall by Room 7	Passed		8/10/2020 11:19 AM
54	Smoke Detector	L3D35	notifier	SDX-551	s-1 hall by Room 11	Passed		8/10/2020 11:18 AM
55	Smoke Detector	L4D08	notifier	SDX-551	s-1 above FCPS	Passed		8/10/2020 11:29 AM
56	Smoke Detector	L1D73	notifier	SDX-551	s-1 Rm 08	Passed		8/11/2020 1:45 PM
57	Smoke Detector	L1D74	notifier	SDX-551	s-1 Rm 09	Passed		8/11/2020 1:46 PM
58	Smoke Detector	L1D75	notifier	SDX-551	s-1 Rm 10	Passed		8/11/2020 1:50 PM
59	Smoke Detector	L1D76	notifier	SDX-551	s-1 Rm 11	Passed		8/11/2020 1:52 PM
60	Smoke Detector	L1D77	notifier	SDX-551	s-1 Rm 12	Passed		8/11/2020 1:55 PM
61	Smoke Detector	L1D78	notifier	SDX-551	s-1 Rm 13	Passed		8/11/2020 1:54 PM
62	Smoke Detector	L1D79	notifier	SDX-551	s-1 Rm 14	Passed		8/11/2020 1:49 PM
63	Smoke Detector	L1D80	notifier	SDX-551	s-1 Rm 15	Passed		8/11/2020 1:47 PM
64	Smoke Detector	L1D81	notifier	SDX-551	s-1 Rm 16	Passed		8/11/2020 1:44 PM
65	Smoke Detector	L1D82	notifier	SDX-551	s-1 Rm 17	Passed		8/11/2020 1:43 PM
66	Smoke Detector	L1D83	notifier	SDX-551	s-1 Rm 18	Passed		8/11/2020 1:40 PM
67	Smoke Detector	L1D84	notifier	SDX-551	s-1 Rm 19	Passed		8/11/2020 1:38 PM
68	Smoke Detector	L1D85	notifier	SDX-551	s-1 Rm 20	Passed		8/11/2020 1:35 PM
69	Smoke Detector	L1D86	notifier	SDX-551	s-1 Rm 21	Passed		8/11/2020 1:33 PM
70	Smoke Detector	L1D87	notifier	SDX-551	s-1 Rm 22	Passed		8/11/2020 1:31 PM
71	Smoke Detector	L1D88	notifier	SDX-551	s-1 Rm 23	Passed		8/11/2020 1:28 PM
72	Smoke Detector	L1D66	notifier	SDX-551	s-1 Rm 01	Passed		8/11/2020 1:25 PM
73	Smoke Detector	L1D67	notifier	SDX-551	s-1 Rm 02	Passed		8/11/2020 1:27 PM
74	Smoke Detector	L1D68	notifier	SDX-551	s-1 Rm 03	Passed		8/11/2020 1:31 PM
75	Smoke Detector	L1D69	notifier	SDX-551	s-1 Rm 04	Passed		8/11/2020 1:34 PM
76	Smoke Detector	L1D70	notifier	SDX-551	s-1 Rm 05	Passed		8/11/2020 1:37 PM
77	Smoke Detector	L1D71	notifier	SDX-551	s-1 Rm 06	Passed		8/11/2020 1:39 PM
78	Smoke Detector	L1D72	notifier	SDX-551	s-1 Rm 07	Passed		8/11/2020 1:42 PM
79	Smoke Detector	L1D89	notifier	SDX-551	s-1 Rm 24	Passed		8/11/2020 1:24 PM
80	Smoke Detector	L1D90	notifier	SDX-551	s-1 conference Room	Passed		8/11/2020 1:59 PM
81	Smoke Detector	L1D91	notifier	SDX-551	s-1 conference Room	Passed		8/11/2020 1:58 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Heat Detector	L1D92	notifier	FDX-551	S-1 RM 27	Passed		8/10/2020 11:24 AM
83	Smoke Detector	L1D93	notifier	SDX-551	s-1 RM 28	Passed		8/10/2020 11:23 AM
84	Smoke Detector	L3D30	notifier	SDX-551	s-1 linen rm	Passed		8/11/2020 1:26 PM
85	Manual Pull Station	L4M01	Notifier	BGX-101L	Main Entrance	Passed		8/10/2020 9:32 AM
86	Manual Pull Station	L1M07	Notifier	BGX-101L	Sta Exit S 5 Stairs	Passed		8/10/2020 9:45 AM
87	Manual Pull Station	L1M05	Notifier	BGX-101L	Sta Dining Rm Exit	Passed		8/11/2020 9:46 AM
88	Manual Pull Station	L1M13	Notifier	BGX-101L	Delivery Exit Area	Passed		8/11/2020 9:21 AM
89	Manual Pull Station	L1M04	Notifier	BGX-101L	Sta Gym Exit	Passed		8/11/2020 9:58 AM
90	Manual Pull Station	L3M07	Notifier	BGX-101L	s-1 Tech office	Passed		8/10/2020 11:30 AM
91	Manual Pull Station	L3M10	Notifier	BGX-101L	S-1 Fire Exit Yard	Passed		8/10/2020 11:20 AM
92	Manual Pull Station	L4M02	Notifier	BGX-101L	S-1 Sta Vest 1039 A	Failed		8/11/2020 1:24 PM
93	Manual Pull Station	L4M03	Notifier	BGX-101L	S-1 Sta Vest 1039 B	Passed		8/11/2020 1:25 PM
94	Manual Pull Station	L3M01	Notifier	BGX-101L	S-2Fire Exit to yard	Passed		8/11/2020 8:03 AM
95	Manual Pull Station	L3M04	Notifier	BGX-101L	S-2 Tech office	Passed		8/11/2020 12:05 PM
96	Smoke Detector	L4D03	notifier	SDX-551	1 flr s Ele lobby	Passed		8/10/2020 10:03 AM
97	Smoke Detector	L4D06	notifier	SDX-551	S ELE Pit 1st floor	Passed		8/11/2020 10:57 AM
98	Heat Detector	L4D07	notifier	FDX-551	S ELE Pit 1ST floor	Passed		8/11/2020 10:57 AM
99	Smoke Detector	L4D01	notifier	SDX-551	N ELE Shaft Top North Basmt.	Passed		8/10/2020 10:12 AM
100	Heat Detector	L4D02	notifier	FDX-551	N ELE Shaft Top North Bart.	Passed		8/11/2020 9:44 AM
101	Heat Detector	L4D29	notifier	FDX-551	N ELE Pit	Passed		8/11/2020 9:40 AM
102	Duct Detector	L1D32		SDX-551	Duct Det. T. Rec.	Passed		8/11/2020 9:08 AM
103	Heat Detector	L1D50	notifier	FDX-551	Bathroom Main Lobby	Passed		8/11/2020 10:58 AM
104	Duct Detector	L1D39		SDX-551	Duct Det. O.T.	Passed		8/11/2020 9:12 AM
105	Duct Detector	L1D24		SDX-551	Duct Det. Canteen Kitchen	Passed		8/11/2020 12:06 PM
106	Duct Detector	L1D36		SDX-551	T. Rec. Storage Duct Det.	Passed		8/11/2020 9:14 AM
107	Heat Detector	L4D28	notifier	FDX-551	N ELE Pit	Passed		8/10/2020 10:13 AM

2nd Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D48	notifier	SDX-551	S-4 Dayroom	Passed		8/11/2020 8:59 AM
2	Heat Detector	L3D47	notifier	FDX-551	west stairs	Passed		8/10/2020 10:09 AM
3	Heat Detector	L3D49	notifier	FDX-551	S-4 custodial Closet	Passed		8/11/2020 9:00 AM
4	Smoke Detector	L3D46	notifier	SDX-551	S-4 Dayroom	Passed		8/11/2020 8:59 AM
5	Smoke Detector	L3D45	notifier	SDX-551	S-4 Dayroom	Passed		8/11/2020 9:10 AM
6	Smoke Detector	L4D24	notifier	SDX-551	S-4 pipe chase	Passed		8/11/2020 8:57 AM
7	Smoke Detector	L3D44	notifier	SDX-551	S-4 by tech office	Passed		8/11/2020 8:55 AM
8	Smoke Detector	L3D73	notifier	SDX-551	S-4 coat closet	Passed		8/11/2020 8:56 AM
9	Smoke Detector	L3D43	notifier	SDX-551	S-4 Hall by rm 1	Passed		8/11/2020 8:47 AM
10	Smoke Detector	L3D41	notifier	SDX-551	S-4 Hall by rm 5	Passed		8/11/2020 9:11 AM
11	Smoke Detector	L3D39	notifier	SDX-551	S-4 Hall by rm 8	Passed		8/11/2020 8:26 AM
12	Smoke Detector	L3D38	notifier	SDX-551	S-4 Hall by rm 12	Passed		8/11/2020 8:11 AM
13	Smoke Detector	L3D37	notifier	SDX-551	S-4 Hall by rm 16	Passed		8/11/2020 8:06 AM
14	Smoke Detector	L3D36	notifier	SDX-551	S-4 stairs to yard	Passed		8/11/2020 9:13 AM
15	Smoke Detector	L2D93	notifier	SDX-551	S-4 rm 17	Passed		8/11/2020 8:05 AM
16	Smoke Detector	L2D92	notifier	SDX-551	S-4 rm 16	Passed		8/11/2020 8:08 AM
17	Smoke Detector	L2D94	notifier	SDX-551	S-4 rm 18	Passed		8/11/2020 8:07 AM
18	Smoke Detector	L2D95	notifier	SDX-551	S-4 rm 19	Passed		8/11/2020 8:09 AM
19	Smoke Detector	L2D91	notifier	SDX-551	S-4 rm 15	Passed		8/11/2020 8:10 AM
20	Smoke Detector	L2D90	notifier	SDX-551	S-4 rm 14	Passed		8/11/2020 8:12 AM
21	Smoke Detector	L2D96	notifier	SDX-551	S-4 rm 20	Passed		8/11/2020 8:14 AM
22	Smoke Detector	L2D97	notifier	SDX-551	S-4 rm 21	Passed		8/11/2020 8:15 AM
23	Smoke Detector	L2D89	notifier	SDX-551	S-4 rm 13	Passed		8/11/2020 8:16 AM
24	Smoke Detector	L2D98	notifier	SDX-551	S-4 rm 22	Passed		8/11/2020 8:19 AM
25	Smoke Detector	L2D88	notifier	SDX-551	S-4 rm 12	Passed		8/11/2020 8:18 AM
26	Smoke Detector	L2D99	notifier	SDX-551	S-4 rm 23	Passed		8/11/2020 8:22 AM
27	Smoke Detector	L2D87	notifier	SDX-551	S-4 rm 11	Passed		8/11/2020 8:24 AM
28	Smoke Detector	L3D96	notifier	SDX-551	S-4 rm 24	Passed		8/11/2020 8:25 AM
29	Smoke Detector	L2D86	notifier	SDX-551	S-4 rm 10	Passed		8/11/2020 8:27 AM
30	Smoke Detector	L2D85	notifier	SDX-551	S-4 rm 09	Passed		8/11/2020 8:28 AM
31	Smoke Detector	L2D84	notifier	SDX-551	S-4 rm 08	Passed		8/11/2020 8:29 AM
32	Smoke Detector	L3D97	notifier	SDX-551	S-4 rm 25	Passed		8/11/2020 8:30 AM
33	Smoke Detector	L3D98	notifier	SDX-551	S-4 rm 26	Passed		8/11/2020 8:31 AM
34	Smoke Detector	L3D99	notifier	SDX-551	S-4 rm 27	Passed		8/11/2020 8:38 AM
35	Smoke Detector	L2D82	notifier	SDX-551	S-4 rm 06	Passed		8/11/2020 8:35 AM
36	Smoke Detector	L2D81	notifier	SDX-551	S-4 rm 05	Passed		8/11/2020 8:36 AM
37	Smoke Detector	L3D51	notifier	SDX-551	S-4 rm 28	Passed		8/11/2020 8:39 AM
38	Smoke Detector	L2D80	notifier	SDX-551	S-4 rm 04	Passed		8/11/2020 8:41 AM
39	Smoke Detector	L2D79	notifier	SDX-551	S-4 rm 03	Passed		8/11/2020 8:43 AM
40	Smoke Detector	L2D78	notifier	SDX-551	S-4 rm 02	Passed		8/11/2020 8:55 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L2D77	notifier	SDX-551	S-4 rm 01	Passed		8/11/2020 8:53 AM
42	Smoke Detector	L3D73	notifier	SDX-551	S-4 coat closet	Passed		8/11/2020 9:13 AM
43	Smoke Detector	L3D55	notifier	SDX-551	S-5 mech rm	Passed		8/10/2020 1:38 PM
44	Smoke Detector	L3D52	notifier	SDX-551	S-5 south end of hall	Passed		8/11/2020 12:06 PM
45	Smoke Detector	L3D53	notifier	SDX-551	S-5 south end of hall	Passed		8/11/2020 12:07 PM
46	Smoke Detector	L3D57	notifier	SDX-551	S-3 Day Room	Passed		8/10/2020 10:56 AM
47	Smoke Detector	L3D58	notifier	SDX-551	S-3 day Room	Passed		8/10/2020 10:14 AM
48	Smoke Detector	L3D59	notifier	SDX-551	S-3 day Room	Passed		8/10/2020 10:14 AM
49	Heat Detector	L3D60	notifier	FDX-551	S-3 custodial Closet	Passed		8/10/2020 11:15 AM
50	Heat Detector	L3D62	notifier	FDX-551	S-3 Med. Room	Passed		8/10/2020 11:14 AM
51	Smoke Detector	L3D63	notifier	SDX-551	S-3 by tech office	Passed		8/10/2020 10:16 AM
52	Smoke Detector	L3D64	notifier	SDX-551	S-3 Hall by Room 28	Passed		8/10/2020 10:32 AM
53	Smoke Detector	L3D65	notifier	SDX-551	S-3 Hall by Room 1	Passed		8/10/2020 11:00 AM
54	Smoke Detector	L3D67	notifier	SDX-551	S-3 Hall by Room 4	Passed		8/10/2020 10:33 AM
55	Smoke Detector	L3D69	notifier	SDX-551	S-3 Hall by Room 7	Passed		8/10/2020 10:45 AM
56	Smoke Detector	L3D70	notifier	SDX-551	S-3 Hall by Room 11	Passed		8/10/2020 10:30 AM
57	Smoke Detector	L3D71	notifier	SDX-551	S-3 stairs to yard	Passed		8/10/2020 10:59 AM
58	Smoke Detector	L3D72	notifier	SDX-551	S-3 closet by tech	Passed		8/10/2020 10:22 AM
59	Smoke Detector	L4D22	notifier	SDX-551	S-3 above FCPS	Passed		8/10/2020 12:02 PM
60	Smoke Detector	L2D70	notifier	SDX-551	S-3 Rm 22	Passed		8/10/2020 10:26 AM
61	Smoke Detector	L2D51	notifier	SDX-551	S-3 Rm 03	Passed		8/10/2020 10:25 AM
62	Smoke Detector	L2D71	notifier	SDX-551	S-3 conference room	Passed		8/10/2020 10:29 AM
63	Smoke Detector	L2D72	notifier	SDX-551	S-3 conference room	Passed		8/10/2020 11:17 AM
64	Smoke Detector	L2D50	notifier	SDX-551	S-3 Rm 02	Passed		8/10/2020 10:26 AM
65	Smoke Detector	L2D49	notifier	SDX-551	S-3 Rm 01	Passed		8/10/2020 10:27 AM
66	Smoke Detector	L2D73	notifier	SDX-551	S-3 Rm 25	Passed		8/10/2020 10:31 AM
67	Heat Detector	L3D66	notifier	FDX-551	S-3 linen room	Passed		8/10/2020 10:20 AM
68	Smoke Detector	L2D74	notifier	SDX-551	S-3 Rm 26	Passed		8/10/2020 12:02 PM
69	Heat Detector	L2D75	notifier	FDX-551	S-3 Smoking RM	Passed		8/10/2020 11:11 AM
70	Smoke Detector	L2D76	notifier	SDX-551	S-3 RM 28	Passed		8/10/2020 11:12 AM
71	Manual Pull Station	L3M18	Notifier	BGX-101L	S-3 Fire Exit to yard	Passed		8/10/2020 12:00 PM
72	Manual Pull Station	L3M11	Notifier	BGX-101L	S-4 Fire Exit to yard	Passed		8/11/2020 10:23 AM
73	Manual Pull Station	L2M01	Notifier	BGX-101L	S-5 Stair Door	Passed		8/10/2020 1:03 PM
74	Manual Pull Station	L3M14	Notifier	BGX-101L	S-4 Day Room	Passed		8/11/2020 10:24 AM
75	Manual Pull Station	L3M16	Notifier	BGX-101L	S-3 Day Room	Passed		8/10/2020 10:11 AM
76	Smoke Detector	L2D44	notifier	SDX-551	S-5 top of stairs	Passed		8/10/2020 12:59 PM
77	Smoke Detector	L2D47	notifier	SDX-551	S-5 day Room	Passed		8/10/2020 1:29 PM
78	Smoke Detector	L2D48	notifier	SDX-551	S-5 day Room	Passed		8/10/2020 1:28 PM
79	Smoke Detector	L2D05	notifier	SDX-551	S-5 by janitor closet	Passed		8/10/2020 1:21 PM
80	Heat Detector	L2D19	notifier	FDX-551	S-5 Janitors closet	Passed		8/10/2020 1:26 PM
81	Smoke Detector	L2D18	notifier	SDX-551	S-5 linen Room	Passed		8/10/2020 1:25 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Heat Detector	L2D20	notifier	FDX-551	S-5 Bathroom	Passed		8/10/2020 1:24 PM
83	Smoke Detector	L2D08	notifier	SDX-551	S-5 rm 18	Passed		8/10/2020 1:20 PM
84	Smoke Detector	L2D17	notifier	SDX-551	S-5 rm 25	Passed		8/10/2020 1:17 PM
85	Smoke Detector	L2D06	notifier	SDX-551	S-5 Hall by rm 23	Passed		8/10/2020 1:12 PM
86	Smoke Detector	L2D16	notifier	SDX-551	S-5 rm 24	Passed		8/10/2020 1:13 PM
87	Smoke Detector	L2D09	notifier	SDX-551	S-5 rm 19	Passed		8/10/2020 1:18 PM
88	Smoke Detector	L2D15	notifier	SDX-551	S-5 rm 23	Passed		8/10/2020 1:10 PM
89	Smoke Detector	L2D14	notifier	SDX-551	S-5 rm 22	Passed		8/10/2020 1:09 PM
90	Smoke Detector	L2D07	notifier	SDX-551	S-5 Hall by Room 21	Passed		8/10/2020 1:06 PM
91	Smoke Detector	L2D10	notifier	SDX-551	S-5 med. Room	Passed		8/10/2020 1:13 PM
92	Smoke Detector	L2D11	notifier	SDX-551	S-5 rm 21	Passed		8/10/2020 1:15 PM
93	Smoke Detector	L2D13	notifier	SDX-551	S-5 group Room	Passed		8/10/2020 1:04 PM
94	Smoke Detector	L2D12	notifier	SDX-551	S-5 group Room	Passed		8/10/2020 1:05 PM
95	Smoke Detector	L2D23	notifier	SDX-551	S-5 tech office	Passed		8/10/2020 1:01 PM
96	Smoke Detector	L2D22	notifier	SDX-551	S-5 Staff bathroom	Passed		8/10/2020 1:02 PM
97	Heat Detector	L2D25	notifier	FDX-551	S-5 smoking rm	Passed		8/11/2020 10:25 AM
99	Smoke Detector	L2D41	notifier	SDX-551	S-5 rm 17	Passed		8/11/2020 10:29 AM
100	Heat Detector	L2D42	notifier	FDX-551	S-5 fan rm	Passed		8/11/2020 12:08 PM
101	Smoke Detector	L2D43	notifier	SDX-551	S-5 Hall by rm 1	Passed		8/11/2020 10:26 AM
102	Smoke Detector	L2D16	notifier	SDX-551	S-5 rm 26	Passed		8/11/2020 12:09 PM
103	Smoke Detector	L2D26	notifier	SDX-551	S-5 rm 02	Passed		8/11/2020 10:27 AM
104	Smoke Detector	L2D27	notifier	SDX-551	S-5 rm 03	Passed		8/11/2020 10:31 AM
105	Smoke Detector	L2D28	notifier	SDX-551	S-5 rm 04	Passed		8/11/2020 10:35 AM
106	Smoke Detector	L2D29	notifier	SDX-551	S-5 rm 05	Passed		8/11/2020 10:38 AM
107	Smoke Detector	L2D30	notifier	SDX-551	S-5 rm 06	Passed		8/11/2020 10:41 AM
108	Smoke Detector	L2D31	notifier	SDX-551	S-5 rm 07	Passed		8/11/2020 10:44 AM
109	Smoke Detector	L2D32	notifier	SDX-551	S-5 rm 08	Passed		8/11/2020 10:46 AM
110	Smoke Detector	L2D34	notifier	SDX-551	S-5 rm 10	Passed		8/11/2020 10:48 AM
111	Smoke Detector	L2D35	notifier	SDX-551	S-5 rm 11	Passed		8/11/2020 10:45 AM
112	Smoke Detector	L2D36	notifier	SDX-551	S-5 rm 12	Passed		8/11/2020 10:42 AM
113	Smoke Detector	L2D37	notifier	SDX-551	S-5 rm 13	Passed		8/11/2020 10:40 AM
114	Smoke Detector	L2D38	notifier	SDX-551	S-5 rm 14	Passed		8/11/2020 10:37 AM
115	Smoke Detector	L2D39	notifier	SDX-551	S-5 rm 15	Passed		8/11/2020 10:32 AM
116	Smoke Detector	L2D40	notifier	SDX-551	S-5 rm 16	Passed		8/11/2020 10:30 AM
117	Smoke Detector	L2D41	notifier	SDX-551	S-5 rm 17	Passed		8/11/2020 12:09 PM
118	Smoke Detector	L2D33	notifier	SDX-551	S-5 rm 09	Passed		8/11/2020 10:47 AM
119	Smoke Detector	L2D43	notifier	SDX-551	S-5 Hall by rm 1	Passed		8/11/2020 12:10 PM
120	Smoke Detector	L2D45	notifier	SDX-551	S-5 Hall by rm 4	Passed		8/11/2020 10:36 AM
121	Smoke Detector	L2D46	notifier	SDX-551	S-5 Hall by rm 8	Passed		8/11/2020 12:10 PM
122	Smoke Detector	L2D04	notifier	SDX-551	S-5 by back Hall	Passed		8/10/2020 1:31 PM
123	Smoke Detector	L2D03	notifier	SDX-551	S-5 back Hall	Passed		8/10/2020 1:32 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
124	Smoke Detector	L2D02	notifier	SDX-551	S-5 back Hall by bell	Passed		8/10/2020 1:33 PM
125	Smoke Detector	L2D01	notifier	SDX-551	S-5 back Hall by roof	Passed		8/10/2020 1:34 PM
126	Heat Detector	L4D19	notifier	FDX-551	S-5 EQ rm 2040 A 1 floor long Hall	Passed		8/11/2020 12:07 PM
127	Smoke Detector	L4D17	notifier	SDX-551	S-5 2ND Ele lobby	Passed		8/11/2020 10:51 AM
128	Smoke Detector	L4D18	notifier	SDX-551	S-5 ELE EQ RM 2040 A	Passed		8/11/2020 10:24 AM
129	Heat Detector	L4D15	notifier	FDX-551	S-5 S ELE Shaft Top	Passed		8/11/2020 10:52 AM
130	Smoke Detector	L4D14	notifier	SDX-551	S-5 S ELE Shaft Top	Passed		8/11/2020 10:47 AM
131	Heat Detector	L3D20	notifier	FDX-551	S-4 med. RM	Passed		8/11/2020 9:04 AM
132	Duct Detector	L4D13	Notifier		S4 Duct Smoke	Passed		8/11/2020 8:45 AM
133	Duct Detector	L4D10	Notifier		Duct Det S-3 2nd Floor	Passed		8/10/2020 12:00 PM
134	Manual Pull Station	L4M02	Notifier	BGX-101L	Vestibule 1039A	Passed		8/11/2020 12:11 PM
135	Manual Pull Station	L4M03	Notifier	BGX-101L	Vestibule 1039B	Passed		8/11/2020 12:08 PM

Basement TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Heat Detector	L1D05	Notifier	FDX-551	air handling rm	Passed		8/11/2020 12:19 PM
2	Heat Detector	L1D02	Notifier	FDX-551	Pt. storage	Passed		8/11/2020 9:29 AM
3	Heat Detector	L1D03	Notifier	FDX-551	nonflammable storage	Passed		8/11/2020 9:25 AM
4	Heat Detector	L1D01	Notifier	FDX-551	PT storage	Passed		8/11/2020 9:27 AM
5	Smoke Detector	L1D09	Notifier	SDX-551	elevator lobby	Passed		8/11/2020 9:19 AM
6	Smoke Detector	L1D08	Notifier	SDX-551	utilities rm	Passed		8/11/2020 12:12 PM
7	Heat Detector	L1D11	Notifier	FDX-551	transformer rm	Passed		8/11/2020 9:23 AM
8	Heat Detector	L1D14	Notifier	FDX-551	Gym vestibule	Passed		8/11/2020 9:53 AM
9	Heat Detector	L1D13	Notifier	FDX-551	weight rm	Passed		8/11/2020 9:20 AM
10	Heat Detector	L1D12	Notifier	FDX-551	weight rm	Passed		8/11/2020 9:55 AM
11	Heat Detector	L1D15	Notifier	FDX-551	gym kitchen	Passed		8/11/2020 9:52 AM
12	Smoke Detector	L4D26	Notifier	SDX-551	N ELE EQ RM	Passed		8/11/2020 9:22 AM
13	Heat Detector	L4D27	Notifier	FDX-551	N ELE EQ Rm	Passed		8/11/2020 12:21 PM
14	Smoke Detector	L4D28	Notifier	SDX-551	N ELE Pit	Passed		8/11/2020 12:19 PM
15	Heat Detector	L1D19	Notifier	FDX-551	Gym North East	Passed		8/14/2020 11:04 AM
16	Heat Detector	L1D18	Notifier	FDX-551	Gym North Center	Passed		8/14/2020 11:03 AM
17	Heat Detector	L1D17	Notifier	FDX-551	Gym North West	Passed		8/14/2020 11:03 AM
18	Heat Detector	L1D20	Notifier	FDX-551	Gym South East	Passed		8/14/2020 11:03 AM
19	Heat Detector	L1D21	Notifier	FDX-551	Gym South Center	Passed		8/14/2020 11:02 AM
20	Heat Detector	L1D22	Notifier	FDX-551	Gym South West	Passed		8/14/2020 11:02 AM
21	Duct Detector	L1D23	Notifier		S Gym Duct Det	Passed		8/11/2020 9:56 AM
22	Duct Detector	L1D06	Notifier		Duct Det. AHU 1	Passed		8/11/2020 9:30 AM
23	Duct Detector	L1D07	Notifier		Duct Det. RAF 1	Passed		8/11/2020 12:18 PM

Roof TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Duct Detector	L1D29	Notifier		Duct Det. Canteen Roof	Passed		8/11/2020 11:01 AM
2	Duct Detector	L2D41	Notifier		Duct Det RTU-5	Passed		8/11/2020 12:40 PM
3	Duct Detector	L2D42	Notifier		Duct Det RTU-5 return	Passed		8/11/2020 12:44 PM
4	Duct Detector	L3D26	Notifier		Duct Det RTU-4 supply	Passed		8/11/2020 12:47 PM
5	Duct Detector	L3D27	Notifier		Duct Det RTU-4 return	Passed		8/11/2020 12:47 PM
6	Duct Detector	L3D29	Notifier		Duct Det RTU-2 supply	Passed		8/11/2020 12:54 PM
7	Duct Detector	L3D30	Notifier		Duct Det RTU-2 return	Passed		8/11/2020 12:54 PM
8	Duct Detector	L3D32	Notifier		Duct Det RTU-3 supply	Passed		8/11/2020 12:51 PM
9	Duct Detector	L3D33	Notifier		Duct Det RTU-3 return	Passed		8/11/2020 12:52 PM

2nd Floor Continued TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D23	Notifier	FSP-851	Program Managers Office S-4	Passed		8/11/2020 10:25 AM
2	Smoke Detector	L2D83	Notifier	FSP-851	S-4 Rm 07	Passed		8/11/2020 10:48 AM
3	Smoke Detector	L2D99	Notifier	FSP-851	S-4 Rm 23	Passed		8/10/2020 12:01 PM
4	Smoke Detector	L2D60	Notifier	FSP-851	S-3 Rm 12	Passed		8/10/2020 10:57 AM
5	Smoke Detector	L2D61	Notifier	FSP-851	S-3 Rm 13	Passed		8/10/2020 10:51 AM
6	Smoke Detector	L2D62	Notifier	FSP-851	S-3 Rm 14	Passed		8/10/2020 10:48 AM
7	Smoke Detector	L2D63	Notifier	FSP-851	S-3 Rm 15	Passed		8/10/2020 10:48 AM
8	Smoke Detector	L2D64	Notifier	FSP-851	S-3 Rm 16	Passed		8/10/2020 10:43 AM
9	Smoke Detector	L2D65	Notifier	FSP-851	S-3 Rm 17	Passed		8/10/2020 10:41 AM
11	Smoke Detector	L2D67	Notifier	FSP-851	S-3 Rm 19	Passed		8/10/2020 12:00 PM
12	Smoke Detector	L3D66	Notifier	FSP-851	S-3 linen	Passed		8/10/2020 12:00 PM
13	Smoke Detector	L2D69	Notifier	FSP-851	S-3 Rm 21	Passed		8/10/2020 12:01 PM
14	Smoke Detector	L2D52	Notifier	FSP-851	S-3 Rm 04	Passed		8/10/2020 10:37 AM
15	Smoke Detector	L2D53	Notifier	FSP-851	S-3 Rm 05	Passed		8/10/2020 10:42 AM
16	Smoke Detector	L2D54	Notifier	FSP-851	S-3 Rm 06	Passed		8/10/2020 12:01 PM
17	Smoke Detector	L2D55	Notifier	FSP-851	S-3 Rm 07	Passed		8/10/2020 10:42 AM
18	Smoke Detector	L2D56	Notifier	FSP-851	S-3 Rm 08	Passed		8/10/2020 10:44 AM
19	Smoke Detector	L2D57	Notifier	FSP-851	S-3 Rm 09	Passed		8/10/2020 10:47 AM
20	Smoke Detector	L2D58	Notifier	FSP-851	S-3 Rm 10	Passed		8/10/2020 10:50 AM
21	Smoke Detector	L2D59	Notifier	FSP-851	S-3 Rm 11	Passed		8/10/2020 10:52 AM

1st floor continued TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D01	Notifier	FSP851	S-2 Hall by Room 214	Passed		8/11/2020 11:56 AM
2	Smoke Detector	L3D02	Notifier	FSP851	S-2 Hall by Room 221	Passed		8/11/2020 12:04 PM
3	Smoke Detector	L3D03	Notifier	FSP851	S-2 Hall by Room 223	Passed		8/11/2020 12:03 PM
4	Smoke Detector	L3D04	Notifier	FSP851	S-2 Hall by Room 203	Passed		8/11/2020 12:03 PM
5	Smoke Detector	L3D07	Notifier	FSP851	S-2 Hall by Room 232	Passed		8/11/2020 12:03 PM
6	Smoke Detector	L3D08	Notifier	FSP851	S-2 by tech office	Passed		8/11/2020 12:02 PM
7	Smoke Detector	L3D09	Notifier	FSP851	S-2 Day Room	Passed		8/11/2020 12:02 PM
8	Smoke Detector	L3D10	Notifier	FSP851	S-2 Day Room	Passed		8/11/2020 12:01 PM
9	Smoke Detector	L3D11	Notifier	FSP851	S-2 Day Room	Passed		8/11/2020 12:00 PM
10	Smoke Detector	L3D12	Notifier	FSP851	S-2 Day Room	Passed		8/11/2020 12:00 PM
11	Smoke Detector	L3D76	Notifier	FSP851	S-2 Room 224	Passed		8/11/2020 7:44 AM
12	Smoke Detector	L3D77	Notifier	FSP851	S-2 Room 223	Passed		8/11/2020 7:46 AM
13	Smoke Detector	L3D78	Notifier	FSP851	S-2 Room 222	Passed		8/11/2020 7:49 AM
14	Smoke Detector	L3D79	Notifier	FSP851	S-2 Room 221	Passed		8/11/2020 7:50 AM
15	Smoke Detector	L3D80	Notifier	FSP851	S-2 Room 220	Passed		8/11/2020 7:51 AM
16	Smoke Detector	L3D81	Notifier	FSP851	S-2 Room 219	Passed		8/11/2020 7:53 AM
17	Smoke Detector	L3D82	Notifier	FSP851	S-2 Room 218	Passed		8/11/2020 11:59 AM
18	Smoke Detector	L3D83	Notifier	FSP851	S-2 Room 217	Passed		8/11/2020 7:59 AM
19	Smoke Detector	L3D84	Notifier	FSP851	S-2 Room 216	Passed		8/11/2020 8:02 AM
20	Smoke Detector	L3D85	Notifier	FSP851	S-2 Room 214	Passed		8/11/2020 8:01 AM
21	Smoke Detector	L3D86	Notifier	FSP851	S-2 Room 213	Passed		8/11/2020 7:58 AM
22	Smoke Detector	L3D87	Notifier	FSP851	S-2 Room 212	Passed		8/11/2020 7:55 AM
23	Smoke Detector	L3D88	Notifier	FSP851	S-2 Room 211	Passed		8/11/2020 7:52 AM
24	Smoke Detector	L3D89	Notifier	FSP851	S-2 Room 210	Passed		8/11/2020 7:49 AM
25	Smoke Detector	L3D90	Notifier	FSP851	S-2 Room 209	Passed		8/11/2020 7:47 AM
26	Smoke Detector	L3D91	Notifier	FSP851	S-2 Room 208	Passed		8/11/2020 7:45 AM
27	Smoke Detector	L3D92	Notifier	FSP851	S-2 Room 206	Passed		8/11/2020 7:42 AM
28	Smoke Detector	L3D93	Notifier	FSP851	S-2 Room 205	Passed		8/11/2020 7:39 AM
29	Smoke Detector	L3D94	Notifier	FSP851	S-2 Room 204	Passed		8/11/2020 7:38 AM
30	Smoke Detector	L3D95	Notifier	FSP851	S-2 Room 203	Passed		8/11/2020 7:35 AM
31	Heat Detector	L3D05	Notifier		S-2 Linen 202	Passed		8/11/2020 7:34 AM
32	Heat Detector	L3D14	Notifier		S-2 custodial Closet	Passed		8/11/2020 11:59 AM
33	Heat Detector	L3D15	Notifier		S-2 chart room	Passed		8/11/2020 11:58 AM
34	Smoke Detector	L1D94	Notifier	FSP851	S-2 Room 232	Passed		8/11/2020 11:57 AM
35	Smoke Detector	L1D95	Notifier	FSP851	S-2 Room 231	Passed		8/11/2020 11:57 AM
36	Smoke Detector	L1D96	Notifier	FSP851	S-2 Room 230	Passed		8/11/2020 7:32 AM
37	Smoke Detector	L1D97	Notifier	FSP851	S-2 Room 229	Passed		8/11/2020 7:32 AM
38	Smoke Detector	L1D98	Notifier	FSP851	S-2 Room 228	Passed		8/11/2020 7:36 AM
39	Smoke Detector	L1D99	Notifier	FSP851	S-2 Room 227	Passed		8/11/2020 7:37 AM
40	Smoke Detector	L3D13	Notifier	FSP851	S-2 Cora closet by tech	Passed		8/11/2020 11:56 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2020 Annual Inspection Summary

Result Totals

Devices	Control Valve Switch	PIV	Standpipe Water Flow	Water Flow Pressure Switch
Passed	9	1	1	5
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	9	1	1	5

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Water Flow Pressure Switch	L1M30	Janitor Closet	Passed			8/18/2020 11:10 AM
2	Water Flow Pressure Switch	L3M23	S-2 Mop closet	Passed			8/18/2020 11:14 AM
3	Control Valve Switch	L1M31	Janitor Closet	Passed			8/18/2020 11:13 AM
4	Control Valve Switch	L3M24	S-2 Janitor Closet	Passed			8/18/2020 11:13 AM
5	PIV	L1M35	Outside	Passed			8/18/2020 11:13 AM

2nd Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Water Flow Pressure Switch	L2M02	S-5 Sprinkler closet	Passed			8/18/2020 11:14 AM
2	Water Flow Pressure Switch	L3M21	S-4 Mop closet	Passed			8/18/2020 11:16 AM
3	Control Valve Switch	L2M03	S-5 Sprinkler closet	Passed			8/18/2020 11:16 AM
4	Control Valve Switch	L3M22	S-4 Janitor Closet	Passed			8/18/2020 11:15 AM
5	Water Flow Pressure Switch	L3M21	S-4 Mop closet	Passed			8/18/2020 11:15 AM
6	Control Valve Switch	L3M22	S-4 Janitor Closet	Passed			8/18/2020 11:15 AM

Basement TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1m32	main Flow switch	Passed			8/18/2020 11:16 AM
2	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/18/2020 11:20 AM
3	Control Valve Switch	L1M36	Basement Elev. Eq	Passed		Main Tamper	8/18/2020 11:20 AM
4	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/18/2020 11:17 AM
5	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/18/2020 11:17 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	5	6
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	5	6

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Control room
Model	AFP1010
Voltage/Current	120VAC
s/Communication	Yes Passed

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP1010		Control room	Passed		8/18/2020 10:35 AM
2	Power Supply	Notifier	FCPS-24	L1M09	Above panel	Passed	Batteries were replaced 1-14-2019 voltage is running a little low charger on power supply might be going bad.	8/18/2020 10:34 AM
3	Power Supply	Notifier	FCPS-24	L3M03	S2 Electrical Closet	Passed		8/18/2020 10:33 AM
5	Power Supply	Notifier	FCPS	L4M07	S-1 Closet	Passed		8/18/2020 10:31 AM
6	Annuciator	Notifier			S1 ward	Passed		8/18/2020 10:31 AM
7	Annuciator	Notifier			S2 ward	Passed		8/18/2020 10:30 AM
8	Annuciator	Notifier			S3 ward	Passed		8/18/2020 10:30 AM
9	Annuciator	Notifier			S4 ward	Passed		8/18/2020 10:29 AM
10	Annuciator	Notifier			S5 ward	Passed		8/18/2020 10:29 AM
11	Power Supply	Notifier	FCPS24S8		s-2 closet	Passed		8/18/2020 10:29 AM

2nd Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L4M08	S-3 Closet	Passed		8/18/2020 10:36 AM

Basement TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L4M22	Rm 02	Passed		8/18/2020 10:37 AM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH	Notifier	AFP1010	9-27-2019	1st Floor Control room	Passed	Right
1	12V26AH	Notifier	AFP1010	9-7-2019	1st Floor Control room	Passed	Left
2	12V8AH	Notifier	FCPS-24	1-14-19	1st Floor Above panel	Passed	
2	12V8AH	Notifier	FCPS-24	1-14-2019	1st Floor Above panel	Passed	
3	12V8AH	Notifier	FCPS-24	9-25-2019	1st Floor S2 Electrical Closet	Passed	
3	12V8AH	Notifier	FCPS-24	9-25-2019	1st Floor S2 Electrical Closet	Passed	
5	12V8AH			8-15-2019	1st Floor S-1 Closet	Passed	
5	12V8AH			8-15-19	1st Floor S-1 Closet	Passed	
11	12V8AH	Notifier		1-13-2019	1st Floor s-2 closet	Passed	
11	12V8AH	Notifier		1-13-2019	1st Floor s-2 closet	Passed	
1	12V8AH	Notifier	FCPS-24	1-13-2019	2nd Floor S-3 Closet	Passed	
1	12V8AH	Notifier	FCPS-24	1-13-2019	2nd Floor S-3 Closet	Passed	
1	12V8AH	Notifier	FCPS-24	9-5-2019	Basement Rm 02	Passed	
1	12V8AH	Notifier	FCPS-24	9-15-2019	Basement Rm 02	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	AFP1010	120VAC	Control room	1st Floor	Passed	24hr 5min	
2	L1M09	Power Supply	Notifier	FCPS-24	120	Above panel	1st Floor	Passed	24/15	Batteries were replaced 1-14-2019 voltage is running a little low charger on power supply might be going bad.
3	L3M03	Power Supply	Notifier	FCPS-24	120VAC	S2 Electrical Closet	1st Floor	Passed		
5	L4M07	Power Supply	Notifier	FCPS		S-1 Closet	1st Floor	Passed		
6		Annuciator	Notifier			S1 ward	1st Floor	Passed		
7		Annuciator	Notifier			S2 ward	1st Floor	Passed		
8		Annuciator	Notifier			S3 ward	1st Floor	Passed		
9		Annuciator	Notifier			S4 ward	1st Floor	Passed		
10		Annuciator	Notifier			S5 ward	1st Floor	Passed		
11		Power Supply	Notifier	FCPS24S8	120	s-2 closet	1st Floor	Passed	24/15	
1	L4M08	Power Supply	Notifier	FCPS-24	120	S-3 Closet	2nd Floor	Passed	24-15	
1	L4M22	Power Supply	Notifier	FCPS-24	120	Rm 02	Basement	Passed	24-15	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP19 Shutdown 2020 Annual Inspection Summary

Result Totals

Devices	Fan	Relays
Passed	13	28
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	13	28

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder Kitchen RM 100	Passed		8/18/2020 10:42 AM
2	Relays				Door Holder 132 N. East	Passed		8/18/2020 10:47 AM
3	Relays				Door Holder 132 N. West	Passed		8/18/2020 10:46 AM
4	Relays				Door Holder 132 S. East	Passed		8/18/2020 10:46 AM
5	Relays				Door Holder 132 S. West	Passed		8/18/2020 10:45 AM
6	Relays				Door Holder Canteen Hall Door	Passed		8/18/2020 10:45 AM
7	Relays				Door Holder 135 S-1 Entrane	Passed		8/18/2020 10:44 AM
8	Relays				Door Holder 155 S.	Passed		8/18/2020 10:44 AM
9	Relays				Door Holder 155 N.	Passed		8/18/2020 10:44 AM
10	Relays				Door Holder RM 1012 S-2 Entrance	Passed		8/18/2020 10:43 AM
11	Relays				Door Holder 192 S.	Passed		8/18/2020 10:43 AM
12	Relays				Door Holder 192 N.	Passed		8/18/2020 10:42 AM

2nd Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder RM 278 Entrance	Passed		8/18/2020 10:47 AM
2	Relays				Door Holder 243 S.	Passed		8/18/2020 11:01 AM
3	Relays				Door Holder 243 N.	Passed		8/18/2020 11:01 AM
4	Relays				Door Holder 280 S-4 Entrance	Passed		8/18/2020 11:00 AM
5	Relays				Door Holder 284 S.	Passed		8/18/2020 10:50 AM
6	Relays				Door Holder 284 N.	Passed		8/18/2020 10:50 AM
7	Fan	L4M05			2nd flr s-3	Passed		8/18/2020 10:50 AM
8	Relays	L3M02			Smoke relay damper	Passed		8/18/2020 10:49 AM
9	Relays	L3M08			Smoke relay damper	Passed		8/18/2020 10:48 AM
10	Relays	L4M04			Smoke relay damper S-4	Passed		8/18/2020 10:48 AM
11	Relays	L4M20			Smoke relay elevator lobby	Passed		8/18/2020 10:47 AM

Basement TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder tunnel door	Passed		8/18/2020 11:10 AM
2	Relays				Door Holder electrical vestibule	Passed		8/18/2020 11:09 AM
3	Relays				Door Holder Steam vestibule	Passed		8/18/2020 11:09 AM
4	Relays	L1M58			Door Holders	Passed		8/18/2020 11:08 AM
5	Relays	L4M23			Door Holders LL	Passed		8/18/2020 11:08 AM
6	Fan	L1M01			AHU 1	Passed		8/18/2020 11:07 AM
7	Fan	L1M02			RAF 1	Passed		8/18/2020 11:07 AM
8	Fan	L1M14			AHU 4	Passed		8/18/2020 11:06 AM
9	Fan	L1M16			AHU 10	Passed		8/18/2020 11:06 AM
10	Fan	L1M17			AHU S Gym	Passed		8/18/2020 11:05 AM
11	Fan	L1M18			AHU 8	Passed		8/18/2020 11:05 AM
12	Fan	L1M19			AHU 9	Passed		8/18/2020 11:04 AM
13	Fan	L1M20			AHU 7	Passed		8/18/2020 11:04 AM
14	Fan	L1M21			AHU 3	Passed		8/18/2020 11:03 AM
15	Fan	L1M22			AHU 6	Passed		8/18/2020 11:03 AM
16	Fan	L1M23			AHU 2	Passed		8/18/2020 11:02 AM
17	Fan	L1M24			AHU 5	Passed		8/18/2020 11:02 AM
18	Relays	L4M21			Basement Damper	Passed		8/18/2020 11:02 AM

Supercomponent Results

Number	Type	Zone/address	Make	Model	Location	Layout	Result	Comments
7	Fan	L4M05			2nd flr s-3	2nd Floor	Passed	
6	Fan	L1M01			AHU 1	Basement	Passed	
7	Fan	L1M02			RAF 1	Basement	Passed	
8	Fan	L1M14			AHU 4	Basement	Passed	
9	Fan	L1M16			AHU 10	Basement	Passed	
10	Fan	L1M17			AHU S Gym	Basement	Passed	
11	Fan	L1M18			AHU 8	Basement	Passed	
12	Fan	L1M19			AHU 9	Basement	Passed	
13	Fan	L1M20			AHU 7	Basement	Passed	
14	Fan	L1M21			AHU 3	Basement	Passed	
15	Fan	L1M22			AHU 6	Basement	Passed	
16	Fan	L1M23			AHU 2	Basement	Passed	
17	Fan	L1M24			AHU 5	Basement	Passed	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Account: LRC Bldg. # 9 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Heat Detector	Manual Pull Station	Smoke Detector
Passed	27	5	22
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	27	5	22

This inspection was performed on 8/14/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D20	Notifier	SDX-551	Main office	Passed		8/14/2020 11:31 AM
2	Smoke Detector	L1D28	Notifier	SDX-551	Hall by Mech Rm	Passed		8/14/2020 11:31 AM
3	Smoke Detector	L1D51	Notifier	SDX-551	Hall by 115	Passed		8/14/2020 11:30 AM
4	Heat Detector	L1D23	Notifier	FDX-551	Mech Rm	Passed		8/14/2020 11:30 AM
5	Smoke Detector	L1D50	Notifier	SDX-551	Hall by 113	Passed		8/14/2020 11:30 AM
6	Smoke Detector	L1D42	Notifier	SDX-551	Hall by 108	Passed		8/14/2020 11:30 AM
7	Smoke Detector	L1D49	Notifier	SDX-551	Hall by 110	Passed		8/14/2020 11:29 AM
8	Heat Detector	L1D45	Notifier	FDX-551	Admin Cloak Rm	Passed		8/14/2020 11:29 AM
9	Heat Detector	L1D48	Notifier	FDX-551	Large Conference	Passed		8/14/2020 11:29 AM
10	Smoke Detector	L1D38	Notifier	SDX-551	North Corridor	Passed		8/14/2020 11:28 AM
11	Heat Detector	L1D46	Notifier	FDX-551	Admin Storage	Passed		8/14/2020 11:28 AM
12	Smoke Detector	L1D40	Notifier	SDX-551	Admin Reception Area	Passed		8/14/2020 11:27 AM
13	Smoke Detector	L1D41	Notifier	SDX-551	Reception Area	Passed		8/14/2020 11:27 AM
14	Smoke Detector	L1D39	Notifier	SDX-551	Hall by 147	Passed		8/14/2020 11:27 AM
15	Smoke Detector	L1D33	Notifier	SDX-551	Hall by 130	Passed		8/14/2020 11:27 AM
16	Heat Detector	L1D34	Notifier	FDX-551	Rm 130	Passed		8/14/2020 11:26 AM
17	Heat Detector	L1D35	Notifier	FDX-551	Rm 141	Passed		8/14/2020 11:26 AM
18	Heat Detector	L1D36	Notifier	FDX-551	Rm 140	Passed		8/14/2020 11:26 AM
19	Smoke Detector	L1D32	Notifier	SDX-551	Hall by Lounge	Passed		8/14/2020 11:25 AM
20	Heat Detector	L1D37	Notifier	FDX-551	Lounge	Passed		8/14/2020 11:25 AM
21	Heat Detector	L1D14	Notifier	FDX-551	Mop Closet West	Passed		8/14/2020 11:25 AM
22	Smoke Detector	L1D31	Notifier	SDX-551	Hall by bus storage	Passed		8/14/2020 11:24 AM
23	Heat Detector	L1D22	Notifier	FDX-551	Business Storage	Passed		8/14/2020 11:24 AM
24	Smoke Detector	L1D21	Notifier	SDX-551	Copy machine area	Passed		8/14/2020 11:23 AM
25	Smoke Detector	L1D30	Notifier	SDX-551	Hall by Stairs	Passed		8/14/2020 11:23 AM
26	Heat Detector	L1D19	Notifier	FDX-551	patient accounts	Passed		8/14/2020 11:22 AM
27	Heat Detector	L1D18	Notifier	FDX-551	patient accounts	Passed		8/14/2020 11:22 AM
28	Heat Detector	L1D17	Notifier	FDX-551	patient accounts	Passed		8/14/2020 11:22 AM
29	Smoke Detector	L1D29	Notifier	SDX-551	Hall by Lobby Door	Passed		8/14/2020 11:21 AM
30	Heat Detector	L1D15	Notifier	FDX-551	vending machine rm	Passed		8/14/2020 11:21 AM
31	Heat Detector	L1D16	Notifier	FDX-551	museum	Passed		8/14/2020 11:21 AM
32	Heat Detector	L1D53	Notifier	FDX-551	Penthouse Equipment rm	Passed		8/14/2020 11:21 AM
33	Heat Detector	L1D25	Notifier	FDX-551	medical records	Passed		8/14/2020 11:18 AM
34	Heat Detector	L1D26	Notifier	FDX-551	medical records	Passed		8/14/2020 11:18 AM
35	Heat Detector	L1D43	Notifier	FDX-551	North RR	Passed		8/14/2020 11:18 AM
36	Heat Detector	L1D44	Notifier	FDX-551	North RR	Passed		8/14/2020 11:17 AM
37	Smoke Detector	L1D09	Notifier	SDX-551	lobby nw	Passed		8/14/2020 11:17 AM
38	Smoke Detector	L1D11	Notifier	SDX-551	lobby ne	Passed		8/14/2020 11:16 AM
39	Smoke Detector	L1D12	Notifier	SDX-551	lobby Se	Passed		8/14/2020 11:16 AM
40	Smoke Detector	L1D10	Notifier	SDX-551	lobby Sw	Passed		8/14/2020 11:12 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L1D13	Notifier	FDX-551	Lobby Storage	Passed		8/14/2020 11:12 AM
42	Heat Detector	L1D27	Notifier	FDX-551	med records manager office	Passed		8/14/2020 11:11 AM
43	Manual Pull Station	L1M04	Notifier	BGX-101L	south Hall by lobby	Passed		8/14/2020 11:10 AM
44	Manual Pull Station	L1M01	Notifier	BGX-101L	southeast lobby exit	Passed		8/14/2020 11:09 AM
45	Manual Pull Station	L1M03	Notifier	BGX-101L	West Exit south Hall	Passed		8/14/2020 11:09 AM
46	Manual Pull Station	L1M06	Notifier	BGX-101L	North End west Hall	Passed		8/14/2020 11:08 AM
46	Manual Pull Station	L1M05	Notifier	BGX-101L	North End east Hall	Passed		8/14/2020 11:07 AM

BASEMENT TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D03	Notifier	SDX-551	corridor	Passed		8/14/2020 11:34 AM
2	Smoke Detector	L1D04	Notifier	SDX-551	processing	Passed		8/14/2020 11:34 AM
3	Heat Detector	L1D05	Notifier		Processing	Passed		8/14/2020 11:33 AM
4	Heat Detector	L1D06	Notifier		Processing	Passed		8/14/2020 11:33 AM
5	Heat Detector	L1D08	Notifier		Records Storage	Passed		8/14/2020 11:33 AM
6	Heat Detector	L1D07	Notifier		Equipment Rm	Passed		8/14/2020 11:33 AM
7	Heat Detector	L1D02	Notifier	FDX-551	Telephone rm	Passed		8/14/2020 11:32 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Account: LRC Bldg. # 9 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Bell	Horn Strobe	Strobe
Passed	5	1	10
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	5	1	10

This inspection was performed on 8/14/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	statistics analyst	Passed		8/14/2020 11:44 AM
2	Horn Strobe			statistics analyst	Passed		8/14/2020 11:43 AM
3	Bell		KMS-8-24VDC/P	Lobby	Passed		8/14/2020 11:43 AM
4	Strobe		SS24110ADA	Lobby	Passed		8/14/2020 11:42 AM
5	Strobe		SS24110ADA	men’s rr	Passed		8/14/2020 11:39 AM
6	Strobe		SS24110ADA	women’s rr	Passed		8/14/2020 11:39 AM
7	Strobe		SS24110ADA	Medical records	Passed		8/14/2020 11:39 AM
8	Strobe		SS24110ADA	conference rm	Passed		8/14/2020 11:38 AM
9	Strobe		SS24110ADA	across from health info manager	Passed		8/14/2020 11:37 AM
10	Bell		KMS-8-24VDC/P	Across from health info manager	Passed		8/14/2020 11:36 AM
11	Strobe		SS24110ADA	men’s RR	Passed		8/14/2020 11:36 AM
12	Strobe		SS24110ADA	Women’s RR	Passed		8/14/2020 11:36 AM
13	Bell		KMS-8-24VDC/P	Financial	Passed		8/14/2020 11:35 AM
14	Strobe		SS24110ADA	Financial	Passed		8/14/2020 11:35 AM
15	Bell		KMS-8-24VDC/P	basement Hall	Passed		8/14/2020 11:34 AM
16	Strobe		SS24110ADA	basement hall	Passed		8/14/2020 11:34 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 9 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Power Supply
Passed	2
Mitigated	-
New - Passed	-
Failed	-
Removed	-
Not Inspected	-
Total	2

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Main office
Model	AFP1010
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/14/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP1010		Main office	Passed		8/14/2020 11:49 AM
2	Power Supply	Notifier	MPS-24A		Main office	Passed		8/14/2020 11:49 AM

BASEMENT TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L1M10	mech rm	Passed		8/14/2020 11:49 AM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH			9-6-2017	1st Floor Main office	Passed	Left
1	12V26AH			9-6-2017	1st Floor Main office	Passed	Right
1	12V8AH			3-7-2018	BASEMENT mech rm	Passed	Left
1	12V8AH			3-7-2018	BASEMENT mech rm	Passed	Right

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	AFP1010	120	Main office	1st Floor	Passed		
2		Power Supply	Notifier	MPS-24A	110	Main office	1st Floor	Passed		
1	L1M10	Power Supply	Notifier	FCPS-24		mech rm	BASEMENT	Passed		

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency:2020 Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2020 Annual Inspection Summary

Result Totals

Devices	Control Valve Switch	PIV	Standpipe Water Flow
Passed	5	1	4
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	5	1	4

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M32	1st Floor Flow	Passed			8/18/2020 5:48 PM
2	Control Valve Switch	L1M33	1st floor valve	Passed			8/18/2020 5:49 PM
3	PIV	L1M23	outside	Passed			8/18/2020 5:49 PM

2nd Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L2M20	2nd Floor Flow	Passed			8/18/2020 5:49 PM
2	Control Valve Switch	L2M21	2 Floor valve	Passed			8/18/2020 5:50 PM

LOWER LEVEL TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M28	Riser room	Passed			8/18/2020 5:50 PM
2	Control Valve Switch	L1M29	Basement valve	Passed			8/18/2020 5:51 PM
3	Control Valve Switch	L1M26	Sprinkler drain	Passed			8/18/2020 5:51 PM
4	Control Valve Switch	L1M27	1st and second isolation	Passed			8/18/2020 5:51 PM
5	Standpipe Water Flow	L1M31	Riser room	Passed			8/18/2020 5:52 PM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	6	16	12	61
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	6	16	12	61

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D01	notifier	FSP-851	Foyer by panel	Passed		8/14/2020 12:48 PM
2	Smoke Detector	L1D03	notifier	FSP-851	Hall by center stair	Passed		8/14/2020 12:48 PM
3	Heat Detector	L1D05	Notifier	FDX-551	Maintenance Room	Passed		8/14/2020 12:47 PM
4	Smoke Detector	L1D06	notifier	FSP-851	Hall by Rm 133	Passed		8/14/2020 12:47 PM
5	Smoke Detector	L1D14	notifier	FSP-851	Hall by Rm 135	Passed		8/14/2020 12:47 PM
6	Smoke Detector	L1D15	notifier	FSP-851	Hall by South Exit	Passed		8/14/2020 12:47 PM
7	Smoke Detector	L1D16	notifier	FSP-851	Hall by rm 150	Passed		8/14/2020 12:47 PM
8	Smoke Detector	L1D17	notifier	FSP-851	Hall by rm 149	Passed		8/14/2020 12:46 PM
9	Smoke Detector	L1D18	notifier	FSP-851	Hall by rm 158	Passed		8/14/2020 12:46 PM
10	Smoke Detector	L1D19	notifier	FSP-851	149	Passed		8/14/2020 12:46 PM
11	Heat Detector	L1D20	Notifier	FDX-551	Rm 158	Passed		8/14/2020 12:46 PM
12	Smoke Detector	L1D26	notifier	FSP-851	Hall by reception	Passed		8/14/2020 12:45 PM
13	Smoke Detector	L1D27	notifier	FSP-851	Hall by Lobby	Passed		8/14/2020 12:45 PM
14	Smoke Detector	L1D28	notifier	FSP-851	Hall by 105	Passed		8/14/2020 12:45 PM
15	Smoke Detector	L1D30	notifier	FSP-851	Hall by 102	Passed		8/14/2020 12:44 PM
16	Smoke Detector	L1D34	notifier	FSP-851	Dental Hallway	Passed		8/14/2020 12:44 PM
17	Smoke Detector	L1D36	notifier	FSP-851	reception Hallway	Passed		8/14/2020 12:43 PM
18	Smoke Detector	L1D39	notifier	FSP-851	Hall by North Exit	Passed		8/14/2020 12:43 PM
19	Smoke Detector	L1D40	notifier	FSP-851	Hall by Rm 128	Passed		8/14/2020 12:42 PM
20	Smoke Detector	L1D41	notifier	FSP-851	Hall by Rm 161	Passed		8/14/2020 12:42 PM
21	Smoke Detector	L1D43	notifier	FSP-851	Hall by Rm 165	Passed		8/14/2020 12:39 PM
22	Smoke Detector	L1D46	notifier	FSP-851	Hall by Rm 167	Passed		8/14/2020 12:38 PM
23	Heat Detector	L1D47	Notifier	FDX-551	Janitor closet	Passed		8/14/2020 12:38 PM
24	Smoke Detector	L1D48	notifier	FSP-851	Hall by Rec storage	Passed		8/14/2020 12:38 PM
25	Manual Pull Station	L1M03	Notifier	BGX-101L	South Exit	Passed		8/14/2020 12:38 PM
26	Manual Pull Station	L1M05	Notifier	BGX-101L	North Exit	Passed		8/14/2020 12:38 PM
27	Manual Pull Station	L1M24	Notifier	BGX-101L	South Exit	Passed		8/14/2020 12:37 PM
28	Manual Pull Station	L1M01	Notifier	BGX-101L	Front Entrance	Passed		8/14/2020 12:37 PM
29	Smoke Detector	L1D25	notifier	FSP-851	elevator lobby	Passed		8/14/2020 12:37 PM
30	Heat Detector	L1D35	Notifier	FDX-551	Dental Exam	Passed		8/14/2020 12:37 PM
31	Manual Pull Station	L1M04	Notifier	BGX-101L	Lobby Exit	Passed		8/14/2020 12:37 PM

2nd Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L2D33	Notifier	FSP-851	Hall by Rm 223	Passed		8/14/2020 12:28 PM
2	Smoke Detector	L2D35	Notifier	FSP-851	Hall by N Fire Doors	Passed		8/14/2020 12:27 PM
3	Smoke Detector	L2D37	Notifier	FSP-851	Hall by Room 216	Passed		8/14/2020 12:27 PM
4	Smoke Detector	L2D38	Notifier	FSP-851	room 222	Passed		8/14/2020 12:26 PM
5	Smoke Detector	L2D39	Notifier	FSP-851	room 204	Passed		8/14/2020 12:26 PM
6	Smoke Detector	L2D40	Notifier	FSP-851	Hall by rm 214	Passed		8/14/2020 12:26 PM
7	Smoke Detector	L2D41	Notifier	FSP-851	Hall by rm 212	Passed		8/14/2020 12:25 PM
8	Smoke Detector	L2D42	Notifier	FSP-851	North stairway	Passed		8/14/2020 12:25 PM
9	Smoke Detector	L2D28	Notifier	FSP-851	Elevator lobby	Passed		8/14/2020 12:25 PM
10	Smoke Detector	L2D31	Notifier	FSP-851	Elevator top of shaft	Passed		8/14/2020 12:25 PM
11	Smoke Detector	L2D32	Notifier	FSP-851	Elevator top of shaft	Passed		8/14/2020 12:24 PM
12	Manual Pull Station	L2M03	Notifier		Tech station	Passed		8/14/2020 12:24 PM
13	Manual Pull Station	L2M05	Notifier		Tech station	Passed		8/14/2020 12:23 PM
14	Heat Detector	L2D02	notifier	FDX-551	Penthouse	Passed		8/14/2020 12:23 PM
15	Heat Detector	L2D44	notifier	FDX-551	Maintenance 236	Passed		8/14/2020 12:23 PM
16	Smoke Detector	L2D03	Notifier	FSP-851	Hall by RM 222	Passed		8/14/2020 12:22 PM
17	Smoke Detector	L2D05	Notifier	FSP-851	RM 295	Passed		8/14/2020 12:21 PM
18	Smoke Detector	L2D09	Notifier	FSP-851	Hall by RM 226	Passed		8/14/2020 12:20 PM
19	Smoke Detector	L2D10	Notifier	FSP-851	Hall by RM 278	Passed		8/14/2020 12:20 PM
20	Smoke Detector	L2D15	Notifier	FSP-851	Hall by RM 287	Passed		8/14/2020 12:19 PM
21	Smoke Detector	L2D16	Notifier	FSP-851	Hall by RM 289	Passed		8/14/2020 12:19 PM
22	Smoke Detector	L2D17	Notifier	FSP-851	RM 265	Passed		8/14/2020 12:18 PM
23	Smoke Detector	L2D19	Notifier	FSP-851	Hall By RM 269	Passed		8/14/2020 12:18 PM
24	Smoke Detector	L2D21	Notifier	FSP-851	Hall By RM 261	Passed		8/14/2020 12:17 PM
25	Smoke Detector	L2D24	Notifier	FSP-851	Hall By RM 260	Passed		8/14/2020 12:17 PM
26	Smoke Detector	L2D25	Notifier	FSP-851	Nurse Station	Passed		8/14/2020 12:16 PM
27	Smoke Detector	L2D27	Notifier	FSP-851	Hall by med room	Passed		8/14/2020 12:15 PM
28	Smoke Detector	L2D43	Notifier	FSP-851	Center Stairway	Passed		8/14/2020 12:15 PM
29	Smoke Detector	L2D46	Notifier	FSP-851	Hall by RM 237	Passed		8/14/2020 12:15 PM
30	Smoke Detector	L2D47	Notifier	FSP-851	Hall by RM 258	Passed		8/14/2020 12:14 PM
31	Smoke Detector	L2D49	Notifier	FSP-851	Hall by RM 256	Passed		8/14/2020 12:14 PM
32	Smoke Detector	L2D50	Notifier	FSP-851	Hall by RM 254	Passed		8/14/2020 12:13 PM
33	Smoke Detector	L2D51	Notifier	FSP-851	South Stairwell	Passed		8/14/2020 12:13 PM
34	Duct Detector	L2D01	Notifier		Penthouse	Passed		8/14/2020 12:08 PM

LOWER LEVEL TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Duct Detector	L1D58	Notifier		Equipment Rm	Passed		8/14/2020 1:08 PM
2	Heat Detector	L1D61	Notifier	FDX-551	Canteen South	Passed		8/14/2020 1:08 PM
3	Heat Detector	L1D63	Notifier	FDX-551	Canteen North	Passed		8/14/2020 1:07 PM
4	Smoke Detector	L1D64	Notifier	SDX-551	Canteen by doors	Passed		8/14/2020 1:07 PM
5	Smoke Detector	L1D65	Notifier	SDX-551	Canteen by doors	Passed		8/14/2020 1:07 PM
6	Smoke Detector	L1D66	Notifier	SDX-551	Kitchen Laundry	Passed		8/14/2020 1:07 PM
7	Duct Detector	L1D67	Notifier		S Mech rm	Passed		8/14/2020 1:07 PM
8	Smoke Detector	L1D69	Notifier	SDX-551	Tunnel Hallway	Passed		8/14/2020 1:06 PM
9	Smoke Detector	L1D73	Notifier	SDX-551	Hall by pool rm	Passed		8/14/2020 1:06 PM
10	Smoke Detector	L1D75	Notifier	SDX-551	Hall by mech rm	Passed		8/14/2020 1:04 PM
11	Smoke Detector	L1D77	Notifier	SDX-551	Hall by north Exit	Passed		8/14/2020 1:04 PM
12	Smoke Detector	L1D79	Notifier	SDX-551	Hall by generator	Passed		8/14/2020 1:04 PM
13	Heat Detector	L1D80	Notifier	FDX-551	generator rm	Passed		8/14/2020 1:04 PM
14	Duct Detector	L1D82	Notifier		AHU 1	Passed		8/14/2020 1:03 PM
15	Duct Detector	L1D87	Notifier		AHU 2	Passed		8/14/2020 1:03 PM
16	Manual Pull Station	L1M06	Notifier	BGX-101L	South Stairs	Passed		8/14/2020 1:03 PM
17	Manual Pull Station	L1M13	Notifier	BGX-101L	Hall by center Stairs	Passed		8/14/2020 1:02 PM
18	Manual Pull Station	L1M14	Notifier	BGX-101L	Mech Equipment Rm	Passed		8/14/2020 1:02 PM
19	Manual Pull Station	L1M17	Notifier	BGX-101L	Generator Rm Hall	Passed		8/14/2020 1:01 PM
20	Manual Pull Station	L1M38	Notifier	BGX-101L	Kitchen E Door	Passed		8/14/2020 1:00 PM
21	Smoke Detector	L1D70	Notifier	SDX-551	basement elevator lobby	Passed		8/14/2020 1:00 PM
22	Heat Detector	L1D91	Notifier	FDX-551	Elevator machine room	Passed		8/14/2020 1:00 PM
23	Heat Detector	L1D92	Notifier	FDX-551	Elevator machine room	Passed		8/14/2020 12:58 PM
24	Heat Detector	L1D93	Notifier	FDX-551	Elevator machine room	Passed		8/14/2020 12:58 PM
25	Smoke Detector	L1D94	Notifier	SDX-551	Elevator machine rm	Passed		8/14/2020 12:57 PM
27	Heat Detector	L1DD84	Notifier	FDX-551	Equipment Maintenance Rm	Passed		8/14/2020 12:56 PM
28	Heat Detector	L1D85	Notifier	FDX-551	Equipment Maintenance	Passed		8/14/2020 12:56 PM
29	Heat Detector	L1D86	Notifier	FDX-551	Equipment Maintenance	Passed		8/14/2020 12:56 PM
30	Duct Detector	L1D83	Notifier		AHU 1 E	Passed		8/14/2020 12:55 PM
31	Heat Detector	L1D80	Notifier	FDX-551	Generator Rm	Passed		8/14/2020 12:55 PM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	2	3
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	2	3

Supercomponent Information	
Type	3 - FACP
Location	1st Floor Front Entrance
Model	AFP-1010
Voltage/Current	120VAC
s/Communication	Yes Passed

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFA72, 2010 Ed.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	02	Maint 108	Passed		8/18/2020 5:54 PM
2	Annuciator	Notifier			Front lobby	Passed		8/18/2020 5:59 PM
3	FACP	Notifier	AFP-1010		Front Entrance	Passed		8/18/2020 5:59 PM

2nd Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L2M06	Maint. rm 209	Passed		8/18/2020 6:00 PM
2	Annuciator	Notifier			tech station	Passed		8/18/2020 6:00 PM

LOWER LEVEL TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	M12	AHU Rm	Passed		8/18/2020 6:03 PM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V8AH			2-21-19	1st Floor Maint 108	Passed	
1	12V8AH			2-21-19	1st Floor Maint 108	Passed	
3	12V26AH	Notifier	AFP-1010	2-21-19	1st Floor Front Entrance	Passed	Left
3	12V26AH	Notifier	AFP-1010	2-21-2019	1st Floor Front Entrance	Passed	Right
1	12V8AH			2-21-2019	2nd Floor Maint. rm 209	Passed	
1	12V8AH			2-21-2019	2nd Floor Maint. rm 209	Passed	
1	12V8AH			2-21-2019	LOWER LEVEL AHU Rm	Passed	
1	12V8AH			2-21-2019	LOWER LEVEL AHU Rm	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1	02	Power Supply	Notifier	FCPS-24	120	Maint 108	1st Floor	Passed	24-5	
2		Annuciator	Notifier			Front lobby	1st Floor	Passed		
3		FACP	Notifier	AFP-1010	120VAC	Front Entrance	1st Floor	Passed		
1	L2M06	Power Supply	Notifier	FCPS-24	120	Maint. rm 209	2nd Floor	Passed		
2		Annuciator	Notifier			tech station	2nd Floor	Passed		
1	M12	Power Supply	Notifier	FCPS-24	120	AHU Rm	LOWER LEVEL	Passed		

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP19 Shutdown 2020 Annual Inspection Summary

Result Totals

Devices	Fan	Relays
Passed	5	24
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	5	24

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 126 E.	Passed		8/18/2020 5:37 PM
2	Relays				Door Holder 126 W.	Passed		8/18/2020 5:41 PM
3	Relays				Door Holder 105 E.	Passed		8/18/2020 5:40 PM
4	Relays				Door Holder 105 W.	Passed		8/18/2020 5:40 PM
5	Relays				Door Holder 148 N.	Passed		8/18/2020 5:39 PM
6	Relays				Door Holder 148 S.	Passed		8/18/2020 5:39 PM
7	Relays				Door Holder 154 N.	Passed		8/18/2020 5:39 PM
8	Relays				Door Holder 154 S.	Passed		8/18/2020 5:38 PM
9	Relays				Door Holder Chapel RM 140	Passed		8/18/2020 5:38 PM
10	Relays	L1M11			Door Holder module	Passed		8/18/2020 5:38 PM
11	Relays	L1M09			Smoke relay 1st damper	Passed		8/18/2020 5:37 PM

2nd Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder Dining RM 212	Passed		8/18/2020 5:46 PM
2	Relays				Door Holder 217 N.	Passed		8/18/2020 5:45 PM
3	Relays				Door Holder 217 S.	Passed		8/18/2020 5:45 PM
4	Relays				Door Holder 207 N.	Passed		8/18/2020 5:45 PM
5	Relays				Door Holder 207 S.	Passed		8/18/2020 5:44 PM
6	Relays				Door Holder 238 E.	Passed		8/18/2020 5:44 PM
7	Relays				Door Holder 238 W.	Passed		8/18/2020 5:44 PM
8	Relays				Door Holder 239 E.	Passed		8/18/2020 5:43 PM
9	Relays				Door Holder 239 W.	Passed		8/18/2020 5:43 PM
10	Relays				Door Holder 227 Corridor	Passed		8/18/2020 5:43 PM
11	Relays				Door Holder 249 Corridor	Passed		8/18/2020 5:42 PM
12	Fan	L2M01			penthouse fan	Passed		8/18/2020 5:42 PM
13	Relays	L2M01			Smoke relay 2nd damper	Passed		8/18/2020 5:42 PM

LOWER LEVEL TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 005	Passed		8/18/2020 5:46 PM
2	Fan	L1M07			Canteen fan	Passed		8/18/2020 5:46 PM
3	Fan	L1M15			AHU 1	Passed		8/18/2020 5:47 PM
4	Fan	L1M16			AHU 2	Passed		8/18/2020 5:47 PM
5	Fan	L1M22			AHU	Passed		8/18/2020 5:48 PM

Supercomponent Results

Number	Type	Zone/address	Make	Model	Location	Layout	Result	Comments
12	Fan	L2M01			penthouse fan	2nd Floor	Passed	
2	Fan	L1M07			Canteen fan	LOWER LEVEL	Passed	
3	Fan	L1M15			AHU 1	LOWER LEVEL	Passed	
4	Fan	L1M16			AHU 2	LOWER LEVEL	Passed	
5	Fan	L1M22			AHU	LOWER LEVEL	Passed	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Bell	Horn	Horn Strobe	Strobe
Passed	18	1	8	30
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	18	1	8	30

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Outside 110	Passed		8/14/2020 1:35 PM
2	Strobe		SS24110ADA	Outside 110	Passed		8/14/2020 1:35 PM
3	Strobe		SS24110ADA	126C	Passed		8/14/2020 1:34 PM
4	Strobe		SS24110ADA	126B	Passed		8/14/2020 1:34 PM
5	Strobe		SS24110ADA	outside 150	Passed		8/14/2020 1:34 PM
6	Bell		KMS-8-24VDC/P	Outside 150	Passed		8/14/2020 1:34 PM
7	Bell		KMS-8-24VDC/P	Outside 138	Passed		8/14/2020 1:33 PM
8	Strobe		SS24110ADA	outside 138	Passed		8/14/2020 1:27 PM
9	Strobe		SS24110ADA	outside 140	Passed		8/14/2020 1:27 PM
10	Bell		KMS-8-24VDC/P	Outside 140	Passed		8/14/2020 1:27 PM
11	Bell		KMS-8-24VDC/P	Outside 155	Passed		8/14/2020 1:27 PM
12	Strobe		SS24110ADA	outside 155	Passed		8/14/2020 1:26 PM
13	Bell		KMS-8-24VDC/P	Outside 160	Passed		8/14/2020 1:26 PM
14	Strobe		SS24110ADA	outside 160	Passed		8/14/2020 1:26 PM
15	Strobe			outside 130	Passed		8/14/2020 1:26 PM
16	Bell		KMS-8-24VDC/P	Outside 130	Passed		8/14/2020 1:26 PM

2nd Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Penthouse	Passed		8/14/2020 1:22 PM
2	Strobe		SS24110ADA	Penthouse	Passed		8/14/2020 1:22 PM
3	Bell		KMS-8-24VDC/P	Outside 235	Passed		8/14/2020 1:21 PM
4	Strobe		SS24110ADA	Outside 235	Passed		8/14/2020 1:21 PM
5	Bell		KMS-8-24VDC/P	Outside 233	Passed		8/14/2020 1:21 PM
6	Strobe		SS24110ADA	Outside 233	Passed		8/14/2020 1:21 PM
7	Bell		KMS-8-24VDC/P	Outside 210	Passed		8/14/2020 1:21 PM
8	Strobe		SS24110ADA	Outside 210	Passed		8/14/2020 1:21 PM
9	Bell		KMS-8-24VDC/P	Outside 203	Passed		8/14/2020 1:15 PM
10	Strobe		SS24110ADA	Outside 203	Passed		8/14/2020 1:15 PM
11	Horn			Tech Station	Passed		8/14/2020 1:15 PM
12	Strobe		SS24110ADA	tech station	Passed		8/14/2020 1:14 PM
13	Bell		KMS-8-24VDC/P	Outside 213	Passed		8/14/2020 1:14 PM
14	Strobe		SS24110ADA	outside 213	Passed		8/14/2020 1:13 PM
15	Bell		KMS-8-24VDC/P	Rm 210 kitchen	Passed		8/14/2020 1:13 PM
16	Strobe		SS24110ADA	Rm 210 kitchen	Passed		8/14/2020 1:12 PM
17	Strobe		SS24110ADA	Shower 223A	Passed		8/14/2020 1:12 PM
18	Strobe		SS24110ADA	Shower 223B	Passed		8/14/2020 1:11 PM
19	Strobe		SS24110ADA	Shower 223	Passed		8/14/2020 1:11 PM

LOWER LEVEL TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Elevator Lobby	Passed		8/14/2020 1:55 PM
2	Strobe		SS24110ADA	Elevator Lobby	Passed		8/14/2020 1:54 PM
3	Bell		KMS-8-24VDC/P	Outside 002	Passed		8/14/2020 1:54 PM
4	Strobe		SS24110ADA	outside 002	Passed		8/14/2020 1:54 PM
5	Horn Strobe		P2W	Outside Canteen	Passed		8/14/2020 1:54 PM
6	Horn Strobe		P2W	mech rm	Passed		8/14/2020 1:54 PM
7	Horn Strobe		P2W	Kitchen offices	Passed		8/14/2020 1:53 PM
8	Strobe		SCW	Kitchen offices RR	Passed	Ceiling	8/14/2020 1:53 PM
9	Strobe		SCW	Kitchen offices RR	Passed	Ceiling	8/14/2020 1:53 PM
10	Horn Strobe		P2W	Kitchen	Passed		8/14/2020 1:53 PM
11	Horn Strobe		P2W	Kitchen	Passed		8/14/2020 1:53 PM
12	Horn Strobe		P2W	Kitchen a Dock	Passed		8/14/2020 1:52 PM
13	Horn Strobe		P2W	Dry Storage	Passed		8/14/2020 1:52 PM
14	Horn Strobe		P2W	Dish wash Area	Passed		8/14/2020 1:51 PM
15	Strobe		SW	kitchen fridge Area	Passed		8/14/2020 1:51 PM
16	Strobe		SS24110ADA	RM 011	Passed		8/14/2020 1:51 PM
17	Strobe		SS24110ADA	RM 012	Passed		8/14/2020 1:43 PM
18	Strobe		SS24110ADA	Outside Rm 13	Passed		8/14/2020 1:43 PM
19	Bell		KMS-8-24VDC/P	Outside Rm 13	Passed		8/14/2020 1:43 PM
20	Strobe		SS24110ADA	RM 014	Passed		8/14/2020 1:43 PM
21	Bell		KMS-8-24VDC/P	AHU Rm	Passed		8/14/2020 1:42 PM
22	Strobe		SS24110ADA	AHU Rm	Passed		8/14/2020 1:42 PM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL.
Power Plant, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

Address: 801 West Prospector PL.
Power Plant, Lincoln, NE 68522

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Heat Detector	Manual Pull Station
Passed	25	3
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	25	3

This inspection was performed on 8/21/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Manual Pull Station	L1M02	Notifier	BGX-101L	East Exit	Passed		8/21/2020 11:42 AM
2	Manual Pull Station	L1M03	Notifier	BGX-101L	South Exit	Passed		8/21/2020 11:42 AM
3	Heat Detector	L1D01	Notifier	FDX-511	Southwest Heat Det.	Passed		8/21/2020 11:42 AM
4	Heat Detector	L1D02	Notifier	FDX-511	SouthCenter Heat Det.	Passed		8/21/2020 11:42 AM
5	Heat Detector	L1D02	Notifier	FDX-511	SouthCenter Heat Det.	Passed		8/21/2020 11:42 AM
6	Heat Detector	L1D03	Notifier	FDX-511	Southeast Heat Det.	Passed		8/21/2020 11:42 AM
7	Heat Detector	L1D04	Notifier	FDX-511	Northeast Heat Det.	Passed		8/21/2020 11:42 AM
8	Heat Detector	L1D06	Notifier	FDX-511	Northwest Heat Det.	Passed		8/21/2020 11:42 AM
9	Heat Detector	L1D07	Notifier	FDX-511	Southwest Heat Det.	Passed		8/21/2020 11:42 AM
10	Heat Detector	L1D08	Notifier	FDX-511	Northwest Heat Det.	Passed		8/21/2020 11:42 AM
11	Heat Detector	L1D09	Notifier	FDX-511	North Center Heat Det.	Passed		8/21/2020 11:41 AM
12	Heat Detector	L1D10	Notifier	FDX-511	South Center Heat Det.	Passed		8/21/2020 11:41 AM
13	Heat Detector	L1D11	Notifier	FDX-511	NorthEast Heat Det.	Passed		8/21/2020 11:41 AM
14	Heat Detector	L1D12	Notifier	FDX-511	SouthEast Heat Det.	Passed		8/21/2020 11:41 AM
15	Heat Detector	L1D13	Notifier	FDX-511	Boiler room office	Passed		8/21/2020 11:41 AM
16	Heat Detector	L1M25	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:41 AM
17	Manual Pull Station	L1M01	Notifier	BGX-101L	South Exit	Passed		8/21/2020 11:41 AM
18	Heat Detector	L1M14	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:41 AM
19	Heat Detector	L1M15	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:36 AM
20	Heat Detector	L1M16	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
21	Heat Detector	L1M17	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:36 AM
22	Heat Detector	L1M18	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
23	Heat Detector	L1M19	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
24	Heat Detector	L1M20	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:41 AM
25	Heat Detector	L1M21	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
26	Heat Detector	L1M22	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
27	Heat Detector	L1M23	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM
28	Heat Detector	L1M24	Notifier		Boiler Area	Passed	Thermo tech	8/21/2020 11:35 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL.
Power Plant, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

Address: 801 West Prospector PL.
Power Plant, Lincoln, NE 68522

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Bell	Horn	Strobe
Passed	2	1	2
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	2	1	2

This inspection was performed on 8/21/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Across from pop machine	Passed		8/21/2020 11:56 AM
2	Strobe		SS24110ADA	Across from pop machine	Passed		8/21/2020 11:57 AM
3	Strobe		SS24110ADA	Boiler Room Left of panel	Passed		8/21/2020 11:56 AM
4	Bell		KMS-8-24VDC/P	Left of main panel	Passed		8/21/2020 11:56 AM
5	Horn			Above FACP	Passed		8/21/2020 11:56 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL.
Power Plant, Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

Address: 801 West Prospector PL.
Power Plant, Lincoln, NE 68522

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Power Supply
Passed	1
Mitigated	-
New - Passed	-
Failed	-
Removed	-
Not Inspected	-
Total	1

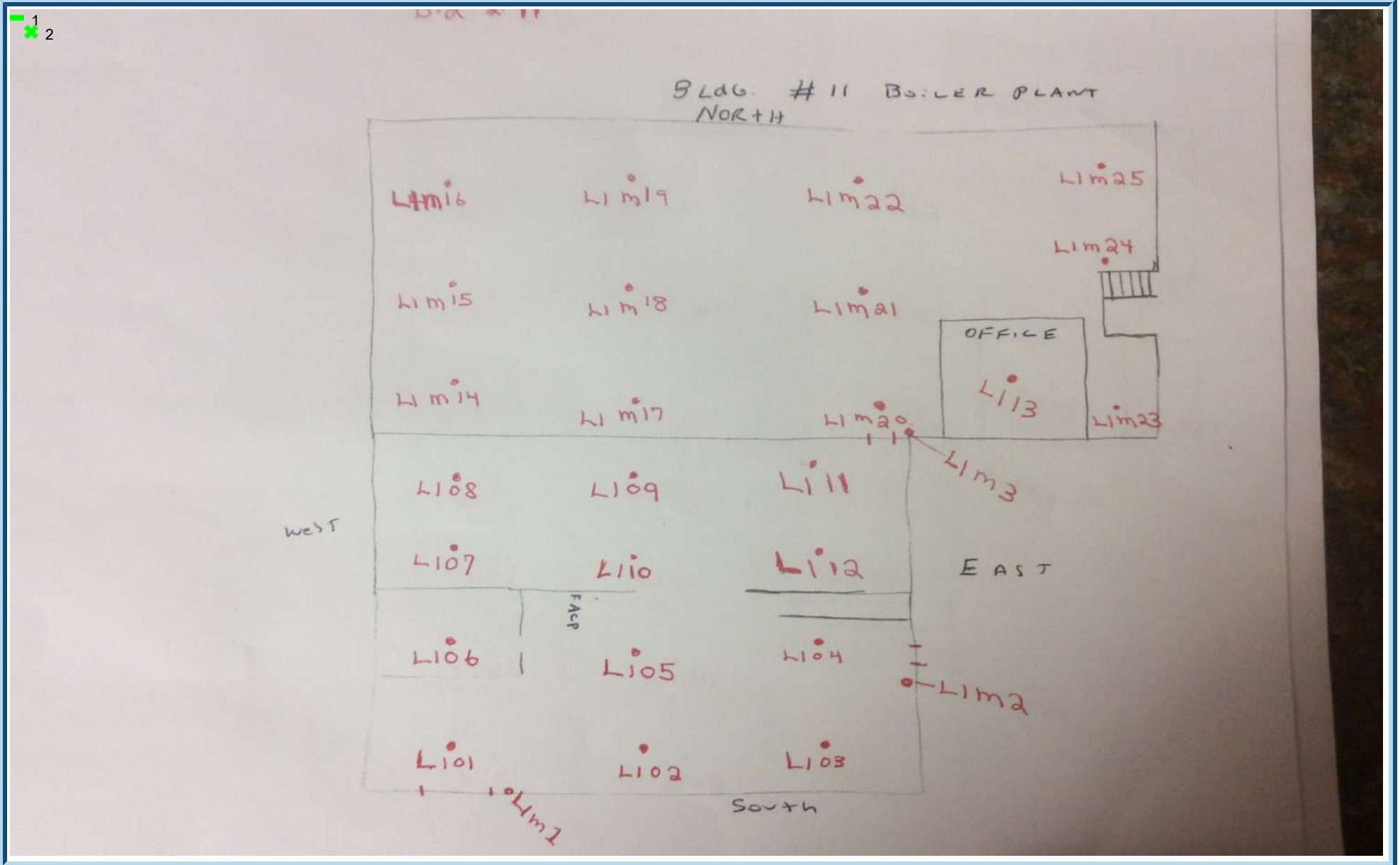
Supercomponent Information	
Type	1 - FACP
Location	1st Floor Boiler Room
Model	AFP1010
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/21/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP1010		Boiler Room	Passed		8/21/2020 11:57 AM
2	Power Supply	MPS-24A	Notifier		Panel power supply	Passed	Possibly weak charger or charger going bad	8/21/2020 11:57 AM



FACP

Power Supply

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH	Notifier	AFP1010	4-16-2019	1st Floor Boiler Room	Passed	Right
1	12V26AH	Notifier	AFP1010	4-16-2019	1st Floor Boiler Room	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	AFP1010	120	Boiler Room	1st Floor	Passed	24 HRs	
2		Power Supply	MPS-24A	Notifier	110	Panel power supply	1st Floor	Passed		Possibly weak charger or charger going bad

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 14 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2020 Annual Inspection Summary

Result Totals

Devices	Duct Detector	Heat Detector	Kitchen Hood Monitor	Manual Pull Station	Monitor Module	Smoke Detector
Passed	2	130	1	19	4	138
Mitigated	-	-	-	-	-	-
New - Passed	-	-	-	-	-	-
Failed	-	-	-	-	-	-
Removed	-	-	-	-	-	-
Not Inspected	-	-	-	-	-	-
Total	2	130	1	19	4	138

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

GROUND FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D71	Notifier	SDX-551	Lobby Maintenance	Passed		8/19/2020 6:25 PM
2	Heat Detector	L1D40	Notifier	FDX-551	Asbestos Room	Passed		8/19/2020 6:24 PM
3	Heat Detector	L1D42	Notifier	FDX-551	Housekeeping Office	Passed		8/19/2020 6:25 PM
4	Heat Detector	L1D43	Notifier	FDX-551	Housekeeping Office	Passed		8/19/2020 6:23 PM
5	Smoke Detector	L1D44	Notifier	SDX-551	Hall By O.T. Stairs	Passed		8/19/2020 6:23 PM
6	Smoke Detector	L1D45	Notifier	SDX-551	Hall By House Keeping	Passed		8/19/2020 6:23 PM
7	Smoke Detector	L1D47	Notifier	SDX-551	Hall By O.T.	Passed		8/19/2020 6:22 PM
8	Smoke Detector	L1D48	Notifier	SDX-551	Hall By O.T.	Passed		8/19/2020 6:22 PM
9	Smoke Detector	L1D49	Notifier	SDX-551	Hall By O.T.	Passed		8/19/2020 6:21 PM
10	Heat Detector	L1D50	Notifier	FDX-551	O.T. Room	Passed		8/19/2020 6:21 PM
11	Heat Detector	L1D51	Notifier	FDX-551	O.T. Room	Passed		8/19/2020 6:21 PM
12	Heat Detector	L1D52	Notifier	FDX-551	O.T. Small Storage	Passed		8/19/2020 6:20 PM
13	Heat Detector	L1D53	Notifier	FDX-551	O.T. Storage	Passed		8/19/2020 6:20 PM
14	Smoke Detector	L1D55	Notifier	SDX-551	West Hall	Passed		8/19/2020 6:19 PM
15	Heat Detector	L1D57	Notifier	FDX-551	O.T. RR Storage	Passed		8/19/2020 6:19 PM
16	Smoke Detector	L1D58	Notifier	SDX-551	West Hall	Passed		8/19/2020 6:18 PM
17	Heat Detector	L1D59	Notifier	FDX-551	Patient Storage	Passed		8/19/2020 6:18 PM
18	Smoke Detector	L1D60	Notifier	SDX-551	Hall By Engineer Files	Passed		8/19/2020 6:18 PM
19	Heat Detector	L1D61	Notifier	FDX-551	RM 022	Passed		8/19/2020 6:17 PM
20	Heat Detector	L1D62	Notifier	FDX-551	Engineering Copy Room	Passed		8/19/2020 6:17 PM
21	Smoke Detector	L1D63	Notifier	SDX-551	Hall By Architecture	Passed		8/19/2020 6:16 PM
22	Smoke Detector	L1D64	Notifier	SDX-551	Hall By Engineer	Passed		8/19/2020 6:16 PM
23	Heat Detector	L1D65	Notifier	FDX-551	Pipe Chase	Passed		8/19/2020 6:15 PM
24	Smoke Detector	L1D66	Notifier	SDX-551	Engineering Sec. Office	Passed		8/19/2020 6:15 PM
25	Smoke Detector	L1D67	Notifier	SDX-551	Hall By Women's RR	Passed		8/19/2020 6:15 PM
26	Heat Detector	L1D69	Notifier	FDX-551	Mech Equipment Room	Passed		8/19/2020 6:13 PM
27	Smoke Detector	L1D72	Notifier	SDX-551	Maintenance Break Room	Passed		8/19/2020 6:13 PM
28	Duct Detector	L1D80	Innovair/Notifier	SDX-551	Mech Rm 15	Passed		8/19/2020 6:12 PM
29	Manual Pull Station	L1M10	Notifier	BGX-101L	O.T. Stairs	Passed		8/19/2020 6:12 PM
30	Manual Pull Station	L1M12	Notifier	BGX-101L	Exit By Women's RR	Passed		8/19/2020 6:11 PM
31	Manual Pull Station	L1M14	Notifier	BGX-101L	North Exit	Passed		8/19/2020 6:11 PM
32	Heat Detector	L1D39	Notifier	FDX-551	Main Electrical RM	Passed		8/19/2020 6:11 PM
33	Smoke Detector	L1D46	Notifier	SDX-551	Hall By House Keeping	Passed		8/19/2020 6:10 PM
34	Manual Pull Station	L1M05	Notifier	BGX-101L	Center Stairs Exit	Passed		8/19/2020 6:10 PM
35	Heat Detector	L1D41	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/19/2020 6:09 PM
36	Heat Detector	L1D01	Notifier	FDX-551	Exercise RM	Passed		8/19/2020 6:09 PM
37	Heat Detector	L1D02	Notifier	FDX-551	Exercise RM	Passed		8/19/2020 6:09 PM
38	Smoke Detector	L1D03	Notifier	SDX-551	North Hall	Passed		8/19/2020 6:08 PM
39	Heat Detector	L1D05	Notifier	FDX-551	Women's Shower	Passed		8/19/2020 6:08 PM
40	Heat Detector	L1D06	Notifier	FDX-551	Dressing Room	Passed		8/19/2020 6:07 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L1D07	Notifier	FDX-551	Maintenance Storage	Passed		8/19/2020 6:07 PM
42	Heat Detector	L1D08	Notifier	FDX-551	Contractor Storage	Passed		8/19/2020 6:06 PM
43	Smoke Detector	L1D09	Notifier	SDX-551	Mini Gym	Passed		8/19/2020 6:06 PM
44	Smoke Detector	L1D10	Notifier	SDX-551	Mini Gym	Passed		8/19/2020 6:06 PM
45	Smoke Detector	L1D11	Notifier	SDX-551	Mini Gym	Passed		8/19/2020 6:05 PM
46	Smoke Detector	L1D12	Notifier	SDX-551	East Hall	Passed		8/19/2020 6:05 PM
47	Heat Detector	L1D14	Notifier	FDX-551	Staff Restroom	Passed		8/19/2020 6:04 PM
48	Heat Detector	L1D15	Notifier	FDX-551	East Game Room	Passed		8/19/2020 6:04 PM
49	Heat Detector	L1D17	Notifier	FDX-551	East Game Room	Passed		8/19/2020 6:04 PM
50	Smoke Detector	L1D18	Notifier	SDX-551	East Hall	Passed		8/19/2020 6:03 PM
51	Heat Detector	L1D19	Notifier	FDX-551	East Hall	Passed		8/19/2020 6:03 PM
52	Heat Detector	L1D20	Notifier	FDX-551	East Game Room	Passed		8/19/2020 6:02 PM
53	Heat Detector	L1D21	Notifier	FDX-551	East Hall	Passed		8/19/2020 6:02 PM
54	Heat Detector	L1D22	Notifier	FDX-551	Student Office	Passed		8/19/2020 6:02 PM
55	Heat Detector	L1D23	Notifier	FDX-551	East Group RM	Passed		8/19/2020 6:01 PM
56	Heat Detector	L1D24	Notifier	FDX-551	West Group RM	Passed		8/19/2020 6:00 PM
57	Heat Detector	L1D25	Notifier	FDX-551	Maintenance Office	Passed		8/19/2020 6:00 PM
58	Heat Detector	L1D26	Notifier	FDX-551	Laundry Dryer RM	Passed		8/19/2020 5:59 PM
59	Smoke Detector	L1D27	Notifier	SDX-551	Hall by sewing	Passed		8/19/2020 5:59 PM
60	Heat Detector	L1D28	Notifier	FDX-551	Sewing Room	Passed		8/19/2020 5:59 PM
61	Smoke Detector	L1D29	Notifier	SDX-551	North Tunnel	Passed		8/19/2020 5:58 PM
62	Smoke Detector	L1D31	Notifier	SDX-551	Hall by Converter Rm	Passed		8/19/2020 5:58 PM
63	Heat Detector	L1D32	Notifier	FDX-551	Chiller Room	Passed		8/19/2020 5:57 PM
64	Smoke Detector	L1D33	Notifier	SDX-551	Hall by Laundry	Passed		8/19/2020 5:57 PM
65	Heat Detector	L1D34	Notifier	FDX-551	Laundry Wash Room	Passed		8/19/2020 5:57 PM
66	Heat Detector	L1D35	Notifier	FDX-551	Center Hall	Passed		8/19/2020 5:56 PM
67	Smoke Detector	L1D36	Notifier	SDX-551	Hall by telephone Rm	Passed		8/19/2020 5:56 PM
68	Smoke Detector	L1D37	Notifier	SDX-551	Hall by telephone Rm	Passed		8/19/2020 5:55 PM
69	Heat Detector	L1D41	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/19/2020 5:55 PM
70	Heat Detector	L1D76	Notifier	FDX-551	E Storage by S Tunnel	Passed		8/19/2020 5:54 PM
71	Heat Detector	L1D77	Notifier	FDX-551	W Storage by S Tunnel	Passed		8/19/2020 5:54 PM
72	Smoke Detector	L1D78	Notifier	SDX-551	South Tunnel Doors	Passed		8/19/2020 5:54 PM
73	Smoke Detector	L1D79	Notifier	SDX-551	South Tunnel Doors	Passed		8/19/2020 5:53 PM
74	Duct Detector	L1D81	Innovair		Mech Rm 65	Passed		8/19/2020 5:51 PM
75	Manual Pull Station	L1M01	Notifier	BGX-101L	North East Exit	Passed		8/19/2020 5:50 PM
76	Manual Pull Station	L1M02	Notifier	BGX-101L	North Hall Exit	Passed		8/19/2020 5:49 PM
77	Manual Pull Station	L1M03	Notifier	BGX-101L	East Exit	Passed		8/19/2020 5:47 PM
78	Smoke Detector	L1D16	Notifier	SDX-551	East Game room	Passed		8/19/2020 5:46 PM
79	Manual Pull Station	L1M06	Notifier	BGX-101L	North Main Exit	Passed		8/19/2020 5:37 PM
80	Monitor Module	L1M04	Notifier		Restroom 061	Passed	Probe Style Heat	8/19/2020 5:37 PM
81	Monitor Module	L1M20	Notifier		Water heater Rm 042	Passed	Probe Style Heat Detector	8/19/2020 5:36 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Monitor Module	L1M19	Notifier		Return Tank Rm 045	Passed	Probe Style Heat Detector	8/19/2020 5:36 PM
83	Monitor Module	L1M18	Notifier		Converter Room 049	Passed	Probe Style Heat Detector	8/19/2020 5:35 PM
84	Smoke Detector	L1D82	Notifier	FSP-851	Elevator Equipment Rm	Passed		8/19/2020 5:35 PM
85	Heat Detector	L1D83	Notifier	FDX-551	Elevator Equip Rm	Passed		8/19/2020 5:34 PM
86	Smoke Detector	L1D38	Notifier	SDX-551	Elevator Lobby	Passed		8/19/2020 5:34 PM
87	Smoke Detector	L1D73	Notifier	SDX-551	Elevator Lobby street lvl	Passed		8/19/2020 5:33 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module | Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

GROUND FLOOR

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Heat Detector	L2D60	Notifier	FDX-551	Room 108	Passed		8/19/2020 4:21 PM
2	Heat Detector	L2D45	Notifier	FDX-551	Room 148	Passed		8/19/2020 4:21 PM
3	Heat Detector	L2D46	Notifier	FDX-551	Room 147A	Passed		8/19/2020 4:21 PM
4	Heat Detector	L2D47	Notifier	FDX-551	Room 147B	Passed		8/19/2020 4:20 PM
5	Smoke Detector	L2D48	Notifier	SDX-551	Hall By West Tech St	Passed		8/19/2020 4:20 PM
6	Smoke Detector	L2D49	Notifier	SDX-551	Hall By Room124	Passed		8/19/2020 4:19 PM
7	Smoke Detector	L2D50	Notifier	SDX-551	Hall By West Tech St	Passed		8/19/2020 4:19 PM
8	Smoke Detector	L2D51	Notifier	SDX-551	Hall By Rm 123	Passed		8/19/2020 4:18 PM
9	Smoke Detector	L2D52	Notifier	SDX-551	Hall By Rm 113	Passed		8/19/2020 4:18 PM
10	Heat Detector	L2D53	Notifier	FDX-551	Room 113	Passed		8/19/2020 4:18 PM
11	Smoke Detector	L2D55	Notifier	SDX-551	Hall By Rm 119	Passed		8/19/2020 4:17 PM
12	Smoke Detector	L2D56	Notifier	SDX-551	Hall By Rm 117	Passed		8/19/2020 4:17 PM
13	Heat Detector	L2D57	Notifier	FDX-551	Room 109	Passed		8/19/2020 4:16 PM
14	Heat Detector	L2D58	Notifier	FDX-551	Room 102	Passed		8/19/2020 4:16 PM
15	Smoke Detector	L2D59	Notifier	SDX-551	Hall By Rm 106	Passed		8/19/2020 4:15 PM
16	Heat Detector	L2D60	Notifier	FDX-551	Room 108	Passed		8/19/2020 4:15 PM
17	Heat Detector	L2D61	Notifier	FDX-551	Room 104	Passed		8/19/2020 4:15 PM
18	Smoke Detector	L2D62	Notifier	SDX-551	Rm 122	Passed		8/19/2020 4:14 PM
19	Smoke Detector	L2D63	Notifier	SDX-551	Rm 123	Passed		8/19/2020 4:14 PM
20	Smoke Detector	L2D64	Notifier	SDX-551	Rm 125	Passed		8/19/2020 4:13 PM
21	Heat Detector	L2D88	Notifier	FDX-551	Room 112	Passed		8/19/2020 4:13 PM
22	Manual Pull Station	L2M06	Notifier	nag-12lx	West tech st	Passed		8/19/2020 4:12 PM
23	Heat Detector	L2D44	Notifier	FDX-551	Room 126	Passed		8/19/2020 4:12 PM
24	Heat Detector	L2D41	Notifier	FDX-551	Room 151	Passed		8/19/2020 4:11 PM
25	Heat Detector	L2D42	Notifier	FDX-551	Room 149	Passed		8/19/2020 4:08 PM
26	Heat Detector	L2D40	Notifier	FDX-551	Room 127	Passed		8/19/2020 4:07 PM
27	Smoke Detector	L2D39	Notifier	SDX-551	Hall by rm 127	Passed		8/19/2020 4:07 PM
28	Smoke Detector	L2D34	Notifier	SDX-551	Hall by rm 157	Passed		8/19/2020 4:06 PM
29	Smoke Detector	L2D38	Notifier	SDX-551	top of O.T. Stairs	Passed		8/19/2020 4:06 PM
30	Smoke Detector	L2D36	Notifier	SDX-551	Hall by Rm 154	Passed		8/19/2020 4:05 PM
31	Heat Detector	L2D35	Notifier	FDX-551	Hall by rm 131	Passed		8/19/2020 4:05 PM
32	Heat Detector	L2D37	Notifier	FDX-551	Room 128	Passed		8/19/2020 4:04 PM
33	Smoke Detector	L2D33	Notifier	SDX-551	Hall by south Exit	Passed		8/19/2020 4:04 PM
34	Smoke Detector	L2D30	Notifier	SDX-551	Rm 133	Passed		8/19/2020 4:03 PM
35	Smoke Detector	L2D26	Notifier	SDX-551	Hall by Rm 153	Passed		8/19/2020 4:03 PM
36	Heat Detector	L2D27	Notifier	FDX-551	Room 163	Passed		8/19/2020 4:02 PM
37	Smoke Detector	L2D28	Notifier	SDX-551	Rm 162	Passed		8/19/2020 4:02 PM
38	Heat Detector	L2D29	Notifier	FDX-551	Room 134	Passed		8/19/2020 4:01 PM
39	Smoke Detector	L2D25	Notifier	SDX-551	Hall by Rm 137	Passed		8/19/2020 4:01 PM
40	Smoke Detector	L2D24	Notifier	SDX-551	Hall by Rm 138	Passed		8/19/2020 4:00 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L2D22	Notifier	FDX-551	Room 167	Passed		8/18/2020 6:59 PM
42	Heat Detector	L2D23	Notifier	FDX-551	kitchen ice machine	Passed		8/18/2020 6:59 PM
43	Heat Detector	L2D20	Notifier	FDX-551	Room 166	Passed		8/18/2020 6:58 PM
44	Heat Detector	L2D21	Notifier	FDX-551	Elec Equip Rm kitchen	Passed		8/18/2020 6:58 PM
45	Heat Detector	L2D19	Notifier	FDX-551	Dining Room 168	Passed		8/18/2020 6:57 PM
46	Heat Detector	L2D18	Notifier	FDX-551	Room 169	Passed		8/18/2020 6:57 PM
47	Heat Detector	L2D17	Notifier	FDX-551	Room 170	Passed		8/18/2020 6:55 PM
48	Smoke Detector	L2D16	Notifier	SDX-551	Hall by Rm 139	Passed		8/18/2020 6:56 PM
49	Manual Pull Station	L2M03	Notifier	nag-12lx	east tech station	Passed		8/18/2020 6:50 PM
50	Smoke Detector	L2D11	Notifier	SDX-551	Hall by East Tech	Passed		8/18/2020 6:49 PM
51	Heat Detector	L2D14	Notifier	FDX-551	Room 173A	Passed		8/18/2020 6:49 PM
52	Smoke Detector	L2D12	Notifier	SDX-551	Hall by East Tech	Passed		8/18/2020 6:48 PM
53	Heat Detector	L2D15	Notifier	FDX-551	Room 173	Passed		8/18/2020 6:48 PM
54	Smoke Detector	L2D13	Notifier	SDX-551	Hall by Rm 141	Passed		8/18/2020 6:47 PM
55	Smoke Detector	L2D65	Notifier	FSP-851	Rm 175	Passed		8/18/2020 6:47 PM
56	Smoke Detector	L2D66	Notifier	FSP-851	Rm 138 Closet	Passed		8/18/2020 6:47 PM
57	Smoke Detector	L2D09	Notifier	SDX-551	Hall by Showers	Passed		8/18/2020 6:46 PM
58	Heat Detector	L2D10	Notifier	FDX-551	Room 177	Passed		8/18/2020 6:46 PM
59	Heat Detector	L2D87	Notifier	FDX-551	Room 178	Passed		8/18/2020 6:45 PM
60	Heat Detector	L2D07	Notifier	FDX-551	Room 179	Passed		8/18/2020 6:45 PM
61	Smoke Detector	L2D06	Notifier	SDX-551	Hall by Rm 189	Passed		8/18/2020 6:45 PM
62	Smoke Detector	L2D05	Notifier	SDX-551	Rm 182	Passed		8/18/2020 6:44 PM
63	Heat Detector	L2D04	Notifier	FDX-551	Room 183	Passed		8/18/2020 6:44 PM
64	Smoke Detector	L2D03	Notifier	SDX-551	Hall by North Stairs	Passed		8/18/2020 6:43 PM
65	Smoke Detector	L2D02	Notifier	SDX-551	Hall by Rm 192	Passed		8/18/2020 6:43 PM
66	Smoke Detector	L2D01	Notifier	SDX-551	Rm 192	Passed		8/18/2020 6:43 PM
67	Smoke Detector	L2D32	Notifier	SDX-551	Elevator Lobby	Passed		8/18/2020 6:42 PM
68	Smoke Detector	L2D31	Notifier	SDX-551	Elevator Lobby Hall	Passed		8/18/2020 6:42 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module
Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D57	Notifier	FSP-851	Hall outside Day Room	Passed		8/19/2020 4:54 PM
2	Heat Detector	L3D58	Notifier	FST-852	West Storage	Passed		8/19/2020 4:53 PM
3	Smoke Detector	L3D56	Notifier	FSP-851	Hall outside rm 293A	Passed		8/19/2020 4:53 PM
4	Smoke Detector	L3D54	Notifier	FSP-851	Hall outside rm 294	Passed		8/19/2020 4:53 PM
5	Heat Detector	L3D55	Notifier	FST-852	Rm 294	Passed		8/19/2020 4:52 PM
6	Smoke Detector	L3D53	Notifier	FSP-851	Hall outside rm 288A	Passed		8/19/2020 4:52 PM
7	Smoke Detector	L3D52	Notifier	FSP-851	Hall outside rm 282A	Passed		8/19/2020 4:51 PM
8	Smoke Detector	L3D50	Notifier	FSP-851	Nurse Station	Passed		8/19/2020 4:51 PM
9	Manual Pull Station	L3M22	Notifier	NBG-12LX	2 West tech station	Passed		8/19/2020 4:50 PM
10	Smoke Detector	L3D51	Notifier	FSP-851	Hall outside rm 274	Passed		8/19/2020 4:50 PM
11	Smoke Detector	L3D46	Notifier	FSP-851	Hall outside rm 268A	Passed		8/19/2020 4:50 PM
12	Smoke Detector	L3D47	Notifier	FSP-851	Hall outside Laundry	Passed		8/19/2020 4:49 PM
13	Heat Detector	L3D48	Notifier	FST-852	Laundry Rm	Passed		8/19/2020 4:47 PM
14	Heat Detector	L3D49	Notifier	FST-852	Kitchen	Passed		8/19/2020 4:46 PM
15	Smoke Detector	L3D44	Notifier	FSP-851	Hall outside rm 265	Passed		8/19/2020 4:46 PM
16	Heat Detector	L3D45	Notifier	FDX-551	Rm 265	Passed		8/19/2020 4:45 PM
17	Smoke Detector	L3D43	Notifier	FSP-851	Hall outside rm 262	Passed		8/19/2020 4:44 PM
18	Smoke Detector	L3D42	Notifier	FSP-851	Hall outside rm 241	Passed		8/19/2020 4:44 PM
19	Smoke Detector	L3D40	Notifier	FSP-851	Hall outside rm 257	Passed		8/19/2020 4:44 PM
20	Smoke Detector	L3D41	Notifier	FSP-851	Elevator Lobby	Passed		8/19/2020 4:41 PM
21	Manual Pull Station	L3M18	Notifier	NBG-12LX	Outside Elevator Lobby	Passed		8/19/2020 4:41 PM
22	Smoke Detector	L3D36	Notifier	FSP-851	Hall outside rm 256	Passed		8/19/2020 4:41 PM
23	Manual Pull Station	L3M19	Notifier	NBG-12LX	2nd Flr South Exit	Passed		8/19/2020 4:40 PM
24	Heat Detector	L3D35	Notifier	FST-852	Rm 257	Passed		8/19/2020 4:40 PM
25	Heat Detector	L3D37	Notifier	FST-852	Rm 256	Passed		8/19/2020 4:38 PM
26	Heat Detector	L3D38	Notifier	FST-852	Rm 255	Passed		8/19/2020 4:37 PM
27	Heat Detector	L3D39	Notifier	FST-852	Rm 254	Passed		8/19/2020 4:37 PM
28	Smoke Detector	L3D32	Notifier	FSP-851	Hall outside rm 252	Passed		8/19/2020 4:36 PM
29	Smoke Detector	L3D33	Notifier	FSP-851	Corridor 241B	Passed		8/19/2020 4:36 PM
30	Smoke Detector	L3D34	Notifier	FSP-851	rm 249	Passed		8/19/2020 4:36 PM
31	Kitchen Hood Monitor	L3M50	Notifier		West Range Hood	Passed		8/19/2020 4:35 PM
32	Smoke Detector	L3D31	Notifier	FSP-851	Hall by Room 247	Passed		8/19/2020 4:35 PM
33	Smoke Detector	L3D25	Notifier	FSP-851	Hall By Rm 243	Passed		8/19/2020 4:34 PM
34	Heat Detector	L3D26	Notifier	FST-852	Electrical Rm 243	Passed		8/19/2020 4:34 PM
35	Smoke Detector	L3D01	Notifier	SDX-551	Outside Conf RM 240	Passed		8/19/2020 4:34 PM
36	Smoke Detector	L3D03	Notifier	SDX-551	Staff wing Hall	Passed		8/19/2020 4:33 PM
37	Smoke Detector	L3D02	Notifier	SDX-551	outside Observ W 230	Passed		8/19/2020 4:33 PM
38	Manual Pull Station	L3M02	Notifier	NBG-12LX	East Stairs	Passed		8/19/2020 4:32 PM
39	Smoke Detector	L3D10	Notifier	SDX-551	Outside Observ N 230	Passed		8/19/2020 4:31 PM
40	Heat Detector	L3D09	Notifier	FDX-551	Electrical Closet	Passed		8/19/2020 4:31 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L3D08	Notifier	SDX-551	Women’s Wing Living Rm	Passed		8/19/2020 4:31 PM
42	Heat Detector	L3D06	Notifier	FDX-551	Closet 225	Passed		8/19/2020 4:30 PM
43	Smoke Detector	L3D07	Notifier	SDX-551	Women’s Wing Hall	Passed		8/19/2020 4:30 PM
44	Heat Detector	L3D05	Notifier	FDX-551	Shower Room 228	Passed		8/19/2020 4:29 PM
45	Heat Detector	L3D04	Notifier	FDX-551	Laundry Room 227	Passed		8/19/2020 4:29 PM
46	Smoke Detector	L3D11	Notifier	SDX-551	Multi Purpose Rm 200	Passed		8/19/2020 4:28 PM
47	Smoke Detector	L3D12	Notifier	SDX-551	Multi Purpose Rm 200	Passed		8/19/2020 4:28 PM
48	Heat Detector	L3D18	Notifier	FDX-551	Pantry 218	Passed		8/19/2020 4:27 PM
49	Heat Detector	L3D19	Notifier	FDX-551	Kitchen 217	Passed		8/19/2020 4:26 PM
50	Smoke Detector	L3D13	Notifier	SDX-551	Men’s Wing Hall S 201	Passed		8/19/2020 4:25 PM
51	Smoke Detector	L3D14	Notifier	FSP-751	Men’s Wing Cntr 201	Passed		8/19/2020 4:25 PM
52	Heat Detector	L3D22	Notifier	FDX-551	Closet 204	Passed		8/19/2020 4:25 PM
53	Heat Detector	L3D20	Notifier	FDX-551	Electrical Room 214	Passed		8/19/2020 4:24 PM
54	Smoke Detector	L3D15	Notifier	SDX-551	Men’s Wing N 201	Passed		8/19/2020 4:24 PM
55	Heat Detector	L3D21	Notifier	FDX-551	Closet 206	Passed		8/19/2020 4:23 PM
56	Smoke Detector	L3D16	Notifier	FSP-751	Hall 202	Passed		8/19/2020 4:23 PM
57	Smoke Detector	L3D17	Notifier	FSP-751	Living Room 207	Passed		8/19/2020 4:22 PM
58	Smoke Detector	L3D59	Notifier	FSP-851	RM 242 Closet	Passed		8/19/2020 4:22 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module
Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

2nd FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

3rd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L4D05	Notifier	SDX-551	Top of N Stairs	Passed		8/19/2020 5:32 PM
2	Heat Detector	L4D01	Notifier	FDX-551	Office Equipment Room	Passed		8/19/2020 5:32 PM
3	Heat Detector	L4D02	Notifier	FDX-551	Office Equipment Storage	Passed		8/19/2020 5:31 PM
4	Heat Detector	L4D03	Notifier	FDX-551	Office Equipment Storage	Passed		8/19/2020 5:31 PM
5	Heat Detector	L4D04	Notifier	FDX-551	Office Equipment Storage	Passed		8/19/2020 5:30 PM
6	Heat Detector	L4D06	Notifier	FDX-551	Maintenance Storage	Passed		8/19/2020 5:29 PM
7	Smoke Detector	L4D07	Notifier	SDX-551	Hall by N Stairs	Passed		8/19/2020 5:29 PM
8	Heat Detector	L4D08	Notifier	FDX-551	Custodial Storage	Passed		8/19/2020 5:29 PM
9	Heat Detector	L4D09	Notifier	FDX-551	Custodial Storage	Passed		8/19/2020 5:28 PM
10	Heat Detector	L4D11	Notifier	FDX-551	Old Equipment Rm	Passed		8/19/2020 5:28 PM
11	Smoke Detector	L4D12	Notifier	SDX-551	Hall by old equipment room	Passed		8/19/2020 5:27 PM
12	Heat Detector	L4D14	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
13	Heat Detector	L4D15	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
14	Heat Detector	L4D16	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
15	Smoke Detector	L4D17	Notifier	SDX-551	Hall by medical records	Passed		8/19/2020 5:25 PM
16	Heat Detector	L4D18	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:25 PM
17	Heat Detector	L4D19	Notifier	FDX-551	Office Equipment Storage	Passed		8/19/2020 5:24 PM
18	Smoke Detector	L4D20	Notifier	SDX-551	Hall by Pipe Chase	Passed		8/19/2020 5:24 PM
19	Heat Detector	L4D21	Notifier	FDX-551	S Office Equipment Storage	Passed		8/19/2020 5:23 PM
20	Heat Detector	L4D23	Notifier	FDX-551	Junk Storage	Passed		8/19/2020 5:23 PM
21	Heat Detector	L4D25	Notifier	FDX-551	Paper Recycle Room	Passed		8/19/2020 5:22 PM
22	Smoke Detector	L4D24	Notifier	SDX-551	Hall by Paper Recycling	Passed		8/19/2020 5:22 PM
23	Heat Detector	L4D26	Notifier	FDX-551	General Storage	Passed		8/19/2020 5:21 PM
24	Smoke Detector	L4D27	Notifier	SDX-551	General Storage	Passed		8/19/2020 5:21 PM
25	Heat Detector	L4D28	Notifier	FDX-551	General Storage	Passed		8/19/2020 5:20 PM
26	Smoke Detector	L4D29	Notifier	SDX-551	Top of East Stairs	Passed		8/19/2020 5:20 PM
27	Heat Detector	L4D30	Notifier	FDX-551	IMS E. Storage	Passed		8/19/2020 5:19 PM
28	Heat Detector	L4D31	Notifier	FDX-551	General File Storage	Passed		8/19/2020 5:19 PM
29	Heat Detector	L4D32	Notifier	FDX-551	General File Storage	Passed		8/19/2020 5:19 PM
30	Smoke Detector	L4D33	Notifier	SDX-551	File Storage	Passed		8/19/2020 5:18 PM
31	Heat Detector	L4D34	Notifier	FDX-551	East Bathroom	Passed		8/19/2020 5:18 PM
32	Smoke Detector	L4D35	Notifier	SDX-551	Hall by Legal Files	Passed		8/19/2020 5:17 PM
33	Heat Detector	L4D36	Notifier	FDX-551	Legal File Storage	Passed		8/19/2020 5:15 PM
34	Heat Detector	L4D37	Notifier	FDX-551	IMS Supply Storage	Passed		8/19/2020 5:15 PM
35	Heat Detector	L4D38	Notifier	FDX-551	Custodian Storage	Passed		8/19/2020 5:14 PM
36	Heat Detector	L4D39	Notifier	FDX-551	Personnel Records	Passed		8/19/2020 5:14 PM
37	Smoke Detector	L4D40	Notifier	SDX-551	Hall by Cust. Office	Passed		8/19/2020 5:13 PM
38	Heat Detector	L4D41	Notifier	FDX-551	Custodial Office	Passed		8/19/2020 5:13 PM
39	Heat Detector	L4D42	Notifier	FDX-551	Conference Rm	Passed		8/19/2020 5:12 PM
40	Smoke Detector	L4D43	Notifier	SDX-551	Hall by Conference Rm	Passed		8/19/2020 5:12 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L4D44	Notifier	SDX-551	Center Stairs	Passed		8/19/2020 5:11 PM
42	Smoke Detector	L4D45	Notifier	SDX-551	Hall by Center Stairs	Passed		8/19/2020 5:11 PM
43	Smoke Detector	L4D46	Notifier	SDX-551	D.D.D	Passed		8/19/2020 5:11 PM
44	Smoke Detector	L4D47	Notifier	SDX-551	Elevator Lobby	Passed		8/19/2020 5:10 PM
45	Smoke Detector	L4D48	Notifier	SDX-551	D.D.D Sec.	Passed		8/19/2020 5:10 PM
46	Smoke Detector	L4D49	Notifier	SDX-551	Outside Rm 307	Passed		8/19/2020 5:09 PM
47	Heat Detector	L4D50	Notifier	FDX-551	D.D.D. Conference Rm	Passed		8/19/2020 5:09 PM
48	Heat Detector	L4D51	Notifier	FDX-551	D.D.D.	Passed		8/19/2020 5:09 PM
49	Heat Detector	L4D52	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/19/2020 5:08 PM
50	Smoke Detector	L4D53	Notifier	SDX-551	Outside Telephone Eq.Rm	Passed		8/19/2020 5:08 PM
51	Smoke Detector	L4D54	Notifier	SDX-551	Outside Computer Rm	Passed		8/19/2020 5:07 PM
52	Smoke Detector	L4D55	Notifier	SDX-551	IMS Offices	Passed		8/19/2020 5:07 PM
53	Smoke Detector	L4D56	Notifier	SDX-551	IMS Offices	Passed		8/19/2020 5:06 PM
54	Smoke Detector	L4D57	Notifier	SDX-551	Computer Rm	Passed		8/19/2020 5:06 PM
55	Smoke Detector	L4D58	Notifier	SDX-551	Hall by west stairs	Passed		8/19/2020 5:06 PM
56	Smoke Detector	L4D59	Notifier	SDX-551	Rm 318	Passed		8/19/2020 5:05 PM
57	Smoke Detector	L4D60	Notifier	SDX-551	Hall by copier	Passed		8/19/2020 5:05 PM
58	Heat Detector	L4D61	Notifier	FDX-551	Pipe Chase	Passed		8/19/2020 5:04 PM
59	Smoke Detector	L4D62	Notifier	SDX-551	Hall by OBRA	Passed		8/19/2020 5:04 PM
60	Smoke Detector	L4D64	Notifier	SDX-551	Hall by OBRA	Passed		8/19/2020 5:04 PM
61	Heat Detector	L4D65	Notifier	FDX-551	DADA confer. rm	Passed		8/19/2020 5:03 PM
62	Smoke Detector	L4D66	Notifier	SDX-551	Hall by Restrooms	Passed		8/19/2020 5:03 PM
63	Smoke Detector	L4D67	Notifier	SDX-551	Hall by N Stairs	Passed		8/19/2020 5:02 PM
64	Smoke Detector	L4D68	Notifier	SDX-551	Top of N stairs	Passed		8/19/2020 5:02 PM
65	Smoke Detector	L4D69	Notifier	SDX-551	DADA	Passed		8/19/2020 5:01 PM
66	Smoke Detector	L4D70	Notifier	SDX-551	DADA	Passed		8/19/2020 5:01 PM
67	Smoke Detector	L4D71	Notifier	SDX-551	Hall by Stairs	Passed		8/19/2020 5:00 PM
68	Heat Detector	L4D72	Notifier	FDX-551	Restroom	Passed		8/19/2020 5:00 PM
69	Heat Detector	L4D73	Notifier	FDX-551	SE DET.	Passed		8/19/2020 5:00 PM
70	Heat Detector	L4D74	Notifier	FDX-551	SW DET.	Passed		8/19/2020 4:59 PM
71	Heat Detector	L4D75	Notifier	FDX-551	NW DET.	Passed		8/19/2020 4:59 PM
72	Heat Detector	L4D76	Notifier	FDX-551	Storage RM	Passed		8/19/2020 4:58 PM
73	Smoke Detector	L4D77	Notifier	SDX-551	Top of Elevator Shaft	Passed		8/19/2020 4:58 PM
74	Smoke Detector	L4D78	Notifier	SDX-551	Top of Stairs	Passed		8/19/2020 4:57 PM
75	Heat Detector	L4D79	Notifier	FDX-551	Elevator Penthouse	Passed		8/19/2020 4:57 PM
76	Heat Detector	L4D89	Notifier	FDX-551	open Storage	Passed		8/19/2020 4:56 PM
77	Manual Pull Station	L4M01	Notifier	BGX-101L	N Stairs	Passed		8/19/2020 4:56 PM
78	Manual Pull Station	L4M03	Notifier	BGX-101L	E Stairs	Passed		8/19/2020 4:56 PM
79	Manual Pull Station	L4M04	Notifier	BGX-101L	Center Stairs	Passed		8/19/2020 4:55 PM
80	Manual Pull Station	L4M06	Notifier	BGX-101L	N Stairs	Passed		8/19/2020 4:55 PM
81	Manual Pull Station	L4M08	Notifier	BGX-101L	Stairs Exit	Passed		8/19/2020 4:54 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module
Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

3rd FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 14 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2020 Annual Inspection Summary

Result Totals

Devices	Bell	Horn Strobe	Strobe
Passed	30	1	75
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	30	1	75

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

GROUND FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe			Men’s 010	Passed		8/21/2020 10:19 AM
2	Strobe			Women’s 011	Passed		8/21/2020 10:19 AM
3	Strobe			Hall Outside Restrooms	Passed		8/21/2020 10:19 AM
4	Bell		KMS-8-24VDC/P	Hall outside Restrooms	Passed		8/21/2020 10:19 AM
5	Bell		KMS-8-24VDC/P	Outside Room 033E	Passed		8/21/2020 10:20 AM
6	Strobe			Outside 033E	Passed		8/21/2020 10:20 AM
7	Strobe			Hallway 033	Passed		8/21/2020 10:20 AM
8	Bell		KMS-8-24VDC/P	Hallway 033	Passed		8/21/2020 10:20 AM
9	Strobe			029	Passed		8/21/2020 10:20 AM
10	Strobe		SS24110ADA	029	Passed		8/21/2020 10:20 AM
11	Strobe		SS24110ADA	Center 040	Passed		8/21/2020 10:20 AM
12	Bell		KMS-8-24VDC/P	Center 040	Passed		8/21/2020 10:20 AM
13	Horn Strobe			East Game Room	Passed		8/21/2020 10:20 AM
14	Strobe		SS24110ADA	East Game Room	Passed		8/21/2020 10:20 AM
15	Strobe		SS24110ADA	Near AHU RM 056B	Passed		8/21/2020 10:21 AM
16	Bell		KMS-8-24VDC/P	Near AHU RM 056 B	Passed		8/21/2020 10:21 AM
17	Bell		KMS-8-24VDC/P	063	Passed		8/21/2020 10:21 AM
18	Strobe		SS24110ADA	063	Passed		8/21/2020 10:21 AM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

GROUND FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SS24110ADA	Outside RM 111	Passed		8/21/2020 10:48 AM
2	Bell		KMS-8-24VDC/P	Outside 111	Passed		8/21/2020 10:48 AM
3	Strobe		SS24110ADA	RM 114	Passed		8/21/2020 10:48 AM
4	Strobe		SS24110ADA	RM 115	Passed		8/21/2020 10:48 AM
5	Bell		KMS-8-24VDC/P	Outside 147	Passed		8/21/2020 10:48 AM
6	Bell		KMS-8-24VDC/P	Room 149	Passed		8/21/2020 10:47 AM
7	Strobe		SS24110ADA	inside Room 149	Passed		8/21/2020 10:47 AM
8	Strobe		SS24110ADA	inside Room 152	Passed		8/21/2020 10:46 AM
9	Strobe		SS24110ADA	inside Room 153	Passed		8/21/2020 10:43 AM
10	Strobe		SS24110ADA	outsideRoom 161	Passed		8/21/2020 10:42 AM
11	Bell		KMS-8-24VDC/P	outside Room 161	Passed		8/21/2020 10:40 AM
12	Strobe		SS24110ADA	inside room 158	Passed		8/21/2020 10:31 AM
13	Strobe		SS24110ADA	inside room 159	Passed		8/21/2020 10:40 AM
14	Strobe		SS24110ADA	dinning Room 168	Passed		8/21/2020 10:31 AM
15	Bell		KMS-8-24VDC/P	dinning Room 168	Passed		8/21/2020 10:31 AM
16	Bell		KMS-8-24VDC/P	east tech station	Passed		8/21/2020 10:27 AM
17	Strobe		SS24110ADA	bathroom 172	Passed		8/21/2020 10:26 AM
18	Strobe		SS24110ADA	bathroom 171	Passed		8/21/2020 10:24 AM
19	Strobe		SS24110ADA	Across Room 179	Passed		8/21/2020 10:23 AM
20	Bell		KMS-8-24VDC/P	Across Room 179	Passed		8/21/2020 10:22 AM
21	Bell		KMS-8-24VDC/P	outside Room 194	Passed		8/21/2020 10:22 AM
22	Strobe		SS24110ADA	Outside Room 194	Passed		8/21/2020 10:22 AM
23	Strobe		SS24110ADA	east tech station	Passed		8/21/2020 10:21 AM
24	Strobe		SS24110ADA	Outside RM 147	Passed		8/21/2020 10:21 AM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SR	RM 298	Passed		8/21/2020 10:58 AM
2	Strobe		SR	RM 299	Passed		8/21/2020 10:58 AM
3	Strobe		SR	Hall outside RM 299	Passed		8/21/2020 10:58 AM
4	Strobe		SR	Hall outside RM 295	Passed		8/21/2020 10:57 AM
5	Bell		SSM24-8	Hall outside rm 295	Passed		8/21/2020 10:57 AM
6	Strobe		SR	Hall outside Rm 290	Passed		8/21/2020 10:57 AM
7	Strobe		SR	Hall outside Rm 281	Passed		8/21/2020 10:57 AM
8	Bell		SSM24-8	Hall outside rm 281	Passed		8/21/2020 10:57 AM
9	Strobe		SR	Hall outside Rm 278	Passed		8/21/2020 10:58 AM
10	Bell		SSM24-8	Hall outside rm 278	Passed		8/21/2020 10:57 AM
11	Strobe		SPR	Rm 274	Passed		8/21/2020 10:57 AM
12	Strobe		SR	Rm 273	Passed		8/21/2020 10:57 AM
13	Strobe		SPR	Rm 272	Passed		8/21/2020 10:57 AM
14	Strobe		SR	outside Rm 269	Passed		8/21/2020 10:56 AM
15	Strobe		FSF204-st	RM 269	Passed		8/21/2020 10:56 AM
16	Strobe		SR	outside Rm 270	Passed		8/21/2020 10:56 AM
17	Strobe		SR	Rm 270	Passed		8/21/2020 10:56 AM
18	Strobe		FSF204-st	RM 266	Passed		8/21/2020 10:56 AM
19	Strobe		SR	outside Rm 259	Passed		8/21/2020 10:56 AM
20	Bell		SSM24-8	Hall outside rm 259	Passed		8/21/2020 10:56 AM
21	Strobe		SR	Elevator lobby	Passed		8/21/2020 10:56 AM
22	Strobe		SR	Outside Elevator lobby	Passed		8/21/2020 10:54 AM
23	Strobe		SR	Outside 254	Passed		8/21/2020 10:53 AM
24	Strobe		SR	Outside 241 B1	Passed		8/21/2020 10:53 AM
25	Strobe		SR	251	Passed		8/21/2020 10:53 AM
26	Strobe		SR	250	Passed		8/21/2020 10:53 AM
27	Strobe		SPR	Rm 252	Passed		8/21/2020 10:53 AM
28	Strobe		SPR	Rm 247	Passed		8/21/2020 10:53 AM
29	Strobe		SPR	Rm 242	Passed		8/21/2020 10:52 AM
30	Strobe		SR	Outside Rm 243	Passed		8/21/2020 10:52 AM
31	Bell		SSM24-8	Hall outside rm 243	Passed		8/21/2020 10:52 AM
32	Strobe		SPR	Center Above pop machines	Passed		8/21/2020 10:52 AM
33	Strobe		SPR	244	Passed		8/21/2020 10:50 AM
34	Strobe		SS24110ADA	Outside Rm 240	Passed		8/21/2020 10:50 AM
35	Bell		SSM24-8	Hall outside rm 240	Passed		8/21/2020 10:50 AM
36	Strobe		SS24110ADA	Rm 240	Passed		8/21/2020 10:50 AM
37	Strobe		SS24110ADA	Outside Rm 230	Passed		8/21/2020 10:50 AM
38	Bell		SSM24-8	Hall outside rm 230	Passed		8/21/2020 10:50 AM
39	Strobe		SS24110ADA	Rm 232	Passed		8/21/2020 10:50 AM
40	Strobe		SS24110ADA	Rm 231	Passed		8/21/2020 10:50 AM

Number	Type	Zone/address	Model	Location	Result	Comments	Date
41	Strobe		SS24110ADA	Outside Rm 225	Passed		8/21/2020 10:49 AM
42	Bell		SSM24-8	Hall outside rm 225	Passed		8/21/2020 10:49 AM
43	Bell		SSM24-8	Hall outside rm 217	Passed		8/21/2020 10:49 AM
44	Strobe		SS24110ADA	Outside Rm 217	Passed		8/21/2020 10:49 AM
45	Strobe		SS24110ADA	Outside Rm 215	Passed		8/21/2020 10:49 AM
46	Bell		SSM24-8	Hall outside rm 215	Passed		8/21/2020 10:49 AM
47	Bell		SSM24-8	Hall outside rm 208	Passed		8/21/2020 10:49 AM
48	Strobe		SS24110ADA	Outside Rm 208	Passed		8/21/2020 10:49 AM
49	Strobe		SS24110ADA	Outside Rm 208 around corner	Passed		8/21/2020 10:48 AM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

3rd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	NE stairwell	Passed		8/21/2020 11:12 AM
2	Strobe		SS24110ADA	NE Stairwell	Passed		8/21/2020 11:12 AM
3	Strobe		SS24110ADA	Hallway 343	Passed		8/21/2020 11:12 AM
4	Bell		KMS-8-24VDC/P	Hallway 343	Passed		8/21/2020 11:12 AM
5	Bell		KMS-8-24VDC/P	Hallway 333	Passed		8/21/2020 11:12 AM
6	Strobe		SS24110ADA	Hallway 333	Passed		8/21/2020 11:12 AM
7	Bell		KMS-8-24VDC/P	Hallway 309	Passed		8/21/2020 11:05 AM
8	Strobe		SS24110ADA	Hallway 309	Passed		8/21/2020 11:05 AM
9	Strobe		SS24110ADA	335	Passed		8/21/2020 11:05 AM
10	Strobe		SS24110ADA	334	Passed		8/21/2020 11:05 AM
11	Strobe		SS24110ADA	337	Passed		8/21/2020 11:05 AM
12	Strobe		SS24110ADA	332	Passed		8/21/2020 11:05 AM
13	Bell		KMS-8-24VDC/P	3rd floor northwest by exit door	Passed		8/21/2020 10:59 AM
14	Strobe		SS24110ADA	3rd floor northwest next to exit	Passed		8/21/2020 10:59 AM
15	Strobe		SS24110ADA	Old Conference	Passed		8/21/2020 10:58 AM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESSMENT REPORTING

3rd FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 14 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP19 Shutdown 2020 Annual Inspection Summary

Result Totals

Devices	Relays
Passed	60
Mitigated	-
New - Passed	-
Failed	-
Removed	-
Not Inspected	-
Total	60

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

GROUND FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays	L1M07	Notifier		Door Release 038A	Passed		8/18/2020 6:35 PM
2	Relays	L1M95	Notifier		Door Release RM041	Passed		8/18/2020 6:41 PM
3	Relays	L1M30	Notifier		Elevator Mech Rm 039	Passed	Primary Recall	8/18/2020 6:40 PM
4	Relays	L1M31	Notifier		Elevator Mech Rm 039	Passed	Alternate Recall	8/18/2020 6:40 PM
5	Relays	L1M32	Notifier		Elevator Mech Rm 039	Passed	Flash Hat	8/18/2020 6:39 PM
6	Relays	L1M33	Notifier		Elevator Mech Rm 039	Passed	Shunt	8/18/2020 6:39 PM
7	Relays	L1M24	Notifier	FRM-1	Mech Rm 014	Passed	AHU-1	8/18/2020 6:39 PM
8	Relays	L1M25	Notifier	FRM-1	Mech Rm 056B	Passed	AHU-2	8/18/2020 6:38 PM
9	Relays	L1M26	Smoke	Damper	SD-001 by 052	Passed		8/18/2020 6:38 PM
10	Relays		Smoke	Damper	SD-002 045	Passed		8/18/2020 6:37 PM
11	Relays	L1M28	Smoke	Damper	SD-003 033e	Passed		8/18/2020 6:37 PM
12	Relays	L1M28	Smoke	Damper	SD-004	Passed		8/18/2020 6:37 PM
13	Relays				Door Holder Hallway 028	Passed	Door Holder	8/18/2020 6:36 PM
14	Relays		Smoke	Damper	1 SD-014	Passed		8/18/2020 6:36 PM

1st FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays	L2M95			Door Release 1st flr	Passed		8/18/2020 6:15 PM
2	Relays		Smoke	Damper	1SD-013	Passed		8/18/2020 6:22 PM
3	Relays		Smoke	Damper	1SD-011 144	Passed		8/18/2020 6:22 PM
4	Relays		Smoke	Damper	1SD-012 127	Passed		8/18/2020 6:22 PM
5	Relays				163 Door Holder	Passed		8/18/2020 6:21 PM
6	Relays				163 Door Holder	Passed		8/18/2020 6:21 PM
7	Relays		Smoke	Damper	1SD-010 163	Passed		8/18/2020 6:20 PM
8	Relays		Smoke	Damper	1SD-009 163	Passed		8/18/2020 6:20 PM
9	Relays		Smoke	Damper	1SD-007 Hall by 157	Passed		8/18/2020 6:19 PM
10	Relays		Smoke	Damper	1SD-008 Hall by 157	Passed		8/18/2020 6:19 PM
11	Relays				174 Door Holder	Passed		8/18/2020 6:19 PM
12	Relays				174 Door Holder	Passed		8/18/2020 6:18 PM
13	Relays		Smoke	Damper	1SD-006 Hall by 174	Passed		8/18/2020 6:18 PM
14	Relays		Smoke	Damper	1SD-005 138 Closet	Passed		8/18/2020 6:17 PM
15	Relays		Smoke	Damper	1SD-003 Patient Telephone	Passed		8/18/2020 6:16 PM
16	Relays		Smoke	Damper	1SD-004 Patient Telephone	Passed		8/18/2020 6:16 PM
17	Relays		Smoke	Damper	1SD-002 178	Passed		8/18/2020 6:15 PM
18	Relays		Smoke	Damper	1SD-001 183	Passed		8/18/2020 6:15 PM

2nd FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays		Smoke	Damper	2-SD001 213	Passed		8/18/2020 6:32 PM
2	Relays		Smoke	Damper	2-SD002 217	Passed		8/18/2020 6:31 PM
3	Relays		Smoke	Damper	2-SD003 218	Passed		8/18/2020 6:31 PM
4	Relays				Door Holder 201	Passed		8/18/2020 6:30 PM
5	Relays				Door Holder 201	Passed		8/18/2020 6:30 PM
6	Relays				Door Holder 200	Passed		8/18/2020 6:29 PM
7	Relays				Door Holder 200	Passed		8/18/2020 6:29 PM
8	Relays		Smoke	Damper	2-SD004 239	Passed		8/18/2020 6:29 PM
9	Relays		Smoke	Damper	2-SD005 239	Passed		8/18/2020 6:28 PM
10	Relays		Smoke	Damper	2-SD006 242 Closet	Passed		8/18/2020 6:28 PM
11	Relays				Door Holder by 241C	Passed		8/18/2020 6:27 PM
12	Relays				Door Holder by 241C	Passed		8/18/2020 6:27 PM
13	Relays		Smoke	Damper	2-SD007 by 258	Passed		8/18/2020 6:27 PM
14	Relays		Smoke	Damper	2-SD008 265	Passed		8/18/2020 6:26 PM
15	Relays		Smoke	Damper	2-SD009 241 M2	Passed		8/18/2020 6:26 PM
16	Relays				Door Holder by 294	Passed		8/18/2020 6:25 PM
17	Relays				Door Holder by 294	Passed		8/18/2020 6:25 PM
18	Relays		Smoke	Damper	2-SD010 by 294	Passed		8/18/2020 6:25 PM
19	Relays		Smoke	Damper	2-SD011 by 294	Passed		8/18/2020 6:24 PM
20	Relays		Smoke	Damper	2-SD012 Stairwell	Passed		8/18/2020 6:23 PM

3rd FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays		Smoke	Damper	3-SD06 314	Passed		8/18/2020 6:35 PM
2	Relays		Smoke	Damper	3-SD05 338	Passed		8/18/2020 6:34 PM
3	Relays		Smoke	Damper	3-SD004 326	Passed		8/18/2020 6:34 PM
4	Relays				Door Holder by 333	Passed		8/18/2020 6:34 PM
5	Relays		Smoke	Damper	3-SD003	Passed		8/18/2020 6:33 PM
6	Relays		Smoke	Damper	3-SD002 351	Passed		8/18/2020 6:33 PM
7	Relays		Smoke	Damper	3-SD001 354	Passed		8/18/2020 6:32 PM
8	Relays				Door Holder Elevator Lobby	Passed		8/18/2020 6:32 PM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 14 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2020 Annual Inspection Summary

Result Totals

Devices	Control Valve Switch	PIV	Standpipe Water Flow
Passed	11	1	5
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	11	1	5

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

GROUND FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M23	042	Passed			8/21/2020 11:20 AM
2	Control Valve Switch	L1M22	Center Hall by 039	Passed			8/21/2020 11:19 AM
3	PIV	L1M21	Outside	Passed			8/21/2020 11:19 AM
4	Control Valve Switch	L1M22	Center Hall by 039	Passed			8/21/2020 11:19 AM
5	Control Valve Switch	L1M23	042	Passed			8/21/2020 11:19 AM
6	Control Valve Switch	L1M23	042	Passed			8/21/2020 11:19 AM
7	Control Valve Switch	L1M23	042	Passed			8/21/2020 11:19 AM
8	Control Valve Switch	L1M23	042	Passed			8/21/2020 11:13 AM

1st FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L2M11	1st Water Flow	Passed			8/21/2020 10:58 AM
2	Control Valve Switch		1st flr hall	Passed			8/21/2020 10:59 AM

2nd FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L3M07	2nd Water Flow	Passed			8/21/2020 11:00 AM
2	Control Valve Switch		2nd flr tamper	Passed			8/21/2020 11:02 AM

3rd FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L4M09	3rd Flr	Passed			8/21/2020 11:04 AM
2	Standpipe Water Flow	L4M10	3rd Flr	Passed			8/21/2020 11:12 AM
3	Control Valve Switch	L4M11	Penthouse supervisory tamper	Passed			8/21/2020 11:12 AM
4	Control Valve Switch		3rd flr store room	Passed			8/21/2020 11:05 AM
5	Control Valve Switch		3rd flr store room	Passed			8/21/2020 11:04 AM

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2020 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

NFPA72, 2010 Ed.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:

Account: LRC Bldg. # 14 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

Scope: Full 100%
Frequency: 2020 Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	8	6
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	8	6

Supercomponent Information	
Type	1 - FACP
Location	GROUND FLOOR 038A
Model	AFP 1010
Voltage/Current	120
s/Communication	-

This inspection was performed on 8/10/2020 in accordance with applicable requirements.

NFPA72, 2010 Ed.

GROUND FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP 1010		038A	Passed		8/21/2020 10:53 AM
2	Power Supply	Notifier	FCPS-24		038A	Passed	NAC 4 not going into trouble when resistor removed. Unused circuit not being used	8/21/2020 10:52 AM
3	Annuciator	Notifier			Front Entrance	Passed		8/21/2020 10:50 AM

1st FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			1st Flr S Exit	Passed		8/21/2020 10:31 AM
2	Annuciator	Notifier			1 West tech station	Passed		8/21/2020 10:27 AM
3	Annuciator	Notifier			east tech station	Passed		8/21/2020 10:26 AM
4	Power Supply	Notifier	FCPS-24	L2M10	Closet 138	Passed		8/21/2020 10:24 AM
5	Power Supply	Notifier	FCPS-24	L2M09	Closet 138	Passed		8/21/2020 10:22 AM

2nd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			2 West Tech Station	Passed		8/21/2020 10:31 AM
2	Annuciator	Notifier			2 Outside Elevator Lobby	Passed		8/21/2020 10:47 AM
3	Annuciator	Notifier			tech 230	Passed		8/21/2020 10:47 AM
4	Power Supply	Notifier	FCPS-24S8	L3M16	242 Closet	Passed	NAC 2 and 4 not going into trouble when wires taken off NAC 4 might be controlling door holders	8/21/2020 10:46 AM
5	Power Supply	Notifier	FCPS-24	L3M06	242 Closet	Passed		8/21/2020 10:40 AM

3rd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Elevator Lobby	Passed		8/21/2020 10:49 AM
2	Power Supply	Notifier	FCPS-24		Near 335 Closet	Passed		8/21/2020 10:49 AM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH			2-12-2019	GROUND FLOOR 038A	Passed	
1	12V26AH			2-12-2019	GROUND FLOOR 038A	Passed	
2	12V8AH	Notifier	FCPS-24	2-19-19	GROUND FLOOR 038A	Passed	
2	12V8AH	Notifier	FCPS-24	2-19-19	GROUND FLOOR 038A	Passed	
4	12V8AH	Notifier	FCPS-24	2-12-18	1st FLOOR Closet 138	Passed	
4	12V8AH	Notifier	FCPS-24	2-12-18	1st FLOOR Closet 138	Passed	
5	12V8AH	Notifier	FCPS-24	2-19	1st FLOOR Closet 138	Passed	
5	12V8AH	Notifier	FCPS-24	2-19	1st FLOOR Closet 138	Passed	
4	12V8AH	Notifier	FCPS-24S8	2-19-19	2nd FLOOR 242 Closet	Passed	
4	12V8AH	Notifier	FCPS-24S8	2-19-19	2nd FLOOR 242 Closet	Passed	
5	12V8AH	Notifier	FCPS-24	2-19-19	2nd FLOOR 242 Closet	Passed	
5	12V8AH	Notifier	FCPS-24	2-19-19	2nd FLOOR 242 Closet	Passed	
2	12V8AH			2-19-19	3rd FLOOR Near 335 Closet	Passed	
2	12V8AH			2-19-19	3rd FLOOR Near 335 Closet	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	AFP 1010	120	038A	GROUND FLOOR	Passed		
2		Power Supply	Notifier	FCPS-24	120	038A	GROUND FLOOR	Passed		NAC 4 not going into trouble when resistor removed. Unused circuit not being used
3		Annuciator	Notifier			Front Entrance	GROUND FLOOR	Passed		
1		Annuciator	Notifier			1st Flr S Exit	1st FLOOR	Passed		
2		Annuciator	Notifier			1 West tech station	1st FLOOR	Passed		
3		Annuciator	Notifier			east tech station	1st FLOOR	Passed		
4	L2M10	Power Supply	Notifier	FCPS-24	120	Closet 138	1st FLOOR	Passed		
5	L2M09	Power Supply	Notifier	FCPS-24	120	Closet 138	1st FLOOR	Passed		
1		Annuciator	Notifier			2 West Tech Station	2nd FLOOR	Passed		
2		Annuciator	Notifier			2 Outside Elevator Lobby	2nd FLOOR	Passed		
3		Annuciator	Notifier			tech 230	2nd FLOOR	Passed		
4	L3M16	Power Supply	Notifier	FCPS-24S8	120VAC	242 Closet	2nd FLOOR	Passed	24hr/5min	NAC 2 and 4 not going into trouble when wires taken off NAC 4 might be controlling door holders
5	L3M06	Power Supply	Notifier	FCPS-24	120VAC	242 Closet	2nd FLOOR	Passed	24hr/5min	
1		Annuciator	Notifier			Elevator Lobby	3rd FLOOR	Passed		
2		Power Supply	Notifier	FCPS-24	120	Near 335 Closet	3rd FLOOR	Passed		

Nebraska State Fire Marshall

Occupancy Permits

Attachment L5

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404702

Name of Facility: **Lincoln Regional Center Bldg #3 Psych Admissions**

Type of Facility: **Hospital**

Location: **PO Box 94949, Folsom & Prospector Str Lincoln**

Maximum Occupancy: **46 Beds**

Date Issued: **1/2/2020**

Inspected By: **8727 Clint Rossman**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404703

Name of Facility:	**Lincoln Regional Center Bldg #5 Forensic**
Type of Facility:	**Hospital**
Location:	**PO Box 94949, Folsom & Prospector St Lincoln**
Maximum Occupancy:	**109 Beds**
Date Issued:	**1/2/2020**

Inspected By: **8727 Clint Rossman**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404709

Name of Facility: **Lincoln Regional Center Bldg #10 Psych Rehab**

Type of Facility: **Hospital**

Location: **PO Box 94949, Folsom & Prospector Str Lincoln**

Maximum Occupancy: **45 Beds**

Date Issued: **1/2/2020**

Inspected By: **8727 Clint Rossman**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 404749

Name of Facility: **Lincoln Regional Center Bldg#14**

Type of Facility: **Hospital**

Location: **PO Box 94949; Folsom & W Prospector Lincoln**

Maximum Occupancy: **85 Beds**

Date Issued: **1/2/2020**

Inspected By: **8727 Clint Rossman**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

DHHS Public Health Licensure Unit Survey

Attachment N1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 000	Initial Comments On 10/5/20-10/8/20, DHHS Public Health representatives conducted a licensure survey to determine compliance with 175 NAC 9, Licensure Regulations for Hospitals. The facility was out of compliance with the regulations identified below at the time of survey: 9-006.08 Infection Control; 9-006.09 G5 & G7 Pharmacy; 9-006.09 H2 Dietary.	I 000		
I 470	0-006.08 Infection Control Each hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control and investigation of infections and communicable diseases. This Standard is not met as evidenced by: Based on staff interviews, review of the facility infection control plan, Infection Control (IC) meeting minutes for 2019 and 2020 and quality data information related to Infection Control the facility failed to have implemented an active infection control program since September of 2019. The facility failed to: Perform surveillance of infections to ensure nosocomial (Health Care Acquired) infections are identified, investigated and controlled; to have a Legionella prevention program for water safety; lacked a system for early detection of outbreaks and prevention; lack of monitoring for treatment appropriateness including failure to have an antibiotic stewardship program to prevent the development and spread of drug resistant organism; lack of any documentation of staff monitoring to ensure infection control policies are followed and corrective action plans developed if needed. The facility census was 87 at the time of the survey.	I 470		

Licensure Unit
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
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 470	Continued From page 1 The deficient practice has the potential to affect all patients. Findings are: A. Record review of the facility document titled "Infection Control Plan" last reviewed 11/18 notes the responsibilities of the Infection Control Coordinator (ICC) who is responsible for ongoing and systematic surveillance of risk or potential for infection, compiles monthly/quarterly patient infection rates, including any healthcare-associated infections, monitors staff infection rates. The ICC presents monthly/quarterly patient infection reports to the Infection Control Committee, Medical Staff and to the Performance Improvement/ Risk Management Committee. The IC plan also includes mandatory reporting of communicable disease to local and state community Public Health agencies. The plan identifies Infection Risk Reduction and Prevention strategies, Monitoring and Accountability for the committee to investigate, control and develop prevention strategies for healthcare-associated infections. The pharmacy reports patient infections resulting in antibiotic use to the Infection Control Committee. The Multi Drug Resistant Organisms are to be monitored throughout the year with chart reviews for any indicated cases to assess IC practices and educate staff as needed. Hand hygiene is to be monitored to maintain compliance to greater than 90 %. The only IC activity found was related to the facility Covid 19 pandemic plan that was part of Emergency Planning. B. Review of data titled Overall Patient Infection Rates found there has not been any surveillance or reporting since September of 2019. Data for Employee Infection reporting found no reports since September of 2019. A report titled	I 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 470	Continued From page 2 "Antibiotics used" for 2020 lists antibiotics used by month with type of infection such as upper respiratory, dental, skin. The report does not identify the patient or unit or any culture reports. There were no surveillance reports to demonstrate IC was monitoring the nosocomial (Health Care Acquired) infections of patients. The last document titled "Action Taken" related to IC was second quarter of 2019 related to cleaning of med rooms, kitchens on the units and coffee machines. C. Record review of Infection Control meeting minutes noted that the IC committee began meeting in July 2020 and had meetings for July, August, and September 2020. All 3 meetings lacked any discussion of surveillance data, infection rates of patients and staff or any monitoring of staff compliance with IC policies and procedures. There were no Antibiotic Stewardship meeting minutes or reports. D. Staff interview on 10/7/20 at 9:30 AM with the Director of Nursing (DON) who is also the Infection Control Coordinator could identify COVID facility policies but stated that Physician's Assistant (PA #1) reviews labs, symptoms, antibiotic use and does surveillance reports. The reports go to the IC committee. The DON took over the role as IC Coordinator this summer and noted that the previous PA who was doing Infection Control left in January of 2020. The DON confirmed that there were no IC meetings prior to July 2020. The DON confirmed there was no antibiotic stewardship committee. The DON confirmed there has not been any monitoring of staff compliance with IC policies and procedures such as handwashing or COVID precaution compliance.	I 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 470	Continued From page 3 E. Staff interview with PA 1 on 10/7/20 at 1:15 PM revealed being new on the IC Committee. The previous PA left 1/2/20 and did not orient me to Infection Control. The PA identified attendance at 1 meeting in August of 2020 and was not asked to provide any reports. The PA stated " I have no IC surveillance data, no antibiotic stewardship committee." The PA was aware the previous PA provided reports at the Medical Staff meetings on infections. The PA stated "I am not sure exactly what my role is, we are trying to figure out what the previous PA did." F. Based on staff interviews and policy review, the facility failed to prevent and control the transmission of potential infections related to Legionella, as evidenced by lack of any policy to assess and promote water safety to prevent the growth of coliform spore bacteria that promotes Legionella (as required for all health care facilities since 2017). Meeting with staff members on 10/5/2020 at 11:00am, the Facility Operations Officer, Maintenance Supervisor and Compliance Staff member, revealed that the facility had not been aware of or established any plan for Legionella risk/mitigation of the facility water system. Maintenance Supervisor related that Housekeeping staff flush drains weekly with bleach but no flushing of lines or monitoring of water systems had been formalized. A discussion of the tool-kit available on the DHHS (Department of Health and Human Services) website which referenced CDC (Center for Disease Control) and ASHRAE (American Society of Heating Refrigeration Air conditioning	I 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 470	Continued From page 4 Engineers) standards was reviewed for potential use for facility to establish a team and begin a program to ensure the safety of the facility water for the 87 individual patients living at facility and corresponding staff that work in the facility.	I 470		
I 560	9-006.09G Pharmacy Services Pharmacy services must be provided to meet the needs of patients directly or through written agreement, and must be under the supervision of a pharmacist licensed in Nebraska. The storage, control, handling, compounding and dispensing of drugs, devices and biologicals must be in accordance with Neb. Rev. Stat. §§ 71-1,142 to 71-1,147.59 and the regulations promulgated thereunder. 9-006.09G1 Emergency drugs, devices and biologicals as determined by the medical staff must be readily available for use at designated locations when an emergency occurs. 9-006.09G2 Current and accurate records must be kept on the receipt and disposition of all controlled substances. 9-006.09G3 The supply of drugs, devices and biologicals and controlled substances must be protected and restricted to use for legally authorized purposes. 9-006.09G4 Abuses and losses of controlled substances must be reported in accordance with Neb. Rev. Stat. §§ 28-401 to 28-445, the Uniform Controlled Substances Act, and the regulations promulgated thereunder. 9-006.09G5 Drugs, devices and biologicals must be stored in locked areas in accordance with the manufacturer ' s instructions for temperature, light, humidity or other storage instructions. 9-006.09G6 Drugs, devices and biologicals	I 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 560	Continued From page 5	I 560		

must be removed from the pharmacy or storage area only by personnel designated in hospital policies and in accordance with state and federal law.
9-006.09G7 The supply of drugs, devices and biologicals must be checked on a regular basis to ensure expired, mislabeled, unlabeled or unusable products are not available for patient use and are disposed of in accordance with hospital policies and state and federal law.
9-006.09G8 Information relating to interactions, contraindications, side effects, toxicology, dosage, indications for use, and routes of administration for drugs, devices and biologicals must be available to staff.

This Standard is not met as evidenced by:
PART 1 (9-006.09 G5)
Based on record review, observations and staff interview, the facility failed to consistently monitor the medication refrigerator temperatures to ensure the temperature maintained a range from 32 degrees to 40 degrees Fahrenheit. This occurred in 6 of 7 medication refrigerators in the facility.

Findings are:

A. A tour of the medication refrigerator in the pharmacy, on the 5 patient units and in the MCM (Medication Cabinet Machine) room were identified as containing medications the pharmacist identified as needing a temperature range of 32-40 degrees Fahrenheit revealed the following:
-The Pharmacy medication refrigerator lacked a temperature log. The thermometer currently read 40 degrees F.
-Unit 1 West medication refrigerator lacked a temperature log. The thermometer currently read

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 560	Continued From page 6 38 degrees F. -Unit 2 West medication refrigerator had an electronic temperature log. Review of the last 4 months of daily monitoring showed 7 days with no temperature recorded. The thermometer currently read 34 degrees F. -Unit 3 West medication refrigerator had an electronic temperature log. Review of the last 4 months of daily monitoring showed 4 days with no temperature recorded. The thermometer currently read 34 degrees F. -Unit 3 East medication refrigerator had an electronic temperature log. Review of the last 4 months of daily monitoring showed 39 days with no temperature recorded. The thermometer currently read 24 degrees F. The medication in the refrigerator was checked and dial adjusted and the recheck was 32 degrees F. -MCM cabinet refrigerator lacked a temperature log. The thermometer currently read 35 degrees F. The medications stored in these refrigerators included but are not limited to vaccines, Injectable Ativan and insulin. Those medications are to be stored in a range of 32-40 degrees F. B. An interview with the Registered Pharmacist (RP A) revealed that, "I was not aware that we were not keeping logs. I know in the pharmacy we were but the staff member that was assigned to monitor it, retired several months ago and it must not have been reassigned. The refrigerator safe zone is 32-40 degrees F. PART 2 (9-006.09 G7) Based on observation and staff interview the facility failed to ensure that expired medications were removed from stock to prevent use for patient care in 1 of 1 crash carts/medication box.	I 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 560	Continued From page 7 Observation of the crash cart/medication box in the locked emergency closet room 221 revealed 3 medications were outdated for use. The lack of removing medications after outdated has the potential to affect patients requiring these medications in an emergency situation. Findings are: A. An observation of the medications in the crash cart/medication box on 10/7/20 at 11:00 AM revealed: -1 injectable cartridge/vial of Diphenhydramine (Benadryl-an antihistamine used for allergic reactions) 50mg (milligrams) / 1 ml (milliliter) with an expiration date of 9/30/2020. -1 injectable cartridge/vial of Phenytoin sodium (Dilantin-a medication to treat seizures) 50 mg/1 ml with an expiration date of 8/31/2020. -1 bottle of Rubbing Alcohol with an expiration date of 6/2020. B. An interview with the Pharmacist on 10/7/20 at 11:00 AM stated, "The crash carts/medication box is to be checked for outdates every week and the outdates are to be removed and replaced. The nurses are supposed to notify us if there is an outdated medication so we can replace it. This job is assigned to a different nurse every month." "The medication box is suppose to be locked also, this isn't today and I am unsure when it was unlocked."	I 560		
I 570	9-006.09H Dietary Services Dietary services must be provided directly or through written agreement to meet the general nutritional needs of patients and must be supervised by a registered dietitian. If there is not	I 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 570	Continued From page 8 a full-time registered dietitian, a person must be designated as full-time director of dietary services and is responsible for the daily management of dietary services. 9-006.09H1 There must be written policies and procedures established and implemented that provide dietary services to meet patient needs. 9-006.09H2 There must be a sufficient number of trained staff to provide dietary services. 9-006.09H3 Menus must be planned, written and followed to meet the nutritional needs of patients. 9-006.09H4 Meals must be served to patients at appropriate intervals. 9-006.09H5 Each hospital stores, prepares, protects, serves and disposes of food in a safe and sanitary manner and in accordance with the Food Code. This Standard is not met as evidenced by: 9-006.09H2 Based on observation, interview and record review, the facility failed to employ a dietary director and sufficient number of dietary staff to ensure preparation of approximately 300 meals daily for the facility. Findings include: Review of dietary department employee roster and schedule revealed the dietary director position had been vacant since January 2020. Facility had not designated an individual to serve as director during this prolonged time frame of nine (9) months. Interview with the Facility Operating Officer (FOO) on 10/6/2020 at 11:15am revealed that the director position had recently been re-classified by Human Resources to a Manager position and facility had just started	I 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 570	Continued From page 9	I 570		

advertising for applicants to apply for the newly classified Dietary Manager position. The FOO further revealed that a contract with a Registered Dietitian was not secured, and the staff were to use the Dietitians at Beatrice State Developmental Center (BSDC) - another State facility who employs three (3) Dietitians.
The Food Service Supervisors did not have a phone number to call for Dietitian questions/direction but were to send e-mail communication.

Review of staff working in the dietary department for September and October 2020, revealed a total of 5.5 dietary staff positions plus a prn (as needed) position were all vacant. The current dietary staff and supervisors were working multiple days in a row (up to 13) without a day off and were also working on average 20 - 40 hours of overtime per pay period to cover the shifts to prepare meals and clean the kitchen.

Staff interview with Food Service Supervisors (2) on 10/6/2020 at 9:35am revealed that the pay scale and volume/complexity of work required in the kitchen were causing dietary staff to leave and go work elsewhere for $3- $5 more per hour for less work required than the kitchen positions.

Review of the menu for the facility revealed the staff were required to prepare and serve hot meals 3 times daily with the exception of Continental Breakfast on Saturday/ Sunday and the occasional sack lunch offering of sandwich meals. To meet the demands of the regular menu service of hot meals to patients, the current staff of 7 employees
were working multiple hours of over-time and with very limited days off from the facility. A total of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(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) COMPLETE DATE
I 570	Continued From page 10 323 hours of Overtime was worked in the previous 6 weeks by dietary staff.	I 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 000	INITIAL COMMENTS The facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 19, "Existing Health Care Occupancies" of the 2000 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. The Norfolk Regional Center Hospital is a three story's with a walk out basement. The facility was built in 1950 and is a Type II (222) construction. The facility is fully sprinkled with smoke detection in the corridors and spaces open to the corridors. The Norfolk Regional Center Hospital was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 482.41 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2000 edition.	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridors free of obstructions. The corridors width was 8' wide. This deficient practice could delay evacuation of residents and staff during an emergency. The facility has the	K 211		

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
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 211	Continued From page 1 capacity for 150 beds with a census of 87 on the day of survey. Findings are: Observations on 10-6-20 between 12:44 pm and 12:48 pm revealed: 1. A clean linen cart along with two trash bags were being stored (not in use) in the hallway in 2nd floor west next to the security observation control room. 2. Holiday decorations hung from the ceiling grid in the hallway measured from the floor between 4'10" to 6'4" for clearance. During an interview on 10-6-20 between 12:44 pm and 12:48 pm, Maintenance Staff A confirmed the carts and trash bags were being stored in the hallway, and the lack of the minimum 6'8" head clearance in an egress path.	K 211		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 321	Continued From page 2 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure a door to a hazardous area was provided with a self-closing device and hazardous equipment was located in a fire rated room. The deficient practices would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 10-6-20 between 11:26 am and 11:40 am revealed the following: 1. Room L21 in the basement off of old cantina area, was being used as a storage room, the 60 min fire rated door failed to be provided with a self-closing device. 2. The pottery kiln located in the basement (PV West) failed to be located in an area that is separated from other spaces by smoke partitions with a door that is self-closing. 3. The Custodial Storage room in the basement failed to have penetrations sealed with the proper sealant. The four, 2 inch conduits were sealed	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 321	Continued From page 3 with non-rated expanding foam. During an interview on 10-6-20 between 11:26 am and 11:40 am, Maintenance Staff A confirmed findings.	K 321		
K 346	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a complete policy regarding the procedures to be taken in the event that the fire alarm system was out of service for more than four hours in any twenty-four hour period. The lack of a complete written policy and procedure could result in staff failing to implement interim safety measures in the event of an emergency. This deficient practice affected all occupants. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Record review on 10-6-20 at 1:09 pm, the facility failed to provide documentation of a fire watch policy. During an interview on 10-6-20 at 1:09 pm, Maintenance Staff confirmed the lack of	K 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 346	Continued From page 4 documentation of a fire watch policy	K 346		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinklers free from foreign material and not obstructed. These deficient practices would affect the operating temperature of the fire sprinklers and increased the potential that the sprinkler system would fail to activate as designed during a fire, which would affect all occupants. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Observations on 10-6-20 between 11:07 am and	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 353	Continued From page 5 11:23 am revealed the following: 1. Seven Sprinklers in the dish room were covered with dust and lint. 2. Twelve Sprinklers in the Kitchen were covered with dust and lint. 3. Two sprinklers in dry storage room were covered with dust and lint. 4. A sprinkler in the walking freezer was obstructed. 5. A sprinkler in the South Refrigerator was obstructed. 6. A sprinkler in the Middle Refrigerator was obstructed. 7. A sprinkler in the Cup and Paper storage room was obstructed. In an interview on 10-6-20 between 11:07 am and 11:23 am, Maintenance Staff A confirmed the foreign material on the fire sprinkler and the obstructions.	K 353		
K 354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.	K 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 354	Continued From page 6 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure that an accurate policy was in place regarding the procedures to be taken in the event that the sprinkler system is out of service for more than ten hours in any twenty-four hour period. The lack of a written policy and procedure would result in staff failing to implement interim safety measures in the event of an emergency. This deficient practice affected all occupants. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Record review on 10-6-20 at 1:08 pm, the facility failed to provide documentation of a fire watch policy. During an interview on 10-6-20 at 1:08 pm, Maintenance Staff A confirmed the lack of documentation of a fire watch policy.	K 354		
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 712	Continued From page 7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to hold fire drills under varied conditions for 2 of 3 shifts reviewed by not conducting the fire drills at least one hour apart from all other drills on the shift. The facility also failed to conduct a fire drills for the third shift for the first, second, and third quarters of 2020 and the fourth quarter of 2019 for second shift. This condition did not provide simulated training for staff to respond to a fire emergency during various activities and staffing levels, which would affect fire procedure response for all residents. The deficient practice would affect all occupants. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Fire drill documentation review on 10-6-20 at 13:28 pm revealed: 1. First shift fire drills were conducted at 1:44 pm on 10-2-19, 7:45 am on 11-30-19, 9:00 am on 2-28-20, 1:30 pm on 5-29-20, 2:00 pm on 6-23-20, and at 10:25 am on 9-31-20. 2. Second shift fire drills were conducted at 3:45 pm on 1-31-20, 9:18 pm on 3-31-20, 6:50 pm on 4-30-20, 4:10 pm on 7-31-20, and at 3:40 pm on 8-31-20. No documentation was provided for a fire drill during the fourth quarter of 2019. 3. Third shift fire drills were conducted at 6:15 am on 12-29-19. No documentation was provided for fire drills for the first, second, and third quarters of 2020. 4. The facility failed to provide documentation	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701**

(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
K 712	Continued From page 8 from a central receiving station on the fire alarm activation records. During an interview on 10-6-20 at 13:28, Maintenance Staff A confirmed the findings.	K 712		
K 753	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to prohibit the use of combustible decorations which would allow fire spread within the exit corridor. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Observations on 10-6-20 at 12:44 pm revealed multiple decorations hanging in the hallways of 2nd floor west wing with no documentation that	K 753		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 753	Continued From page 9 they have been treated with a flame retardant. During an interview on 10-6-20 at 12:44 pm, Maintenance Staff A confirmed the decorations hanging in the hallways.	K 753		
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 918	Continued From page 10 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to provide proper documentation that all of the weekly and monthly load testing was conducted properly. The deficient practices increased the potential that the generator would fail to run during loss of power. The facility has the capacity for 150 beds with a census of 87 on the day of survey. Findings are: Documentation review on 10-6-20 at 13:31 pm revealed the following: 1. The facility failed to provide documentation that the generator monthly load test was conducted and documented that the 30% of the rated capacity was met. 2. The facility failed to provide complete documentation on the weekly generator inspection. a. The lubrication system failed to be inspected and documented weekly. b. The exhaust system failed to be inspected and documented weekly. c. The electrical system failed to be inspected and documented weekly. d. The belts and hoses failed to be inspected and documented weekly. r. The prime mover failed to be inspected and documented weekly. f. The water pump failed to be inspected and documented weekly. g. The jacket water heater failed to be inspected	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 918	Continued From page 11 and documented weekly. h. The radiator failed to be inspected and documented weekly. During an interview on 10-6-20 at 13:31, Maintenance Staff A confirmed the lack of documentation.	K 918		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to use electrical wiring in a way that would not create a fire hazard. This condition	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	770007	A. BUILDING **01 - MAIN BLDG** B. WING _____	**10/08/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD** **NORFOLK, NE 68701**

(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
K 920	Continued From page 12 had the potential to cause a fire. The facility has the capacity for 1 50 beds with a census of 87 on the day of survey. Findings are: Observation on 10-6-20 between 10:58 am and 12:47 pm revealed the following: 1. An extension cord was used in lieu of permanent wiring in the maintenance office located in the basement. 2. 5 sets of Holiday lights were affixed to the walls and ceiling daisy chained together on 2nd floor west wing. In an interview on 10-6-20 between 10:58 am and 12:47 pm, Maintenance Staff A confirmed the findings.	K 920		

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	C 10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	**P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701**

(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) COMPLETE DATE
I 000	Initial Comments On 10/5-10/8/20, DHHS Public Health representatives conducted a licensure complaint investigation to determine compliance with 175 NAC 9, Licensure Regulations for Hospitals related to 9-006.04 Patient Rights. The facility was in compliance with the regulations related to Patient Rights at the time of the survey.	I 000		

Licensure Unit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Plan of Correction

Provider/Supplier Name:	Norfolk Regional Center	Survey Date
STREET ADDRESS, CITY, ZIP:	1700 North Victory Rd, Norfolk, NE 68701	10/8/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	9/19/3323
	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)	COMPLETIONDATE
CITED TAG #	K-211: Means of Egress - General CFR(s): NFPA 101: This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridors free of obstructions. The corridors width was 8' wide. This deficient practice could delay evacuation of residents and staff during an emergency.	
K-211	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all means of egress are free from obstructions.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-211	NRC Quality Assurance Coordinator (QAC) will update the NRC Decorations policy and procedure to ensure a minimum of 6' 8" clearance is maintained in all points of egress.	10/27/2020
K-211	NRC QAC will complete an audit of NRC grounds to ensure compliance with the NRC Decorations policy and procedure and remove all items not in compliance. The results of the audit will be reported to Administrative Council.	11/13/2020
K-211	NRC QAC will update the NRC Environment Inspection Form to reflect the change in policy.	10/27/2020
K-211	NRC QAC will update the NRC Bi-Annual Environmental Inspection Form to reflect the change in policy.	10/27/2020
K-211	NRC will educate all staff on the revised NRC Decorations policy.	12/18/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
K-211	NRC QA department will complete an audit to ensure all environment inspection forms to ensure accurate completion. The audit will be reported to NRC Environment of Care Committee (EOCC). The audit will continue for at least 90 days of 100% compliance.	2/1/2021
K-346	NRC QA Department will conduct an audit of all NRC employee files to ensure staff training has been completed. The results will be reported to Administrative Council. The audit will continue until 100% compliance is achieved.	1/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
I-470	NRC Quality Assurance Coordinator	
CITED TAG #	K-321: Hazardous Areas - Enclosure CFR(s): NFPA 101- This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure a door to a hazardous area was provided with a self-closing device and hazardous equipment was located in a fire rated room. The deficient practices would allow fire, smoke and gasses to migrate into the exit corridor.	
K-321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all hazardous areas are secured with a self-closing devise and fire rated door.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-321	NRC Maintenance Director will install a self-closing device on room L21 (Canteen door).	11/13/2020
K-321	NRC discontinued the use of the pottery kiln and will not use until secured in an area which is separated by smoke partitions and a door which is self-closing.	10/27/2020
K-321	NRC Maintenance Director will get an estimate of cost to install smoke partitions and a self-closing door around the pottery kiln.	12/1/2020

K-321	NRC Maintenance Director will seal all penetrations in the custodial storage room.	11/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
I-470	NRC QAC will coordinate an audit of NRC grounds to assess other penetrations and doors needing self-closing devices and ensure all areas are secured. The audit will continue until 100% compliance has been achieved. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	1/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
I-470	NRC Quality Assurance Coordinator	
CITED TAG #	K-346/K-354: This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a complete policy regarding the procedures to be taken in the event that the fire alarm system was out of service for more than four hours in any twenty-four hour period. The lack of a complete written policy and procedure could result in staff failing to implement interim safety measures in the event of an emergency. This deficient practice affected all occupants.	
K-346/K-354	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure a Fire Watch policy and process is implemented.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-346/K-354	NRC QAC will develop a Fire Watch Policy.	11/3/2020
K-346/K-354	NRC QAC will post Fire Watch reminders in all Fire Panels.	11/6/2020
K-346/K-354	All staff will be educated on the Fire Watch Policy and Procedure.	12/18/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
K-346/K-354	NRC QA Department will conduct an audit of all NRC employee files to ensure staff training has been completed. The audit will continue until 100% compliance is achieved. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	1/1/2021
K-346/K-354	NRC QA Department will complete a survey of staff to ensure they have knowledge of the Fire Watch Process. The results will be reported to EOCC. The audit will continue for at least 90 days of 100% compliance.	4/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
K-346/K-354	NRC Quality Assurance Coordinator	
CITED TAG #	K-353: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinklers free from foreign material and not obstructed. These deficient practices would affect the operating temperature of the fire sprinklers and increased the potential that the sprinkler system would fail to activate as designed during a fire, which would affect all occupants.	
K-353	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all fire sprinklers are free from obstructions and foreign material.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-353	NRC Maintenance Director will ensure all fire sprinklers on NRC grounds are free from dust and lint.	11/13/2020
K-353	NRC Maintenance Director will ensure all fire sprinklers have at least 18" clearance and are free from any items that may obstruct them.	11/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	

K-353	NRC QA department will complete an audit to ensure all fire sprinklers are free from dust and lint and are free from obstruction. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Quality Assurance Coordinator	
CITED TAG #	K-712: Fire Drills: This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to hold fire drills under varied conditions for 2 of 3 shifts reviewed by not conducting the fire drills at least one hour apart from all other drills on the shift. The facility also failed to conduct a fire drills for the third shift for the first, second, and third quarters of 2020 and the fourth quarter of 2019 for second shift. This condition did not provide simulated training for staff to respond to a fire emergency during various activities and staffing levels, which would affect fire procedure response for all residents. The deficient practice would affect all occupants.	
K-712	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure fire drills are completed at least quarterly under varying conditions for each shift.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-712	NRC QAC revised the NRC Fire Drill Schedule.	10/8/2020
K-712	NRC QAC will update the NRC Code Red Policy to reflect the fire drill process.	10/28/2020
K-712	NRC QAC will implement the NRC Fire Drill Schedule.	10/31/2020
K-712	NRC QAC will update the NRC Fire Drill Assessment to ensure the fire pull stations are tested within 24 hours if the drill was completed between the hours of 9pm and 6am.	10/28/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
K-712	NRC QAC will audit all fire drills are completed according to the NRC Fire Drill Schedule and according to policy and procedure. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	
CITED TAG #	K-753: Combustible Decorations CFR(s): NFPA 101- This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to prohibit the use of combustible decorations which would allow fire spread within the exit corridor.	
K-753	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure combustible decorations will not allow fire spread within the exit corridor.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-753	NRC QAC will update the NRC Decorations policy to reflect the process for treating decorations with flame retardant, including maintaining a list of these items.	11/3/2020
K-753	NRC QAC will update the NRC Environment Inspection Form to reflect the change in policy.	10/28/2020
K-753	NRC QAC will update the NRC Bi-Annual Environmental Inspection Form to reflect the change in policy.	10/28/2020
K-753	NRC QAC will ensure all decorations on unit are allowed per NRC policy and are treated with flame retardant.	11/6/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	

K-753	NRC QAC will audit all areas within NRC to ensure compliance with the NRC decorations policy. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	
CITED TAG #	K-918: Electrical Systems - Essential Electric System CFR(s): NFPA 101- This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to provide proper documentation that all of the weekly and monthly load testing was conducted properly. The deficient practices increased the potential that the generator would fail to run during loss of power.	
K-918	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure the generator is tested and monitored as necessary to decrease the likelihood of generator failure during loss of power.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-918	NRC Maintenance Director will update the Monthly NRC Generator Testing form to ensure documentation of load is documented and at least 30% of the generator capacity was met.	10/28/2020
K-918	NRC Maintenance Director will develop a monitoring form to document the weekly inspection of the generator which will include the lubrication system, exhaust system, electrical system, belts and hoses, prime mover, water pump, jacket water heater and radiator.	11/3/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
K-918	NRC QAC will audit the completion of the generator monitoring forms. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	11/13/2020
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
K-918	NRC Quality Assurance Coordinator	
CITED TAG #	K-920: Electrical Equipment - Power Cords and Extends CFR(s): NFPA 101- This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to use electrical wiring in a way that would not create a fire hazard.	
K-920	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all electical wiring is used in a way which does not increase fire hazards.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
K-920	NRC QAC will ensure the holiday lights are removed from all patient living units unless approved through the NRC Decorations policy.	10/28/2020
K-920	NRC QAC will update the NRC Decorations policy to state "daisy chaining" of electrical items is not permitted.	10/28/2020
K-920	NRC QAC will update the NRC Environment Inspection Form to monitor the use of power and electrical cords and ensure "daisy chaining" of electric items does not occur.	10/28/2020
K-920	NRC QAC will update the NRC Bi-Annual Environmental Inspection Form to monitor the use of power and electrical cords and ensure "daisy chaining" of electric items does not occur.	10/28/2020
K-920	NRC Maintenance Director will install permanent wiring in the basement maintenance office and remove the extension cord.	11/6/2020
K-920	NRC will educate all staff on the revised NRC Decorations policy.	12/18/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
K-920	NRC QA Department will conduct an audit of all NRC employee files to ensure staff training has been completed. The audit will continue until 100% compliance has occurred. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	1/1/2021

K-920	NRC QAC will audit all areas within NRC to ensure compliance with the appropriate use of power and electrical cords. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
K-920	NRC Quality Assurance Coordinator	

FACILITY STATEMENT OF COMPLIANCE

PROVIDER NAME:	Norfolk Regional Center	Survey Date
STREET ADDRESS, CITY, ZIP:	1700 North Victory Rd, Norfolk, NE 68701	10/8/2020
	Provider License Number:	9/19/3323
	PROVIDER'S STATEMENT OF COMPLIANCE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)	**DUE DATE**
CITED TAG #	I-470: 0-006.08 Infection Control-The facility failed to: Perform surveillance of infections to ensure nosocomial (Health Care Acquired) infections are identified, investigated and controlled; to have a Legionella prevention program for water safety; lacked a system for early detection of outbreaks and prevention; lack of monitoring for treatment appropriateness including failure to have an antibiotic stewardship program to prevent the development and spread of drug resistant organism; lack of any documentation of staff monitoring to ensure infection control policies are followed and corrective action plans developed if needed.	
I-470	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure surveillance of infections are identified, investigated and controlled. NRC will re-establish the antibiotic stewardship program. NRC will establish audits to ensure staff compliance of infection control practices.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-470	NRC Medical Director assigned the role of Infection Control Coordinator (ICC) to physician assistant.	10/27/2020
I-470	NRC ICC will work with Quality Assurance (QA) Department to re-establish infection control reports; which will include antibiotic stewardship, staff and patient illness.	11/13/2020
I-470	NRC ICC will implement a Antibiotic Stewardship program.	12/1/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
I-470	NRC ICC will work with QA Department to re-establish handwashing audits to ensure compliance is greater than 90% and report to the NRC Infection Control Committee.	12/1/2020
I-470	NRC QA Department will audit Infection Control and Antibiotic Stewardship Committee to ensure they are taking place as scheduled. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (<u>By JOB TITLE, not by NAME</u>) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
I-470	NRC Medical Director	
CITED TAG #	I-470: 0-006.08 Infection Control- The facility failed to: Perform surveillance of infections to ensure nosocomial (Health Care Acquired) infections are identified, investigated and controlled; to have a Legionella prevention program for water safety; lacked a system for early detection of outbreaks and prevention; lack of monitoring for treatment appropriateness including failure to have an antibiotic stewardship program to prevent the development and spread of drug resistant organism; lack of any documentation of staff monitoring to ensure infection control policies are followed and corrective action plans developed if needed.	

I-470	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will implement a Legionella prevention program for water safety.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-470	NRC QA Coordinator (QAC) will work with NRC Maintenance Director to establish a Legionella policy and procedure.	11/13/2020
I-470	NRC QAC will ensure all applicable staff are trained on the Legionella policy and procedures.	12/1/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
I-470	NRC QAC will establish an audit of the Legionella policy and procedure to ensure compliance. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
I-470	Quality Assurance Coordinator	
CITED TAG #	I-560: 9-006.09G Pharmacy Services- Based on record review, observations and staff interview, the facility failed to consistently monitor the medication refrigerator temperatures to ensure the temperature maintained a range from 32 degrees to 40 degrees Fahrenheit. This occurred in 6 of 7 medication refrigerators in the facility.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all medication refrigerators are monitored per policy.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-560	NRC QAC will develop a refrigerator monitoring form to track refrigerator temperatures in lieu of electronic monitoring process.	10/27/2020
I-560	NRC QAC will ensure all refrigerators have a temperature monitoring form.	11/6/2020
I-560	NRC DON will ensure all staff are educated on the revised refrigerator monitoring process.	11/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
I-560	NRC QA Department will complete an audit to ensure the refrigerator monitoring forms are completed. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
I-560	Director of Nursing	
CITED TAG #	I-560: 9-006.09G Pharmacy Services- Based on observation and staff interview the facility failed to ensure that expired medications were removed from stock to prevent use for patient care in 1 of 1 crash carts/medication box.	
I-560	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure crash cart medications are removed from the crash cart.**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-560	NRC Pharmacy Director replaced all expired medications and added plastic lock to storage bin where medications are located.	10/9/2020
I-560	NRC Medical Director reviewed medications on crash cart to assess need.	10/27/2020
I-560	NRC Pharmacy Director will remove all medications from crash cart inventory per NRC Medical Director feedback.	10/27/2020
I-560	NRC Pharmacy Assistant will update medication tracking form for crash cart medication storage bin.	10/30/2020

I-560	NRC Medical Director will assess items on crash cart for necessity. Based upon feedback from this assessment NRC DON will remove any items that are not necessary and will ensure all items remaining on the crash cart are not expired.	11/13/2020
I-560	NRC DON will ensure all crash cart monitoring forms are updated.	11/13/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
I-560	NRC QA department will complete an audit to ensure all crash cart monitoring forms are completed. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM and all staff meetings.	2/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	Director of Nursing	
CITED TAG #	I-570: 9-006.09H Dietary Services- Based on observation, interview and record review, the facility failed to employ a dietary director and sufficient number of dietary staff to ensure preparation of approximately 300 meals daily for the facility.	
I-570	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:**	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-570	NRC Hospital Administrator will assign staff assistant to dietary to assist supervisors with clerical duties.	10/13/2020
I-570	NRC Dietary Supervisor will assess current duties and hours of work for options of support from other departments and options to streamline.	10/16/2020
I-570	NRC Clinical Program Manager will work with Personal Development Supervisor to implement work therapy in dietary for cleaning carts/dishes.	10/19/2020
I-570	NRC Dietary Services Supervisor will Implement sack meals for dinner 2x/week to assist during staffing changes.	11/1/2020
I-570	NRC Dietary Services Supervisor will Implement daily continental breakfast to assist during staffing shortages.	11/1/2020
I-570	NRC Dietary Services Supervisor will Adjust dietary staff schedules to maximize use of FTE.	11/1/2020
I-570	Clinical Program Manager will assess ability to maximize use of work therapy positions including reviewing work therapy in other facilities such as corrections.	1/1/2020
I-570	LRC Food Director will tour NRC kitchen and observe process.	11/6/2020
I-570	NRC Dietary Services Supervisor will post the contact information for Beatrice State Developmental Center dietician in Dietary Services and ensure all staff are aware of the contact information.	11/6/2020
I-570	NRC Hospital Administrator will assess options for assistance in getting deep cleaning in the kitchen and dish room completed.	11/15/2020
I-570	NRC Human Resource Business Partner (HRBP) will expedite reclassification of two open food assistant positions to food cooks.	12/1/2020
I-570	NRC HRBP will Contact community businesses to discuss work options including Liberty Center, Workforce Development and the college. Discuss options to include training for college courses.	12/1/2020
I-570	NRC HRBP will provide a weekly status report to Administrative Council regarding all Food Service poisitons.	10/29/2020
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	

Facility Staffing Information

Staffing Levels

Staff injuries related to assault

Attachment N2

Subject: RE: Ombudsman's Contact

Uhing, Denise <Denise.Uhing@nebraska.gov>
to Whitmire, Don, Banks, Corey, English, Andrew

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020 – 167 positions filled
2. The number of positions vacant as of December 31, 2020 – 39 positions vacant
3. The number of positions needed in your HR staffing plan for FY21 – 206 positions to be full staff
4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020 – 167 positions filled, 5 pending start
5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020 – 20% turnover rate
6. The number of vacant positions as of December 31, 2020 – 39 positions vacant

Don – let me know if you need anything further.

Thank you!

Denise Uhing | *Human Resource Business Partner*
OPERATIONS
Nebraska Department of Health and Human Services
OFFICE 402-370-3201 | CELL 402-750-2080 | FAX 402-370-3566
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Whitmire, Don <Don.Whitmire@nebraska.gov>
Sent: Friday, February 5, 2021 11:46 AM
To: Uhing, Denise <Denise.Uhing@nebraska.gov>; Banks, Corey <Corey.Banks@nebraska.gov>; English, Andrew <Andrew.English@n
Subject: FW: Ombudsman's Contact

Hello everyone. I am needing some help. I told Jerall I would get them him the information next week. Please know I have to run all information through le

Denise can you please give me the info for A.

Corey can you please give me the B information.

Drew can you work on gathering the C. Work with me on questions.

Thank you.

Don Whitmire, MPA | *Hospital Administrator-Interim for the Norfolk Regional Center*
BEHAVIORAL HEALTH
Nebraska Department of Health and Human Services
OFFICE 402-370-4333 | CELL 402-649-2750
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Ombudsman's Contact

Whitmire, Don <[redacted]> Wed, Feb 10, 2021 at 7:07 AM
To: "Moreland, Jerall" [redacted]
Cc: "Nespor, Wes" [redacted], "Kahl, Larry" [redacted]

Good Morning Mr. Moreland,

Please see attached information related to your inquiry.

In 2020 we had 20 staff injuries related to assault.

I have attached a copy of our most recent licensure surveys, which includes a copy of our Life Safety Code inspection- which is the fire marshal review. I did speak with our maintenance director who indicated our Fire Marshal was out for the recertification related to the Life Safety Code inspection and indicated we were found to be in compliance after making the modifications associated with the deficiencies noted. We have not received a copy of this report.

In regards to your request on C below, specifically around internal safety, emergency inspections, and independent standards audits can you help me understand what you are requesting?

Thank you.

Don Whitmire, MPA | *Hospital Administrator-Interim for the Norfolk Regional Center*

BEHAVIORAL HEALTH

Nebraska Department of Health and Human Services

OFFICE: [redacted] | CELL: [redacted]

DHHS.ne.gov | Facebook | Twitter | LinkedIn

[redacted]

Inspections Reports

Bi-Annual 1st Half 2020

Bi-Annual 2nd Half 2020

State Fire Marshall

Attachment N3

Norfolk Regional Center
Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 1 West
Date: 6.12.20
Surveyors Signatures: CS,

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	pillar, obs area, Back room paint peeling in shower room
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	0	1 ceiling tile droop 1 ceiling tile pushed up
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	R 3/3 B 3/3
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	in back Stock room
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	File hasn't been changed since 4/23/2020
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66 %

	Life Safety Management	Score
1	Are means of egress/exit doors clearly and correctly marked?	1
2	Exit signs working and arrows pointed in correct direction?	1
3	Does the fire extinguisher have a current inspection tag?	1
4	Are safety pins in place?	1
5	Are fire alarm pull stations accessible?	1
6	Do fire doors open and security alarms sound?	1

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.	1	
	Section Score: 10/10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5/5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	0	on top shelf, need lowered
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 7/8	**Percentage:** _____ %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5/5	**Percentage:** 100 %	

Norfolk Regional Center
Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 3 East

Date: 6.29.20

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See a Hall
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 11 / 12 **Percentage:** 92 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	missing some dates on Log
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66 %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 /5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 /8	**Percentage:** 100 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 /5	**Percentage:** 100 %	

6-29-20

3 East

S-14 cleared
S-10 cleared

~~Oct~~ 2019

Kitchen - paint

N-5 ~~dust trouble~~

N-7 paint peeling off ceiling 12-26

N-9 paint - ceiling

N-14 - Paint peeling, bubbling 11-26

N-12 - chip paint, bubble, dusty

~~Toilet tank hole~~ 11.22

~~paint dust~~

~~N-10 hot water tank leaking~~ 11.22

~~Food in fridge~~

~~paint chip~~

Mailroom - ~~No hot water~~ 11.22

~~Food in fridge~~ 10.29

paint chip

S-8 paint

S-6 ~~dust~~ frame door light change needed 11.22

hole curtain rods

~~S-10 hole curtain rods~~ 12.26

~~S-15 hole wood replaced~~ 11.22

S-13 paint ~~smells cleaned~~ 11.22

S-9 door frame

S-7 paint ~~dusty~~ 11.22

dust

S-3 paint dusty

frame

S-1 paint

Bubble paint

Dust

S Bathroom ~~doors~~ ~~floor~~ 12.26 ~~ceiling~~

S shower ~~tiles missing~~ 11.22

-paint peel and vent

S Dryhall - curtain missing hooks

-Broken tile

~~Shower floor - Mold on wall~~

Laundry - paint ~~dust~~ 11.22

Vents in shower

Closet

Check water

N-5 holes shower door

N-7 ceiling paint, slip hazard

~~Hall shower~~ 11.22

~~N-12 Shower~~

~~N-14 shower~~ 11.22

N-2 - lock - process

N-8 ~~bathroom~~ paint

~~pipe leak replace~~ ~~Hall 3 east~~ 11.22

ES sink drip

-paint peel

Elevator - Sim 5-1

~~5-11 - dusty~~ 12.26

~~5-14 frame paint~~ 12.26

Pillar Sink hall needs paint

Above - paint

~~5-4 paint dust~~ 10-29

5-4 paint

hole in wall

around frame

Norfolk Regional Center
Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 2 East
Date: 6.18.20
Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	B2 4 R1/4
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 3 / 3 **Percentage:** 100 %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 /5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	medical not to face!!! Good!
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 /8	**Percentage:** 100 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5/5	**Percentage:** 100 %	

6-29-20

2 East

3 Fire Sprinklers

Entrance Room	W-12	S-15 paint
- Paint Bubble	window corner drop	S-16 shade needs replaced
[redacted]	W-10 - door frame paint	S-14 door frame
[redacted]	- paint bed frame	shade
[redacted]	- Vent paint	S-12 [redacted] Frame
[redacted]	W-8 paint [redacted]	S-10 paint, [redacted]
[redacted]	W-6 holes in wall	S-8 paint, bubbles
[redacted]	[redacted] frame S-4 Paint	
Tech office frame paint	W-2 paint	bubble
[redacted] 12-22-19	W-Alcove paint	S-2 vent
[redacted]	EVS closet	paint
[redacted]	- sink leaks	S-door wall paint
[redacted]	- vent rusted	Meeting room
Bathroom	S. Shower - missing tiles	- paint shelf
- Paint Bubbles	[redacted]	S-1 room
[redacted]	[redacted]	paint
Kitchen	Laundry	S-1 E-[redacted]
[redacted]	[redacted]	
[redacted]	- bubbles paint	
	- counter top loose	
W-5 paint frame.	S hallway room mold	
W-1 dirty room	S-3 Frame, paint bubble - wall grade, ceiling vent bulk 11.22	
[redacted] vent missing	S-5 paint [redacted] 11.22 Kitchen wall	Storage - paint
W-11 paint, mossy	S-7 paint	
W-13 paint frame	S-11 [redacted] 11.22 paint missing	
[redacted]	S-9 Frame, [redacted] bubble/repair	
- frame paint	South hallway hole in wall 11-22	

5-1 point
N-0 0 kudos

Norfolk Regional Center
Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 2 West

Date: 6.29.20

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	D 2/4 R 1/4
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	0	in office
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66. %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance espccially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 /5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 /8	**Percentage:** 100 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 /5	**Percentage:** 100 %	

6-29-2020

2W

paint office
~~bathroom~~

~~shower~~
~~laundry~~
~~vent~~

~~basement~~

~~bathroom~~

~~kitchen frame~~

~~wall~~ in wall
S-5- office wall
~~wall~~ repaired

~~wall~~ ~~sheetrock~~

~~W10~~ - Frame
Blade
paint

~~W~~ paint
~~W~~ paint bubble
~~soap~~

~~W2 frame~~

~~wall paint~~

~~wall paint~~

Laundry Room - Paint

~~wall paint frame wall by door~~

toilet #3
Plaster needs replaced
S-1- Paint - outlet box hole near ceiling
S-3- Door frame Paint / Plaster
S-7 Door frame Paint
S-15- Register needs paint
S-16- Door frame - wall paint
S-14- Walls Paint

S-12- Walls & Register paint
S-10- Walls Paint
S-8- Walls Paint
S-4- Walls, Register & Air Unit Paint
S-2- Door frame paint

Norfolk Regional Center
Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 3 west
Date: 6.29.20
Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	B-2 R-2
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83. %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 3 / 3 **Percentage:** 100 %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.	1	
	Section Score: 10/10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 / 5	**Percentage:** 100%	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 / 8	**Percentage:** 100%	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 / 5	**Percentage:** 100%	

3 west 6-29-20

Nurse Offices - Paint Bubbling N wall
Tech office - Bathroom -
N Bathroom - 2nd faucet cooler faucet

N-3 Bugs in light
N-7
N-9
N-11
Conference Room - Bubbling paint 12-31-19

N-10 - Frame paint
Bug on floor 11.22

N-8 Cracked frame
paint in room
register

N-6 Cracked frame
12-31-19

N-4 ceiling bubbling
N-2 (W.1)
(W.1)
Cracked frame
Air unit making noise
Messy 11-22

Dirty Floor

N Drywall
-Drywall holes (3 areas)

Chair

W-2
Sink no hot
W-2
Body vent needs cleaned
needs dusted
Bubble paint
W-3 11.22
Window drawer
Dusted 12-31-19
W-5 11.22
Bathroom vent (needs?)
W-6
vent
11.22
W-4 bubbling paint
needs cleaned

Drywall - paint peel
Bathroom
Faucet 3 - cold hot & tray
10.31.19
Shower tiles missing - Tower 1 Floor 6 water
Window needs cleaned - locked
Vanity - cracked paint window

S-1 - register needs paint
S-3 mold-air
S-5 paint missing (some)
walls & lined vents clean
S-9 mold 11.22

End of Suite L&L
paint peel

S-14
cracked frame
S-12
S-10 paint peel
S-8
S-6 room smells
cracked frame
paint peel
cleaned
S-4 paint cracked
11.22
S-2 cracked paint

S-4 paint bubbling 11.22
S-13 cracked paint (frame
S-11 dirty vent 11.22
S-15 paint peel
S-16 Heater knobs
needs replaced 11-22

3 ~~West~~ East

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
What does SDS stand for?	Safety Data Sheet				✓	X	X	X	
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216					X	X	X	X
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
Do personal electrical items need inspection before use?	Yes	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS	14	(A)
MINUS N/A	0	(B)
	= 14	(C)
	X 4	number of employees questioned (D)
Subtotal	= 56	(E)
Subtract total number of NO answers	- 7	(F)
	= 49	(G)
Divide (G) by (E) X 100	87.5 %	

3-East West

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓		X		
What does SDS stand for?	Safety Data Sheet	✓	✓	✓	✓		X		X
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	✓				X
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
Do personal electrical items need inspection before use?	Yes	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS	14		(A)
MINUS N/A		0	(B)
		= 14	(C)
		X 4	number of employees questioned (D)
Subtotal		= 56	(E)
Subtract total number of NO answers		- 4	(F)
		= 52	(G)
Divide (G) by (E) X 100		92.8	%

2 East

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓				✗	+	+	+
What does SDS stand for?	Safety Data Sheet	✓	✓					+	+
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	-				+
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
Do personal electrical items need inspection before use?	Yes	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS	14	(A)
MINUS N/A	0	(B)
	= 14	(C)
	X 4	number of employees questioned (D)
Subtotal	= 56	(E)
Subtract total number of NO answers	- 6	(F)
	= 50	(G)
Divide (G) by (E) X 100	89.2	%

2 West

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓					*
What does SDS stand for?	Safety Data Sheet	✓	✓	✓					*
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓		✓			*		
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
Do personal electrical items need inspection before use?	Yes	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS	14	(A)
MINUS N/A	0	(B)
	= 14	(C)
	X 4	number of employees questioned (D)
Subtotal	= 56	(E)
Subtract total number of NO answers	- 3	(F)
	= 53	(G)
Divide (G) by (E) X 100	94.6	%

1 West

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
What does SDS stand for?	Safety Data Sheet	✓	✓					x	x
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	✓	✓					2	2
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	●	✓			x		x
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
Do personal electrical items need inspection before use?	Yes	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS	14	(A)
MINUS N/A	0	(B)
	= 14	(C)
	X 4	number of employees questioned (D)
Subtotal	= 56	(E)
Subtract total number of NO answers	- 6	(F)
	= 50	(G)
Divide (G) by (E) X 100	89.2	%

Environmental Inspection Form

Date: 10-26-2020 Area 1 West Living Unit

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.		✓		6/6 - Badges 6/6 - Radios		
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					

Fire						
Fire door/Alarms operable	✓					
Fire door free from obstruction	✓					
Corridors and exits are clear and unobstructed. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked	✓					
Other Fire Safety Deficiencies		✓				
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

M Jones RT 10-26-2020
Staff Signature/Date

NRC Environmental Inspection Form

Date: 12-13-20 Area 3E

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X			Room S-15 is messy. Not clean.		
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X			Radio also in window for staff use.		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity						
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat						
EVS utility rooms locked.	X					
All chemicals are stored properly with appropriate labeling.	X			Chemicals are not behind locked cabinet like other units		
Only hospital approved cleaning supplies in the patient areas.	X					
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

	Y	N	N/A			
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.	X					
Facility Safety						
Gates are operable and no issues with perimeter fence.			X			
Exterior doors are locked and working properly			X			
Exterior lights are working			X			

Additional Comments:

Staff Signature/Date RT 12-13-20

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 12-13-20 Area 2E

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X			Room S-4 needs cleaned.		
Area well lit/no lights out	X			Linen Closet has (2) lights out.		
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X			Radio Also in window for staff use.		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X			Including SSC and Nursing Area		
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat.						
EVS utility rooms locked.	X			Chemicals behind locked cabinet		
All chemicals are stored properly with appropriate labeling.						
Only hospital approved cleaning supplies in the patient areas.						
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

	Y	N	N/A			
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.	X			office windows have papers and decor possibly obstructing view		
Facility Safety						
Gates are operable and no issues with perimeter fence.			X			
Exterior doors are locked and working properly			X			
Exterior lights are working			X			

Additional Comments: SSC: ERC is located in area. Area needs cleaned + sanatized.

James Johnson 12-13-20
Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 2/14/20 Area 1st Floor

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.	✓					
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity						
Code Green Buttons Accessible						
Other Security Deficiencies						
Hazardous Mat.						
EVS utility rooms locked.	✓			Paint is ~~the~~ peeling on door wall		
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked			✓			
No objects blocking sprinklers	✓					
No decorative lighting is used other than on approved artificial trees.			✓			
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

[signature] / 12-14-20

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 12-13-20 Area 3W

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X			South shower drain is backed up.		
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X			bottom outlet in (N) dayhall doesn't work.		
All employees are wearing ID badge in plain sight and carrying radios.	X			Radio in window for staff use		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X					
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat						
EVS utility rooms locked.	X			Chemicals behind locked cabinet		
All chemicals are stored properly with appropriate labeling.	X					
Only hospital approved cleaning supplies in the patient areas.	X					
Fire						
Fire door/Alarms operable and not obstructed	V					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

	Y	N	N/A			
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X			There is door on ceiling but on outside of camera lane.		
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.		X		Decorative lights on beams in dayhall.		
Facility Safety						
Gates are operable and no issues with perimeter fence.			X			
Exterior doors are locked and working properly			X			
Exterior lights are working			X			

Additional Comments:

Observation table closest to Nursing office is unstable, screws loose + coming apart, needs replaced.
- Wiring on phone in North dayhall needs looked at. - Phone cuts in/out.

Staff Signature/Date RT 12-8-20

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 12-15-20 Area IW

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew						
Area well lit/no lights out						
Area free of slip/trip hazards and excess staples						
Unit Restraints accounted for.						
Outlet covers are intact.						
All employees are wearing ID badge in plain sight and carrying radios.						
Electrical panel unobstructed						
Security						
All doors secured						
Window Integrity checked						
Badge Readers are working properly						
Sensitive areas are maintained secure/No unusual activity						
Code Green Buttons Accessible						
Other Security Deficiencies						
Hazardous Mat						
EVS utility rooms locked.						
All chemicals are stored properly with appropriate labeling.						
Only hospital approved cleaning supplies in the patient areas.						
Fire						
Fire door/Alarms operable and not obstructed						
No "daisy-chaining" of electrical items.						

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.						
Fire extinguisher pin in place						
Magnetic doors (in patient area) are latching correctly						
Electrical Panel in staff office is not blocked						
No objects blocking sprinklers						
No decorative lighting is used other than on approved artificial trees.						
Facility Safety						
Gates are operable and no issues with perimeter fence.						
Exterior doors are locked and working properly						
Exterior lights are working						

Additional Comments:

12-16-20

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 12-15-20 Area 2W

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew						
Area well lit/no lights out						
Area free of slip/trip hazards and excess staples						
Unit Restraints accounted for.						
Outlet covers are intact.						
All employees are wearing ID badge in plain sight and carrying radios.						
Electrical panel unobstructed						
Security						
All doors secured						
Window Integrity checked						
Badge Readers are working properly						
Sensitive areas are maintained secure/No unusual activity						
Code Green Buttons Accessible						
Other Security Deficiencies						
Hazardous Mat.						
EVS utility rooms locked.						
All chemicals are stored properly with appropriate labeling.						
Only hospital approved cleaning supplies in the patient areas.						
Fire						
Fire door/Alarms operable and not obstructed						
No "daisy-chaining" of electrical items.						

Covid 19

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.						
Fire extinguisher pin in place						
Magnetic doors (in patient area) are latching correctly						
Electrical Panel in staff office is not blocked						
No objects blocking sprinklers						
No decorative lighting is used other than on approved artificial trees.						
Facility Safety						
Gates are operable and no issues with perimeter fence.						
Exterior doors are locked and working properly						
Exterior lights are working						

Additional Comments:

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11-25-20 Area 1st floor

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X		X	Hallways clean/ not allowed on IW		
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.			X			
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X			Not allowed on IW/ 1st floor personal are wearing Badges!		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X					
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat.						
EVS utility rooms locked.	X					
All chemicals are stored properly with appropriate labeling.	X					
Only hospital approved cleaning supplies in the patient areas.	X		X	Not allowed to venture on IW		
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly			X	not allowed on LW		
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.	X					
Facility Safety:						
Gates are operable and no issues with perimeter fence.	X					
Exterior doors are locked and working properly	X					
Exterior lights are working	X					

Additional Comments:

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11/16/20 **Area** 2W

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.	✓					
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat.	✓					
EVS utility rooms locked.						
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked	✓					
No objects blocking sprinklers	✓					
No decorative lighting is used other than on approved artificial trees.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11-18-2020 Area RT Area

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓		1			
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.			✓			
Electrical panel unobstructed	✓					
Security	✓					
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat.	✓					
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked			✓			
No objects blocking sprinklers	✓					
No decorative lighting is used other than on approved artificial trees.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.			✓			
Exterior doors are locked and working properly			✓			
Exterior lights are working			✓			

Additional Comments:

M Morris RT 11-18-2020
Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11-18-2020 Area OT Area

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓		✓	Yes they are		
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.			✓			
Electrical panel unobstructed	✓					
Security						
All doors secured		✓		Door to OT was not locked		
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat.						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked			✓			
No objects blocking sprinklers	✓					
No decorative lighting is used other than on approved artificial trees.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.			✓			
Exterior doors are locked and working properly			✓			
Exterior lights are working			✓			

Additional Comments:

11-18-2022
Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11-18-20 Area 2East

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X			ON this unit many Patients have "sterile" rooms, cleanliness is not an issue.		
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X			Reminders needed at times.		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X			All staff areas properly secured		
Code Green Buttons Accessible	X					
Other Security Deficiencies		X				
Hazardous Mat.						
EVS utility rooms locked.	X					
All chemicals are stored properly with appropriate labeling.	X			Storage is correct But lock was not on storage shelf within closet.		
Only hospital approved cleaning supplies in the patient areas.	X					
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

	Y	N	N/A			
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.	X					
Facility Safety						
Gates are operable and no issues with perimeter fence.	X					
Exterior doors are locked and working properly	X					
Exterior lights are working	X					

Additional Comments: In SSC all lights and locks are working properly and ERC is located. Kitchen Area is clean + well lit- N/O issues.

James Johnson 11-18-20
Staff Signature/Date

- James Johnson RT

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 1-18-20 Area 3East

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X					
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X			Reminders Needed		
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X					
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat.						
EVS utility rooms locked.	X					
All chemicals are stored properly with appropriate labeling.	X					
Only hospital approved cleaning supplies in the patient areas.	X					
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

Due to Quality Assurance Department by the 15th of each month

	Y	N	N/A			
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
No decorative lighting is used other than on approved artificial trees.	X					
Facility Safety						
Gates are operable and no issues with perimeter fence.	X					
Exterior doors are locked and working properly	X					
Exterior lights are working	X					

Additional Comments:

- Kitchen Area is clean + well lit - No issues.
- Isolation area is locked + clean.

James Johnson 11-18-20

Staff Signature/Date

Due to Quality Assurance Department by the 15th of each month

NRC Environmental Inspection Form

Date: 11-18-2020 Area 6W Living Unit

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.		✓		315-B 315-R		
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat:						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked						
No objects blocking sprinklers	✓					
No decorative lighting is used other than on approved artificial trees.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

M Fenn RN 11-18-2020

Staff Signature/Date

Norfolk Regional Center
Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 1 West
Date: 12 28 22
Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	1	
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	0	3 patient rooms need tile
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	0	Extra room unit ok 14
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 10 / 12	**Percentage:** 83 %	

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	dates missing
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	
	Section Score: 2 / 3	**Percentage:** 66 %	

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	

Section Score: 10 /10 **Percentage:** 100 %

	Hazardous Material Waste and Communication	Score	Comment
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	

Section Score: 5 /5 **Percentage:** 100 %

	Emergency Management/Utility Systems	Score	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	0	top rack, must remove
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	

Section Score: 7 /8 **Percentage:** 88 %

	Medical Equipment Management Plan	Score	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	

Section Score: 5 /5 **Percentage:** 100 %

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish		✓		✓	✓		✓	
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓	✓	✓					✓
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	✓				
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓					✓	✓

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 5 (F)

= 49 (G)

Divide (G) by (E) X 100 88 %

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 3 Lucas
Date: 12-21-22
Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See at the end
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 11 / 12 **Percentage:** 92 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	dates missing med fridge
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66 %

	Life Safety Management	Score
1	Are means of egress/exit doors clearly and correctly marked?	1
2	Exit signs working and arrows pointed in correct direction?	1
3	Does the fire extinguisher have a current inspection tag?	1
4	Are safety pins in place?	1
5	Are fire alarm pull stations accessible?	1
6	Do fire doors open and security alarms sound?	1

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	

Section Score: 10 /10 **Percentage:** 100 %

Hazardous Material Waste and Communication		Score	Comment
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	

Section Score: 5 /5 **Percentage:** 100 %

Emergency Management/Utility Systems		Score	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	0	3rd fl #3 Flush knobs repaired

Section Score: 7 /8 **Percentage:** 88 %

Medical Equipment Management Plan		Score	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	

Section Score: 5 /5 **Percentage:** 100 %

3 west

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				✓
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓					✓	✓	✓
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	✓				
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 4 (F)

= 52 (G)

Divide (G) by (E) X 100 93 %

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 2 East

Date: 12-3-20

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	[illegible]
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	[illegible]
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	[illegible] dates [illegible]
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66 %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	

Section Score: 16 /10 **Percentage:** 10 %

Hazardous Material Waste and Communication **Score** **Comment**

1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	

Section Score: 5 / 5 **Percentage:** 100 %

Emergency Management/Utility Systems **Score**

1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	more in charger
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	

Section Score: 8 / 8 **Percentage:** 100 %

Medical Equipment Management Plan **Score**

1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	

Section Score: 5 / 5 **Percentage:** 100 %

2 Eve

H L JB C H L JB C

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	✓				
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 0 (F)

= 56 (G)

Divide (G) by (E) X 100 100 %

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 2 West

Date: 12.28.20

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	0	Stained - 3 tiles
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	0	clutter
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 9 / 12	**Percentage:** 75 %	

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	0	in office
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	0	dates missing
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	
	Section Score: 1 / 3	**Percentage:** 33 %	

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	

Section Score: 10 /10 **Percentage:** 100 %

	Hazardous Material Waste and Communication	**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	

Section Score: 5 / 5 **Percentage:** 100 %

	Emergency Management/Utility Systems	**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	0	2nd toilet Sanity key to flush, Staff toilet lid to flush

Section Score: 7 / 8 **Percentage:** 87.5 %

	Medical Equipment Management Plan	**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	

Section Score: 5 / 5 **Percentage:** 100 %

2 West

T TM L 5 T TM L 5

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓		✓	✓		✓		
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓		✓	✓		✓		
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓					✓	✓	✓
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216			✓	✓	✓	✓		
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓		✓	✓		✓		
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 8 (F)

= 48 (G)

Divide (G) by (E) X 100 86 %

Norfolk Regional Center
Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 3 East
Date: 12 24 20
Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See work hist
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	0	5-15, 5-1
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?		
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in ~~utility rooms~~ office	1	
2	Refrigerator logs maintained and up to date (~~refrigerator temps are stored on the S drive, temperature folder~~, log on fridge	0	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 2 / 3 **Percentage:** 66 %

	Life Safety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	1	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	1	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 /5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	0	plug in missing
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 7 /8	**Percentage:** 87.5 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 /5	**Percentage:** _____ %	

3E

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	X	X	X	X				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	X	X	X	X				
Who is responsible for making fall reduction a priority?	All NRC staff.	X	X	X	X				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	X	X	X	X				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	X	X	X	X				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	X	X	X	X				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	X	X	X	X				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	X	X	X	X				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	X	X	X	X				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	X	X	X	X				
Where is the hospital incident command center located?	Room 216	X	[illegible]				X	X	X
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	X	X	X	X				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	X	X	X	X				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	X	X	X	X				

TOTAL NUMBER OF QUESTIONS	14	(A)
MINUS N/A	0	(B)
	= 14	(C)
	X [illegible]4	number of employees questioned (D)
Subtotal	= 56 [illegible]	(E)
Subtract total number of NO answers	- [illegible]3	(F)
	= 53	(G)
Divide (G) by (E) X 100	75	%

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
NDOL.Conveyances@nebraska.gov
Office: 402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name NORFOLK REGIONAL CEN
Building Address 1700 N VICTORY RD
Building City NORFOLK
Building State NE
Building Zip 68701
Elevator Name BLDG 16 EAST
State ID Number 4098
Elevator Type HYDRAULIC
Elevator Use PASSENGER
# of Landings 4
Last Annual Inspection Date 11/15/2018
Elevator Speed (feet/min) 100
Elevator Capacity 4000
Elevator Installation Date 1/1/2016
Manufacturer DOVER
Seal Number

ELEVATORS

Devices Tested/Test Requirement
ASME A17.2 Item #
Pass
Fail
N/A
Results/Notes

IN CAR

1 Must make door reopening device operable.
1.1.1
○
○
○

2 Must make car and floor sill's level.
1.3.1.1
○
○
○

3 Must make emergency light operable.
1.5.1 (b)
○
○
○

4 Must make emergency Alarm Bell/Phone operable.
1.6.1
○
○
○

5 Must make restrictors work outside 18” zone to 4” max open.
1.18.1
○
○
○

MACHINE ROOM

6 Ensure permanent/unobstructed access to machines/controls.
11.1.3
○
○
○

7 Must provide ample, guarded, machine room lighting.
2.3.1
○
○
○

8 Must provide sufficient heating/cooling for equipment.
2.6.1
○
○
○

9 Must provide lockable mainline and lighting disconnects.
2.11.1
○
○
○

10 Must have fire extinguisher adjacent to controls/machine areas.
2.7
○
○
○

11 Clear of non-elevator storage, flammables, from oil, grease, dirt.
2.5.1
○
○
○

12 Current relief test records tag/plate for pressure testing 1 year.
2.31.1
○

13 Must provide current governor test tag/plate 1/5 year.
2.13.2.1
(b)(6)

14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+
2.40.1

CAR TOP

15 Must make car top stop switch operable.
3.1.1

16 Must make car top inspection station operable.
3.3.1

17 Must make car top light and GFCI outlet operable.
3.2.1

18 Must make hoist way venting clear and louvers operable.
3.11.1

19 Check that a standard railing is provided where required.
3.4.3.1 (b)

20 Must keep all ropes free from rust/kinks/broken strands.
3.23.1

FIRE

21 Must test Fire Service Phase One & Two monthly.
6.5.2 & 6.5.3

22 Must maintain monthly fire service testing log in control room.
6.1.1

HOISTWAY

23 Must maintain door closing foot pound pressure within limits.
1.8.1

24 Must properly adjust door equipment on car & hall doors.
3.17.1

25 Must maintain door gibs and retainers if provided to code.
1.7.1

26 Escutcheons intact, secure. Access switches & limits work OK.
4.5.1

PIT AREA

27 Must provide pit ladder on all pits over 30”, on P.U. side of door.
5.1.1 (b)

28 Must maintain a dry pit, clean and paint pit equipment.
5.1.1 (e)

○
○

29 Must make pit stop switch operable, locate adjacent to ladder.
5.1.1 (c)
○
○
○

30 Must make pit light operable, switch adjacent to ladder, 18” high
5.1.1 (d)
○
○
○

31 Sump cover must be grated or 5-2” holes to allow water inside.
5.1.1 (e)
○
○
○

32 Must keep pit equipment rust free, clean to bare metal, paint.
5.10-14
○
○
○

ESCALATORS

33 Must keep handrails free from cuts, cracks, pinch points and other hazards.
7.3
○
○
○

34 Must keep covers secure, no tripping hazards, maintain open area for access.
7.4
○
○
○

35 Must keep safety decals or signs in good shape for passengers to read.
7.6
○
○
○

36 Must keep stationary comb plates and escalator step edges which mesh.
7.7.1
○
○
○

37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.
7.17.1

38 Must keep excessive play or rocking movement in steps to a minimum.
7.9.1 (b,1)

39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+
7.19.1

Inspector Name GREG VIRANT
Building Representative This field is required.
Inspection Date 12/16/2019
Save Cancel

State Fire Marshal - Office of Elevator Safety
1313 Farnam, Rm. 233
Omaha, NE 68102
NDOL.Conveyances@nebraska.gov
Office: 402-595-3184
Fax: 402-595-1360

Nebraska Annual Conveyance Safety Inspection Form

Building Name NORFOLK REGIONAL CEN
Building Address 1700 N VICTORY RD
Building City NORFOLK
Building State NE
Building Zip 68701
Elevator Name #2, BLDG. 16 WEST
State ID Number 4095
Elevator Type HYDRAULIC
Elevator Use PASSENGER
# of Landings 4
Last Annual Inspection Date 11/15/2018
Elevator Speed (feet/min) 100
Elevator Capacity 4000
Elevator Installation Date 9/1/1989
Manufacturer KONE
Seal Number

ELEVATORS

Devices Tested/Test Requirement
ASME A17.2 Item #
Pass
Fail
N/A
Results/Notes

IN CAR

1 Must make door reopening device operable.
1.1.1
○
○
○

2 Must make car and floor sill's level.
1.3.1.1
○
○
○

3 Must make emergency light operable.
1.5.1 (b)
○
○
○

4 Must make emergency Alarm Bell/Phone operable.
1.6.1
○
○
○

5 Must make restrictors work outside 18” zone to 4” max open.
1.18.1
○
○
○

MACHINE ROOM

6 Ensure permanent/unobstructed access to machines/controls.
11.1.3
○
○
○

7 Must provide ample, guarded, machine room lighting.
2.3.1
○
○
○

8 Must provide sufficient heating/cooling for equipment.
2.6.1
○
○
○

9 Must provide lockable mainline and lighting disconnects.
2.11.1
○
○
○

10 Must have fire extinguisher adjacent to controls/machine areas.
2.7
○
○
○

11 Clear of non-elevator storage, flammables, from oil, grease, dirt.
2.5.1
○
○
○

12 Current relief test records tag/plate for pressure testing 1 year.
2.31.1
○

13 Must provide current governor test tag/plate 1/5 year.
2.13.2.1
(b)(6)

14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+
2.40.1

CAR TOP

15 Must make car top stop switch operable.
3.1.1

16 Must make car top inspection station operable.
3.3.1

17 Must make car top light and GFCI outlet operable.
3.2.1

18 Must make hoist way venting clear and louvers operable.
3.11.1

19 Check that a standard railing is provided where required.
3.4.3.1 (b)

20 Must keep all ropes free from rust/kinks/broken strands.
3.23.1

FIRE

21 Must test Fire Service Phase One & Two monthly.
6.5.2 & 6.5.3

22 Must maintain monthly fire service testing log in control room.
6.1.1

HOISTWAY

23 Must maintain door closing foot pound pressure within limits.
1.8.1

24 Must properly adjust door equipment on car & hall doors.
3.17.1

25 Must maintain door gibs and retainers if provided to code.
1.7.1

26 Escutcheons intact, secure. Access switches & limits work OK.
4.5.1

PIT AREA

27 Must provide pit ladder on all pits over 30”, on P.U. side of door.
5.1.1 (b)

28 Must maintain a dry pit, clean and paint pit equipment.
5.1.1 (e)

29 Must make pit stop switch operable, locate adjacent to ladder.
5.1.1 (c)

30 Must make pit light operable, switch adjacent to ladder, 18” high
5.1.1 (d)

31 Sump cover must be grated or 5-2” holes to allow water inside.
5.1.1 (e)

32 Must keep pit equipment rust free, clean to bare metal, paint.
5.10-14

ESCALATORS

33 Must keep handrails free from cuts, cracks, pinch points and other hazards.
7.3

34 Must keep covers secure, no tripping hazards, maintain open area for access.
7.4

35 Must keep safety decals or signs in good shape for passengers to read.
7.6

36 Must keep stationary comb plates and escalator step edges which mesh.
7.7.1

37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.
7.17.1

38 Must keep excessive play or rocking movement in steps to a minimum.
7.9.1 (b,1)

39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+
7.19.1

Inspector Name GREG VIRANT
Building Representative This field is required.
Inspection Date 12/16/2019
Save Cancel

STATE OF NEBRASKA*STATE FIRE MARSHAL
246 SOUTH 14TH STREET
LINCOLN, NE 68508-1804

	Fee Sheet Number: 4626
Facility Name Norfolk Regional Center Hospital	Occupant Street Address 1700 N Victory Rd
Operator & Phone number	City / Town Norfolk
Owner / Address / Phone number/Email Tom Barr 402-370-3400 dhhs.nrclicensure@nebraska.gov 1700 N Victory Rd Norfolk, NE 68701-0000	County Madison
	How Occupied Existing Healthcare
Occupant load 150 beds	Date of Inspection 11-30-2020
	Fee Card ☐YES ☒NO ☐N/A

ORDER

Contact person/number :
Initial inspection : 10-6-2020
Revisit inspection : 11-30-2020
Hours of operation :
Plan review numbers :

This is a Revisit of the inspection conducted on 10-06-2020. All deficiencies have been corrected and upon payment of all required inspection fees will be APPROVED at that time.

All items must be corrected to comply with the laws of the State of Nebraska and with rules and regulations adopted by the State Fire Marshal as mandated by section 81-502 to 81-541.01

It is the duty of the owner or person in charge of the above-named facility to immediately take measures to bring the facility into compliance with state regulations. **ALL CORRECTIONS SHALL BE MADE AND ALL ITEMS CORRECTED ON OR BEFORE.** _____

If you have questions on this Order, contact Deputy, by phone **District A:** 402-471-2590 or **District B:** 402-395-2164 or by Email at sfm.inspections@nebraska.gov

Witness my signature at Winnetoon Nebraska this 30th day of November, 2020

By: Robert Folck
Robert Folck , Deputy State Fire Marshal

Subject: FW: Inspection Form - 12/17/2019 - 4095 - 233847

Whitmire, Don <Don.Whitmire@nebraska.gov> Thu, Mar 11, 3:00 PM (23 h
to Devaraju, Usha, Bruegman, James

You are viewing an attached message. Nebraska Legislature Mail can't verify the authenticity of attached messages.

Hello Ms. Devaraju,

My name is Don Whitmire, I am the Interim Hospital Administrator at the Norfolk Regional Center. Our Director of Mainten James Bruegman, forwarded the attached elevator inspection forms he received from you. Mr. Bruegman indicated he had exp concerns with the attached as there were no checkmarks in the pass/fail boxes on the attached but you had verified that we ha all the inspections.

I am wanting to verify this information. I am also wondering if we could have someone from your department send us the con forms with the boxes checked. These reports are required to be turned in as part of our licensure process and I am concerned not complete.

I do need to provide these documents by the end of business tomorrow.

Thank you.

Don Whitmire | *Hospital Administrator Interim- Norfolk Regional Center*
BEHAVIORAL HEALTH
Nebraska Department of Health and Human Services
OFFICE: 402-370-3240
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Bruegman, James <James.Bruegman@nebraska.gov>
Sent: Thursday, March 11, 2021 2:50 PM
To: Whitmire, Don <Don.Whitmire@nebraska.gov>
Subject: FW: Inspection Form - 12/17/2019 - 4095 - 233847

James Bruegman
Facility Maintenance Supervisor
Norfolk Regional Center
1700 N. Victory Rd.
Norfolk NE 68701
(402)649-1376

From: Devaraju, Usha <Usha.Devaraju@nebraska.gov>
Sent: Wednesday, March 10, 2021 11:57 AM
To: Bruegman, James <James.Bruegman@nebraska.gov>
Subject: Inspection Form - 12/17/2019 - 4095 - 233847

Please find the two inspection forms attached. Hope there are only two elevators here.
Thank you,

Whitehall
License Verification

Attachment W1

Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall South, PO Box 94986
Lincoln, NE 68509-4986

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

LRC Whitehall Psychiatric Residential Treatment Facility

MEETS STATUTORY REQUIREMENTS AS
MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER
Lic # MHSU031

Services
MENTAL HEALTH TREATMENT

EXPIRES
9/30/2021

SEAL

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

Cut on heavy line and place on license.

LRC Whitehall Psychiatric Residential Treatment Facility
ADDRESS: 5845 HUNTINGTON AVENUE, LINCOLN, NE 68507

This is to verify that your MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.

DHHS Public Health Licensure Unit

Whitehall survey

Attachment W2

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 22, 2020

Mark Labouchardiere, Administrator
Lrc Whitehall Prtf
5845 Huntington Avenue
Lincoln, NE 68507

Dear . Labouchardiere:

After reviewing the findings of the onsite revisit survey conducted for your Pyschiatric Residential Treatment Facility on September 21, 2020 by a representative of this Department, we are pleased to inform you that your facility is in substantial compliance.

The enclosed form indicates the survey results. Please retain for your files.

The surveyor wishes to thank you and your staff for the courtesy and sending the information to our office. If you have any questions, please contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

ML/ti

Enclosure: CMS-2567
Survey Evaluation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	**5845 HUNTINGTON AVENUE LINCOLN, NE 68507**

(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
N 000	Initial Comments A revisit was conducted to the recertification survey that was completed on 8/4/20 by a DHHS Representative. During the revisit, the facility was found to be in compliance with the Conditions of Participation for Psychiatric Residential Treatment Facilities which had been cited at the time of the survey.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREAT	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(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) COMPLETE DATE
X 000	Initial Comments A representative of the DHHS, Division of Public Health conducted an offsite revisit to the Licensure Survey (ending 9/21/2020) to determine compliance with Title 175 Chapter 19, Regulations Governing Licensure of Mental Health Centers. The facility was found to have corrected the citations cited and is now in compliance with these regulations.	X 000		

Licensure Unit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 22, 2020

Dr. Jesse Foster, Administrator
Lrc Whitehall Psychiatric Residential Treatment Facility
5845 Huntington Avenue
Lincoln, NE 68507

Dear Dr. Foster:

After reviewing the findings of the onsite revisit survey conducted at your Mental Health Substance Use Facility on September 21, 2020 by a representative of this Department, we are pleased to inform you that your facility is in substantial compliance.

The enclosed form indicates the survey results. Please retain for your files.

The surveyor wishes to thank you and your staff for the courtesy and sending the information to our office. If you have any questions, please contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 7, 2020

Mark Labouchardiere
Administrator
Lrc Whitehall Prtf
5845 Huntington Avenue
Lincoln, NE 68507

Dear Mr. Labouchardiere:

The enclosed report documents a finding of noncompliance with the licensure regulations for LRC Whitehall PRTF Psychiatric Residential Treatment Facilities -following the survey at your facility completed on August 4, 2020 by representatives of the Nebraska Department of Health and Human Services Division of Public Health.

The violations found must be corrected to avoid disciplinary action against the facility's license. Therefore, a written statement of compliance must be submitted to the Department within 10 calendar days of receipt of this letter. The statement of compliance must include for each deficiency cited:

1) Action(s) that will be taken to correct the deficiency;
2) The procedure for implementing the corrective action(s);
3) How the facility will monitor its corrective actions/performance to ensure that the violation is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent;
4) Identify person(s) by position, not individual name, who will be responsible for monitoring and ensuring that compliance is achieved and continues;
5) A realistic date by which each violation will be corrected (which should be within 45 days of the exit of the survey); and
6) Signature of the administrator or other authorized official and date.

If you fail to submit and implement a statement of compliance, the Department may initiate disciplinary action against the facility license.

If you have any questions regarding this correspondence, contact this office.

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986
Email: [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(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
N 125	PROTECTION OF RESIDENTS CFR(s): 483.356 (a) Restraint and seclusion policy for the protection of residents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure their restraint and seclusion policy identified their current system of emergency safety intervention in a crisis situation. This had the potential to effect all the clients in the facility. The facility census was 6 at the time of the inspection. Findings: Record review of the facility's policy and procedure manual for the Whitehall facility revealed the policy, Crisis Management and De-Escalation, Policy PC-02, dated 12/2019, revealed a hold can be used up to three (3) minutes in an emergency situation to protect a client in imminent danger of harming themselves or others. Interview with Youth Security Specialist II A on 8/3/2020 at 1:00 P.M. revealed the 3 minute timeframe which was trained as a part of Mandt crisis intervention training and stated that the policy needed to be redone to reflect the Handle with Care guidelines. Interview with the Youth Security Supervisor (Handle with Care trainer) on 8/3/2020 at 2:00 P.M. confirmed the facility no longer utilized Mandt and have implemented the use of Handle with Care stand up holds for interventions requiring a hold until the client has calmed.	N 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	**5845 HUNTINGTON AVENUE LINCOLN, NE 68507**

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(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
E 000	Initial Comments An Emergency Preparedness requirements review was conducted by a DHHS Public Health surveyor ending 8/4/2020. LRC Whitehall PRTF was found to be in compliance with the Emergency Preparedness Requirements for a Psychiatric Residential Treatment Faciility (PRTF), §441.184.The facility census was 6 at the time of the inspection.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

PLAN OF CORRECTION

Provider/Supplier Name:	LRC Whitehall PRTF	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 Huntington Avenue Lincoln, NE 68507	8/4/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28 -	28L032

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

Facility Staffing Information

Staffing Levels

Number of assaults on staff

Attachment W3

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Ombudsman's Contact

Foster, Jesse <Jesse.Foster@nebraska.gov> Thu, Feb 25, 2021 at 9:24 AM
To: "Moreland, Jerall" <jmoreland@leg.ne.gov>

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020 57
2. The number of positions vacant as of December 31, 2020 1
3. The number of positions needed in your HR staffing plan for FY21 58
4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020 57
5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020 [redacted] We have had 10 positions turn over between 1/01/2020 and 12/31/2020.
    1. 1 Youth Security Supervisor [redacted]
    2. 2 Registered Nurses [redacted]
    3. 3 Youth Security Specialist II positions [redacted]
    4. 1 Clinical Director [redacted]
    5. 2 Mental Health Providers [redacted]
    6. 1 Social Worker [redacted]
6. The number of vacant positions as of December 31, 2020 1

B. The number of assaults on staff for calendar year 2020 [redacted]

C. Please provide a copy of the most recent inspections or audit reports for calendar year 2020. To include, but not limited to reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, etc.

If you have any questions, please call and have a great weekend

Jesse Foster, Ph.D, M.Ed | *Facility Administrator*

BEHAVIORAL HEALTH

Nebraska Department of Health and Human Services

OFFICE: [redacted] | CELL: [redacted]

DHHS.ne.gov | Facebook | Twitter | LinkedIn

[Quoted text hidden]

9 attachments

MHSU031 LRC Whitehall Psychiatric Residential Treatment Facility.pdf
13K

PRTF Letter LRCWH.docx
341K

Nebraska State Fire Marshall

Occupancy Permits

Attachment W4

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11303

Name of Facility:	**Whitehall-Warner House**
Type of Facility:	**Mental Health Center**
Location:	**5800 Leighton Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11302

Name of Facility:	**Whitehall-Office, Cafeteria, Clinic**
Type of Facility:	**Mental Health Center**
Location:	**5845 Huntington Ave, Lincoln**
Maximum Occupancy:	**N/A**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11301

Name of Facility:	**Whitehall-Family Life**
Type of Facility:	**Mental Health Center**
Location:	**5819 Huntington Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11300

Name of Facility:	**Whitehall-Community Life**
Type of Facility:	**Mental Health Center**
Location:	**5801 Walker Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

Change in occupancy classification or failure to meet State Fire Marshal codes shall invalidate this occupancy permit.

DHHS Public Health Licensure Unit

HRC Surveys

Attachment H1

State of Nebraska

Department of Health and Human Services
Division of Public Health

State of Nebraska/Department of Health and Human Services/Hastings Regional Center/Hastings Juvenile Chemical Dependency Program
Is hereby authorized in compliance with laws of the State of Nebraska to establish and conduct a
Residential Child-Caring Agency
located at: **4200 W 2nd Hastings NE 68902**

A maximum of **24** children in ages **13 YRS** to **19 YRS** may be in attendance at any one time.

Hastings Regional Center- Hastings Juvenile Chemical Dependency Program is hereby issued License No. **RCCA032** which is effective from **02/05/2018** and will expire on **02/05/2021**

Given under the name and Seal of the Department of Health and Human Services Division of Public Health of the State of Nebraska at Lincoln on **February 12, 2020.**

SEAL

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health & Human Services

State of Nebraska

Department of Health and Human Services
Regulation and Licensure

Lincoln, Nebraska

ISSUES LICENSE NO. SATC009 to STATE OF NEBRASKA HEALTH & HUMAN SERVICES to operate a SUBSTANCE ABUSE TREATMENT CENTER at P O BOX 579, 4200 WEST 2ND, BLDG 7 in the city of HASTINGS, NE. This facility is subject to rules and regulations lawfully promulgated by the State of Nebraska Department of Health and Human Services Regulation and Licensure.

Licensure Issuance Date: October 01, 2001

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

Hastings Regional Center
MEETS STATUTORY REQUIREMENTS AS
MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER

Services
SUBSTANCE USE TREATMENT

Lic # MHSU022

EXPIRES
9/30/2020

SEAL

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

HEALTH AND HUMAN SERVICES SYSTEM
STATE OF
SEAL
NEBRASKA
EST. JAN 1, 1997

Given under my hand and the seal of the State of Nebraska Department of Health and Human Services Regulation and Licensure at Lincoln, Nebraska, on September 25, 2001.

Richard P. Nelson

Richard P. Nelson, Director, Department of Health and Human Services Regulation and Licensure

Risk Assessments

Pro-Active Risk

2020 Annual Hazard Vulnerability

Attachment H2

HASTINGS REGIONAL CENTER

Pro-Active Risk Assessments

To Include New Buildings and Renovations

Prepared by

Grant Johnson, Safety Coordinator

June 15th, 2020

A PRO-ACTIVE RISK ASSESSMENT FOR THE ENVIRONMENT OF THE HASTINGS REGIONAL CENTER

INTRODUCTION

This document is intended to address the environment of the adolescent substance abuse program. It is in response to the JCAHO Environment of Care Standard.

> The organization conducts proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of clients, staff, and other people coming to the organization's facilities.
>
> And:
>
> The organization uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of clients, staff, and other people coming to the organization's facilities.

This report is based on the following inspections:

- A **Suicide Risk Assessment** of the client care buildings and client care areas conducted by members of the Environment of Care Committee
- The **Life Safety Inspections** conducted by the Deputy Fire Marshals
- The **Safety Inspections** conducted by the Safety Coordinator
- The semi-annual **Building Inspections** conducted by the Environment of Care Committee members, Maintenance and other support and staff
- Annual **Alarm checks** conducted by the Safety Coordinator
- **Fire Drill Issues** found during drills or activations
- Various other routes of information or recommendations from Surveyors, Risk Manager, etc.

GENERAL COMMENTS

Hastings Regional Center is a Juvenile Substance Abuse Facility operated by the Nebraska Department of Health and Human Services. It is located on the west edge of Hastings and covers approximately 25 acres. The Hastings Juvenile Chemical Dependency Program (HJCDP) is in Buildings 27, 28 and 29 on the east side of the campus near the entrance. Building 28/29 are used for client living areas. The HJCDP program has a license for 24 youth.

The campus also includes an Administration Building, Maintenance Shop, Power Plant and several other buildings which are not used and will be demolished.

There are 3 main parking lots and several lesser parking areas. The main structures are connected by an underground tunnel system containing pipes for electricity, steam and water. The tunnels are also used for transporting supplies. Travel through the tunnel by the clients is not allowed. Recreation areas are in various outdoor locations and in the chapel.

The facility has procedures and controls in place to enhance safety and mitigate risks:

Client rooms:

- No electric beds.
- No closets or closet rods.
- Velcro curtains in Building 28/29 in client sleeping rooms.
- Sleeping rooms have knobs that lock from outside and have free egress when inside.
- Doors swing out into hallway in Building 28/29.
- No electrical outlets

Restrooms/Bathrooms:

- Shower heads are safety heads in building 28/29.
- Mirrors are polished metal.
- No towel bars in restrooms.
- Shower curtains are attached to the ceiling with a breakaway mechanism.
- Clothing hooks are suicide proof.

Housekeeping:

- Paper bags used in client care areas. Plastic only in locked rooms.
- Housekeeping and maintenance carts have locked doors for hazardous materials.

Physical surroundings/Utilities:

- Building 27 has a generator to supply full power to buildings 27,28, and 29.
- TV's mounted to walls and not allowed in client rooms.
- No toxic plants in client care areas.

- Sprinkler heads are recessed and tamperproof.
- Electrical and mechanical rooms are locked with a key not available to general staff.
- All fire extinguishers in Building 27/28/29 are in locked, marked rooms for client and employee safety.
- Automatic Sprinkler systems in Buildings 27/28/29.
- No smoking on campus.
- Thermostatically limited hot water.
- All appliances brought in by clients and staff are checked by maintenance personnel.
- All man-hole covers were checked to ensure those in client areas could not be easily removed.
- Maps of facility indicate areas where clients are not to walk unescorted, are updated periodically and posted in client care areas.

Security:

- Electronic lock card reader doors for entrance to buildings 3,5,27,28,29.
- No blind spots on units in commons areas Doors to offices/areas not in use are locked.
- Bright LED lit parking lots.
- Employee vehicles are to be locked.
- 2-way radios are available for "all help" calls.
- "STOP" alarms on fire exit doors to warn of someone exiting the area.

Safety:

- Maintenance PPE requirements created for specific duties.
- Medication rooms have locking mechanisms with key available only to Maintenance, nurses and a key that is passed from Med Aide on one shift to Med Aide on the next shift on each unit.
- Medications are counted by nurse and/or Med Aide to ensure proper count.
- Cameras are present when medications are distributed.

Confidentiality:

- Computer and printer in nursing station are not easily reached by clients.
- All employees sign a confidentiality agreement annually and volunteers at the time of orientation.

Policies/Procedures:

- Contraband searches are performed periodically. Training is also completed by Youth Security Supervisors on procedures for thorough searches.
- The treatment team is responsible for evaluating youth's risks and protective factors related to self-harm, suicidality, elopement, substance use and aggressiveness. This information is transmitted to the treatment team and staff by way of the Personal Safety Plan that is completed on each youth the day of admission.
- Threatening Behavior/Violence in the Workplace policy at state and facility level.
- All direct care staff are trained in Crisis Management & De-Escalation techniques.
- CPR and First Aid for all direct care staff.
- A "Personal Safety Plan" is placed on chart of each youth describing signs of losing control or anger; what things help to calm them; what makes them anxious. These are available to direct care staff.
- Charting of any potential threats or behavior by clients which may cause harm to self or others.

Additional procedures/controls/checks put into place in 2017:

Safety

- Building 15 closed and kitchen moved to Building 3.
- Broken windows and doors in vacant buildings were boarded up

Utilities

- Work with LRC electricians to rewire the cafeteria to support kitchen equipment

Emergency

- Simplified Job action sheets to streamline process and make more efficient.
- Trained all staff members on disasters and the Incident Command system. Practice drills held with YSS's.

Security

- Roads through campus were barricaded to prevent unauthorized entry.
- Auctions held on campus to rid surplus supplies in empty buildings

Life Safety

- 30 second delays added to mag door releases to prevent elopement. Approved by Fire Marshall.
- Fire Lane in front of Building 3 was repainted to make for more visibility.

Social Environment:

- Parking lots repainted and cleaned up.

Additional procedures/controls/checks put into place in 2018:

Safety

- A fence was installed around the new construction area to prevent client access
- Broken windows and doors in vacant buildings were boarded up

Utilities

- Electrical upgrades started on the campus
- Kronos badge readers were installed for staff clocking in.

Emergency

- Simplified Job action sheets to streamline process and make more efficient.
- Trained all staff members on snow emergencies.

Security

- Cameras were placed in the tunnels to monitor unauthorized personnel
- Keyed locks were added to improve security on some internal doors

Life Safety

- Corrections noted by the fire marshal were completed quickly.
- Fire Drills were held as expected.

Social Environment:

- Parking lots repainted and cleaned up.

Additional procedures/controls/checks put into place in 2019:

Safety

- A fence was installed around the new construction area to prevent client access
- Broken windows and doors in vacant buildings were boarded up

Utilities

- Campus electrical, water, gas were all updated.
- Unoccupied buildings will be taken off line of all utilities in the summer of 2020.

Emergency

- Simplified Job action sheets to streamline process and make more efficient.
- Trained all staff members on snow emergencies.

Security

- Cameras were placed in the tunnels to monitor unauthorized personnel
- Keyed locks were added to improve security on some internal doors

Life Safety

- Corrections noted by the fire marshal were completed quickly.
- Fire Drills were held as expected.

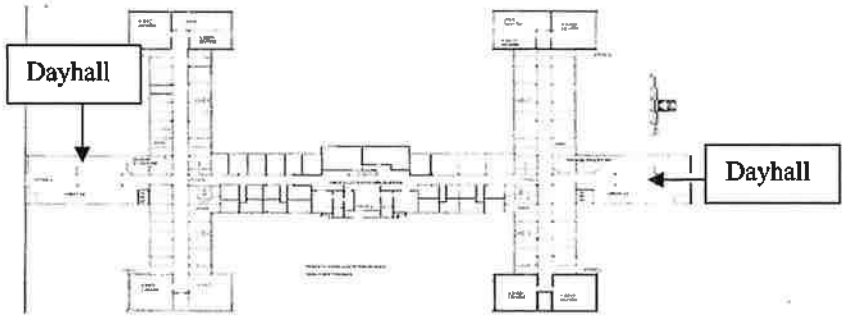
Social Environment:

- Parking lots repainted and cleaned up.

BUILDING 3

- Built in 1937
- 3 story building
- Automatic Sprinkler System

Physical layout of building:



CLIENT UNITS –

- Clients no longer occupy this building,

FIRST FLOOR, SOUTH WING:

- This unit has been shut down and restricted.

SECOND FLOOR, SOUTH WING

- This unit has been shut down and restricted.

GROUND FLOOR

- The **North wing** is occupied by Human Resources personnel.
- The corridor rooms are used for fitness/recreation, staff break room.
- The **SE** wing is used by the Housekeeping and maintenance departments.
- The remainder of the **South** wing has been shut down and restricted.

EXITS

- The front center has a magnetic card reader exit on the first floor. The ground floor has nine exits with magnetic card readers that release 30 seconds after fire alarms are activated. All exit doors are now ADA compliant.
- The former units have fire exit stairwells on the center, east and west wings of each floor that are kept locked and have a STOP alarm activated. All employees in the building have the key to unlock these doors marked with a red plastic ring.

NURSING STATIONS & CLIENT UNITS

- These units have been shut down and access restricted.

CLIENT ROOMS

- No longer located in this building

Building 3

Suicide Risk Assessment

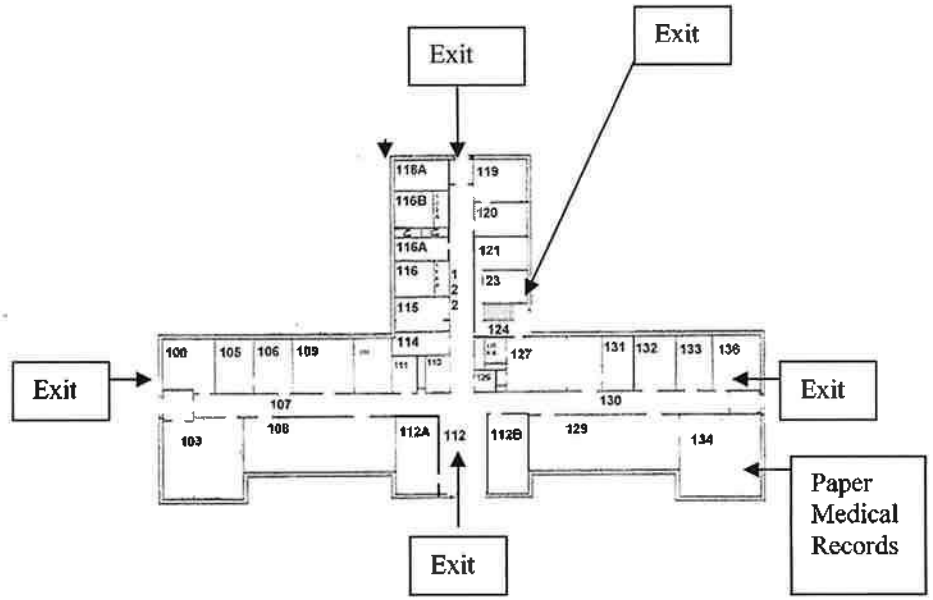
Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
All of Building 3	Has conduit near walls with gap.		• Staff supervise clients. • Suicidality Assessments performed • The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased. • The staffing ratio is 1:4 for days and 1:6 for nights.
	Glass in windows is not safety glass, but panes are small squares.		
	Stairwell doors have push bars for exiting stairwell.		
	Automatic door closures		
	Electrical outlets in corridor extending from wall		
	Door knob on bathroom		
	Pipes under the sink		
	Toilet doors		
	Mounted toilet paper holders		
	Shower knob.		
Bathroom (in main corridor by PVC)	Exposed sink pipes		• Suicidality Assessments performed • The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.
Hallway	Exposed pipes		Staff supervise clients when room is in use.
Location	**Findings**	**Person Responsible**	**Procedure/Control or Repair/Remove**
Weight room	Weight machines and exercise equipment		• Staff supervise clients when room is in use. • Suicidality Assessments performed
	Bathroom has sink pipes and toilet pipes exposed		

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Second Floor Offices	Windows/screens; large openings		Staff supervise clients when room is in use.
	"S" hooks		
	Curtain rod holders		
	Electrical conduit		
	Group Room 280 – curtain rods		
	Client bathroom – Sink and stool pipes and electrical conduit		
First Floor Offices	Sink pipes and electrical conduit in visitor room		Staff supervise clients when room is in use.
	Door closure on entry		
	Locked door to wiring room		
	Curtain rod holders		
	Plant hangers		
	Exam Room – needles, sharps, sink pipes, curtain tracking		
	Hallways have fire alarms extending		
	Cupboard contains heavy duty strapping cords, jump ropes, elastic exercise equipment		• The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased. • The staffing ratio is 1:4 for days and 1:6 for nights.

BUILDING 5

Administration Building

- Built in 1949
- 1 story plus a basement
- Updated sprinkler and alarm system 2020
- Houses the paper medical records



Physical layout of building:

- **EXITS-**
  - 5 exits, one on each side of building, front and back, and one in center, east side.
- **Medical Records**
  - Past medical records are on paper and are being digitally scanned. Present medical records are on computer.
    - These are highly vulnerable to a catastrophe until they are all digitally scanned.
    - The room they are in also has many large windows making them vulnerable to a storm.
- **Security**
- Building has electronic key card door lock entry on all doors. Front entry and east side door are open from 8 a.m. to 4:00 p.m., Monday to Friday only. The switchboard has been relocated to building 3. Most visitors go directly to building 3. Visitors to the Administration building are directed to ring bell for assistance.
- The building underwent major renovation in 2020.
- Cameras are installed in all therapist office, and all common areas of the building.

Bldg 5

Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Bathrooms	Handicap railings		This building is not accessible to clients. Staff supervise the area if clients are present.
	Exposed pipes up to 24" high		
Electrical/ Fixtures	No locks on		
Basement	Handrails		
Ramp to Building	Handrails		
Windows	Openings are large		
Doors	No piano hinges		
	No suicide-proof knobs		
Mechanical Room/ Equipment	Not accessible – in tunnel		

Chapel –

- **Built in 1954**
- **1 story plus upper level and basement**
- **No Sprinkler or Alarm System**
- **Used for youth recreation.**

Physical layout of building:

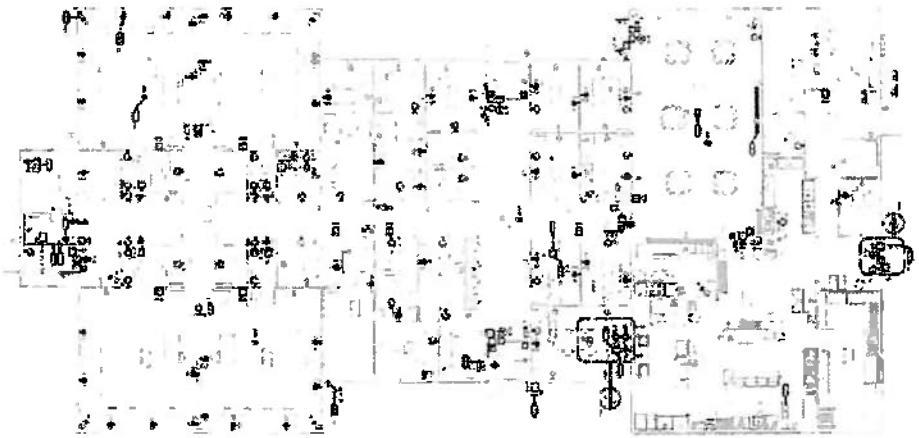
- **EXITS-**
  - 4 exits. 2 on the front side (North) of the building and 1 on each back side (East and West) side.
- **Security**
- Building has keyed locked doors on the front side and back side. The back side exits have STOP alarms that are used to prevent AWOA.
- The upper level is only accessible to authorized staff (Rec, Maint., Safety)
- The basement is used as a storm shelter and currently has nothing in it. It also connects to the tunnel.
- The building will be undergoing major renovation in 2019. This will be updated on the 2020 HVA.

Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Basement	Steam pipes exposed		Area not accessible to youth. Has padlocked gate.
Bathrooms	Hidden/remote areas – stalls		• Staff supervise clients when room is in use. • Suicidality Assessments performed • The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.
Upstairs & basement	Not accessible. Padlocked gate.		Area not accessible to youth. Has padlocked gate.

BUILDING 27

- Built in 2019
- Single story building
- Automatic Sprinkler System



Physical layout of building:

- **EXITS-**
  - 5 exits. 1 on the north side, 1 on east side, 1 on west side, and 2 on south side.
- **Security**
- Building has electronic locked doors on all exits.

South Wing:
- Cafeteria, Kitchen, Mechanical and PVC rooms

Middle Wing:
- Group rooms, exam room, evaluation room, admission room, staff break room

North Wing:
- School classrooms, Art Room, Mechanical room

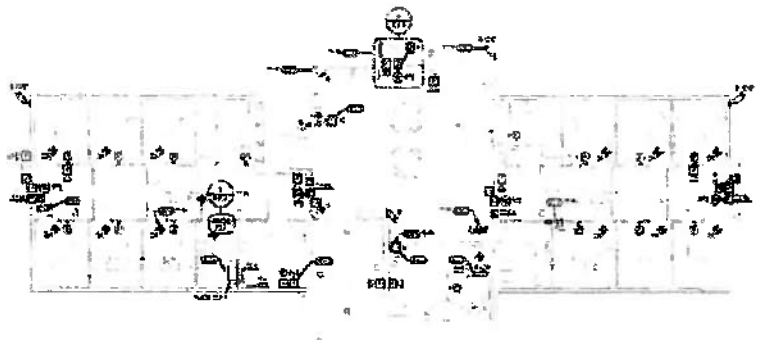
Building 27

Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Bathrooms	• Automatic door closers • Door knobs		• Staff supervise clients. • Suicidality Assessments performed • The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased. • The staffing ratio is 1:4 for days and 1:6 for nights.
Group/Meeting Rooms	• Automatic door closers • Door hinges • Door knobs		
Exam/Admit Evaluation rooms	•		
Cafeteria	•		
PVC Room and Kitchen	•		
School	•		

BUILDING 28/29

- Built in 2019
- Single story building
- Automatic Sprinkler System
- Mirror Images of each other



Physical layout of building:

- **EXITS-**
  - 3 exits. 1 on the north/south side, 1 on east side, 1 on west side.
- **Security**
- Building has electronic locked doors on all exits.

West/East Wings

- Client rooms, Mechanical Room, Bathrooms and Mechanical Room

Middle Wing

- Day hall, weight room/storm shelter, storage room.

Building 28/29

Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Bathrooms	• Automatic door closers • Door knobs		• Staff supervise clients. • Suicidality Assessments performed • The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased. • The staffing ratio is 1:4 for days and 1:6 for nights.
Client Rooms	• Automatic door closers • Door hinges • Door knobs		
Weight Room/Storage	•		
Day hall area	•		

Grounds, General

HASTINGS REGIONAL CENTER
Grounds/General

Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Grounds	Garages by Building 7 – falling in, doors hanging open, lot of junk inside them	Maintenance Dept.	Clients are to walk on sidewalks. Clients have access to the grounds based on a level system which assesses their safety level and are supervised by staff at all times. There are boundary maps to define the safe areas for clients
Roadways	Several bad spots.	Maintenance Dept.	Roadways are repaired as funds permit. The roadways where clients walk have been repaired.

2020 ANNUAL HAZARD VULNERABILITY ASSESSMENT
July 21st, 2020
9:00 AM

Present: Grant Johnson, Safety Coordinator; Ted Buck, Maintenance Supervisor; Marj Colburn, Facility Administrator; James Schulte, Activities Supervisor; Lisa Stramel, Housekeeping/Dietary Supervisor;

The purpose of this meeting is to complete the annual Hazard Vulnerability Assessment for the Hastings Regional Center (HRC). This assessment evaluates the probability, extent of risk and preparedness of HRC for natural, technological and human events and/or hazards. The assessment is completed using the form by the American Society for Healthcare Engineering of the American Hospital Association.

Hastings Regional Center is a Residential Substance Abuse Treatment Facility operated by the Nebraska Health and Human Services System. It is located on the west edge of Hastings and covers approximately 25 acres with several buildings. The Hastings Juvenile Chemical Dependency Program is in Building 3 with a maximum of 24 licensed beds.

The campus also includes an Administration Building, A chapel which has been converted into a gymnasium, Maintenance Shop, and several other buildings which are no longer in use. There are 3 main parking lots and several lesser parking areas.

Each item was reviewed for probability of an event happening; the risk associated with the item in terms of life safety and/or disruption to the facility; and the preparedness of the facility to handle the event through pre-planning, procedures put into place, internal resources and external resources. Each item was reviewed to determine if any changes had taken place in the past year, which would alter the previous scores.

Internal fire, civil disturbance, epidemic and tornado scored the same for vulnerability. As a residential treatment program with all ambulatory young males with no serious medical concerns our risks are lowered for many of the possible events. Contraband searches continue to discover smoking related materials brought in by youth after visits. This was used as a determining factor in the probability of an internal fire. The buildings are fully sprinkled and there is a minimal amount of flammable material so the preparedness was rated "good".

Epidemic was upgraded to a medium probability following the 2020 worldwide Covid-19 Coronavirus pandemic. HRC did have a large disruption but preparedness was good due to all the preventive measures taken.

Civil Disturbance is rated with the same vulnerability due to the backgrounds of the youth and possible gang memberships. All staff are trained in Handle with Care and taught to recognize the warning signs and steps to take to prevent a major disturbance but the threat remains.

A tornado event could cause great health and safety risks but our preparedness is good.

Other weather related events are the vulnerabilities ranked below fire, civil disturbance and tornado. Blizzards, ice storms and severe thunderstorms would all have the same disruption as staffing is the major issue in these types of events. Other issues are minor as the buildings have a generator and there is plenty of food and water available for youth and staff to shelter for several days.

Following are the areas identified as the most vulnerable:

2020 HVA		2019 HVA		2018 HVA	
Event	Rating	Event	Rating	Event	Rating
1. Epidemic	8	1. Tornado	8	1. Tornado	8
2. Tornado	8	2. Civil Disturbance	8	1. Civil Disturbance	8
3. Civil Disturbance	8	3. Fire, Internal	8	2. Fire, Internal	8
4. Blizzard or Ice	6	4. Water Failure	8	3. Water Failure	8
5. Wildfire	6	5. HVAC Failure	8	4. HVAC Failure	8
6. Fire, Internal	6	6. Blizzard or Ice Storm	6	5. Blizzard or Ice Storm	6
7.		7. Temperature Extreme	6	6. Temperature Extreme	6
8.		8. Flood, Internal	6	7. Flood, Internal	6
9.		9. Wild Fire	6	8. Wild Fire	6

The following changes were made to the 2020 Assessment:

- The worldwide Pandemic Covid-19 Coronavirus affected daily operations.
- Electrical, Water, Steam and HVAC failures were reduced due to the new utilities being installed on campus.

The following table shows the location, types and amounts of fuels used by the facility for generators:

Building #	**Type of Fuel**	**Am't of Fuel**	**How long it lasts**	**Supplier**	**Length of time to supply**
3	Diesel	2800 gallons above ground	8 to 10 days which is approx. 14.5 gal/hr.	CPI, Bosselmans, Thompson Oil	Within 24 hours
Lift station (26)	Natural Gas	pipeline	As long as it is not interrupted	Hastings Utilities	Continuous Supply
Power plant (16)	Diesel for generator Natural gas for boiler.	600 gallons above ground of diesel	3 to 4 days	CPI, Bosselmans, Thompson Oil Hastings Utilities	Within 24 hours Continuous supply

Mitigation, Preparedness, Response and Recovery For Hospital Emergency Response Plans						
Emergency Type	**Probability**	**Severity**	**Mitigation**	**Preparedness**	**Response**	**Recovery**
Epidemic	Medium	Health & Safety	• Hazard vulnerability analysis performed. • EOC Emergency policies and procedures. • Following proper procedures during the pandemic. • Staffing protocols keeping interactions between the units minimal •	• DHHS cooperation. • Backup systems testing • Staff training and participation in infection control protocol • Isolation units set up and supply carts made. • Procedures developed for daily temperature checks on both staff and youth. • Visitors suspended during the pandemic. • Regular infection control meetings held.	• Activate emergency procedures, as appropriate. • Internal, external notifications.	• Comprehensive assessment of the response to the pandemic. • Replenish supplies. • Prepare for when it happens again. • Continue to educate staff and youth on preparedness.
Tornado & Severe Thunderstorms & other Weather Related Events	Moderate	Health & Safety	• Hazard vulnerability analysis performed. • EOC Emergency policies and procedures. • Following proper procedures when tornado warnings are in effect. • Updating of storm procedures, storm supplies and emergency procedure cards when indicated. • Staffing protocols for holding staff over when necessary • Extra food supplies kept for disasters and other events.	• Community cooperation. • Backup systems testing • Staff training and participation when warnings are in effect. • Storm carts moved to safer area.	• Activate emergency procedures, as appropriate. • Internal, external notifications • Initial damage assessment. • Call fire department/Adams County Emergency Manager for assistance if appropriate. • Staff held over if necessary. • Meals available for staff held over if necessary.	• Comprehensive damage assessment of critical systems/structure(s), if applicable. • Replenish supplies. • Identification of necessary repair/restoration work and establishment of a repair/restoration timetable. • Post-repair/restoration survey and approval, including certification by the local jurisdiction(s) having authority, if applicable. • Internal and external notification. • Documentation of disaster response and recovery costs. • Review response procedures
Civil Disturbance	Moderate	Health, Safety	• Hazard vulnerability analysis performed • EOC Emergency policies and procedures on "Threatening Behavior and Violence in the Workplace". • Security cameras in place on units and cameras in the cafeteria where more youth are congregated. • Self-locking doors placed on cafeteria doors where large numbers of youth are. • Contraband searches completed to look for hazardous material. • Electronic lock door system for all entry and exit from building and units. • Staff use earbuds on radio to keep conversations secure.	• Staff training through actual occurrences. • Staff training on the signs of gang activity • Staff training in Handle with Care and hold restraint of youth in incident • All front-line staff carry 2-way radios to aid in help calls. • Meetings with Law Enforcement agencies and area schools to familiarize the entities with procedures at Hastings Regional Center and the response we can expect when aid is requested. Also to ensure that extra help is available quickly and that all individuals in community are notified as necessary if a youth absconds.	• Activate emergency procedures, as appropriate. • Internal, external notifications • Initial damage assessment. • Collaborate with the local Law enforcement.	• Replenish supplies. • Internal and external notification. • Documentation via Critical Incident Review (CIR) • Identify issues and resolve through appropriate means.
Fire, Internal	Moderate	Life Threatening	• Frying appliances prohibited; no space heaters allowed. • EOC Emergency policy and procedures in place • Building sprinkled. • Fire equipment tested and maintained on regular basis • No smoking allowed on campus. Contraband searches for smoking materials done after visits.	• Agreements made with LRC and YRTC Kearney for evacuation. • Staff training of YSS's for fire panel responses. • Quarterly fire drills held for all staff. • Knox box with keys to building placed outside for Fire Dept. personnel access.	• Activate emergency procedures, as appropriate. • Internal, external notifications • Initial damage assessment. • Fire Dept. personnel tour campus	• Replenish supplies. • Internal and external notification. • Documentation of disaster response and recovery costs. • Review response procedures

			• Bldg. has little flammable material & bldg. is concrete.			

HAZARD VULNERABILITY ASSESSMENT

EVENT	PROBABILITY				RISK					PREPAREDNESS			TOTAL
	HIGH	MED	LOW	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPTION	MOD DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
NATURAL EVENTS													
Tornado		2				4						1	8
Severe Thunderstorm		2						2				1	4
Snow fall		2							1			1	2
Blizzard		2					3					1	6
Ice Storm		2					3					1	6
Earthquake			1						1			1	1
Temperature Extremes		2						2				1	4
Drought			1						1			1	1
Flood❖, External			1			4						1	4
Wild Fire		2					3					1	6
Epidemic		2				4						1	8

Gray areas are changes from previous year.

EVENT	PROBABILITY				RISK					PREPAREDNESS			TOTAL
	HIGH	MED	LOW	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPTION	MOD DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
TECHNOLOGICAL EVENTS													
Electrical Failure			1					2				1	4
Generator Failure			1					2				1	2
Transportation Failure			1						1			1	1
Fuel Shortage			1				3					1	3
Natural Gas Failure			1				3					1	3
Water Failure			1					2				1	2
Sewer Failure			1					2				1	2
Steam failure				0					1			1	4
Fire Alarm Failure			1					2				1	2
Communications Failure			1					2				1	2
HVAC Failure			1					2				1	2
Information Systems Failure			1					2				1	2
Fire, Internal		2				4						1	8
Flood, Internal		2					3					1	6
Hazmat Exposure, Internal			1			4						1	4
Unavailability of Supplies			1						1			1	1
Structural Damage			1				3					1	3

Gray areas are changes from previous year.

EVENT	PROBABILITY				RISK					PREPAREDNESS			TOTAL
	HIGH	MED	LOW	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPTION	MOD DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
HUMAN EVENTS													
Mass Casualty Incident (trauma)			1		5							1	5
Mass Casualty Incident (medical)			1					2				1	2
Mass Casualty Incident (hazmat)			1			4						1	4
Hazmat Exposure, External			1		5							1	5
Terrorism, Chemical			1		5							1	5
Terrorism, Biological			1		5							1	5
VIP situation			1						1			1	1
Infant Abduction			1						1			1	1
Hostage Situation			1					2				1	2
Civil Disturbance		2				4						1	8
Labor Action			1						1			1	1
Bomb Threat			1					2				1	2

Gray areas are changes from previous year.

Facility Staffing Information

Staffing levels

Staff Assaults

Attachment H3

Nebraska Department of Health and Human Services (NEDHHS) - HRC Data
as of 1/1/2021

Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
H77023	ACTIVITY SPECIALIST	1	0	1	0%	0%
V77024	ACTIVITY SUPERVISOR	0	1	1	100%	
V09121	ADMINISTRATIVE ASSISTANT I	1	0	1	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	0%	0%
C72791	CHEMICAL DEPENDENCY TREATMENT SPECIALIST	2	0	2	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	2	0	2	0%	0%
N00750	FACILITY OPERATING OFFICER	0	1	1	100%	
M80123	FOOD SERVICE COOK	3	2	5	40%	17%
V80230	FOOD SERVICE MANAGER	1	0	1	0%	0%
S02201	HEALTH INFORMATION TECHNICIAN	1	0	1	0%	0%
H76312	HUMAN SERVICES TREATMENT SPECIALIST II	1	0	1	0%	0%
N75450	MEDICAL SERVICES DIRECTOR	0	1	1	100%	
H72431	MENTAL HEALTH PRACTITIONER I	1	0	1	0%	50%
H72432	MENTAL HEALTH PRACTITIONER II	1	2	3	67%	0%
R72432	MENTAL HEALTH PRACTITIONER II	0	1	1	100%	
D75350	NURSE PRACTITIONER	0	1	1	100%	
N74823	PSYCHOLOGIST/LICENSED	1	0	1	0%	0%
H77043	RECREATION SPECIALIST	1	0	1	0%	0%
H75014	REGISTERED NURSE (NEW)	2	0	2	0%	25%
R75014	REGISTERED NURSE (NEW)	0	2	2	100%	
V82330	SAFETY COORDINATOR	1	0	1	0%	0%
C72332	SOCIAL WORKER II	1	0	1	0%	0%
S01841	STAFF ASSISTANT I	1	1	2	50%	33%
T11360	TEACHER (SCATA CONTRACT)	5	1	6	17%	17%
C72481	YOUTH COUNSELOR I	1	0	1	0%	0%
V72483	YOUTH COUNSELOR SUPERVISOR	0	1	1	100%	
P76752	YOUTH SECURITY SPECIALIST II	27	5	32	16%	16%
V76753	YOUTH SECURITY SUPERVISOR	9	0	9	0%	15%
		64	**19**	**83**	**23%**	**18%**

Jacobe, Camella

From: Johnson, Grant
Sent: Monday, February 8, 2021 12:46 PM
To: Jacobe, Camella
Subject: RE: Ombudsman info needed

We had 0 assaults on staff in 2020.

The reports Corinne should have. I know we had a PRTF inspection and child care in 2020. Internal reports I have and can email you as soon as I get a minute.

Ted Buck should have the fire marshal reports and inspections.

Grant Johnson | *Safety Coordinator*
BEHAVIORAL HEALTH – HASTINGS REGIONAL CENTER
Nebraska Department of Health and Human Services
OFFICE: [redacted] | CELL: [redacted] FAX: 402-460-3145
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Jacobe, Camella [redacted]/>
Sent: Monday, February 8, 2021 12:39 PM
To: Johnson, Grant [redacted]/>
Subject: Ombudsman info needed

Grant,

I have the Ombudsman requesting the below information. Could you let me know who I could contact to get this information, so I can get a response back to the Ombudsman by the end of the week?

B. The number of assaults on staff for calendar year 2020

C. Please provide a copy of the most recent inspections or audit reports for calendar year 2020. To include, but not limited to reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, etc.

Thanks,

Camella Jacobe | *State Compliance Coordinator*
CHILDREN & FAMILY SERVICES
Nebraska Department of Health and Human Services
OFFICE: [redacted]
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Inspection Reports

North Dorm

South Dorm

Program Building

Fire Drill Reports

2019/2020 Safety/Security report

Attachment H4

North Dorm

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment Center, 1200 W. 2nd St. Bldg B, Hastings

INSPECTION DATE: 10/19/22

TYPE OCCUPANCY: Residential

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☒	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
HB3168	1	
HB3169	2	

STATUS OF SYSTEM – CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION:
Meininger Fire Protection, Inc
ADDRESS: 2521 West "L" Street, Suite 5
CITY: Lincoln **STATE:** NE
ZIP CODE: 68522
PHONE: 402-466-2616

INSPECTOR SIGNATURE
NE LICENSE #: 05046
TESTER BFP LICENSE #: 8119

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance
of Dry Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm: MFP Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center
Inspector Name: [illegible] Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N
A.1.0	System in service on inspection	✓		
A.1.1	Supply (water) gauge pressure	55 psi		
A.1.2	System (air) gauge pressure	20 psi		
A.1.3	Quick opening device gauge pressure	— psi		
A.1.4	Gauge near compressor	120 psi		
A.1.5	Gauge pressures are normal	✓		
A.2.0	Control valves in normal open or closed position	✓		
A.2.1	Control valves properly locked or supervised	✓		
A.2.2	Control valves accessible	✓		
A.2.3	Control valves provided with appropriate wrenches	✓		
A.2.4	Control valves free from external leaks	✓		
A.2.5	Control valve identification signs in place	✓		
A.2.6	System control valve sign indicates area served		✓	
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position			✓
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓	
A.4.0	Dry pipe valve free of physical damage		✓	
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓		
A.4.2	Dry pipe valve intermediate chamber not leaking	✓		
A.5.0	**ALARM PANEL CLEAR**	✓		
A.6.0	**COMMENTS:**			

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm tested and is operational	✓		
C.2.1	Test conducted with inspectors test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)		✓	
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position ***(semi-annual)***	✓		
C.3.1	Signal restored only when valve returned to normal position ***(semi-annual)***	✓		
C.4.0	One main drain test conducted downstream from backflow preventer	✓		
C.4.1	One main drain test conducted downstream from pressure reducing valve		✓	
C.4.2	Supply water gauge reading before flow (static)	60 psi		
C.4.3	Gauge reading during stable flow (residual)	45 psi		
C.4.4	Time for supply pressure to return to normal	— sec		
C.5.0	Priming water level tested		✓	
C.6.0	Quick opening device(s) (QOD) tested		✓	
C.7.0	Low pressure alarm tested	✓		
C.8.0	Pertinent parties notified of test conclusion	✓		
C.9.0	**ALARM PANEL CLEAR**	✓		
C.10.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.11.0	**COMMENTS:**			

INSPECTOR'S INITIAL [illegible] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP — Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [redacted] — Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)	✓		
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	**ALARM PANEL CLEAR**	✓		

D.8.0 **COMMENTS:**

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.5.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static)	65 psi		
E.5.2	Gauge reading during stable flow (residual)	45 psi		
E.5.3	Time for supply pressure to return to normal	— sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		✓	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓		
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	**ALARM PANEL CLEAR**	✓		
E.11.0	**SYSTEM RETURNED TO SERVICE**	✓		

E.12.0 **COMMENTS:**

Partial trip test

Trip Test Table

Dry Valve	Size	Year	Q.O.D.		Year
Make	Model	Serial No.	Make	Model	Serial No.
Viking	7VBN				

Dry Pipe Operating Test	Time to Trip Thru Test Pipe		Water Pressure	Air Pressure	Time Water Trip Point Air Pressure	Reached Test Outlet		Alarm Operated	
	Min	Sec	PSI	PSI	PSI	Min	Sec	Yes	No
Without Q.O.D		10	40	20	7		1	X	
With Q.O.D									

INSPECTOR'S INITIAL _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [illegible] Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer	✓		
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV		✓	
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	✓		
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	60 psi		
F.5.2	Gauge reading during stable flow (residual)	45 psi		
F.5.3	Time for supply pressure to return to normal	~ sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓	
F.6.5	Forward flow test satisfied by annual fire pump flow test		✓	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		✓	
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	**ALARM PANEL CLEAR**	✓		
F.11.0	**SYSTEM RETURNED TO SERVICE**	✓		
F.12.0	**COMMENTS**			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks			
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure	psi		
G.6.3	System side static pressure	psi		
G.6.4	Supply side residual pressure	psi		
G.6.5	System side residual pressure	psi		
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted **(see AFSA Form 114A)**			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	**ALARM PANEL CLEAR**			
G.11.0	**SYSTEM RETURNED TO SERVICE**			
G.12.0	**COMMENTS:**			

INSPECTOR'S INITIAL [illegible] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance
of Wet Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm: Inspection Contract#
Name of Inspected Property: Nashvegas Youth Treatment Bldg B
Inspector Name: JMM Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N
A.1.0	System in service on inspection	✓		
A.2.0	Supply pressure gauge	60 psi		
A.2.1	System pressure gauge	60 psi		
A.2.2	Gauges appear to be in good condition	✓		
A.3.0	Control valves in normal open or closed position	✓		
A.3.1	Control valves properly locked or supervised	✓		
A.3.2	Control valves accessible	✓		
A.3.3	Control valves provided with appropriate wrenches	✓		
A.3.4	Control valves free from external leaks	✓		
A.3.5	Control valve identification signs in place	✓		
A.3.6	System control valve sign indicates area served	✓		
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓		
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓	
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓	
A.5.1	Alarm valve free of physical damage		✓	
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓	
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓	
A.6.0	ALARM PANEL CLEAR	✓		
A.7.0	COMMENTS:			

INSPECTOR'S INITIAL JMM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 · 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: Inspection Contract#

Name of Inspected Property: Hastings South Treatment Bldg B

Inspector Name: SM Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓		
C.2.1	Test conducted with inspector's test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)		✓	
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Adequate drainage provided before flow testing	✓		
C.3.1	A main drain test conducted downstream from backflow preventer	✓		
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓	
C.3.3	Supply water gauge reading before flow (static)	60 psi		
C.3.4	Gauge reading during stable flow (residual)	45 psi		
C.3.5	Time for supply pressure to return to normal	— sec		
C.4.0	Pertinent parties notified of test conclusion	✓		
C.5.0	**ALARM PANEL CLEAR**	✓		
C.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.7.0	**COMMENTS:**			

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service before testing	✓		
D.1.1	Pertinent parties notified before testing	✓		
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓		
D.2.1	Signal restored only when valve returned to normal position	✓		
D.3.0	Adequate drainage provided before flow testing	✓		
D.3.1	Main drain test conducted	✓		
D.3.2	Supply water gauge reading before flow (static)	60 psi		
D.3.3	Gauge reading during stable flow (residual)	45 psi		
D.3.4	Time for supply pressure to return to normal	— sec		
D.4.0	Pertinent parties notified of test conclusion	✓		
D.5.0	**ALARM PANEL CLEAR**	✓		
D.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
D.7.0	**COMMENTS:**			

INSPECTOR'S INITIAL SM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: Inspection Contract#

Name of Inspected Property: Hastings South Treatment Bldg B

Inspector Name: JM Date: 11/19/24

Inspection Frequency: ☐ Monthly ☐ Quarterly ☐ Annually ☑ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Main drain test conducted	✓		
F.2.1	Supply water gauge reading before flow (static)	60 psi		
F.2.2	Gauge reading during stable flow (residual)	45 psi		
F.2.3	Time for supply pressure to return to normal	— sec		
F.3.0	Antifreeze solution tested and freezing point determined		—	
F.3.1	Antifreeze solution freezing point	— °F		
F.3.2	Antifreeze solution freezing point after adjustment	— °F		
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.4.3	Main drain test conducted (see F.2.0)	✓		
F.5.0	Backflow prevention assembly forward flow test conducted	✓		
F.5.1	System demand flow was achieved through the device	✓		
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		✓	
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		—	
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		—	
F.5.5	Forward flow test satisfied by annual fire pump flow test		—	
F.5.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		—	
F.7.0	Pertinent parties notified of test conclusion	✓		
F.8.0	**ALARM PANEL CLEAR**	✓		
F.9.0	**SYSTEM RETURNED TO SERVICE**	✓		
F.10.0	**COMMENTS:**			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓		
G.2.0	Pertinent parties notified before conducting maintenance	✓		
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
G.3.1	Valve completely closed and reopened	✓		
G.4.0	Adequate drainage provided before flow testing	✓		
G.4.1	Main drain test conducted	✓		
G.4.2	Supply water gauge reading before flow (static)	60 psi		
G.4.3	Gauge reading during stable flow (residual)	45 psi		
G.4.4	Time for supply pressure to return to normal	— sec		
G.5.0	Pertinent parties notified after conclusion of maintenance	✓		
G.6.0	**ALARM PANEL CLEAR**	✓		
G.7.0	**SYSTEM RETURNED TO SERVICE**	✓		
G.8.0	**COMMENTS:**			

INSPECTOR'S INITIAL JM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 11/19/24

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment - Building B
1200 W. 2nd Street, Hastings NE 68901

11-7-19
INSPECTION DATE
Residential
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☑	INITIAL ACCEPTANCE OF SYSTEM
☒	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☐	REPORT OF INSPECTION	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
~~47626~~ 48368	1	Wet System
~~47627~~ 48369	2	Dry System

STATUS OF SYSTEM – CHECK ONE

☑ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION:
Meininger Fire Protection, Inc
ADDRESS: 2521 West "L" Street, Suite 5
CITY: Lincoln **STATE:** NE
ZIP CODE: 68522
PHONE: 402-466-2616

INSPECTOR SIGNATURE
NE LICENSE #: 05046
TESTER BFP LICENSE #: 7932

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

NEBRASKA STATE FIRE MARSHAL'S OFFICE

Contractor's Material and Test Certificate for Aboveground Piping

PROCEDURE
Upon completion of work, inspection and tests shall be made by the contractor's representative and witnessed by an owner's representative. All defects shall be corrected and system left in service before contractor's personnel finally leave the job.

A certificate shall be filled out and signed by both representatives. Copies shall be prepared for approving authorities, owners and contractor. It is understood the owner's representative's signature in no way prejudices any claim against contractor for faulty material, poor workmanship, or failure to comply with approving authority's requirements or local ordinances.

PROPERTY NAME	HASTINGS YOUTH TREATMENT - BLDG B	DATE	
PROPERTY ADDRESS	1500 W 2ND ST HASTINGS NE 68901		
PLANS	ACCEPTED BY APPROVING AUTHORITIES (NAMES) NFSM		
	ADDRESS LINCOLN		
	INSTALLATION CONFORMS TO ACCEPTED PLANS	☑ YES	☐ NO
	EQUIPMENT USED IS APPROVED IF NO, EXPLAIN DEVIATIONS	☑ YES	☐ NO
INSTRUCTIONS	HAS PERSON IN CHARGE OF FIRE EQUIPMENT BEEN INSTRUCTED AS TO LOCATION OF CONTROL VALVES AND CARE AND MAINTENANCE OF THIS NEW EQUIPMENT? IF NO, EXPLAIN	☑ YES	☐ NO
	HAVE COPIES OF THE FOLLOWING BEEN LEFT ON THE PREMISES:		
	1. SYSTEM COMPONENTS INSTRUCTIONS	☑ YES	☐ NO
	2. CARE AND MAINTENANCE INSTRUCTIONS	☑ YES	☐ NO
	3. NFPA 25	☑ YES	☐ NO
LOCATION OF SYSTEM	SUPPLIES BUILDINGS		

SPRINKLERS

MAKE	MODEL	YEAR OF MANUFACTURE	ORIFICE SIZE	QUANTITY	TEMPERATURE RATING
VIKING	VK300	19	1/2	2	200
VIKING	VK404	19	7/16	33	200
VIKING	VK460	19	7/16	2	155
TYCO	TY3261	19	1/2	13	155
TYCO	TY3261	19	1/2	15	155

PIPE AND FITTINGS
Type of Pipe STEEL
Type of Fittings STEEL

ALARM VALVE OR FLOW INDICATOR

ALARM DEVICE			MAXIMUM TIME TO OPERATE THROUGH TEST CONNECTION	
TYPE	MAKE	MODEL	MINIMUM	SECONDS

DRY PIPE OPERATING TEST

DRY VALVE			Q.O.D.		
MAKE	MODEL	SERIAL NO.	MAKE	MODEL	SERIAL NO.
Victaulic	768N	13259-3			

	TIME TO TRIP THROUGH TEST CONNECTION*		WATER PRESSURE	AIR PRESSURE	TRIP POINT AIR PRESSURE	TIME WATER REACHED TEST OUTLET*		ALARM OPERATED PROPERLY	
	MIN.	SEC.	PSI	PSI	PSI	MIN.	SEC.	YES	NO
Without Q.O.D.		3	35	16	6		10	—	
With Q.O.D									

IF NO, EXPLAIN

*MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHAL'S OFFICE

DELUGE & PREACTION VALVES

OPERATION ☐ PNEUMATIC ☐ ELECTRIC ☐ HYDRAULIC

PIPING SUPERVISED ☐ YES ☐ NO | DETECTING MEDIA SUPERVISED ☐ YES ☐ NO

DOES VALVE OPERATE FROM THE MANUAL TRIP AND/OR REMOTE CONTROL STATIONS ☐ YES ☐ NO

IS THERE AN ACCESSIBLE FACILITY IN EACH CIRCUIT FOR TESTING? ☐ YES ☐ NO | IF NO, EXPLAIN

MAKE	MODEL	DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM		DOES EACH CIRCUIT OPERATE VALVE RELEASE		MAXIMUM TIME TO OPERATE RELEASE	
		YES	NO	YES	NO	MIN.	SEC.

PRESSURE REDUCING VALVE TEST

LOCATION & FLOOR	MAKE & MODEL	SETTING	STATIC PRESSURE		RESIDUAL PRESSURE (FLOWING)		FLOW RATE
			INLET (PSI)	OUTLET (PSI)	INLET (PSI)	OUTLET (PSI)	FLOW (GPM)

TEST DESCRIPTION

HYDROSTATIC: Hydrostatic tests shall be made at not less than 200 psi (13.6 bars) for two hours of 50 psi (3.4 bars) above static pressure in excess of 150 psi (10.2 bars) for two hours. Differential dry-pipe valve clappers shall be left open during test to prevent damage. All aboveground piping leakage shall be stopped.

PNEUMATIC: Establish 40 psi (2.7 bars) air pressure and measure drop, which shall not exceed 1-1/2 psi (0.1 bars) in 24 hours. Test pressure tanks at normal water level and air pressure and measure air pressure drop, which shall not exceed 1-1.2 psi (0.1 bars) in 24 hours.

TESTS

ALL PIPING HYDROSTATICALLY TESTED AT 200 PSI FOR 2 HRS. | IF NO, STATE REASON
DRY PIPING PNEUMATICALLY TESTED ☐ YES ☐ NO
EQUIPMENT OPERATES PROPERLY ☐ YES ☐ NO

DRAIN TEST | READING OF GAUGE LOCATED NEAR WATER SUPPLY TEST CONNECTION: 35 PSI | RESIDUAL PRESSURE WITH VALVE IN TEST CONNECTION OPEN WIDE 30 PSI

UNDERGROUND MAINS AND LEAD IN CONNECTIONS TO SYSTEM RISERS FLUSHED BEFORE CONNECTION MADE TO SPRINKLER PIPING.
VERIFIED BY COPY OF THE U FORM NO. 85B ☐ YES ☐ NO
FLUSHED BY INSTALLER OF UNDERGROUND SPRINKLER PIPING ☐ YES ☐ NO
OTHER EXPLAIN

IF POWDER DRIVEN FASTENERS ARE USED IN CONCRETE, HAS REPRESENTATIVE SAMPLE TESTING BEEN SATISFACTORILY COMPLETED? ☐ YES ☐ NO | IF NO, EXPLAIN

BLANK TESTING GASKETS

NUMBER USED	LOCATIONS	NUMBER REMOVED

WELDING

WELDED PIPING ☐ YES ☐ NO

IF YES . . .

DO YOU CERTIFY AS THE SPRINKLER CONTRACTOR THAT WELDING PROCEDURES COMPLY WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3? ☐ YES ☐ NO

DO YOU CERTIFY THAT THE WELDING WAS PERFORMED BY WELDERS QUALIFIED IN COMPLIANCE WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3? ☐ YES ☐ NO

DO YOU CERTIFY THAT WELDING WAS CARRIED OUT IN COMPLIANCE WITH A DOCUMENTED QUALITY CONTROL PROCEDURE TO INSURE THAT ALL DISCS ARE RETRIEVED, THAT OPENINGS IN PIPING ARE SMOOTH, THAT SLAG AND OTHER WELDING RESIDUE ARE REMOVED, AND THAT THE INTERNAL DIAMETERS OF PIPING ARE NOT PENETRATED? ☐ YES ☐ NO

CUTOUTS (DISCS)

DO YOU CERTIFY THAT YOU HAVE A CONTROL FEATURE TO ENSURE THAT ALL CUTOUTS (DISCS) ARE RETRIEVED ☐ YES ☐ NO

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHAL'S OFFICE

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED ☐ YES ☐ NO	IF NO, EXPLAIN
REMARKS	DATE LEFT IN SERVICE WITH ALL CONTROL VALVES OPEN:	
SIGNATURES	NAME OF SPRINKLER CONTRACTOR MEININGER FIRE PROTECTION, 2521 West L St., Suite #5, Lincoln, NE 68522 • 402-466-2616	
	TESTS WITNESSED BY	
	FOR PROPERTY OWNER (SIGNED) TITLE DATE	
	FOR SPRINKLER CONTRACTOR (SIGNED) TITLE DATE D Peters Fitter 11-7-19	
	FOR AUTHORITY HAVING JURISDICTION (IF WITNESSED) TITLE DATE (G. + DSFM) 11-7-19	

ADDITIONAL EXPLANATION AND NOTES

SEND TO: Nebraska State Fire Marshal - 246 South 14th Street - Lincoln, NE 68508-1804
A copy of this completed form shall be forwarded to the State Fire Marshal's Office and a duplicate shall be maintained at the system riser.

MEININGER FIRE PROTECTION INC.

P.O. BOX 85535, LINCOLN, NE 68501 VOICE: 402.466.2616 FAX: 402.466.2617

ATTIC STOCK RECEIPT

JOB: Building B

DESCRIPTION	QUANTITY
Ty 3381 165°	2
TY 3281 165°	1
VK 664 200°	1
VK 300 200°	1
VK 630 155°	1

OWNER: _____

DATE: _____

GENERAL: _____

DATE: _____

MFP: _____

DATE: 11-7-19

FIRE ALARM INSPECTION

GT Fire & Security

Customer: Hastings Youth Treatment Facility
4200 W 2 Street
Hastings, NE 68901

Location: North Dorm

Panel Type: Notifier 320
100 % Smoke Test: 10-31-19
Frequency: 4/10
Notes:

100 % Heat Test:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations		
3.	Remote Annunciators		
4.	Heat Detectors		
5	Smoke Detectors	~~14~~ 21	21
6.	Duct Detectors	2	2
7.	Flow Switches	1	1
8.	Pressure Switches	2	2
9	Tamper Switches	3	3
10.	Audibles	6	6
11.	Visuals	21	21
12.	Door Holders		
13.	Fan Relays		
14.	Smoke Relays		
15	FCPS		
16	Voice Evac		

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? Yes No N/A
3. Signals received at receiving station? Yes No N/A
4. Are system components functioning properly? Yes No
5. Did Trouble Signal Operate Properly? Yes No
6. Checked system in Emergency Power? Yes No
7. Elevator Recall? Yes No N/A
8. Main Power (AC) Test Value: _____
9. Emergency Power (Gell Cell) Test Value: 27.1 v
10. FACP Battery Change Out Date: 2023
11. Voice Evac Battery Chang e Out: _____
12. FCPS Battery Change Out: _____
13. FCPS Battery Change Out: _____
14. FCPS Battery Change Out: _____

Comments: System Tested Okay

Inspection Start Time: 9:40 am
Inspections Date: 1-7-2020

Inspection End Time: 10:05 am
Last Inspected: 10-31-19

Inspector: Lucas Canfield

License #: H79 Exp: 2023

Customer:

Witness:

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility North Dorm

Device Type	Address	Location	Visual Inspection		Functional Test	
			Pass	Fail	Pass	Fail
NORTH DORM			☐	☐	☐	☐
Smoke Detector	L1/D1	Front Desk by FACP	☐	☐	☑	☐
Duct Detector	L1/D2	East Hall	☐	☐	☑	☐
Smoke Detector	L1/D3	Room 313	☐	☐	☑	☐
Smoke Detector	L1/D4	Room 312	☐	☐	☑	☐
Smoke Detector	L1/D5	Room 311	☐	☐	☑	☐
Smoke Detector	L1/D6	Room 308	☐	☐	☑	☐
Smoke Detector	L1/D7	Room 309	☐	☐	☑	☐
Smoke Detector	L1/D8	Room 310	☐	☐	☑	☐
Duct Detector	L1/D9	West Hall	☐	☐	☑	☐
Smoke Detector	L1/D10	Data Room 318	☐	☐	☑	☐
Smoke Detector	L1/D11	Room 319	☐	☐	☑	☐
Smoke Detector	L1/D12	Room 320	☐	☐	☑	☐
Smoke Detector	L1/D13	Room 321	☐	☐	☑	☐
Smoke Detector	L1/D14	Room 324	☐	☐	☑	☐
Smoke Detector	L1/D15	Room 323	☐	☐	☑	☐
Smoke Detector	L1/D16	Room 322	☐	☐	☑	☐
Flow Monitor	L1/M1	Sprink Wet Fl, Me. Rm.	☐	☐	☑	☐
Tamper Monitor	L1/M2	Spri. Wet Tam, Me.Rm	☐	☐	☑	☐
Pressure Monitor	L1/M3	Spri. Low Air, Me. Rm	☐	☐	☑	☐
Pressure Monitor	L1/M4	Spri,. Dry Flo, Me. Rm.	☐	☐	☑	☐
Monitor	L1/M5	Sprink Spare, Me. Rm.	☐	☐	☑	☐
Tamper Monitor	L1/M6	Spri Dry Tamp, Me. Rm	☐	☐	☑	☐
Wall Horn Strobe		Exercise 305	☐	☐	☑	☐
Wall Horn Strobe		Lounge 304	☐	☐	☑	☐
Wall Strobe		Restroom 303	☐	☐	☑	☐
Wall Strobe		Bedroom 331	☐	☐	☑	☐
Wall Strobe		Bedroom 320	☐	☐	☑	☐
Wall Strobe		Bedroom 319	☐	☐	☑	☐
Wall Strobe		Bedroom 313	☐	☐	☑	☐
Wall Strobe		Bedroom 312	☐	☐	☑	☐
Wall Strobe		Bedroom 311	☐	☐	☑	☐
Wall Horn Strobe		West Corridor 316	☐	☐	☑	☐
Wall Horn Strobe		West Corridor 316	☐	☐	☑	☐
Wall Horn Strobe		Outside Bath 307	☐	☐	☑	☐
Wall Horn Strobe		Outside Bedroom 310	☐	☐	☑	☐
Wall Strobe		Bedroom 322	☐	☐	☑	☐
Wall Strobe		Bedroom 323	☐	☐	☑	☐
Wall Strobe		Bedroom 324	☐	☐	☑	☐
Wall Strobe		Laundry 326	☐	☐	☑	☐
Wall Strobe		Bath 307	☐	☐	☑	☐

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility North Dorm **Page: 2**

Device Type	Address	Location	Visual Inspection Pass	Visual Inspection Fail	Functional Test Pass	Functional Test Fail
Wall Strobe		Bedroom 308	☐	☐	☒	☐
Wall Strobe		Bedroom 309	☐	☐	☒	☐
Wall Strobe		Bedroom 310	☐	☐	☒	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

South Dorm

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment - Bldg A 1200 W. 2nd St. Hastings, NE	10/19/20 **INSPECTION DATE** Residential **TYPE OCCUPANCY**

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
483166	1	
483167	2	

STATUS OF SYSTEM – CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION: Meininger Fire Protection, Inc	
ADDRESS: 2521 West "L" Street, Suite 5	**INSPECTOR SIGNATURE**
CITY: Lincoln **STATE:** NE	**NE LICENSE #:** 05046
ZIP CODE: 68522	**TESTER BFP LICENSE #:** 8115
PHONE: 402-466-2616	
	OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance
of Wet Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm:
Name of Inspected Property: Hastings Youth Bldg A
Inspector Name:
Inspection Contract#
Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.2.0	Supply pressure gauge				40 psi
A.2.1	System pressure gauge				100 psi
A.2.2	Gauges appear to be in good condition	✓			
A.3.0	Control valves in normal open or closed position	✓			
A.3.1	Control valves properly locked or supervised	✓			
A.3.2	Control valves accessible	✓			
A.3.3	Control valves provided with appropriate wrenches	✓			
A.3.4	Control valves free from external leaks	✓			
A.3.5	Control valve identification signs in place	✓			
A.3.6	System control valve sign indicates area served	✓			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓		
A.5.1	Alarm valve free of physical damage		✓		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓		
A.6.0	**ALARM PANEL CLEAR**	✓			
A.7.0	**COMMENTS:**				

INSPECTOR'S INITIAL AM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL ____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: Inspection Contract#

Name of Inspected Property: Hastings City Hall

Inspector Name: JM Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properlly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓		
C.2.1	Test conducted with inspector's test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)		✓	
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Adequate drainage provided before flow testing	✓		
C.3.1	A main drain test conducted downstream from backflow preventer	✓		
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓	
C.3.3	Supply water gauge reading before flow (static)	60 psi		
C.3.4	Gauge reading during stable flow (residual)	45 psi		
C.3.5	Time for supply pressure to return to normal	— sec		
C.4.0	Pertinent parties notified of test conclusion	✓		
C.5.0	**ALARM PANEL CLEAR**	✓		
C.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.7.0	**COMMENTS:**			

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service before testing	✓		
D.1.1	Pertinent parties notified before testing	✓		
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓		
D.2.1	Signal restored only when valve returned to normal position	✓		
D.3.0	Adequate drainage provided before flow testing	✓		
D.3.1	Main drain test conducted		✓	
D.3.2	Supply water gauge reading before flow (static)	60 psi		
D.3.3	Gauge reading during stable flow (residual)	45 psi		
D.3.4	Time for supply pressure to return to normal	— sec		
D.4.0	Pertinent parties notified of test conclusion	✓		
D.5.0	**ALARM PANEL CLEAR**	✓		
D.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
D.7.0	**COMMENTS:**			

INSPECTOR'S INITIAL JM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: Inspection Contract#

Name of Inspected Property: Hastings South Bldg A

Inspector Name: DM Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Main drain test conducted	✓		
F.2.1	Supply water gauge reading before flow (static)	60 psi		
F.2.2	Gauge reading during stable flow (residual)	45 psi		
F.2.3	Time for supply pressure to return to normal	— sec		
F.3.0	Antifreeze solution tested and freezing point determined		—	
F.3.1	Antifreeze solution freezing point	— °F		
F.3.2	Antifreeze solution freezing point after adjustment	— °F		
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.4.3	Main drain test conducted (see F.2.0)	✓		
F.5.0	Backflow prevention assembly forward flow test conducted	✓		
F.5.1	System demand flow was achieved through the device	✓		
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		—	
F.5.5	Forward flow test satisfied by annual fire pump flow test		—	
F.5.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		—	
F.7.0	Pertinent parties notified of test conclusion	✓		
F.8.0	**ALARM PANEL CLEAR**	✓		
F.9.0	**SYSTEM RETURNED TO SERVICE**	✓		
F.10.0	**COMMENTS:**			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓		
G.2.0	Pertinent parties notified before conducting maintenance	✓		
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
G.3.1	Valve completely closed and reopened	✓		
G.4.0	Adequate drainage provided before flow testing	✓		
G.4.1	Main drain test conducted	✓		
G.4.2	Supply water gauge reading before flow (static)	60 psi		
G.4.3	Gauge reading during stable flow (residual)	45 psi		
G.4.4	Time for supply pressure to return to normal	— sec		
G.5.0	Pertinent parties notified after conclusion of maintenance	✓		
G.6.0	**ALARM PANEL CLEAR**	✓		
G.7.0	**SYSTEM RETURNED TO SERVICE**	✓		
G.8.0	**COMMENTS:**			

INSPECTOR'S INITIAL DM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm: MFP
Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center Bldg A
Inspector Name: [illegible]
Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N
A.1.0	System in service on inspection	✓		
A.1.1	Supply (water) gauge pressure	50 psi		
A.1.2	System (air) gauge pressure	20 psi		
A.1.3	Quick opening device gauge pressure	– psi		
A.1.4	Gauge near compressor	110 psi		
A.1.5	Gauge pressures are normal	✓		
A.2.0	Control valves in normal open or closed position	✓		
A.2.1	Control valves properly locked or supervised	✓		
A.2.2	Control valves accessible	✓		
A.2.3	Control valves provided with appropriate wrenches	✓		
A.2.4	Control valves free from external leaks	✓		
A.2.5	Control valve identification signs in place	✓		
A.2.6	System control valve sign indicates area served	✓		
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓		
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓	
A.4.0	Dry pipe valve free of physical damage	✓		
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓		
A.4.2	Dry pipe valve intermediate chamber not leaking	✓		
A.5.0	**ALARM PANEL CLEAR**	✓		
A.6.0	**COMMENTS:**			

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly		✓	
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm tested and is operational	✓		
C.2.1	Test conducted with inspectors test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)	–		
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position *(semi-annual)*	✓		
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	✓		
C.4.0	One main drain test conducted downstream from backflow preventer	✓		
C.4.1	One main drain test conducted downstream from pressure reducing valve		✓	
C.4.2	Supply water gauge reading before flow (static)	60 psi		
C.4.3	Gauge reading during stable flow (residual)	45 psi		
C.4.4	Time for supply pressure to return to normal	– sec		
C.5.0	Priming water level tested	–	✓	
C.6.0	Quick opening device(s) (QOD) tested		✓	
C.7.0	Low pressure alarm tested	✓		
C.8.0	Pertinent parties notified of test conclusion	✓		
C.9.0	**ALARM PANEL CLEAR**	✓		
C.10.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.11.0	**COMMENTS:**			

INSPECTOR'S INITIAL [illegible] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP
Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center Bldg M
Inspector Name: [illegible]
Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)	✓		
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	**ALARM PANEL CLEAR**	✓		

D.8.0 COMMENTS:

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.5.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static) 60 psi			
E.5.2	Gauge reading during stable flow (residual) 45 psi			
E.5.3	Time for supply pressure to return to normal — sec			
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		✓	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓	W	
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	**ALARM PANEL CLEAR**	✓		
E.11.0	**SYSTEM RETURNED TO SERVICE**	✓		

E.12.0 COMMENTS:

1) PARTIAL TRIP TEST

Trip Test Table

Dry Valve Make	Size	Year	Model	Serial No.	Q.O.D. Make	Model	Year Serial No.
Viking	2½"		Model N				

Dry Pipe Operating Test	Time to Trip Thru Test Pipe Min	Time to Trip Thru Test Pipe Sec	Water Pressure PSI	Air Pressure PSI	Time Water Trip Point Air Pressure PSI	Reached Test Outlet Min	Reached Test Outlet Sec	Alarm Operated Yes	Alarm Operated No
Without Q.O.D		10	60	20	7		1	X	
With Q.O.D									

INSPECTOR'S INITIAL JM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 · 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP — Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [illegible] — Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer		✓	
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV	✓		
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	✓		
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	40 psi		
F.5.2	Gauge reading during stable flow (residual)	45 psi		
F.5.3	Time for supply pressure to return to normal	— sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓	
F.6.5	Forward flow test satisfied by annual fire pump flow test		✓	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		✓	
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	**ALARM PANEL CLEAR**	✓		
F.11.0	**SYSTEM RETURNED TO SERVICE**	✓		
F.12.0	**COMMENTS**			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks			
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure			psi
G.6.3	System side static pressure			psi
G.6.4	Supply side residual pressure			psi
G.6.5	System side residual pressure			psi
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted **(see AFSA Form 114A)**			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	**ALARM PANEL CLEAR**			
G.11.0	**SYSTEM RETURNED TO SERVICE**			
G.12.0	**COMMENTS:**			

INSPECTOR'S INITIAL [illegible] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A) Page 3 of 3

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment - Building A
1200 W 2nd Street, Hastings NE 68901

INSPECTION DATE: 11-7-19

TYPE OCCUPANCY: Residential

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☑	INITIAL ACCEPTANCE OF SYSTEM
☒	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☐	REPORT OF INSPECTION	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
48366	1	Wet System
48367	2	Dry System

STATUS OF SYSTEM – CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION:
Meininger Fire Protection, Inc
ADDRESS: 2521 West "L" Street, Suite 5
CITY: Lincoln **STATE:** NE
ZIP CODE: 68522
PHONE: 402-466-2616

INSPECTOR SIGNATURE
NE LICENSE #: 05046
TESTER BFP LICENSE #: 7722

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

NEBRASKA STATE FIRE MARSHAL'S OFFICE

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED ☐ YES ☐ NO	IF NO, EXPLAIN
REMARKS	DATE LEFT IN SERVICE WITH ALL CONTROL VALVES OPEN:	
SIGNATURES	NAME OF SPRINKLER CONTRACTOR MEININGER FIRE PROTECTION, 2521 West L St., Suite #5, Lincoln, NE 68522 • 402-466-2616	
	TESTS WITNESSED BY	
	FOR PROPERTY OWNER (SIGNED) — TITLE — DATE	
	FOR SPRINKLER CONTRACTOR (SIGNED) — TITLE: Fitter — DATE: 11-7-19	
	FOR AUTHORITY HAVING JURISDICTION (IF WITNESSED) — TITLE — DATE: 11-7-19	

ADDITIONAL EXPLANATION AND NOTES

SEND TO: Nebraska State Fire Marshal - 246 South 14th Street - Lincoln, NE 68508-1804
A copy of this completed form shall be forwarded to the State Fire Marshal's Office and a duplicate shall be maintained at the system riser.

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHAL'S OFFICE

Contractor's Material and Test Certificate for Aboveground Piping

PROCEDURE
Upon completion of work, inspection and tests shall be made by the contractor's representative and witnessed by an owner's representative. All defects shall be corrected and system left in service before contractor's personnel finally leave the job.

A certificate shall be filled out and signed by both representatives. Copies shall be prepared for approving authorities, owners and contractor. It is understood the owner's representative's signature in no way prejudices any claim against contractor for faulty material, poor workmanship, or failure to comply with approving authority's requirements or local ordinances.

PROPERTY NAME	HASTINGS YOUTH TREATMENT - BLDG A	DATE	
PROPERTY ADDRESS	4200 W. 2ND ST, HASTINGS NE 68901		
PLANS	ACCEPTED BY APPROVING AUTHORITIES (NAMES) NSFM		
	ADDRESS LINCOLN		
	INSTALLATION CONFORMS TO ACCEPTED PLANS	☐ YES	☐ NO
	EQUIPMENT USED IS APPROVED IF NO, EXPLAIN DEVIATIONS	☐ YES	☐ NO
INSTRUCTIONS	HAS PERSON IN CHARGE OF FIRE EQUIPMENT BEEN INSTRUCTED AS TO LOCATION OF CONTROL VALVES AND CARE AND MAINTENANCE OF THIS NEW EQUIPMENT? IF NO, EXPLAIN	☑ YES	☐ NO
	HAVE COPIES OF THE FOLLOWING BEEN LEFT ON THE PREMISES:		
	1. SYSTEM COMPONENTS INSTRUCTIONS	☐ YES	☐ NO
	2. CARE AND MAINTENANCE INSTRUCTIONS	☑ YES	☐ NO
	3. NFPA 25	☑ YES	☐ NO
LOCATION OF SYSTEM	SUPPLIES BUILDINGS		

SPRINKLERS	MAKE	MODEL	YEAR OF MANUFACTURE	ORIFICE SIZE	QUANTITY	TEMPERATURE RATING
	VIKING	VK300	19	1/2	2	200
	VIKING	VK491	19	3/4	23	200
	VIKING	VK420	19	3/4	2	155
	TYCO	TY3281	19	1/2	13	155
	TYCO	TY3301	19	1/2	15	155

PIPE AND FITTINGS — Type of Pipe STEEL
Type of Fittings STEEL

ALARM VALVE OR FLOW INDICATOR	ALARM DEVICE			MAXIMUM TIME TO OPERATE THROUGH TEST CONNECTION	
	TYPE	MAKE	MODEL	MINIMUM	SECONDS

DRY PIPE OPERATING TEST	DRY VALVE			Q.O.D.		
	MAKE	MODEL	SERIAL NO.	MAKE	MODEL	SERIAL NO.
	Victaulic	769N	12259-3			

	TIME TO TRIP THROUGH TEST CONNECTION*		WATER PRESSURE	AIR PRESSURE	TRIP POINT AIR PRESSURE	TIME WATER REACHED TEST OUTLET*		ALARM OPERATED PROPERLY	
	MIN.	SEC.	PSI	PSI	PSI	MIN.	SEC.	YES	NO
Without Q.O.D.		41	35	16	6		14	✓	
With Q.O.D									

IF NO, EXPLAIN

*MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHAL'S OFFICE

DELUGE & PREACTION VALVES

OPERATION ☐ PNEUMATIC ☐ ELECTRIC ☐ HYDRAULIC

PIPING SUPERVISED ☐ YES ☐ NO | DETECTING MEDIA SUPERVISED ☐ YES ☐ NO

DOES VALVE OPERATE FROM THE MANUAL TRIP AND/OR REMOTE CONTROL STATIONS ☐ YES ☐ NO

IS THERE AN ACCESSIBLE FACILITY IN EACH CIRCUIT FOR TESTING? ☐ YES ☐ NO | IF NO, EXPLAIN

MAKE	MODEL	DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM		DOES EACH CIRCUIT OPERATE VALVE RELEASE		MAXIMUM TIME TO OPERATE RELEASE	
		YES	NO	YES	NO	MIN.	SEC.

PRESSURE REDUCING VALVE TEST

LOCATION & FLOOR	MAKE & MODEL	SETTING	STATIC PRESSURE		RESIDUAL PRESSURE (FLOWING)		FLOW RATE
			INLET (PSI)	OUTLET (PSI)	INLET (PSI)	OUTLET (PSI)	FLOW (GPM)

TEST DESCRIPTION

HYDROSTATIC: Hydrostatic tests shall be made at not less than 200 psi (13.6 bars) for two hours of 50 psi (3.4 bars) above static pressure in excess of 150 psi (10.2 bars) for two hours. Differential dry-pipe valve clappers shall be left open during test to prevent damage. All aboveground piping leakage shall be stopped.

PNEUMATIC: Establish 40 psi (2.7 bars) air pressure and measure drop, which shall not exceed 1-1/2 psi (0.1 bars) in 24 hours. Test pressure tanks at normal water level and air pressure and measure air pressure drop, which shall not exceed 1-1.2 psi (0.1 bars) in 24 hours.

TESTS

ALL PIPING HYDROSTATICALLY TESTED AT 200 PSI FOR 2 HRS. | IF NO, STATE REASON

DRY PIPING PNEUMATICALLY TESTED ☐ YES ☐ NO

EQUIPMENT OPERATES PROPERLY ☐ YES ☐ NO

DRAIN TEST | READING OF GAUGE LOCATED NEAR WATER SUPPLY TEST CONNECTION: 35 PSI | RESIDUAL PRESSURE WITH VALVE IN TEST CONNECTION OPEN WIDE 30 PSI

UNDERGROUND MAINS AND LEAD IN CONNECTIONS TO SYSTEM RISERS FLUSHED BEFORE CONNECTION MADE TO SPRINKLER PIPING.

VERIFIED BY COPY OF THE U FORM NO. 856 ☐ YES ☐ NO | OTHER EXPLAIN

FLUSHED BY INSTALLER OF UNDERGROUND SPRINKLER PIPING ☐ YES ☐ NO

IF POWDER DRIVEN FASTENERS ARE USED IN CONCRETE, HAS REPRESENTATIVE SAMPLE TESTING BEEN SATISFACTORILY COMPLETED? ☐ YES ☐ NO | IF NO, EXPLAIN

BLANK TESTING GASKETS

NUMBER USED | LOCATIONS | NUMBER REMOVED

WELDING

WELDED PIPING ☐ YES ☐ NO

IF YES . . .

DO YOU CERTIFY AS THE SPRINKLER CONTRACTOR THAT WELDING PROCEDURES COMPLY WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3? ☐ YES ☐ NO

DO YOU CERTIFY THAT THE WELDING WAS PERFORMED BY WELDERS QUALIFIED IN COMPLIANCE WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3? ☐ YES ☐ NO

DO YOU CERTIFY THAT WELDING WAS CARRIED OUT IN COMPLIANCE WITH A DOCUMENTED QUALITY CONTROL PROCEDURE TO INSURE THAT ALL DISCS ARE RETRIEVED, THAT OPENINGS IN PIPING ARE SMOOTH, THAT SLAG AND OTHER WELDING RESIDUE ARE REMOVED, AND THAT THE INTERNAL DIAMETERS OF PIPING ARE NOT PENETRATED? ☐ YES ☐ NO

CUTOUTS (DISCS)

DO YOU CERTIFY THAT YOU HAVE A CONTROL FEATURE TO ENSURE THAT ALL CUTOUTS (DISCS) ARE RETRIEVED ☐ YES ☐ NO

MEININGER FIRE PROTECTION INC.

P.O. BOX 85535, LINCOLN, NE 68501 VOICE: 402.466.2616 FAX: 402.466.2617

ATTIC STOCK RECEIPT

JOB: BUILDING A

DESCRIPTION	QUANTITY
TY 3251 165°	2
TY 3281 165°	1
VK664 200°	1
VK 300 200°	1
VK 630 155°	1

OWNER: _____

DATE: _____

GENERAL: _____

DATE: _____

MFP: _____

DATE: 11-7-19

FIRE ALARM INSPECTION

GT Fire & Security

Customer: Hastings Youth Treatment Facility
4200 W 2 Street
Hastings, NE 68901

Location: South Dorm

Panel Type: Notifier 320
100 % Smoke Test: 10-31-19
Frequency: 4/10
Notes:

100 % Heat Test:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations		
3.	Remote Annunciators		
4.	Heat Detectors		
5	Smoke Detectors	14 21	21
6..	Duct Detectors	2	2
7.	Flow Switches	1	1
8.	Pressure Switches	2	2
9	Tamper Switches	3	3
10.	Audibles	6	6
11.	Visuals	21	21
12.	Door Holders		
13.	Fan Relays		
14.	Smoke Relays		
15	FCPS		
16	Voice Evac		

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? (Yes) No N/A
3. Signals received at receiving station? (Yes) No N/A
4. Are system components functioning properly? (Yes) No
5. Did Trouble Signal Operate Properly? (Yes) No
6. Checked system in Emergency Power? Yes (No)
7. Elevator Recall? Yes No (N/A)
8. Main Power (AC) Test Value: 120vAC
9. Emergency Power (Gell Cell) Test Value: 27.2v
10. FACP Battery Change Out Date: 2023
11. Voice Evac Battery Chang e Out: _____
12. FCPS Battery Change Out: _____
13. FCPS Battery Change Out: _____
14. FCPS Battery Change Out: _____

Comments: System Tested Okay

Inspection Start Time: 9:20 am
Inspections Date: 7-7-2020

Inspection End Time: 9:40am
Last Inspected: 10-31-19

Inspector: Lucas Canfield

License #: H79 Exp: 2023

Customer: [signature]

Witness: _____

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility

Device Type	Address	Location	Visual Inspection		Functional Test	
			Pass	Fail	Pass	Fail
SOUTH DORM			☐	☐	☐	☐
Smoke Detector	L1/D1	Front Desk by FACP	☐	☐	☑	☐
Duct Detector	L1/D2	East Hall	☐	☐	☑	☐
Smoke Detector	L1/D3	Room 213	☐	☐	☑	☐
Smoke Detector	L1/D4	Room 212	☐	☐	☑	☐
Smoke Detector	L1/D5	Room 211	☐	☐	☑	☐
Smoke Detector	L1/D6	Room 208	☐	☐	☑	☐
Smoke Detector	L1/D7	Room 209	☐	☐	☑	☐
Smoke Detector	L1/D8	Room 210	☐	☐	☑	☐
Duct Detector	L1/D9	West Hall	☐	☐	☑	☐
Smoke Detector	L1/D10	Data Room 218, W Hall	☐	☐	☑	☐
Smoke Detector	L1/D11	Room 219	☐	☐	☑	☐
Smoke Detector	L1/D12	Room 220	☐	☐	☑	☐
Smoke Detector	L1/D13	Room 221	☐	☐	☑	☐
Smoke Detector	L1/D14	Room 224	☐	☐	☑	☐
Smoke Detector	L1/D15	Room 223	☐	☐	☑	☐
Smoke Detector	L1/D16	Room 222	☐	☐	☑	☐
Monitor	L1/M1	Sprin Wet Tamp/Me Rm	☐	☐	☑	☐
Monitor	L1/M2	Waterflow, Mech Rm	☐	☐	☑	☐
Monitor	L1/M3	Sprink Low Air, Mec Rm	☐	☐	☑	☐
Monitor	L1/M4	Waterflow, Mech Rm	☐	☐	☑	☐
Monitor	L1/M5	Sprin Dry Tamp, Me Rm	☐	☐	☑	☐
Monitor	L1/M6	Sprink Spare, Mech Rm	☐	☐	☑	☐
Wall Horn Strobe		Exercise 205	☐	☐	☑	☐
Wall Horn Strobe		Lounge 204	☐	☐	☑	☐
Wall Strobe		Restroom 203	☐	☐	☑	☐
Wall Strobe		Bedroom 221	☐	☐	☑	☐
Wall Strobe		Bedroom 220	☐	☐	☑	☐
Wall Strobe		Bedroom 219	☐	☐	☑	☐
Wall Strobe		Bedroom 213	☐	☐	☑	☐
Wall Strobe		Bedroom 212	☐	☐	☑	☐
Wall Strobe		Bedroom 211	☐	☐	☑	☐
Wall Horn Strobe		West Corridor 216	☐	☐	☑	☐
Wall Horn Strobe		West Corridor 216	☐	☐	☑	☐
Wall Horn Strobe		Outside Bath 207	☐	☐	☑	☐
Wall Horn Strobe		Outside Bedroom 210	☐	☐	☑	☐
Wall Strobe		Bedroom 222	☐	☐	☑	☐
Wall Strobe		Bedroom 223	☐	☐	☑	☐
Wall Strobe		Bedroom 224	☐	☐	☑	☐
Wall Strobe		Laundry 226	☐	☐	☑	☐

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility **Page: 2**

Device Type	Address	Location	Visual Inspection		Functional Test	
			Pass	Fail	Pass	Fail
Wall Strobe		Bath 207	☐	☐	☑	☐
Wall Strobe		Bedroom 208	☐	☐	☑	☐
Wall Strobe		Bedroom 209	☐	☐	☑	☐
Wall Strobe		Bedroom 210	☐	☐	☑	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Program Building

Central, Inc

RANGE HOOD INSPECTION

Area: Frequency:

Bill To:

Facility: Hastings Regional Center

Contact:

System Model: Ansul R102 Location: Kitchen

Link & Indicator Changeout Date: ~~2-1-21~~ Next Hydrotest Date: 2031

Fuel Shut Off: (circle one) Gas Electric (Both) None N/A

Facility Notes:

Additional Questions

1. Pressure gauge indicator is in the operable range	1. Yes	No	(N/A)
2. For Ansul Only: Weight of CO2 Cartridge	2. 32 oz		
3. All lead and wire seals are intact	3. (Yes)	No	N/A
4. Check positioning of all nozzles	4. (Yes)	No	N/A
5. Check action on all self-closing caps or covers	5. (Yes)	No	N/A
6. Check fuse links, clean grease from links.	6. (Yes)	No	N/A
7. Did you replace the fuse links?	7. (Yes)	No	N/A
8. Test system for proper operation from terminal	8. (Yes)	No	N/A
9. Test system for proper operation from manual and remote manual	9. (Yes)	No	N/A
10. Test microswitch and/or gas valve	10. (Yes)	No	N/A
11. Check exhaust fan for proper operation	11. (Yes)	No	N/A
12. Clean system cylinder and component	12. (Yes)	No	N/A
13. Check inspection and service tag on system cylinder	13. (Yes)	No	N/A
14. Are all cooking surfaces protected	14. (Yes)	No	N/A

Comments:

System tested OK's.

Changed 4-360° Type K fuselinks (2020)

Inspector 1: DS License #: K86

Inspector 2: License #:

A.H.J.: Customer:

Insp. Date: 2-1-21 Insp. Start Time: Insp. End Time:

Start Drive Time: Start Mileage: End Mileage:

Last Inspected By:

Office - White, State - Yellow, City - Pink, Customer - Gold

Last Inspected:

Protex Central, Inc

RANGE HOOD INSPECTION

Account # Area: Frequency:

Bill To:

Facility: Hastings Regional Cath. Youth Treatment Facility

Contact:

System Model: Ansul R102 Location: Kitchen

Link & Indicator Changeout Date: 1/7/20 Next Hydrotest Date: 2031

Fuel Shut Off: (circle one) Gas Electric (Both) None N/A

Facility Notes:

Additional Questions

1. Pressure gauge indicator is in the operable range	1. Yes No (N/A)	
2. For Ansul Only: Weight of CO2 Cartridge	2. 35 oz.	
3. All lead and wire seals are intact	3. (Yes) No N/A	
4. Check positioning of all nozzles	4. (Yes) No N/A	
5. Check action on all self-closing caps or covers	5. (Yes) No N/A	
6. Check fuse links, clean grease from links.	6. (Yes) No N/A	
7. Did you replace the fuse links?	7. Yes (No) N/A	
8. Test system for proper operation from terminal	8. (Yes) No N/A	
9. Test system for proper operation from manual and remote manual	9. (Yes) No N/A	
10. Test microswitch and/or gas valve	10. (Yes) No N/A	
11. Check exhaust fan for proper operation	11. (Yes) No N/A	
12. Clean system cylinder and component	12. (Yes) No N/A	
13. Check inspection and service tag on system cylinder	13. (Yes) No N/A	
14. Are all cooking surfaces protected	14. (Yes) No N/A	

Comments:

System Tested OK

Pull Station Difficult to Pull

Inspector 1 [signature] License # 823

Inspector 2 License #

A.H.J. Customer

Insp. Date 8/10/20 Insp. Start Time Insp. End Time

Start Drive Time Start Mileage End Mileage

Last Inspected By: Last Inspected:

Office - White, State - Yellow, City - Pink, Customer - Gold

RANGE HOOD FIRE SUPPRESSION SYSTEM REPORT

INTEGRATED SECURITY SOLUTIONS
1710 West 2nd Street Hastings, NE 68901
2620 East Highway 30 Kearney, NE 68847
Phone (402) 462-0348 Fax (308) 236-7323
info@iss-ne.net www.iss-ne.com

DATE OF SERVICE

ANNUAL ☐ SEMI-ANNUAL ☐ RECHARGE ☐ INSTALLATION ☑ RENOVATION ☐

LOCATION OF SYSTEM CYLINDERS: Kitchen

MANUFACTURER: Ansul | MODEL NUMBER: R-102 | WET ☐ | DRY CHEMICAL ☑

CYLINDER SIZE MASTER: 3gal | CYLINDER SIZE SLAVE:

FUSE LINKS 360°F: 3 | FUSE LINKS 450°F: | FUSE LINKS 500°F:

FUEL SHUT-OFF ☑ | ELECTRIC ☑ | GAS ☑

LAST HYDRO TEST DATE: Nov 2020 | LAST RECHARGE DATE:

Name Hasting Youth Treatment Facility

Address 4200 West 2nd Street

City Hasting, NE 68901 State Zip Code

Telephone Store No.

NOTIFICATION OF DEFICIENCIES

☐ A mark made in the adjacent box indicates that deficiencies exist with the current condition of the Fire Suppression System. If this is the case, the customer's authorized representative, by this or his or her signature and initials acknowledges these deficiencies represent an **IMMEDIATE AND SERIOUS SAFETY CONCERN** that the customer must correct. Integrated Security Solutions, LLC. shall not be responsible if the Fire Suppression System malfunctions or fails to function. It is the owner's responsibility to ensure that all deficiencies are removed or repaired. See Comments

CUSTOMER INITIALS: _____

AUTHORITY HAVING JURISDICTION OR INSURANCE NOTES _____

SIGNATURE [signature] DATE 1-7-2020

	YES	NO	N/A
1. Duct and plenum properly covered	☑	☐	☐
2. Check positioning of all nozzles	☑	☐	☐
3. System installed in accordance with UL300	☑	☐	☐
4. Check if seals intact, evidence of tampering	☑	☐	☐
5. Pressure gauge in proper range (If gauged)	☐	☐	☑
6. Check cartridge weight (if applicable)	☑	☐	☐
7. Hydrostatic test date	2032		
8. Inspect cylinder and mount	☑	☐	☐
9. Operate system from terminal link	☑	☐	☐
10. Check operation of micro switch	☑	☐	☐
11. Check operation of gas valve	☑	☐	☐
12. Proper nozzle covers in place	☑	☐	☐
13. Replaced fuse links	3		
14. Check travel of cable nuts/S-hooks	☑	☐	☐

	YES	NO	N/A
15. Piping & conduit securely bracketed	☑	☐	☐
16. Exhaust fan in operation order	☑	☐	☐
17. All filters replaced	☑	☐	☐
18. Manual & remote set/seals in place	☑	☐	☐
19. Replace systems covers	☑	☐	☐
20. System operational & seals in place	☑	☐	☐
21. Slave system operational	☐	☑	☐
22. Fan warning sign on hood	☑	☐	☐
23. Personnel present instructed in manual operation of system	☑	☐	☐
24. Proper hand portable extinguishers	☑	☐	☐
25. Service & Certification tag on system	☑	☐	☐
26. Grease Level L ☐ M ☐ H ☐			
27. Recommend Cleaning Y ☐ N ☑			
28. Tamper Seals in place	☑	☐	☐

NOTE DISCREPANCIES OR DEFICIENCIES BELOW

COMMENTS: _____

On this date, the above system was tested and inspected in accordance with procedures of the presently adopted editions of NFPA 17, 17A, 96 and the manufacturer's manual and was operated according to these procedures with results indicated above.

X [signature]

SERVICE TECHNICIAN | DATE | CUSTOMERS AUTHORIZED AGENT

The above service technician certifies that the system was personally inspected and found conditions to be as indicated on this report.

FIRE ALARM INSPECTION

GT Fire & Security

Customer: Hastings Youth Treatment Facility
4200 W 2 Street
Hastings, NE 68901

Location: Program Bldg

Panel Type: Notifier 320
100 % Smoke Test: 10-31-19
Frequency: 4/10
Notes:

100 % Heat Test:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations		
3.	Remote Annunciators		
4.	Heat Detectors		
5	Smoke Detectors	1	
6..	Duct Detectors	4 - 0	0
7.	Flow Switches	1	1
8.	Pressure Switches	2	2
9	Tamper Switches	2 ea	0
10.	Audibles	14	14
11.	Visuals	48	48
12.	Door Holders		
13.	Fan Relays		
14.	Smoke Relays		
15	FCPS		
16	Voice Evac		

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? Yes No N/A
3. Signals received at receiving station? Yes No N/A
4. Are system components functioning properly? Yes No
5. Did Trouble Signal Operate Properly? Yes No
6. Checked system in Emergency Power? Yes No
7. Elevator Recall? Yes No N/A
8. Main Power (AC) Test Value: 120v
9. Emergency Power (Gell Cell) Test Value: 27.3v
10. FACP Battery Change Out Date: 2023
11. Voice Evac Battery Chang e Out: _____
12. FCPS Battery Change Out: _____
13. FCPS Battery Change Out: _____
14. FCPS Battery Change Out: _____

Comments: System Tested Okay

Inspection Start Time: 8:50 am
Inspections Date: 7-7-2020

Inspection End Time: 9:20 am
Last Inspected: 10-31-19

Inspector: Lucas Canfield

License #: 479 Exp: 2023

Customer: [signature]

Witness: _____

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility Program Bldg

Device Type	Address	Location	Visual Inspection		Functional Test	
			Pass	Fail	Pass	Fail
PROGRAM ADMIN BLDG			☐	☐	☐	☐
Smoke Detector	L1/D1	W Entry Vestibule over FACP	☐	☐	☒	☐
Pressure Monitor	L1/M1	Sprink. Low Air, Mech. Rm.	☐	☐	☒	☐
Tamper Monitor	L1/M2	Dry Tamper/Bkflow, Mech Rm	☐	☐	☒	☐
Pressure Monitor	L1/M3	Sprink. Dry Flow, Mech. Rm.	☐	☐	☒	☐
Tamper Monitor	L1/M3	Sprink. Tamper, Mech. Rm.	☐	☐	☒	☐
Flow Monitor	L1/M4	Sprink. Wet Flow, Mech. Rm.	☐	☐	☒	☐
Monitor	L1/M5	Kitchen Hood System	☐	☐	☒	☐
Wall Strobe		Outside Storage 144	☐	☐	☒	☐
Wall Horn Strobe		By Restroom 139	☐	☐	☒	☐
Wall Strobe		Kitchen 138	☐	☐	☒	☐
Wall Horn Strobe		Kitchen 138	☐	☐	☒	☐
Wall Horn Strobe		Kitchen 138	☐	☐	☒	☐
Wall Strobe		Cafeteria 136	☐	☐	☒	☐
Wall Horn Strobe		Cafeteria 136	☐	☐	☒	☐
Wall Strobe		Small Meeting Room 118	☐	☐	☒	☐
Wall Strobe		PVX 115	☐	☐	☒	☐
Wall Strobe		Small Meeting 114	☐	☐	☒	☐
Wall Strobe		Medium Meeting 119	☐	☐	☒	☐
Wall Strobe		Small Meeting 117	☐	☐	☒	☐
Wall Horn Strobe		Outside Sm Meeting 117	☐	☐	☒	☐
Wall Strobe		Visitor Meeting 116	☐	☐	☒	☐
Wall Strobe		Small Meeting 113	☐	☐	☒	☐
Wall Horn Strobe		Outside Sleeping Un 104A	☐	☐	☒	☐
Wall Strobe		Outside Visitor Meeting 110	☐	☐	☒	☐
Wall Strobe		Sleeping Unit 104A	☐	☐	☒	☐
Wall Strobe		Intake Health 103	☐	☐	☒	☐
Wall Strobe		Restroom 112	☐	☐	☒	☐
Wall Strobe		Restroom 111	☐	☐	☒	☐
Wall Strobe		Exam 104B	☐	☐	☒	☐
Wall Strobe		Restroom 105	☐	☐	☒	☐
Wall Strobe		Restroom 106	☐	☐	☒	☐
Wall Horn Strobe		Outside Restroom 106	☐	☐	☒	☐
Wall Strobe		Admin Work 109A	☐	☐	☒	☐
Wall Strobe		Admin Break 109B	☐	☐	☒	☐
Wall Strobe		Waiting 108A	☐	☐	☒	☐
Wall Horn Strobe		Outside Art 120	☐	☐	☒	☐
Wall Strobe		Art 120	☐	☐	☒	☐
Wall Strobe		Study 121	☐	☐	☒	☐
Wall Strobe		Classroom 132	☐	☐	☒	☐

DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility

Page: 2

Device Type	Address	Location	Visual Inspection		Functional Test	
			Pass	Fail	Pass	Fail
Wall Strobe		Classroom 131	☐	☐	☑	☐
Wall Horn Strobe		Outside Restroom 122	☐	☐	☑	☐
Wall Strobe		Restroom 122	☐	☐	☒	☐
Wall Horn Strobe		Outside Restroom 123	☐	☐	☒	☐
Wall Strobe		Restroom 123	☐	☐	☒	☐
Wall Strobe		Corridor 134	☐	☐	☑	☐
Wall Horn Strobe		Corridor 134	☐	☐	☑	☐
Wall Strobe		Restroom 124	☐	☐	☑	☐
Wall Horn Strobe		Classroom 133	☐	☐	☑	☐
Wall Strobe		Restroom 124	☐	☐	☑	☐
Wall Horn Strobe		Classroom 130	☐	☐	☑	☐
Wall Strobe		Restroom 125	☐	☐	☑	☐
Wall Strobe		Oasis 133B	☐	☐	☑	☐
Wall Strobe		Oasis 130B	☐	☐	☑	☐
Wall Horn Strobe		Library 126	☐	☐	☑	☐
Wall Strobe		Outside IT Data 128	☐	☐	☑	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 - 402-466-2616

Report of Inspection, Testing & Maintenance
of Wet Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm: MFP — Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center
Inspector Name: [signature] — Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.2.0	Supply pressure gauge				60 psi
A.2.1	System pressure gauge				60 psi
A.2.2	Gauges appear to be in good condition	✓			
A.3.0	Control valves in normal open or closed position	✓			
A.3.1	Control valves properly locked or supervised	✓			
A.3.2	Control valves accessible	✓			
A.3.3	Control valves provided with appropriate wrenches	✓			
A.3.4	Control valves free from external leaks	✓			
A.3.5	Control valve identification signs in place	✓			
A.3.6	System control valve sign indicates area served	✓			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓		
A.5.1	Alarm valve free of physical damage		✓		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓		
A.6.0	ALARM PANEL CLEAR	✓			
A.7.0	COMMENTS:				

INSPECTOR'S INITIAL [signature] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 106A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM:	10/19/20 INSPECTION DATE
Hastings Youth Treatment Center 4200 W. 2nd Street Hastings, NE	Educational TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☒	DRY PIPE VALVE TEST	☒	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
48361	5	
48362	1	
48363	2	
48364	7	
48365	7	

STATUS OF SYSTEM – CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION: Meininger Fire Protection, Inc	
ADDRESS: 2521 West "L" Street, Suite 5	**INSPECTOR SIGNATURE**
CITY: Lincoln **STATE:** NE	**NE LICENSE #:** 05046
ZIP CODE: 68522	**TESTER BFP LICENSE #:** 5115
PHONE: 402-466-2616	
	OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [signature] Date: 10/19/26

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly			
B.3.9	FDC interior inspected where caps missing		—	
B.3.10	FDC obstructions removed as necessary		—	
B.4.0	Pressure reducing control valves (PRV) indicate open		—	
B.4.1	PRV not leaking		—	
B.4.2	PRV maintaining downstream pressure per design		—	
B.4.3	PRV in good condition		—	
B.4.4	PRV handwheel installed and not broken		—	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓		
C.2.1	Test conducted with inspector's test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)		—	
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Adequate drainage provided before flow testing	✓		
C.3.1	A main drain test conducted downstream from backflow preventer	✓		
C.3.2	A main drain test conducted downstream from pressure reducing valve		—	
C.3.3	Supply water gauge reading before flow (static)	60 psi		
C.3.4	Gauge reading during stable flow (residual)	45 psi		
C.3.5	Time for supply pressure to return to normal	— sec		
C.4.0	Pertinent parties notified of test conclusion	✓		
C.5.0	**ALARM PANEL CLEAR**	✓		
C.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.7.0	**COMMENTS:**			

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service before testing	✓		
D.1.1	Pertinent parties notified before testing	✓		
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓		
D.2.1	Signal restored only when valve returned to normal position	✓		
D.3.0	Adequate drainage provided before flow testing	✓		
D.3.1	Main drain test conducted	✓		
D.3.2	Supply water gauge reading before flow (static)	60 psi		
D.3.3	Gauge reading during stable flow (residual)	45 psi		
D.3.4	Time for supply pressure to return to normal	— sec		
D.4.0	Pertinent parties notified of test conclusion	✓		
D.5.0	**ALARM PANEL CLEAR**	✓		
D.6.0	**SYSTEM RETURNED TO SERVICE**	✓		
D.7.0	**COMMENTS:**			

INSPECTOR'S INITIAL [signature] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/26

(AFSA Form 106A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...*continued*

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [signature] Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Main drain test conducted	✓		
F.2.1	Supply water gauge reading before flow (static)	60 psi		
F.2.2	Gauge reading during stable flow (residual)	45 psi		
F.2.3	Time for supply pressure to return to normal	— sec		
F.3.0	Antifreeze solution tested and freezing point determined		—	
F.3.1	Antifreeze solution freezing point	— °F		
F.3.2	Antifreeze solution freezing point after adjustment	— °F		
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.4.3	Main drain test conducted (see F.2.0)	✓		
F.5.0	Backflow prevention assembly forward flow test conducted	✓		
F.5.1	System demand flow was achieved through the device	✓		
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		—	
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)			—
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)			—
F.5.5	Forward flow test satisfied by annual fire pump flow test			—
F.5.6	Backflow preventer performance test conducted as required by the AHJ	—		
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve			—
F.7.0	Pertinent parties notified of test conclusion	✓		
F.8.0	ALARM PANEL CLEAR	✓		
F.9.0	SYSTEM RETURNED TO SERVICE	✓		
F.10.0	COMMENTS:			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓		
G.2.0	Pertinent parties notified before conducting maintenance	✓		
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
G.3.1	Valve completely closed and reopened	✓		
G.4.0	Adequate drainage provided before flow testing	✓		
G.4.1	Main drain test conducted	✓		
G.4.2	Supply water gauge reading before flow (static)	60 psi		
G.4.3	Gauge reading during stable flow (residual)	45 psi		
G.4.4	Time for supply pressure to return to normal	— sec		
G.5.0	Pertinent parties notified after conclusion of maintenance	✓		
G.6.0	ALARM PANEL CLEAR	✓		
G.7.0	SYSTEM RETURNED TO SERVICE	✓		
G.8.0	COMMENTS:			

INSPECTOR'S INITIAL [signature] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 · 402-466-2616

Report of Inspection, Testing & Maintenance
of Dry Pipe Fire Sprinkler Systems

AFSA American Fire Sprinkler Association

ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED
(Weekly inspection tasks are NOT included in this report)

Inspecting Firm: MFP — Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [signature] — Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N			Y	N/A	N
A.1.0	System in service on inspection	✓			A.2.6	System control valve sign indicates area served		✓	
A.1.1	Supply (water) gauge pressure	110 psi			A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓		
A.1.2	System (air) gauge pressure	24 psi			A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge			✓
A.1.3	Quick opening device gauge pressure	[illegible] psi			A.4.0	Dry pipe valve free of physical damage		✓	
A.1.4	Gauge near compressor	110 psi			A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓		
A.1.5	Gauge pressures are normal	✓			A.4.2	Dry pipe valve intermediate chamber not leaking	✓		
A.2.0	Control valves in normal open or closed position	✓			A.5.0	**ALARM PANEL CLEAR**	✓		
A.2.1	Control valves properly locked or supervised	✓			A.6.0	**COMMENTS:**			
A.2.2	Control valves accessible	✓							
A.2.3	Control valves provided with appropriate wrenches	✓							
A.2.4	Control valves free from external leaks	✓							
A.2.5	Control valve identification signs in place	✓							

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	N/A		
B.3.10	FDC obstructions removed as necessary			✓
B.4.0	Pressure reducing control valves (PRV) indicate open			✓
B.4.1	PRV not leaking			✓
B.4.2	PRV maintaining downstream pressure per design			✓
B.4.3	PRV in good condition			✓
B.4.4	PRV handwheel installed and not broken			✓
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓		
C.1.1	Pertinent parties notified before testing	✓		
C.1.2	Adequate drainage provided before flow testing	✓		
C.2.0	Water flow alarm tested and is operational	✓		
C.2.1	Test conducted with inspectors test connection	✓		
C.2.2	Test conducted with bypass connection (freezing weather)	✓		
C.2.3	Test conducted per manufacturer's instructions	✓		
C.2.4	Alarm devices appear free of physical damage	✓		
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position *(semi-annual)*	✓		
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	✓		
C.4.0	One main drain test conducted downstream from backflow preventer	✓		
C.4.1	One main drain test conducted downstream from pressure reducing valve		✓	
C.4.2	Supply water gauge reading before flow (static)	60 psi		
C.4.3	Gauge reading during stable flow (residual)	45 psi		
C.4.4	Time for supply pressure to return to normal	— sec		
C.5.0	Priming water level tested		✓	
C.6.0	Quick opening device(s) (QOD) tested		✓	
C.7.0	Low pressure alarm tested	✓		
C.8.0	Pertinent parties notified of test conclusion	✓		
C.9.0	**ALARM PANEL CLEAR**	✓		
C.10.0	**SYSTEM RETURNED TO SERVICE**	✓		
C.11.0	**COMMENTS:**			

INSPECTOR'S INITIAL [signature] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP
Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center
Inspector Name:
Date: 10/19/20
Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)		✓	
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	ALARM PANEL CLEAR	✓		

D.8.0 COMMENTS:

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.5.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static)	60 psi		
E.5.2	Gauge reading during stable flow (residual)	45 psi		
E.5.3	Time for supply pressure to return to normal	sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		✓	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓		
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	ALARM PANEL CLEAR	✓		
E.11.0	SYSTEM RETURNED TO SERVICE	✓		

E.12.0 COMMENTS:

PARTIAL TRIP TEST

Trip Test Table

Dry Valve Make	Size	Year	Model	Serial No.	Q.O.D. Make	Model	Year Serial No.
Victaulic	4"		716 BAL				

Dry Pipe Operating Test	Time to Trip Thru Test Pipe Min	Time to Trip Thru Test Pipe Sec	Water Pressure PSI	Air Pressure PSI	Time Water Trip Point Air Pressure PSI	Reached Test Outlet Min	Reached Test Outlet Sec	Alarm Operated Yes	Alarm Operated No
Without Q.O.D		14	60	24	7		1	X	
With Q.O.D									

INSPECTOR'S INITIAL JM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP — Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center

Inspector Name: [illegible] — Date: 10/19/20

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open *(required at full flow every 3 years)*	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer		✓	
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV	✓		
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison		✓	
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	120 psi		
F.5.2	Gauge reading during stable flow (residual)	95 psi		
F.5.3	Time for supply pressure to return to normal	– sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)			✓
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)			✓
F.6.5	Forward flow test satisfied by annual fire pump flow test			✓
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve			✓
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)			✓
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	ALARM PANEL CLEAR	✓		
F.11.0	SYSTEM RETURNED TO SERVICE	✓		
F.12.0	COMMENTS			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks			
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure	psi		
G.6.3	System side static pressure	psi		
G.6.4	Supply side residual pressure	psi		
G.6.5	System side residual pressure	psi		
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted (see AFSA Form 114A)			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	ALARM PANEL CLEAR			
G.11.0	SYSTEM RETURNED TO SERVICE			
G.12.0	COMMENTS:			

INSPECTOR'S INITIAL [signature] (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10/19/20

(AFSA Form 107A)

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION

Backflow Maintenance Form

Business/Building Hastings Youth Treatment Center

Service Address 4200 W. 2nd Street

Contact Person _____ Phone Number _____

☑ Annual Test ☑ DC ☐ RPP	4"	Colt	DC200	TC-1012	
	Size	Manufacturer	Model No.	Serial #	
☐ New Installation ☐ Replacement ☐ DC ☐ RPP					
	Size	Manufacturer	Model No.	Serial #	

☐ Domestic Containment ☐ Irrigation ☑ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc.) _____

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location Riser Room N/Side of Bldg

Check Valve #1	Check Valve #2	Pressure Relief Valve	PVB/SVB
INITIAL TEST			
Held at 2.6 PSID	Held at 2.6 PSID	Opened at PSID	Air Inlet
Leaked ☐ Yes ☑ No	Closed Tight ☑ Yes ☐ No	Did not open	Opened at PSID
Cleaned	Leaked ☐ Yes ☑ No	Cleaned	Did not open
Replaced	Cleaned	Replaced	Check Valve
	#2 Shut Off Closed Tight ☐ Yes ☐ No		Held at PSID
			Leaked
			Cleaned
			Replaced
FINAL TEST			Check Valve PSID
	Closed Tight ☐ Yes ☐ No		Air Inlet PSID
PSID	PSID	Replaced PSID	

I hereby certify the above backflow preventer has been tested in accordances with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System Title 17, and that all readings are true and accurate to the best of my ability.

Questions Call 402-466-2616
MEININGER FIRE PROTECTION
2521 West L Street, Suite 5
Lincoln, NE 68522

Nick Nabity — MFP — 7932 — 402-853-5786
State Certified Technician (please print) — Company — Grade 6 Certificate No. — Cell/Phone No.

State Certified Technician (signature) — Customer Signature — 10/19/20 Date of Test

Apollo — 11050196 — 12/19/19
Test Gauge Manufacturer — Test Gauge Serial No. — Date of Calibration

Comments

Please Type or Print Legibly
White Copy (Water Department) Yellow Copy (MFP) Pink Copy (Business)

MEININGER FIRE PROTECTION

Backflow Maintenance Form

Business/Building Hastings Youth Treatment

Service Address 4200 W. 2nd ST Hastings NE 68901

Contact Person _____ Phone Number _____

☐ Annual Test
☐ DC ☐ RPP

Size	Manufacturer	Model No.	Serial #

☑ New Installation ☐ Replacement
☐ DC ☐ RPP

Size	Manufacturer	Model No.	Serial #
4"	Colt	DC200	TC-1012

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc.) _____
☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location _____

Check Valve #1	Check Valve #2	Pressure Relief Valve	PVB/SVB
INITIAL TEST			
Held at 3.4 PSID	Held at 3.2 PSID	Opened at PSID	Air Inlet
Leaked ☐ Yes ☑ No	Closed Tight ☑ Yes ☐ No	Did not open	Opened at PSID
Cleaned	Leaked ☐ Yes ☑ No	Cleaned	Did not open
Replaced	Cleaned	Replaced	Check Valve
	#2 Shut Off Closed Tight ☑ Yes ☐ No		Held at PSID
			Leaked
			Cleaned
			Replaced
FINAL TEST			
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordances with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System Title 17, and that all readings are true and accurate to the best of my ability.

Questions Call 402-466-2616
MEININGER FIRE PROTECTION
2521 West L Street, Suite 5
Lincoln, NE 68522

Nick Nobbe — State Certified Technician (please print)
MFP — Company
7932 — Grade 6 Certificate No.
402(853-1578) — Cell/Phone No.

State Certified Technician (signature)
Customer Signature
11-5-18 — Date of Test

Apollo — Test Gauge Manufacturer
11050196 — Test Gauge Serial No.
12-7-18 — Date of Calibration

Comments

Please Type or Print Legibly
White Copy (Water Department) Yellow Copy (MFP) Pink Copy (Business)

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment Center
4200 W. 2nd Street, Hastings NE 68901

10/31/19 — **INSPECTION DATE**

Educational — **TYPE OCCUPANCY**

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☒	INITIAL ACCEPTANCE OF SYSTEM
☒	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☐	REPORT OF INSPECTION	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
48361	5	BACKFLOW
48362	1	WET SYSTEM
48363	2	DRY SYSTEM
48364	7	CONTROL VALVE BUILDING A
48365	7	CONTROL VALVE BUILDING B
		BUILDING A
48366	1	WET SYSTEM
48367	2	DRY SYSTEM
		BUILDING B
48368	1	WET SYSTEM
48369	2	DRY SYSTEM

STATUS OF SYSTEM – CHECK ONE

☐ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION:
Meininger Fire Protection, Inc
ADDRESS: 2521 West "L" Street, Suite 5
CITY: Lincoln **STATE:** NE
ZIP CODE: 68522
PHONE: 402-466-2616

INSPECTOR SIGNATURE
NE LICENSE #: 05046
TESTER BFP LICENSE #:

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

11-7-19

NEBRASKA STATE FIRE MARSHAL'S OFFICE

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED ☑ YES ☐ NO	IF NO, EXPLAIN
REMARKS	DATE LEFT IN SERVICE WITH ALL CONTROL VALVES OPEN: 10/31/19	
SIGNATURES	NAME OF SPRINKLER CONTRACTOR MEININGER FIRE PROTECTION, 2521 West L St., Suite #5, Lincoln, NE 68522 • 402-466-2616	
	TESTS WITNESSED BY	
	FOR PROPERTY OWNER (SIGNED) TITLE DATE	
	FOR SPRINKLER CONTRACTOR (SIGNED) TITLE: Fitter DATE: 11-7-19	
	FOR AUTHORITY HAVING JURISDICTION (IF WITNESSED) TITLE DATE	

ADDITIONAL EXPLANATION AND NOTES

VIKING	VK630	14'	3/4	8	155°
TYCO	TY3251	14'	1/2	31	155°
TYCO	TY3461	14'	1/2	26	155°
VICTAULIC	V3302	16	1/2	6	200°

SEND TO: Nebraska State Fire Marshal - 246 South 14th Street - Lincoln, NE 68508-1804
A copy of this completed form shall be forwarded to the State Fire Marshal's Office and a duplicate shall be maintained at the system riser.

NEBRASKA STATE FIRE MARSHAL'S OFFICE

Contractor's Material and Test Certificate for Aboveground Piping

PROCEDURE
Upon completion of work, inspection and tests shall be made by the contractor's representative and witnessed by an owner's representative. All defects shall be corrected and system left in service before contractor's personnel finally leave the job.

A certificate shall be filled out and signed by both representatives. Copies shall be prepared for approving authorities, owners and contractor. It is understood the owner's representative's signature in no way prejudices any claim against contractor for faulty material, poor workmanship, or failure to comply with approving authority's requirements or local ordinances.

PROPERTY NAME: HASTINGS YOUTH TREATMENT | DATE: 10/21/19

PROPERTY ADDRESS: 4200 W. 2ND STREET, HASTINGS NE 68901

PLANS	ACCEPTED BY APPROVING AUTHORITIES (NAMES): NSFM		
	ADDRESS: LINCOLN		
	INSTALLATION CONFORMS TO ACCEPTED PLANS	☑ YES	☐ NO
	EQUIPMENT USED IS APPROVED IF NO, EXPLAIN DEVIATIONS	☐ YES	☐ NO
INSTRUCTIONS	HAS PERSON IN CHARGE OF FIRE EQUIPMENT BEEN INSTRUCTED AS TO LOCATION OF CONTROL VALVES AND CARE AND MAINTENANCE OF THIS NEW EQUIPMENT? IF NO, EXPLAIN	☑ YES	☐ NO
	HAVE COPIES OF THE FOLLOWING BEEN LEFT ON THE PREMISES:		
	1. SYSTEM COMPONENTS INSTRUCTIONS	☑ YES	☐ NO
	2. CARE AND MAINTENANCE INSTRUCTIONS	☑ YES	☐ NO
	3. NFPA 25	☑ YES	☐ NO
LOCATION OF SYSTEM	SUPPLIES BUILDINGS		

SPRINKLERS

MAKE	MODEL	YEAR OF MANUFACTURE	ORIFICE SIZE	QUANTITY	TEMPERATURE RATING
VIKING	VK463	14	1/2	96	155
VIKING	VK636	14	3/4	2	155
VIKING	VK300	14	1/2	55	155/200
VIKING	VK694	14	1/2	46	200
VIKING	VK681	14	3/4	27	200

PIPE AND FITTINGS
Type of Pipe: STEEL
Type of Fittings: STEEL

ALARM VALVE OR FLOW INDICATOR

ALARM DEVICE TYPE	MAKE	MODEL	MAXIMUM TIME TO OPERATE THROUGH TEST CONNECTION: MINIMUM	SECONDS
	[illegible]			

DRY PIPE OPERATING TEST

DRY VALVE

MAKE	MODEL	SERIAL NO.
Victaulic	768N	12259-3

Q.O.D.

MAKE	MODEL	SERIAL NO.

	TIME TO TRIP THROUGH TEST CONNECTION* MIN.	TIME TO TRIP THROUGH TEST CONNECTION* SEC.	WATER PRESSURE PSI	AIR PRESSURE PSI	TRIP POINT AIR PRESSURE PSI	TIME WATER REACHED TEST OUTLET* MIN.	TIME WATER REACHED TEST OUTLET* SEC.	ALARM OPERATED PROPERLY YES	ALARM OPERATED PROPERLY NO
Without Q.O.D.		14	35	15	7		37	✓	
With Q.O.D									

IF NO, EXPLAIN

*MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHAL'S OFFICE

DELUGE & PREACTION VALVES	OPERATION ☐ PNEUMATIC ☐ ELECTRIC ☐ HYDRAULIC									
	PIPING SUPERVISED ☐ YES ☐ NO			DETECTING MEDIA SUPERVISED ☐ YES ☐ NO						
	DOES VALVE OPERATE FROM THE MANUAL TRIP AND/OR REMOTE CONTROL STATIONS ☐ YES ☐ NO									
	IS THERE AN ACCESSIBLE FACILITY IN EACH CIRCUIT FOR TESTING? ☐ YES ☐ NO			IF NO, EXPLAIN						
	MAKE	MODEL	DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM		DOES EACH CIRCUIT OPERATE VALVE RELEASE		MAXIMUM TIME TO OPERATE RELEASE			
			YES	NO	YES	NO	MIN.	SEC.		
PRESSURE REDUCING VALVE TEST	LOCATION & FLOOR	MAKE & MODEL	SETTING	STATIC PRESSURE		RESIDUAL PRESSURE (FLOWING)		FLOW RATE		
				INLET (PSI)	OUTLET (PSI)	INLET (PSI)	OUTLET (PSI)	FLOW (GPM)		
TEST DESCRIPTION	HYDROSTATIC: Hydrostatic tests shall be made at not less than 200 psi (13.6 bars) for two hours of 50 psi (3.4 bars) above static pressure in excess of 150 psi (10.2 bars) for two hours. Differential dry-pipe valve clappers shall be left open during test to prevent damage. All aboveground piping leakage shall be stopped. PNEUMATIC: Establish 40 psi (2.7 bars) air pressure and measure drop, which shall not exceed 1-1/2 psi (0.1 bars) in 24 hours. Test pressure tanks at normal water level and air pressure and measure air pressure drop, which shall not exceed 1-1.2 psi (0.1 bars) in 24 hours.									
TESTS	ALL PIPING HYDROSTATICALLY TESTED AT 200 PSI FOR 2 HRS. DRY PIPING PNEUMATICALLY TESTED ☐ YES ☐ NO EQUIPMENT OPERATES PROPERLY ☐ YES ☐ NO					IF NO, STATE REASON				
	DRAIN TEST	READING OF GAUGE LOCATED NEAR WATER SUPPLY TEST CONNECTION: 35 PSI				RESIDUAL PRESSURE WITH VALVE IN TEST CONNECTION OPEN WIDE 30 PSI				
	UNDERGROUND MAINS AND LEAD IN CONNECTIONS TO SYSTEM RISERS FLUSHED BEFORE CONNECTION MADE TO SPRINKLER PIPING. VERIFIED BY COPY OF THE U FORM NO. 85B ☐ YES ☐ NO FLUSHED BY INSTALLER OF UNDERGROUND SPRINKLER PIPING ☐ YES ☐ NO					OTHER EXPLAIN				
	IF POWDER DRIVEN FASTENERS ARE USED IN CONCRETE, HAS REPRESENTATIVE SAMPLE TESTING BEEN SATISFACTORILY COMPLETED? ☐ YES ☐ NO					IF NO, EXPLAIN				
BLANK TESTING GASKETS	NUMBER USED	LOCATIONS				NUMBER REMOVED				
WELDING	WELDED PIPING							☐ YES	☐ NO	
	IF YES . . .									
	DO YOU CERTIFY AS THE SPRINKLER CONTRACTOR THAT WELDING PROCEDURES COMPLY WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3?							☐ YES	☐ NO	
	DO YOU CERTIFY THAT THE WELDING WAS PERFORMED BY WELDERS QUALIFIED IN COMPLIANCE WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3?							☐ YES	☐ NO	
	DO YOU CERTIFY THAT WELDING WAS CARRIED OUT IN COMPLIANCE WITH A DOCUMENTED QUALITY CONTROL PROCEDURE TO INSURE THAT ALL DISCS ARE RETRIEVED, THAT OPENINGS IN PIPING ARE SMOOTH, THAT SLAG AND OTHER WELDING RESIDUE ARE REMOVED, AND THAT THE INTERNAL DIAMETERS OF PIPING ARE NOT PENETRATED?							☐ YES	☐ NO	
CUTOUTS (DISCS)	DO YOU CERTIFY THAT YOU HAVE A CONTROL FEATURE TO ENSURE THAT ALL CUTOUTS (DISCS) ARE RETRIEVED							☐ YES	☐ NO	

WHITE - AHJ YELLOW - MFP PINK - OWNER

Fire Drill Reports

FIRE DRILL REPORTS for 2020
Building 3

2020

1st Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
Days 6:30am-3:00pm	**2/20/20 @12:00pm Announced**	Testing System	All staff responded correctly.	Staff said they would exit through school fire exits	40	NA
Evenings 2:30pm – 11:00pm	**3/6/20 @ 3:00pm Announced**	Testing System	All staff responded correctly	Staff said they would exit through the school fire exits.	40	NA
Nights 10:45pm – 6:45pm	**2/28/20 @ 11:30pm Announced**	Silent Drill	All staff responded correctly	Staff said they would exit through the fire exits on the ends	18	NA
2nd Quarter	**Date/Time Announced/ Unannounced**	**Problem/Issue**	**Initial response**	**Action taken/Incident Commander**	**# Staff, Client, Visitors**	**Evacuation Time**
Days 6:30am-3:00pm	6/22/20@1:30pm Unannounced	Drill-Fire Pull	Staff evacuated the building and took the youth to the safe areas.	Brett Hopkins was IC. He had a role call and announced an all clear.	45 Staff, 6 clients, 0 Visitors	3 minutes
Evenings 2:30pm – 11:00pm	6/22/20 @ 8:42pm Unannounced	Drill	Staff gathered youth in safe area and waited for further instructions from IC.	RYAN HARE WAS IC. HE DID A ROLE CALL AND ANNOUNCED ALL CLEAR	9 Staff, 6 clients, 0 visistors	2 minutes.
Nights 10:45pm – 6:45pm	**6/24/20 @ 1am Announced**	Drill	Staff reported they would gather youth in the safe area and await further instructions.	Janet Schueler was IC.	8 Staff, 6 clients, 0 Visitors	NA
3rd Quarter	**Date/Time Announced/ Unannounced**	**Problem/Issue**	**Initial response**	**Action taken/Incident Commander**	**# Staff, Client, Visitors**	**Evacuation Time**
Days 6:30am-3:00pm	8/9/20 @ 2:05pm Unannounced	Unknown Alarm	Staff all gathered in safe area.	Diane Powell was IC. Staff and youth all gathered in safe area	7 Staff, 9 clients, 0 Visitors	NA

Evenings 2:30pm – 11:00pm	9/1/20 @ 4:35pm Unannounced	Detector Head	Staff gathered youth in safe area.	Jerrid Wichmann was IC. All done correctly	7 staff, 7 clients, 0 Visitors	NA
Nights 10:45pm – 6:45pm	9/5/20 @ 6:00am Announced	Drill	Staff gathered youth in safe area.	Danny Pendergast was IC.	7 staff, 7 clients, 0 visitors.	NA
Annual	**Date/Time Announced/ Unannounced**	**Problem/Issue**	**Initial response**	**Action taken/Incident Commander**	**# Staff, Client, Visitors**	**Evacuation Time**
Bldg. 3	6/22/20@1:30pm Unannounced	Drill-Fire Pull	Staff evacuated the building and took the youth to the safe areas.	Brett Hopkins was IC. He had a role call and announced an all clear.	45 Staff, 6 clients, 0 Visitors	3 minutes
Bldg. 5						
Bldg. 6						
Bldg. 16						
Bldg. 21						
Bldg. 27						
Data	# Drills in client areas	#Unannounced	Percentage (Over 50%)	Average Evacuation Time		
	10	5	50 %	2.5 minutes		
Building 28						
3rd Quarter	**Date/Time Announced/ Unannounced**	**Problem/Issue**	**Initial response**	**Action taken/Incident Commander**	**# Staff, Client, Visitors**	**Evacuation Time**
1st Shift						
2nd Shift						
3rd Shift						

4th Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2nd Shift						
3rd Shift						

Building 29						
3rd Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2nd Shift						
3rd Shift						
4th Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2nd Shift						
3rd Shift						

2019/2020 Safety/Security Report

2019-2020 Safety / Security Incident Report

Description/Type				
Fire Safety	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Smoking Contraband Found	• Blue lighter found in the lawn in front of B4	•	• Vape pen found in youth's room • 2 youth had lighters in their pockets when returning from pass. • Cigarette butt found near B3 elevator. • Youth had a lighter in pocket after pass. • Vape pen found outside in fire exit • Vape pen found outside on building wall. • Vape pen found in visitor locker room.	• Juul pod and charger found in youth's room • Juul found plugged into computer. • Staff found matches and cigarettes outside building • Juul and charger found in youth's room. • Youth had vape pen after pass, turned into staff. • Juul pod found in school bathroom. • Juul and charger turned in by youth. • A lighter was found on the front pillars of building 3.
Smoking	•	•		
Other				
Fire Equipment	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Tampering	•	•	•	• Youth pulled the fire alarm in an attempt to escape • Youth punched exit sign and broke it.
Injuries	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Other	<u>Injury Severity 1</u> • 0 youth behavioral • 1 youth misc. • Staff pulled muscle on back refilling sanitizer solution. <u>Injury Severity 2</u> • Staff fell in the women's restroom and had 2 seizures, taken by ambulance to ER.	<u>Injury Severity 1</u> • 3 youth behavioral • 3 youth misc. • Staff member had 5 bug bites on his leg. Saw the bug while at work.	<u>Injury Severity 1</u> • 6 youth behavioral • 3 youth misc. • 2 youth hitting ping pong balls at each other. Left red marks. • Staff had knee pain after kneeling during annual physical assessment. • Staff had keys taken from her at YRTC-K, injured her hand. • Staff punched in the face 3x while at YRTC-K.	<u>Injury Severity 1</u> • 7 youth behavioral • 18 youth misc. • Staff hit in face during basketball. • Staff bent finger playing football. <u>Injury Severity 2</u> • Youth behavioral. Youth upset and punched walls, broken hand.

			• Staff twisted knee while working at YRTC-K. Workman's Comp claim.	
Sport Injuries/not falls	**Injury Severity 1** • 2 youth injured during sports **Injury Severity 2** • Youth playing basketball and ran into peer, had laceration to eyebrow, taken to ML ER for sutures.	**Injury Severity 1** • 7 youth injured during sports	**Injury Severity 1** • 7 youth injured during sports	**Injury Severity 1** • 11 youth injured during sports
Falls (also see Fall Report)	**Injury Severity 0** • Youth kicked a soccer ball, missed and fell backwards. Refused to see nurse. **Injury Severity 1** •	**Injury Severity 0** • Youth sat on chair and tipped it over. **Injury Severity 1** • Youth fell playing basketball and bruised his arm. • Youth tripped on sidewalk and fell to his knees scraping them, also twisted ankle.	**Injury Severity 0** • Youth slipped on ice walking back from chapel • Youth slipped on ice running back from chapel. • Youth fell playing basketball. • Youth slipped on floor that had been recently mopped. • Youth fell lifting weights. • 3 youth fell playing basketball • 1 youth missed a stair, tripped and fell **Injury Severity 1** • Staff fell on grass while trying to avoid icy sidewalk	**Injury Severity 0** • Youth slipped on wet spot in the chapel playing basketball. • Youth leaned back in chair and fell over backwards **Injury Severity 1** • Youth fell on knee playing basketball. Ice and IB. • Youth fell and hit his knee playing basketball. • Youth fell playing volleyball and caught himself with hand. Reports pain in hand. • Youth fell on knee playing basketball. Abrasion on knee • Youth slipped playing basketball, abrasion on knee. • Youth fell playing basketball, abrasion on top of his hand.
Injuries During physical altercations			• 2 youth had minor injuries following altercation.	• Youth on youth assault, youth was stuck by peer and had a red mark on face. Hotline notified.

			• Staff received a small cut on his wrist while separating 2 youth. • 2 youth slapping each other, left red marks.	• Youth slapped by peer. Had red mark on face. Hotline notified. • Youth was hit in face by peer and caused bleeding from the mouth. Hotline notified.
Abuse/Neglect Hotline	•	• 2 youth reported a staff member was making sexually inappropriate comments to them. Investigation complete, employee terminated.	• 2 youth injured each other during physical hold. • 2 youth wrote sexual messages to youth. • Youth made comment staff grabbed his genitals. • 2 youth slapping each other, left red marks. • 2 youth hitting ping pong balls at each other. Left red marks.	•
Miscellaneous	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Contraband	• A razor blade knife was found on the street outside the chapel. • Youth's room had a school book and green tea in it.	• Self-tattooing material found in 2 youth's room. • Homemade alcohol found in youth's room. • Dab scrapper found in youth's belongings before discharge • Staff found coffee creamer and a small screw in youth's room. • Staff found coffee maker and can of disinfectant in 81 bathroom. • Staff found a saw blade with duct tape. Determined to belong to maintenance.	• Nicotine Lozenge found in foyer • Youth had broken glass in his room • Tobacco pouch found outside. • Can of chewing tobacco found outside.	• Youth had cellphone and tried to charge it on TV. • Youth had prescribed pills in room. Determined youth was cheeking his meds. • Youth had window crank, melted plastic and crushed white substance in room.
Broken doors/windows, etc.	•	• Broken glass from window on 81 found while mowing.	• Youth knocked window out of his room while "playing around"	
Medication/pills found on floor/other			•	• Housekeeper found green pill on floor of staff locker room. Pill belonged to staff (potassium) and was disposed of.

Miscellaneous other			• Youth stole 2 Five Hour energy drinks from Wal-Mart.	
Security	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Theft			• Auxiliary cord may have been purchased by past employee using state charge card.	• Maintenance shop as broken into and $2000 of tools and keys were stolen. Locks replaced. • Multiple items were stolen from the kitchen area by a dietary staff member. Staff member resigned.
Damage to state property			• Wardrobe in youth's room had a lot of tagging, was removed. • Glass in southeast door cracked. Unknown how it happened. • Staff broke windshield wiper off van. Replaced.	• MP3 player thrown in toilet and ruined. • Youth broke broom and then slammed door to his room breaking the door. • Multiple computer wires were cut and split in the privacy room at school.
Internet use/ computer misuse/ HIPAA			•	• Youth got on to unapproved website on his school computer. • Youth got on teacher's computer and played music videos.
Keys/badge lost			•	• During maintenance shop break in, a set of campus wide keys were stolen. Buildings effected had locks replaced.
Suspicious car/other on campus	• 2 vehicles on campus in front of B4. HPD notified and came out. Multiple suspects found and told to leave.	• Staff heard a loud noise in program building. Mntc. Door unlocked and water running.	•	• Staff report gunshots from south end of campus. HPD notified.
Door problems				
Security (cont.)	**3rd Quarter 2020**	**2nd Quarter 2020**	**1st quarter 2020**	**4th quarter 2019**
Elopement			•	• Youth kicked out his window and eloped. Was returned by HPD the following day.

Other			• 2 physical holds • 2 incidents of youth being left unsupervised. • 1 incident of attempted suicide. Youth transported to MLH.	• 3 physical holds • 2 incidents of youth being left unsupervised.

YRTC- Lincoln

Inspection Surveys

Food Inspection report

Checklist for Residential Board & Care/Health Institutions

Attachment YLF 1

Lincoln-Lancaster County Health Department
Environmental Health Division
3131 O Street
Lincoln, Nebraska 68510

Time In	Purpose	Inspection Date
11:00 AM	Regular	10/29/2019
Time Out	**Facility Codes**	
11:45 AM	20X	

FIRM LANCASTER YOUTH SERVICES OWNER LANCASTER YOUTH SERVICES

ADDRESS 1200 RADCLIFF ST LINCOLN NE, 68512

TOTAL VIOLATONS

PRIORITY 0 CORE 2

PRIORITY FOUNDATION 0

FOOD ESTABLISHMENT INSPECTION REPORT

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Supervision

1	IN COMPLIANCE	PIC present, demonstrates knowledge, and performs duties

Employee Health/Responding to Contamination Events

2	IN COMPLIANCE	Management and food employee knowledge,
3	IN COMPLIANCE	Proper use of restriction and exclusion

Good Hygienic Practices

4	IN COMPLIANCE	Proper eating, tasting, drinking, or tobacco use
5	IN COMPLIANCE	No discharge from eyes, nose, and mouth

Control of Hands as a Vehicle of Contamination

6	IN COMPLIANCE	Hands clean properly washed
7	IN COMPLIANCE	No bare hand contact with RTE foods or a pre-approved alternate properly followed
8	IN COMPLIANCE	Adequate handwashing sinks, properly supplied and accessible

Approved Source

9	IN COMPLIANCE	Food obtained from approved source
10	NOT OBSERVED	Food received at proper temperature
11	IN COMPLIANCE	Food in good condition, safe, and unadulterated
12	NOT APPLICABLE	Required records available: shellstock tags, parasite destruction

Protection from Contamination

13	IN COMPLIANCE	Food separated and protected
14	IN COMPLIANCE	Food-contact surfaces: cleaned sanitized
15	IN COMPLIANCE	Proper disposition of returned, previously served, reconditioned, and unsafe food

Time Temperature Control for Safety Food (TCS Food)

16	NOT OBSERVED	Proper cooking time and temperatures
17	NOT OBSERVED	Proper reheating procedures for hot holding
18	NOT OBSERVED	Proper cooling time and temperatures
19	NOT OBSERVED	Proper hot holding temperatures
20	IN COMPLIANCE	Proper cold holding temperatures
21	IN COMPLIANCE	Proper date marking and disposition
22	NOT APPLICABLE	Time as a Public Health Control: procedures and records

Consumer Advisory

23	NOT APPLICABLE	Consumer advisory provided for raw or undercooked food

Highly Susceptible Population

24	NOT APPLICABLE	Pasteurized foods used; prohibited foods not offered

Food/Color Additives and Toxic Substances

25	NOT APPLICABLE	Food additives: approved and properly used
26	IN COMPLIANCE	Toxic substances properly identified, stored, and used; held for retail sale, properly stored

Conformance with Approved Procedures

27	NOT APPLICABLE	Compliance with variance, specialized process, ROP criteria or HACCP plan

GOOD RETAIL PRACTICES

Safe Food and Water

28	IN COMPLIANCE	Pasteurized eggs used where required
29	IN COMPLIANCE	Water and ice from approved source
30	IN COMPLIANCE	Variance obtained or specialized processing methods

Food Temperature Control

31	IN COMPLIANCE	Proper cooling methods used; adequate equipment for temperature control
32	IN COMPLIANCE	Plant food properly cooked for hot holding
33	IN COMPLIANCE	Approved thawing methods used
34	IN COMPLIANCE	Thermometers provided and accurate

Food Identification

35	IN COMPLIANCE	Food properly labeled; original container

Prevention of Food Contamination

36	IN COMPLIANCE	Insects, rodents and animals not present
37	IN COMPLIANCE	Contamination prevented during food preparation, storage and display
38	IN COMPLIANCE	Personal cleanliness; hair restrained
39	OUT OF COMPLIANCE	Wiping cloths; properly used and stored
40	IN COMPLIANCE	Washing fruits and vegetables

Proper Use of Utensils

41	IN COMPLIANCE	In-use utensils; properly stored
42	IN COMPLIANCE	Utensils, equipment and linens; properly stored, dried, handled
43	IN COMPLIANCE	Single-use/single-service articles; properly stored, used
44	IN COMPLIANCE	Gloves used properly

Utensils, Equipment, and Vending

45	OUT OF COMPLIANCE	Food and non-food contact surfaces cleanable, properly designed, constructed, and used
46	IN COMPLIANCE	Warewashing facilities, installed, maintained, used, test strips
47	IN COMPLIANCE	Non-food-contact surfaces clean

Physical Facilities

48	IN COMPLIANCE	Hot and cold water available; adequate pressure
49	IN COMPLIANCE	Plumbing installed; proper backflow devices
50	IN COMPLIANCE	Sewage and waste water properly disposed
51	IN COMPLIANCE	Toilet facilities: properly constructed, supplied, clean
52	IN COMPLIANCE	Garbage and refuse properly disposed; facilities maintained
53	IN COMPLIANCE	Physical facilities installed, maintained, and clean
54	IN COMPLIANCE	Adequate ventilation and lighting; designated areas used

TEMPERATURE OBSERVATIONS

FOOD PRODUCT	° F	LOCATION
Milk	39	Cooler (reach-in)

STAFFING/RECORDS REQUIREMENTS

Food Handler Permits IN COMPLIANCE

Permit Records IN COMPLIANCE

VIOLATION DETAIL

Code / Priority Level / Location	Critical Risk	Repeat Factor	Violation Description / Remarks / Food Code Citation	Corrected	Correct By
3-304.14	☐	☐	**Wiping cloth bucket of sanitizer solution measured too strong. Apply chlorine between 50-100PPM.** RF 39 Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114; and(2) Laundered daily as specified under 4-802.11(D).	☑	**CORRECTED**
4-501.11	☐	☐	**Dishmachine with thick lime deposits on doors and top. Water/ ice dispenser with corrosion as well. Delime.** RF 45 Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.	☐	**11/28/2019**

Remarks:

338469331029201911232O

☐ **Follow-up**

Printed 10/29/2019 11:44:54 AM FIR201

Environmental Health Specialist

DAVE VOBORIL, REHS, CP-FS 65
dvoboril@lincoln.ne.gov (402) 441-8633

Received by Person-In Charge

MACHMER JOHANNA RUTH
MANAGER

Obtain Food Handler and alcohol server/seller permits at
www.lincoln.ne.gov search word "Food".

INSPECTION CHECKLIST
FOR RESIDENTIAL BOARD & CARE/HEALTH INSTITUTIONS

CITY OF LINCOLN NEBRASKA
lincoln.ne.gov

BUILDING & SAFETY DEPARTMENT
Bureau of Fire Prevention
555 S. 10th St., Suite 203, Lincoln, NE 68508
P: 402-441-7521

Occupancy Class: Institutional License Number: L1900171

Address: 1200 Radcliff St.

Name of Business: Youth Services Center

Date of Inspection: 8/27/2020 Approved Occupant Load: 45 beds

FACILITY		EVACUATION CAPABILITY		LOCATION	
☐ Small	☑ Existing	☐ Prompt	☑ Slow	☐ Above Grade	
☑ Large	☐ New	☐ Impractical		☐ Below Grade	
	☐ Remodeling			☑ Grade	
	☐ Licensing Change			# of Stories ____	

All Code Numbers from 2012 101 Life Safety Codes

Yes	No	N/A	EXITS
☑	☐	☐	Unobstructed 33.3.2.1
☑	☐	☐	Properly identified 33.3.2.1
☑	☐	☐	Proper door swing 33.3.2.1
☑	☐	☐	Emergency lighting (if required) 33.3.2.9
☑	☐	☐	Generator 2012 IFC 604

Yes	No	N/A	MISCELLANEOUS
☑	☐	☐	Mechanical rooms in compliance 33.2.3.2
☑	☐	☐	Storage areas in compliance 33.2.3.2
☑	☐	☐	Housekeeping 33.3.2.5
☑	☐	☐	Room Doors closes/latches 33.2.3.6.3
☑	☐	☐	Illegal cords, splices, makeshift 605.5 2012 IFC 605

Yes	No	N/A	GAS APPLIANCES
☐	☐	☑	Approved venting 33.2.5.2.1
☐	☐	☑	Approved installation 33.2.5.2.1

Yes	No	N/A	HAZARDOUS AREAS
☑	☐	☐	Meets rating requirements 33.2.3.2
☑	☐	☐	Door closes/latches 33.2.3.2
☑	☐	☐	Corridor penetrations 33.2.3.6.2

Yes	No	N/A	EMERGENCY PLANNING
☑	☐	☐	Safety & Evacuation Plan 33.7.1
☑	☐	☐	Fire drills 33.7.3
☑	☐	☐	Training 33.7.2

Yes	No	N/A	ALARM SYSTEMS
☑	☐	☐	Required alarm system 33.3.3.4.1
☐	☑	☐	Properly maintained 33.3.3.4.1 P.I.V
☑	☐	☐	Sprinkler system (if required) 33.2.3.5.2
☐	☐	☑	Approved range hood system 9.7.3
☑	☐	☐	Carbon monoxide alarms 9.8

Yes	No	N/A	FLOOR SEPARATION
☐	☐	☑	Primary means escape 33.2.2.2.1
☐	☐	☑	Bedroom egress windows 33.2.2.3
☐	☐	☑	Smoke detectors 33.3.3.4.7
☐	☐	☑	Rating between floors 33.2.3.1.1

LARGE FACILITIES ONLY

Yes	No	N/A	FIRE EXTINGUISHERS
☑	☐	☐	Approved size 9.7.4.1
☑	☐	☐	Approved type 9.7.4.1
☑	☐	☐	Properly maintained 9.7.4.1

Yes	No	N/A	TRAVEL DISTANCE TO EXITS
☐	☐	☐	Under 75 feet 33.3.2.6.1
☑	☐	☐	Under 125 feet (sprinkled) 33.2.6.1

☐ Approved ____ 9/22/2020 KH
☒ Denied (see comments)

COMMENTS: P.I.V tamper still not working

You are ordered to comply with all 'No' items by the following date: 10/27/2020 **in accordance with provisions of the Regulations Promulgated by the Nebraska State Fire Marshal, governing Safety to Life from Fire and Like Emergencies.**

FIRE INSPECTOR: Ken Hilger Date: 8/27/2020

Facility Staffing Information

Staffing levels

Youth to Staff Assaults

Youth to Youth Assaults

Attachment YLF 2

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020
   As of December 31, 2020, staffing was as follows:
   Facility Administrator
   Staff Assistant
   2 Behavior Technician Supervisors
   9 Behavior Technician Leads
   24 Behavior Technician
   2 Activity Specialists
   3 Teachers
   Board Certified Behavior Analyst Supervisor
   Program Coordinator
   Licensed Mental Health Practitioner
   Provisional Licensed Mental Health Practitioner (hired and started in January)
   Psychiatrist

2. The number of positions vacant as of December 31, 2020
   Total of 6 vacancies/positions to fill as of 12/31/2020 (1 BT Lead and 5 Behavior Technicians)

3. The number of positions needed in your HR staffing plan for FY21
   Behavior Support Specialist
   Program Coordinator

4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020
   As of December 31, 2020 there were a total of 47 employees at the Lincoln Facility.

5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020
   Approximately 30 employees hired are no longer employed at the facility.

6. The number of vacant positions as of December 31, 2020
   Total of 6 vacancies/positions to fill as of 12/31/2020 (1 BT Lead and 5 Behavior Technicians)

B. The number of assaults on staff for calendar year 2020
   Youth to Staff Assaults – 19
   Youth to Youth Assaults – 5

C. Please provide a copy of the most recent inspections or audit reports for calendar year 2020. To include, but not limited to reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, etc.
   PREA Audit completed January 2021 (awaiting official results from Auditor)
   Monthly emergency response/evacuation completed

Daily facility/building searches and checks for functioning
Building and Safety inspection attached.
Lincoln-Lancaster County Health Department inspection attached.
(Next inspections scheduled for next week/delayed due to COVID)

Facility Staffing Information

Staffing Levels

Staff Assaults

Attachment G1

Nebraska Department of Health and Human Services (NEDHHS) - YRTC-G Data

as of 1/1/2021

Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
V09121	ADMINISTRATIVE ASSISTANT I	1	0	1	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	0	1	1	100%	100%
I79510	BARBER/BEAUTICIAN	0	1	1	100%	
N78560	DHHS FACILITY ADMINISTRATOR	1	0	1	0%	50%
M80123	FOOD SERVICE COOK	0	2	2	100%	100%
V80220	FOOD SERVICE SUPERVISOR	0	1	1	100%	
G11900	PRINCIPAL	0	1	1	100%	
H77043	RECREATION SPECIALIST	0	1	1	100%	100%
H75014	REGISTERED NURSE (NEW)	0	1	1	100%	
C79920	RELIGIOUS COORDINATOR	0	1	1	100%	100%
C72332	SOCIAL WORKER II	0	2	2	100%	0%
S01841	STAFF ASSISTANT I	0	1	1	100%	
S01511	SWITCHBOARD OPERATOR/RECEPTIONIST	0	1	1	100%	
T11360	TEACHER (SCATA CONTRACT)	3	2	5	40%	57%
R11370	TEACHER/SUBSTITUTE	0	2	2	100%	100%
R11380	TEACHER/TEMPORARY	0	1	1	100%	
C72481	YOUTH COUNSELOR I	1	0	1	0%	33%
V72483	YOUTH COUNSELOR SUPERVISOR	0	1	1	100%	
P76752	YOUTH SECURITY SPECIALIST II	7	15	22	68%	35%
R76752	YOUTH SECURITY SPECIALIST II	0	5	5	100%	
V76753	YOUTH SECURITY SUPERVISOR	1	4	5	80%	67%
		14	**43**	**57**	**75%**	**50%**

Jacobe, Camella

From: Jacobe, Camella
Sent: Wednesday, February 10, 2021 8:29 AM
To: Jacobe, Camella
Subject: FW: Ombudsman's Contact

From: Swartz, Jodeen [redacted]
Sent: Monday, February 8, 2021 12:39 PM
To: Jacobe, Camella [redacted]
Subject: RE: Ombudsman's Contact

B is 0 (we didn't have any assaults during 2020)

C –I don't have anything.

JoDeen Swartz [redacted]
CHILDREN & FAMILY SERVICES
Nebraska Department of Health and Human Services
OFFICE: [redacted]
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Jacobe, Camella [redacted]
Sent: Monday, February 8, 2021 12:34 PM
To: Swartz, Jodeen [redacted]
Subject: FW: Ombudsman's Contact

I am assuming B. is 0, we didn't have any assaults in 2020 correct?

And for C. do you have anything on that list that you can provide for Geneva?

From: Jerall Moreland [redacted]
Sent: Friday, February 5, 2021 12:26 PM
To: Jacobe, Camella [redacted]
Subject: Ombudsman's Contact

Hi Camella,

As discussed, please see the following information that I am interested in obtaining from YRTC- Geneva and Hastings Regional Center for Calendar year 2020:

Requested Information:

A. Facility Staffing Levels as of December 31, 2020:

1. The number of positions filled as of December 31, 2020
2. The number of positions vacant as of December 31, 2020
3. The number of positions needed in your HR staffing plan for FY21
4. The number of positions filled in your HR staffing plan for FY21 as of December 31, 2020
5. The aggregate turnover rate for the period of 12/2019 - 12/31/2020
6. The number of vacant positions as of December 31, 2020

B. The number of assaults on staff for calendar year 2020

C. Please provide a copy of the most recent inspections or audit reports for calendar year 2020. To include, but not limited to reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, etc.

If you have any questions, please call and have a great weekend

Yours Truly,

--
Jerall Moreland, Deputy Ombudsman for Institutions
Nebraska Legislature- Ombudsman's Office
4[redacted]
J[redacted]

Administration Building Construction

Attachment G2

Jacobe, Camella

From: Jacobe, Camella
Sent: Wednesday, February 17, 2021 4:27 PM
To: Jacobe, Camella
Subject: FW: Ombudsman information

Camella Jacobe | *State Compliance Coordinator*
CHILDREN & FAMILY SERVICES
Nebraska Department of Health and Human Services
OFFICE: [redacted]
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Jacobe, Camella [redacted]
Sent: Wednesday, February 17, 2021 3:07 PM
To: Jacobe, Camella <[redacted]
Subject: RE: Ombudsman information

Camella Jacobe | *State Compliance Coordinator*
CHILDREN & FAMILY SERVICES
Nebraska Department of Health and Human Services
OFFICE: [redacted]
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Zoeller, Kenny [redacted]
Sent: Friday, February 12, 2021 2:32 PM
To: Jacobe, Camella <[redacted]
Subject: RE: Ombudsman information

Hey Camella,

Here is what we were able to pull together:

We had a some construction work/remodel going on in the Admin building at Geneva in 2020, below are the dates that Fire Marshall was involved. Other than these dates, I don't believe we had any other major construction projects that would have been under my watch at Geneva during 2020.

Fire Marshall Design Plan Review – 2/18
Fire Marshall Project Check ins – 4/8, 5/22, 8/12
Fire Marshall Final Walk-through – 10/8

Thanks,

Kenny Zoeller, C.L.S.S.Y.B.

Fire Drill

Attachment G3

FIRE DRILL

La Fleische

Building

YOUTH REHABILITATION AND TREATMENT CENTER

Geneva , NE

Tornado or disaster drills do not substitute for fire drills.

Each time a Fire Drill is completed, a form will be filled out in detail and placed on permanent file in the office of the Safety Officer.

DATE OF FIRE DRILL: 8-5-20

DESIGNATED TIME: 1217

EXIT: 12B

NUMBER OF STUDENTS: 3

NUMBER OF STAFF: 9

CONDUCTED BY: SO Boon

COMMENTS:

Standards Compliance Reaccreditation Audit

Attachment K1

COMMISSION ON ACCREDITATION FOR CORRECTIONS

STANDARDS COMPLIANCE REACCREDITATION AUDIT

Nebraska Department of Health & Human Services
Youth Rehabilitation and Treatment Center - Kearney
Kearney, Nebraska

July 8 - 10, 2020

VISITING COMMITTEE MEMBERS

Gregory T. Knowlin, Chairperson
ACA Auditor

Roger Chute
ACA Auditor

Randy P. Cross
ACA Auditor

A. Introduction

The audit of the Nebraska Department of Health and Human Services Youth Rehabilitation and Treatment Center – Kearney, Kearney, Nebraska was conducted on July 8-10, 2020 by the following team: Gregory T. Knowlin, Chairperson; Roger Chute, Member; and Randy Cross, Member.

B. Facility Demographics

Rated Capacity:	172
Actual Population:	68
Average Daily Population for the last 12 months:	95
Average Length of Stay:	9 ½ Months
Security/Custody Level:	Medium
Age Range of Offenders:	14-18
Gender:	Male and Female
Full-Time Staff:	156

Administrative -5, Support - 18, Program - 161, Security - 19, Part-Time Staff - 16

C. Facility Description

The Youth Rehabilitation and Treatment Center – Kearney (YRTC – Kearney) is operated by the Nebraska Department of Health and Human Services. The Facility is located at 2802 30th Avenue on the western side of Kearney, Nebraska. Kearney is located in south central Nebraska approximately 130 miles west of Lincoln, Nebraska. YRTC – Kearney opened in 1879, was the only state operated facility for delinquent males. In August 2019 YRTC – Kearney received its first female youths. The Population of youth are classified as medium security, the physical facility is an open campus with 12 foot perimeter fencing being added for additional security in January 2019. Additional extension to the perimeter fence was added in January 2020, with a completion to the addition of the fence being completed in July 2020.

The Dodge Administration Building; Morton, Washington, Lincoln, Bryant, Creighton, and Dickson living units; West Kearney High School; the Dining Hall; Chapel; Boiler Plant; Maintenance Building; and outdoor recreational areas are located on 30 acres on the campus. Most of the buildings are connected with a tunnel system that houses utility services and steam heat pipes. The tunnels also serves as tornado evacuation shelters for the staff and youth.

The Dickson living unit is also called the Behavior Stabilization Unit, which houses male youth that are non-compliant and exhibited assaultive behavior. The youth length of stay in the living unit is a two week process with four phases that must be completed prior to being released. The Bryant living unit is an open unit that houses males that have vulnerable concerns in the general population. During the audit there were nine youth assigned to the living unit. The Creighton, Washington, and Lincoln living units houses male youths in an open unit setting with general population youth.

The Morton living houses the female youths. During the audit there were 15 female youths assigned to the living unit, with a maximum capacity for 42 rooms.

D. Pre-Audit Meeting

On July 7, 2020 at approximately 8:00pm only one team member was able to meet with officials from TRTC – Kearney to discuss information provided by the ACA at Cunningham's on the Lake for dinner. The other two auditors had travel delays.

The chairperson divided standards into the following groups:

Standards # 5A-01 through 6E-14 to Gregory T. Knowlin (Chairperson)
Standards # 1A-01 through 3E-01 to Roger Chute (Member)
Standards # 4A-01 through 4E-07 & 6F-01 through 6G-14 to Randy Cross (Member)

E. The Audit Process

1. Transportation

   The team was escorted to the facility by Nikki Berggren, Juvenile Justice Administrator.

2. Entrance Interview

   The audit team proceeded to the proceeded to the Conference Room B where they met with Facility Administrator, Paul Gordon, Facility Director, Mark Labouchardiere, Facility Program Manager, Cindy Krolikowski, and Nikki Berggren, Juvenile Justice Administrator. The team expressed the appreciation of the Association for the opportunity to be involved with the Youth Rehabilitation and Treatment Center – Kearney in the reaccreditation process.

   Paul Gordon, Facility Administrator escorted the team to the Canteen where the formal entry meeting was held.

   The following persons were in attendance:

   Scott English, Director of School
   Sara Thomas, Clinical Program Director
   Cindy Krolikowski, Facility Program Manager
   Laura Bugay, Mental Health Supervisor
   JoDeen Swartz, Admin. Assistant Compliance
   Gary Leffler, Compliance Specialist
   Joni Suhr, Nursing Supervisor
   Theresa Childers, Food Service Supervisor
   Daniel Cole, Religious Coordinator
   Chris Hellerich, Unit Manager

Tyler Mertens, Unit Manager
James Orme, Food Service Director
Holly Trumball, Unit Manager
Chris Nemetz, Unit Manager
Camella Jacobe, YRTC-Geneva Facility Administrator
Nancy Krueger, Admin. Assistant YRTC – Kearney
Fred Boon, Compliance Specialist
Ralph Healey, Compliance Specialist
Paul Gordon, YRTC – K Facility Administrator
Rita Uldrich, Business Manager
Mark LaBouchardiere, Facilities Director
Nicole Berggren, Juvenile Justice Administrator

It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The team toured the entire facility from 10:00 a.m. to 1:30 p.m. on the first day of the audit. The second day of the audit the audit team completed the tour of the facility from 8:10 a.m. to 10:17 a.m. The following persons accompanied the team on the tour and responded to the team's questions concerning facility operations:

Paul Gordon, YRTC – K Facility Administrator
Nicole Berggren, Juvenile Justice Administrator
Ralph Healey, Compliance Specialist
Fred Boon, Compliance Specialist
Gary Leffler, Compliance Specialist
Cindy Krolikowski, Facility Program Manager
Mark LaBouchardiere, Facility Director

The audit team observed Audit notices were posted throughout the facility, and Staff and youth were aware of the audit.

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security:

Security of juveniles and of the facility is achieved through a combination of methodologies. All staff members provide direct, "eyeball", supervision of youth. Primary security duties are assigned to direct care staff. Direct supervision is augmented by 167 motion sensor cameras that have the capability to record and maintain sixty (60) days, minimally, of video. Since the last audit, about 33 acres of the facility have been enclosed by a perimeter fence. Work continues to enhance the fence by adding to the height resulting in a (15) foot "candy cane" type fence. The extensions have not been completed on some gates. The fence is designed to prevent youth from grasping and propelling themselves over the fence. The fence is well maintained with no weak areas observed. The enhanced fence has resulted in a reduction in the number of escapes from the facility.

Exterior doors are locked and are opened electronically. There is control center that is operational and staffed around the clock. Personnel assigned to the control center monitor radio communication, movement of residents, fire alarm system, and cameras. Perimeter fence checks are routinely conducted.

There are two electronic "walk gates" that are opened by swiping the employee badge. There are also two vehicle (truck) gates that are opened remotely or by staff badge. One "man gate" is located on each side of the fence to allow staff to more readily pursue, by foot, youth attempting to escape custody. Finally, there is one additional double truck gate that is padlocked. Knox boxes have been installed as recommended at the previous audit.

Verbal de-escalation is the primary and preferred method of controlling youth behavior. Staff members are well trained in appropriate de-escalation techniques and safe physical management techniques. Use of chemical agents is prohibited.

Tools and culinary equipment were managed at a high level with all areas storing tools doing so in a secure area. Accurate inventories are maintained, and a well-organized system of check-in and check-out is present and is followed. The system includes reconciliation daily or at shift change. Most tools are maintained on shadow boards. Sharps were also securely stored and inventoried. A single staff member is designated to maintain locks and cut new keys when needed.

Custody staff are trained to manage incidents using verbal de-escalation techniques, appropriate physical intervention and self-defense techniques, specifically, Handle with Care. These techniques are reinforced, annually, through planned training.

Environmental Conditions:

The grounds surrounding the facility had no loose papers, clutter or litter of any kind.

The grounds are appropriately landscaped giving the facility a pleasant "curb appeal". Living units are well maintained, neat and orderly. Adequate space is provided for individual counseling and group meetings.

Temperature controls were adequate, in compliance with local statutory requirements, and maintained at a comfortable level during the audit. Use of natural light and artificial light is ample and adds to the pleasantness of the facility. Living areas, the education department, and all other areas of the facility use artificial and natural light in an effective manner making the facility feel comfortable. Noise levels were at acceptable ranges. Air circulation and lighting levels were maintained in compliance with standards.

Provision for garbage pick-up services is provided by the City of Kearney with daily pick-up. There are sufficient covered receptacles available throughout the facility. Potable water is provided by the Kearney public utility company. YRTC-Kearney is connected to the public sewer system. Toilets and washbasins were found to be insufficient in the female housing unit, Morton, and related standard found in non-compliance since the ratio of toilets and sinks was 1:15. Other areas of the facility had adequate numbers of toilets and sinks for the residents and staff in the facility.

The facility was well maintained showing commitment to preventative maintenance. There was no evidence of water damage or pest infestation.

The audit team inspected the janitor closets, rooms housing electrical equipment and pipe chasses. There were no major problems or potential hazards noted in these areas.

The facility was graffiti free.

Sanitation:

During the tour and subsequent visits, the observed the buildings to be clean. There was little indication of the presence of yesterday's dirt. Staff members obviously take pride have "buy in" to the appearance of the facility and demonstrate adherence to the facility's housekeeping plan that involves daily, weekly, and monthly cleanings. Residents are responsible for cleaning their living areas. There were no offensive odors noted in the facility.

Health department inspections of YRTC-Kearney were reviewed and found to be in order. No major deficiencies have been cited.

Fire Safety:

Inspections of fire safety equipment and prevention practices are completed in a thorough and timely manner. The facility's safety officer conducts all inspections and participates in the annual inspections by fire, health and safety officials. Annual inspections of the fire alarm system, sprinkler system, hood suppression system, and fire extinguishers are conducted by Protex Central.

Outside fire protection services are provided by the Kearney Fire Department with response coming from a station located close by, approximately four blocks away with a response time of five minutes or less. Fire extinguishers were located throughout the facility. Fire extinguishers were charged, appeared to be in good working order, and had been inspected monthly with exception of one located in the vocational had not been checked since May 2020; however, there has been no use of the area since that time since the school is on a summer schedule. As noted, the facility utilizes a contract with a licensed vendor who visits the facility and maintains the extinguishers and the hood suppression system in the kitchen. Plans are submitted to the local authority having jurisdiction as required. Fire drills and had been periodically conducted. Youth and staff interviewed knew what they are required to do during these drills. The facility carefully reviews the fire specifications of any furnishing that are being considered for purchase.

The facility, overall, has a good program for the control of flammable, toxic and caustic materials. Control begins with purchase in that the facility purchases chemical that are less hazardous. Bulk chemicals that are hazardous items are stored properly. Proper inventories are maintained, and the documentation clearly indicates the issuance, use and return to storage of these supplies. The team encountered one problem with proper storage of a product, HDQ Neutral, in the barber shop. The team brought to the attention of facility staff who immediately resolved the issue. It was recommended that the Safety Data Sheet books kept in areas when there were hazardous products were maintained be reviewed and that SDS for products kept in the area be removed.

The facility has six back-up generators for use in the event electrical power is disrupted. Five of the generators are natural gas fueled and one is diesel powered. Generators are routinely inspected to assure they are operational when needed.

During the tour, the team noted that the evacuation plans posted in many locations were adequate. The diagrams depicted clear designation of primary and secondary evacuation routes. There was indication of "you are here" making easy to read the plan. It was noted that some of these posted plans bear dates that are several years old, and it was recommended that the dates be updated at the next review.

Food Service:

Food service is located in the renamed Gomez Dining Hall after receiving female youths. The building contains two dining halls, the kitchen, food storage areas, the facility warehouse, and laundry. The food service staff consist of one Food Service Director, one Food Service Supervisor, six Food Service Staff. There are four vacancies during the audit for food service staff. No youth are assigned to work in the Dining Hall.

Three meals are served daily: breakfast from 6:30 a.m. until 7:30 a.m., lunch from 11:30 a.m. until 12:30 p.m., and dinner from 5:30 p.m. until 6:30 p.m. (on weekends, breakfast is one hour later, and lunch is 30 minutes later). Snacks are available at 4:00 p.m. and 8:00 p.m. The menu is developed on a five-week cycle. Menus are approved by a registered dietician. The food service program participates in the USDA Child Nutrition Program. During January 2020 thru June 2020 a total of 64,000 meals were served.

During the audit the dining halls were not being utilized due to COVID-19 and social distancing guidelines that were being adhered to the facility. Each housing unit was escorted to the dining hall, where they received their trays and returned to their housing unit to eat their meals. The kitchen and dining were clean; very clean. All temperatures were checked by the audit team and found to be in compliance with standards. Tool control of the kitchen utensils were accounted for and located on appropriate shadow boards.

Special diets were provided when ordered by medical staff. Religious diets are provided with the approval of the Religious Coordinator.

The audit team ate lunch on Wednesday in the conference room. The lunch meal consisted of meat nachos, salad, mixed berries salad, and a choice of beverage. The meal had adequate portions and the temperature were appropriate. The meal was tasteful and appropriately seasoned. Several youth interviewed about the meals had no complaints about the meals being served at the facility.

Medical Care:

The medical unit is located in a building connected to Creighton cottage. The medical area contains one examination room, two offices, a medication storage area, a general storage area and a dental suite. There is a waiting area for patients that has access to water, a bathroom, educational materials and health pamphlets.

The medical authority is Dr. Rogers and he visits the unit one day a week. Staff includes a full-time nursing supervisor (RN), who oversees the day to day delivery of care. There is also one full-time registered nurse, one full-time licensed practical nurse and a RN who works “on call” as needed. Shifts are normally ten hours a day, five days a week.

The weekend is covered by a five- hour shift on both Saturday and Sunday. During off hours the nursing supervisor and the medical authority are on call.

Although there is a centralized medical unit, medical staff routinely is moving about the campus and interacting with the residents. All new medical personnel receive facility orientation, medical orientation and OJT training. All nurses have basic life support certification through the American Heart Association. Nurse supervisor, Joni Suhr, presented a genuine enthusiasm for the care of the residents, which is shared by the other medical staff. A number of the residents refer to Ms. Suhr as Mama Suhr.

The residents received at YRTC have a history of high-risk behaviors, or there is a likelihood of a lack of previous medical care, have mental health issues and are more susceptible to chronic illnesses. Residents arriving at the facility receive a health screening within one hour of arrival. They receive a full nurse's assessment within two to three days which includes bloodwork. The residents are then seen by the physician within seven days, who also has access to the results of the blood work. This exceeds the standard.

Also, upon admittance the residents receive a manual to aid in the adjustment to the correctional setting. This document contains information regarding medical services, sick call process, grievance procedures and hygiene rules. The residents are also informed about MRSA, AIDS, Hepatitis and the spread of HIV through blood-borne pathogens. Additionally, they are provided with written material designed to help them complete the treatment program.

YRTC has a disability placement program that provides housing accessible to residents with needs. This includes accessible lockers, beds with grab bars, accessible TTY phones, volume control phones and accessible dayroom tables. Residents needing disability services are housed in the Dickson living unit.

YRTC users Kearney Regional Medical Center and CHI Good Samaritan Hospital for inpatient treatment. There is an agreement for emergency transportation with Kearney Fire EMS which has a response time of three to four minutes. Also, Good Samaritan ambulance can be utilized with the response time of five to seven minutes. Non-emergent medical transportation is done by facility staff to either a hospital or a community provider for offsite appointments and consultations.

During the last audit there was a recommendation for a response vehicle for medical staff to use during emergencies due to the vast size of the complex. A vehicle has since been acquired and is utilized as needed. The medical staff maintains an emergency response bag which contains emergency protocol medications.

Sick call is accessed through a written request placed in a designated, lockbox in the housing units. Sick call is provided seven days a week in general population and in the special housing unit, Dickson cottage.

The average number of monthly patient encounters is between 175 and 200. This includes sick call as well as basic health issues and educational encounters with residents of the facility. Sick call requests are triaged daily and the patient is normally seen within two to three days. Any patient with symptoms is seen within 24 hours.

Specialty services such as optometry, orthopedics, physical therapy, ENT, dermatology, ophthalmology and audiology are provided through contracted offsite specialists. The turnaround time to see a specialist normally is one to two weeks. Chronic health issues such as asthma and diabetes are addressed on campus with scheduled clinics and treatment. Patients who require infirmary level care or negative pressure rooms are admitted to one of the two hospitals utilized.

YRTC has a dispensary and acquires its medications through Diamond Pharmacy. Ordered medications are normally delivered next day by FedEx. STAT medications are provided through the local Walgreens pharmacy. There are a number of stock medications maintained at YRTC. The RN supervisor audits the dispensary weekly. Medications are stored in a medication room and secured behind double locks. A random inventory count on sharps, controlled medications and narcotics was conducted during the audit. All inventories were accurate, up-to-date and well documented.

Youth Program Specialists (YPS) are trained to administer medication to the residence during off hours of the medical staff. The training is done by the nursing supervisor and documented in training records. Certifications were reviewed during the audit were found to be current. Medications are administered two times a day seven days a week. Administration times are 7:00 a.m. and 6:00 p.m. The medications are administered from secure medication cabinets within the individual cottages.

A paper Medication Administration Record (MAR) is utilized for documentation. It was the auditors' recommendation that consideration be given to converting the MAR to an electronic file that will integrate with electronic medical records.

Prior to administration of medication, the resident's identification is confirmed with a comparison picture. Mouth cavities are checked after the administration of the medication. Each cottage has a medication refrigerator, though infrequently used. The nurse supervisor or the RN audits and replenishes the cabinets weekly or as new medications are added. No-shows or refusals for medication are documented and referred to the physician. The nurse supervisor reviews the MAR's for missed dosages.

Residents are not allowed to keep medications on their person or allowed over the counter medications. Insulin shots are administered at the point of contact, in the housing unit. These are self-administered under strict supervision. There were no insulin dependent diabetics in the facility at the time of the audit.

At the time of the audit there were 50 residents on prescription medications. There were three residents on controlled medications.

Expired, unused, discontinued and recalled medications are disposed by returning to the pharmacy for credit or disposed through Stericycle. Residents are provided a 30-day supply of medication when released and the medical department schedules any follow up appointments required for the continued treatment of the youth.

There is a drug treatment program offered at the facility. Youths that require detoxification are transferred to an appropriate facility or medical center.

YRTC Medical does only blood draws on site. Once the specimens are drawn, they are spun and sent to a contracted lab. There is no set schedule for sending blood samples, this is done as needed. Results are received by fax within 24 to 48 hours. STAT labs are sent directly to the provider within two to four hours. The medical department runs blood labs two to four times a month plus on incoming residents. Radiology services are provided through a private contractor, which is Kearney Regional Hospital.

All YPS staff members are trained as first responders with CPR, first aid and AED training. There is a master SDS maintained in the medical area. The facility was using paper medical records at the time of the audit but was in the process of converting to electronic records. Medical grievances are handled by the grievance coordinator in conjunction with the nurse supervisor. All issues are handled within 1 to 2 days and there were no substantiated grievances during the audit period.

MRSA precautions are used throughout the facility. Universal precautions are also practiced throughout the facility. There are first aid kits, AED units, blood-borne pathogen kits and eyewash stations throughout the cottages and common areas. There were hand sanitizing bottles located strategically throughout the entire facility. The facility does TB testing on all incoming residents, as well as new employees. Monthly tests average seven to ten a month. All residents are given yearly TB tests.

Protocols for COVID-19 had been implemented throughout the facility. These include limiting public access, education for residents, emphasized hand sanitation, distancing, in-depth screening of all incoming residents and an isolation period for all new residents.

Medical diets are coordinated with the food service program as needed. Food service has predesignated diets for a number of different medical conditions that were developed by a registered dietician.

Critical incidents were reviewed with the nurse supervisor during the audit. There was a youth that was suicidal, twice constricted his neck by ligature and both times became unconscious.

The youth was able to be revived and transported to the hospital both times and both times required no further medical treatment. The youth has since been released from the facility.

A review of the medical service outcomes was conducted and there were three areas of concern. The first was a notable reduction of mental health interventions in the past 12 months for 2019/2020. The second a notable reduction of mental health treatment plans in the past 12 months for 2019/2020. The third was the number of suicide attempts in the year 2019 for the months of February March and April.

The reduction in the interventions and treatment plans for the past year is due to the reduced population of the facility. The population of the facility has been reduced by approximately one half. The suicide attempts for 2019 was attributed to the way the numbers were tabulated for those three months. The tabulations are now made using only overt attempts at suicide.

Dental

The dental unit is housed in the medical area. The suite contains a dental chair, bite wing x-ray machine, cabinets for storage and supplies, a counter area for paperwork and a closet for Instruments not being used for that day. The area was well organized and displayed a high level of sanitation.

Dental staff consists of one dentist, one dental assistant, and a dental hygienist two times a week. Dr. Jason Herman has been with the facility for nearly 20 years and displayed an obvious passion for patient care. Dr. Herman is in the suite one day a week and will normally see everyone who has made request plus any follow-up visits that have been scheduled.

The wait time to be seen is no longer than one week. The dentist is on call for urgent conditions and will come to the facility or have the patient sent to his private office, if needed. The dental clinic normally has 60 to 80 visits per month. Patients access dental care through the sick call process.

Care provided includes basic dentistry, prophylaxis, fillings, extractions, cleaning, cancer screening, patient education, root canals and "flippers." The root canals are done off site at Dr. Herman's office. A "flipper" is an interim, partial denture for missing teeth. Dr. Herman emphasized that it was important the patient have the denture for chewing, linguistics and boost self-esteem.

During the audit a review was conducted of credentialing, review of patient records, and a random inventory of sharps, instruments and drugs. License were found to be up-to-date. Patient records were complete and legible. The inventory of sharps, instruments and drugs were found to be complete, timely and well documented. The audit also reviewed spore testing and found it was completed weekly and all testing results were well documented.

Dosimeter readings are not required by the state of Nebraska. Universal precautions are routinely utilized. Dental supplies and equipment are provided by Schien Dental Supply. Broken tools are document and disposed through Stericycle. Stericycle also disposes of any biohazard waste.

Mental Health

Mental health is staffed with a Mental Health Supervisor, a Clinical Program Director, three Mental Health Practitioners I and six Mental Health Practitioners II. Mental health care is normally provided Monday through Friday 8:00 a.m. through 4:30 p.m. One mental health practitioner is on site early to see patients who are housed in the Dickson unit. Residents in the Dickson unit are also seen on weekends.

Patients can access mental health care by verbal request and can also be referred by staff and medical personnel. Residents are seen immediately during normal business hours and in off hours there is always a staff member on call. Approximately 60 youths are seen individually each month and approximately 32 youths are seen for programming. Every resident in the facility is it seen at least once a month.

Mental health care provided includes crisis intervention, individual counseling, group counseling, medication management and drug / alcohol abuse programming. The chemical dependency treatment program is provided for youth who are mild to moderate risk level. Youths that require a high level of dependency treatment are transferred to an appropriate facility. Any youth with a severe development issue or acute mental condition is transferred to the Richard H Young hospital.

Any suicidal indication is referred to mental health and are monitored constantly. All youth are always site and sound supervised. Acute level ideations are monitored one on one. Dickson cottage is used for suicide observation rooms, if needed. There are suicide garments available.

YRTC does not use restraints for health services or psychiatric purposes.

Recreation:

YRTC – Kearney has a full time Recreation Manager, two Recreation Assistants, and one Recreation Aide. All recreation staff are certified in CPR, Lifeguard, and pool operations. Recreation has its own budget to purchase equipment and supplies. All living units have a schedule seven days a week where the youth are offered recreation. The recreation program has a gym, weight room, indoor swimming pool, outdoor play pads, soccer field/football field, volleyball court, and a softball field. Indoor recreational activities include movie viewing, board games, and video games. Some of the weight equipment was donated by the University of Nebraska at Kearney. Staff can utilize the weight room after working hours.

Religious Programming:

Religious services/programs are supervised by the Religious Coordinator. The Religious Coordinator is available for counseling. Prior to the COVID-19 voluntary Protestant services were conducted each Sunday at 9:00 a.m. Religious services in the Chapel have been suspended temporarily due to practicing social distancing. All faith are provided religious services, even though the majority of the youth are Protestant. The Religious Coordinator approves religious diets. The Chapel is also used for facility training for staff.

Offender Work Programs:

Youth assigned to the facility are not assigned jobs. Youth are required to maintain cleanliness and sanitation in their living areas. There is a Work Project where a youth can any job outside of the dorm and earn up to $ 2.50 per hour. Youths can participate in on-campus work assignments such as landscaping and the kitchen.

:

Academic and Vocational Education:

The West Kearney High School (WKHS) offers Academic and Vocational programs located on the campus of YRTC – Kearney. WKHS is accredited by the Nebraska State Board of Education as an accredited Special Purpose School. It is also accredited as an optional school through the North Central Association Commission on Accreditation and School Improvement, as well as Advanced ED. The school is an institutional member of the Correctional Education Association.

WKHS is staffed with one acting principal, 16 teachers assigned during audit. There is a vacant principal and three vacant teachers. The school day runs from 8:30 a.m. until 3:45 p.m., with an hour lunch break. Students work from individualized education plans. The following subjects are offered: Math, English, Social Studies, Business Information, Family Life, Physical Education Science, Health, and Life Skills. Vocational programs offered include: Art, Advance Art, Ceramics, Building Trades, and Forklift Simulator License.

Students can earn credits that transfer to their home school district. Students are also afforded the opportunity to earn a GED or their high school diploma. During the audit cycle WKHS graduated approximately five to seven youths. There is a graduation after each semester that's held in the gym. The summer graduation was suspended, due to COVID-19 and social distancing practices. WKHS did have one youth to graduate during the session.

WKHS has purchased two modular buildings that are being converted into classrooms for the female students. During the audit only one classroom was being utilized. The high school was on summer break during the audit. The acting principal was available to be interviewed by the auditors.

During the audit the youth assigned to school rotated to school. The students come twice a week, due to reduce staffing.

Social Services:

YRTC – Kearney utilizes a Biopsychosocial model of treatment. Within this model the facility treatment team is composed of Youth Counselors and case managers, mental health practitioners, clinical program director, and a contract psychiatrist through Boys Town. The treatment team focuses overall health mental health, trauma history and past and present social environments that must be considered when attempting to understand and mitigate a youth's problematic behaviors.

The facility uses evidence-based Aggression Replacement Training (ART). The philosophy is to help youth handle aggressive tendencies and anger issues. The youth participate in group meetings.

Anger Management, Social Skills and Social Decision-Making meetings are held to help youth change their behaviors and way of thinking. Every youth receives a STEPS to Change Handbook to assist them.

Upon arrival at the facility, all youth are evaluated by mental health professionals for safety issues, trauma, and other mental health concerns. Every youth receives the following assessments: YLS/CMI, How I Think (HIT) Questionnaire, SASSI for substance abuse, Marijuana Use Inventory Callous/Unemotional Traits to assess callousness. If indicated, youth may receive additional assessments for intellectual functioning, a personality assessment inventory, and risk of sex offending.

The social services program is staffed by nine mental health professionals, one mental health supervisor, one clinical program director, and 13 case managers. A contract psychiatrist provides psychiatric evaluations and psychotropic medication management.

Visitation:

Visitation is conducted Sunday through Saturday from 8:00 a.m. until 3:30 p.m. In addition to the weekly visits, visitation is also allowed on major holidays. Youth also get extra visits during the holidays. During graduation ceremonies students can have family members attend graduations. Visitation is only allowed with immediate family to include parents, grandparents, guardian, foster family, mentor, and clergy. There two indoor areas and one outdoor area for visits. Visitation was temporarily suspended during the audit, due to COVID-19 guideline with social distancing.

Library Services:

The library is located in the WKHS, under the supervision of the Librarian. The library has 6,000 books, 25 magazines, and 3 newspapers. Most books are purchase and a few are donated. All donated books are reviewed by the librarian. Youth can check out up to four books at a time. Youth can also checkout videos to view in their living area.

Laundry:

The laundry is located in the basement of the Dining Hall. The laundry is supervised by one Laundry worker. The laundry contains five dryers and four washers. Laundry services are conducted daily. Uniforms are washed five days a week. Each living unit has a day when linen is washed. During the audit it was observed that the lent traps had excess lent buildup. The audit team recommended that the lent traps be cleaned more frequently. Procedures were immediately implemented for cleaning the lent traps more frequently.

F. Examination of Records

Following the facility tour, the team proceeded to the Conference room B to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

   Over the last three years, the facility had no consent decrees, class action lawsuits or adverse judgments.

2. Significant Incidents/Outcome Measures

   Upon reviewing the Significant Incident Report for the audit cycle the audit team observed that the escapes were down from the previous audit report, however the team was concerned with the number of escapes. The Facility Administrator explained that the escapes have dropped during the three year audit cycle. In 2017-2018 (14) escapes, 2018 - 2019 (9) escapes, and 2019 - 2020 (13) escapes. The facility did not have perimeter fencing around the campus. The Facility Administrator tightened security practices, added hourly counts, increase perimeter security, and strategic staff positioning. In January 2019 construction of a 12 foot chain link fence was placed around the perimeter of the facility.

   A curved no climb extension was added to the top of the fence for added security. Completion of the fence is scheduled for July 2020. The audit team felt the facility was taking proactive measures to increase security for the facility.

The medical auditor reviewed the Healthcare Outcome Measures with no issues or concerns.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Medical	Joni Suhr, Nurse Supervisor; Jason Herman, Dentist; Jackie Buetter, Dental Assistant; Tammy Sanders, LPN; Cali Nelson, RN
School	Scott English, Director of School; Lisa Irwin, Media Center Specialist
Religious Services	Daniel Cole, Religious Coordinator
Training	Dan Theobald, Training Coordinator
Food Service	James Orme, Food Service Director; Teresa Childers, Food Service Supervisor
Recreation	Tim Smallwood, Recreation Aide; David Scoonhoven, Recreation Specialist
Front Line	Sean McKinney, Youth Program Specialist II, 1st shift; Steven Marten, Youth Program Specialist II, 3rd shift; Jamar Love, Youth Security Supervisor, 3rd shift
Living Units	Levi Hadley, Unit Manager; Barboza Washington, Youth Program Specialist II; Jacob Vega, Youth Case Manager
Administration	Paul Gordon, Facility Administrator; Mark LaBouchardiere, Facilities Director; Cindy Krolikowski, Facility Program Manager; Nicole Berggren, Juvenile Justice Administrator; Ralph Healey, Compliance Specialist; Fred Boon, Compliance Specialist

4. Shifts

a. Day Shift

The team was present at the facility during the day shift from 9:30 a.m. to 5:15 p.m. and made most of the observations above regarding conditions of confinement, health services and program offerings.

The Audit Team was able to observe count procedures in the living units, movement of youth being escorted to the dining hall, school, medical, and recreation.

b. Evening Shift

The team was present at the facility during the evening shift from 2:00 p.m. to 6:00 p.m. Members of the audit team were able to observe the change of shifts and the transfer of vital information from the day shift. A member of the audit team walked the perimeter of the fence to observe the newly constructed perimeter fence.

c. Night Shift

The team was present at the facility during the night shift from 9:15 p.m. to 10:30 p.m. The Audit Team was able to interview security staff reporting for duty prior to their shift. The night shift generally has limited contact with the youth since the youth are in bed when they arrive and in bed when shift ends.

5. Status of Previously Non-compliant Standards/Plans of Action

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

Standard # 4-JCF-2A-07

The Standard is now compliant as post orders are customized for each individual position on each shift and living unit.

Standard # 4-JCF-5G-03

The Standard is now compliant as to all living units have a schedule for daily recreation, with documentation to support.

Standard # 4-JCF-5G-06

The Standard is now compliant as to the facility created documentation for each individual youth describing community services and volunteer projects, they participated in during their stay at YRTC – Kearney.

Standard # 4-JCF-6B-14

The Standard is now compliant as to the Facility Administrator now approves permitted financial transactions between juveniles, juveniles and staff, or juveniles and volunteers.

Standard # 4-JCF-6C-10

The Standard is now compliant as to the facility does not exceed ten percent vacancy rate for any 18 month period.

G. Interviews

During the course of the audit, team members met with both staff and offenders to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interviews

In the course of the audit the team interviewed approximately 46 youth. The youth appeared relaxed and open to discussing their conditions of confinement and sense of safety. No youth reported feeling unsafe and none reported substantial issues communicating with staff. The youth reported that their basic needs were met.

2. Staff Interviews

The Audit Team interviewed approximately 48 staff members from all departments. Staff appeared very satisfied with facility policies and practices and expressed confidence in the executive staff. The staff showed a dedicated committed ownership in the facility and were proud to be part of the organization.

Most interviewees were pleased the facility was headed in a more positive direction. There were consistent comments that moral is good, and staff work well together.

H. Exit Discussion

The exit interview was held at 12:00 p.m. in the Canteen with the Facility Administrator and 20 staff in attendance.

The following person was also in attendance:

John S. Lowe, Nebraska State Senator District 37

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Juvenile Correctional Facilities, 4th Edition	
Supplement	2016 Standards Supplement	
Facility/Program	Youth Rehabilitation and Treatment Center – Kearney	
Audit Dates	July 8 – 10, 2020	
Auditor(s)	Gregory T. Knowlin, Chairperson Roger Chute, Member Randy Cross, Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	38	331
Number Not Applicable	3	6
Number Applicable	35	325
Number Non-Compliance	0	1
Number in Compliance	35	324
Percentage (%) of Compliance	100%	99.7%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Nebraska Department of Health and Human Services
Youth Rehabilitation and Treatment Center – Kearney
Kearney, Nebraska

July 8 – 10, 2020

Visiting Committee Findings

Non-Mandatory Standards

Non-Compliance

Standard #4-JCF-1C-04

UNLESS OTHERWISE SPECIFIED BY NATIONAL, STATE, OR LOCAL CODES, PLUMBING FIXTURES INCLUDING SHOWERS, SINKS, AND TOILETS ARE PROVIDED AS FOLLOWS:

- ALL HOUSING UNITS WITH FIVE OR MORE JUVENILES HAVE AT LEAST TWO TOILETS.
- AT LEAST ONE TOILET IS PROVIDED FOR EVERY 12 MALE JUVENILES (1:12). URINALS MAY BE SUBSTITUTED FOR UP TO ONE-HALF OF THE TOILETS IN MALE FACILITIES.
- AT LEAST ONE TOILET IS PROVIDED FOR EVERY EIGHT FEMALE JUVENILES (1:8).
- AT LEAST ONE SINK WITH HOT AND COLD RUNNING WATER PROVIDED FOR EVERY 12 JUVENILES (1:12).

JUVENILES HAVE ACCESS TO OPERABLE SHOWERS WITH TEMPERATURE CONTROLLED HOT AND COLD RUNNING WATER, AT A MINIMUM RATIO OF ONE SHOWER FOR EVERY EIGHT INMATES (1:8). WATER FOR SHOWERS IS THERMOSTATICALLY CONTROLLED TO TEMPERATURES RANGING FROM 100 DEGREES FAHRENHEIT TO 120 DEGREES FAHRENHEIT TO ENSURE THE SAFETY OF INMATES AND TO PROMOTE HYGIENIC PRACTICES.

FINDINGS:

At the time of the audit, Morton Housing Unit housed 16 female juveniles. Prior to August 2019, Morton Housing Unit housed 16 male juveniles. The unit is a 2-story building. The first floor is used for Program services. The second floor is where the juvenile sleeping rooms are located. Scheduling and Post Orders stipulate that juveniles are to go to their rooms/beds at 9:30pm. Juveniles are not allowed to return to the first floor. There is one restroom in the sleeping area. The restroom is equipped with one toilet and one sink.

The standard requires one toilet for every eight female juveniles and one sink for every 12 juveniles. The facility does not meet the toilet or sink ratio.

AGENCY RESPONSE:

Waiver Request

The particular issue as it applies to compliance with this standard is that the upstairs of the Morton Living Unit, in which the female youth are housed, does not have enough toilets available to accommodate female youth.

The YRTC-Kearney, since 1892, has only housed male youth. Since that time, any upgrades or modifications to buildings were made to accommodate a male youth population. The female youth who were formally housed at the Youth Rehabilitation and Treatment Center (YRTC) in Geneva, Nebraska, were temporarily re-located to the YRTC-Kearney. This move occurred due to damage sustained by the facility as girls were destroying property and low staffing contributed to an unsafe environment. This move took place on August 19, 2019 and was intended as a temporary move as repairs were made to the YRTC-Geneva facility.

Recently, Nebraska Department of Health and Human Services (DHHS), which oversees the YRTC system, has decided to make plans to re-locate the female youth to an already existing facility in Hastings, Nebraska. This move will occur in March of 2021. Nebraska DHHS will establish the YRTC-Hastings and this facility will be exclusively for female youth.

The YRTC-Kearney campus at that time will exclusively house male youth and will then be in compliance with this standard.

AUDITOR'S RESPONSE:

The audit team supports the facilities request for a waiver. The audit team observed that prior to the female juveniles arriving in August 19, 2019, the facility was in compliance with the standard, with the female juveniles being moved to another facility in March 2021, the audit felt that it would not be cost effective to make any renovations to comply with the standard. There were no complaints from the female juveniles assigned to the housing unit.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Nebraska Department of Health and Human Services
Youth Rehabilitation and Treatment Center – Kearney
Kearney, Nebraska

July 8 – 10, 2020

Visiting Committee Findings

Mandatory Standards

Not Applicable

Standard # 4-JCF-2A-18 Revised January 2011 (MANDATORY)

FOUR-/FIVE-POINT RESTRAINTS ARE USED ONLY IN EXTREME INSTANCES AND ONLY WHEN OTHER TYPES OF RESTRAINTS HAVE PROVEN INEFFECTIVE OR THE SAFETY OF THE JUVENILE IS IN JEOPARDY. ADVANCE APPROVAL IS SECURED FROM THE FACILITY ADMINISTRATOR/DESIGNEE BEFORE A JUVENILE IS PLACED IN A FOUR-/FIVE-POINT RESTRAINT. SUBSEQUENTLY, THE HEALTH AUTHORITY OR DESIGNEE MUST BE NOTIFIED TO ASSESS THE JUVENILE'S MEDICAL AND MENTAL HEALTH CONDITION, AND TO ADVISE WHETHER, ON THE BASIS OF SERIOUS DANGER TO SELF OR OTHERS, THE JUVENILE SHOULD BE IN A MEDICAL/MENTAL HEALTH UNIT FOR EMERGENCY INVOLUNTARY TREATMENT WITH SEDATION AND/OR OTHER MEDICAL MANAGEMENT, AS APPROPRIATE. IF THE JUVENILE IS NOT TRANSFERRED TO A MEDICAL/MENTAL HEALTH UNIT AND IS RESTRAINED IN A FOUR-/FIVE-POINT POSITION, THE FOLLOWING MINIMUM PROCEDURES ARE FOLLOWED:

- DIRECT VISUAL OBSERVATION BY STAFF IS CONTINUOUS PRIOR TO OBTAINING APPROVAL FROM THE HEALTH AUTHORITY OR DESIGNEE.
- SUBSEQUENT VISUAL OBSERVATION IS MADE AT LEAST 15 MINUTES.
- RESTRAINT PROCEDURES ARE IN ACCORDANCE WITH GUIDELINES APPROVED BY THE DESIGNATED HEALTH AUTHORITY.
- ALL DECISIONS AND ACTIONS ARE DOCUMENTED.

FINDINGS:

Youth Rehabilitation and Treatment Facility – Kearney does not allow the use of four/five Point restraints.

Standard # 4-JCF-2A-27 (Mandatory)

THE LEVEL OF AUTHORITY, ACCESS, AND CONDITIONS REQUIRED FOR THE AVAILABILITY, CONTROL, AND USE OF CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE MUST BE SPECIFIED. CHEMICAL AGENTS ARE USED ONLY WITH THE AUTHORIZATION OF THE FACILITY ADMINISTRATOR, MEDICAL DIRECTOR, OR DESIGNEE.

1. CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE ARE INVENTORIED AT LEAST MONTHLY TO DETERMINE THEIR CONDITION AND EXPIRATION DATES.
2. PERSONNEL USING CHEMICAL AGENTS TO CONTROL JUVENILES SUBMIT WRITTEN REPORTS TO THE FACILITY ADMINISTRATOR OR DESIGNEE NO LATER THAN THE CONCLUSION OF THE TOUR OF DUTY.
3. ALL PERSONS CONTAMINATED IN AN INCIDENT INVOLVING THE USE OF A CHEMICAL AGENT MUST RECEIVE AN IMMEDIATE MEDICAL EXAMINATION AND TREATMENT.

FINDINGS:

Youth Rehabilitation and Treatment Center – Kearney does not utilize any chemical Agents.

Standard # 4-JCF-4C-47 (MANDATORY)

GUIDELINES REGARDING THE USE OF RESTRAINTS ON JUVENILES FOR MEDICAL AND MENTAL HEALTH PURPOSES AT A MINIMUM SHALL INCLUDE:

1. CONDITIONS UNDER WHICH RESTRAINTS MAY BE APPLIED
2. TYPES OF RESTRAINTS TO BE APPLIED
3. IDENTIFICATION OF A QUALIFIED MEDICAL OR MENTAL HEALTH PROFESSIONAL AND HEALTH CARE PRACTITIONER WHO MAY AUTHORIZE THE USE OF RESTRAINTS AFTER REACHING THE CONCLUSION THAT LESS INTRUSIVE MEASURES ARE NOT SUCCESSFUL
4. MONITORING PROCEDURES
5. LENGTH OF TIME RESTRAINTS ARE TO BE APPLIED
6. LESS-RESTRICTIVE-TREATMENT-PLAN ALTERNATIVES ARE DEVELOPED AND IMPLEMENTED AS SOON AS POSSIBLE
7. AFTER-INCIDENT REVIEW

FINDINGS:

Youth Rehabilitation and Treatment Center – Kearney does not use restraints for medical or mental health purposes.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Nebraska Department of Health and Human Services
Youth Rehabilitation and Treatment Center – Kearney
Kearney, Nebraska

July 8 – 10, 2020

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard # 4-JCF-1A-03

RENOVATION, ADDITION, NEW PLANT. THE JUVENILE CORRECTIONAL FACILITY OPERATES WITH LIVING UNITS OF NO MORE THAN 16 JUVENILES EACH. THE JUVENILE CORRECTIONAL FACILITY DOES NOT EXCEED A BED CAPACITY OF 150 JUVENILES.

FINDINGS:

YTRC – Kearney is not a new plant and has not undergone any renovation or addition during this audit period.

Standard # 4-JFC-1A-04

IF THE JUVENILE FACILITY IS ON THE GROUNDS OF ANY OTHER TYPE OF CORRECTIONAL FACILITY, IT IS A SEPARATED, SELF-CONTAINED UNIT.

FINDINGS:

YRTC – Kearney is not on the grounds of any other type of correctional facility.

Standard # 4-JCF-3E-01

THE FACILITY PROVIDES SERVICES AND OPPORTUNITIES THAT ENCOURAGE JUVENILES TO TAKE RESPONSIBILITY FOR THEIR ACTIONS AND MAKE RESTITUTION TO THE VICTIMS OF THEIR CRIME(S) AND/OR TO THE COMMUNITY, WHEN REQUIRED. OPPORTUNITIES ARE BASED ON COMMUNITY INPUT AND ARE FASHIONED IN A WAY THAT SEEKS TO AMELIORATE THE HARM DONE.

FINDINGS:

YRTC – Kearney has no court orders requiring restitution and does not have contact with victims so there is no restitution program.

Standard # 4-JCF-6A-03

IF SERVICES FOR ADULT AND JUVENILE OFFENDERS ARE PROVIDED BY THE SAME AGENCY, STATEMENTS OF PHILOSOPHY, POLICY, PROGRAM, AND PROCEDURE DISTINGUISH BETWEEN CRIMINAL CODES AND THE STATUTES THAT ESTABLISH, GIVE DIRECTION, AND GUIDE PROGRAMS FOR JUVENILES.

FINDINGS:

The Nebraska Department of Health and Human Services does not serve adult offenders.

Standard # 4-JCF-5I-04

WHERE STATUTES PERMIT, JUVENILES SHOULD BE AFFORDED OPPORTUNITIES FOR GRADUATED RELEASE AND PARTICIPATION IN EMPLOYMENT AND EDUCATION PROGRAMS.

FINDINGS:

YRTC – Kearney has no opportunities for graduated release or participation in Employment/education programs.

Standard # 4-JCF-6G-07

CONSISTENT WITH JURISDICTIONAL LAWS, REGISTERED CRIME VICTIM(S) ARE NOTIFIED OF A JUVENILE OFFENDER'S RELEASE PRIOR TO ANY PLANNED RELEASE FROM CONFINEMENT AND/OR ESCAPE FROM CUSTODY. FOLLOW-UP NOTIFICATION TO VICTIMS OCCURS WHEN ESCAPEES ARE RETURNED TO CUSTODY.

FINDINGS:

There is no statutory provision for victim notification for juvenile offenders.

Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: Youth Rehabilitation and Treatment Center - Kearney
Reporting Period: June 2019 through May 2020

Incident Type	**Months** ⇨	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sept 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**	**Apr 2020**	**May 2020**	**Total for Reporting Period**
Escapes		3	0	2	1	0	0	1	2	1	3	0	0	13
Disturbances*		0	0	0	0	0	0	0	0	1	0	0	0	1
Sexual Violence		1	0	0	0	0	0	0	0	0	0	0	0	1
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender/ Offender	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender/ Staff	0	1	0	0	0	1	0	0	1	2	0	0	5
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		1	2	1	0	0	0	1	2	1	1	0	0	9

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

		Health Care Outcomes		2019
Performance Standard	Outcome Measure	YRTC-Kearney	Value	Calculated Outcome Measure
A		On-Site Health Care		
		Outcome Measures		
	(1)	Number of juveniles seen by nursing during health call in the past 12 months divided by the number of health call requests in the past 12 months.	(227% with all nursing visits)	100%
	(2)	Number of juveniles seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months divided by the number of juvenile referred to be seen the responsible physician or health care practitioner in the past 12 months.		100%
	(3)	Number of juveniles seen by the dentist in the past 12 months divided by the number of juveniles referred to be seen by the dentist in the past 12months.	(108% with all dentist visits)	100%
	(4)	Number of juveniles seen by the psychiatrist in the past 12 months divided by the number of juveniles referred to be seen by the psychiatrist in the past 12 months.		100%
	(5)	Number of female juveniles seen by OB/GYN in the past 12 months divided by the number of female juveniles referred to be seen by the OB/GYN in the past 12 months.		0%
	(6)	Number of intake health screenings (intersystem and intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.		0%
	(7)	Number of examinations (intersystem) completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission date within the past 12 months divided by the number of admissions to the facility within the past 12 months.		100%
		Data Collection		

		Number of health call requests in the past 12 months.	1663	
		Number of juveniles seen by nursing during health call in the past 12 months.	3779	
		Number of juveniles referred to be seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months.	481	
		Number of juveniles seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months.	481	
		Number of juveniles referred to be seen by the dentist in the past 12 months.	331	
		Number of juveniles seen by the dentist in the past 12 months.	359	
		Number of juveniles referred to be seen by the psychiatrist in the past 12 months.	74	
		Number of juveniles seen by the psychiatrist in the past 12 months.	74	
		Number of female juveniles referred to be seen by OB/GYN in the past 12 months.	0	
		Number of juveniles seen by OB/GYN in the past 12 months.	0	
		Number of intake health screenings completed (intersystem and intrasystem) at admission in the past 12 months.	0	
		Number of examinations completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission (intersystem) date within the past 12 months.	108	
		Number of intrasystem transfers within the past 12 months.	0	
		Number of intersystem transfers within the past 12 months.	0	
		Specialty Consultants		
		Outcome Measures		

	(8)	Number of juvenile specialty consults completed (on-site and off-site) in the past 12 months divided by the number of specialty consults (on-site and off-site) ordered by the responsible physician, health care practitioner (N.P., P.A.) or dentist in the past 12 months.		100%
		Data Collection		
		Number of referrals to specialty consults on-site and off-site ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months.	22	
		Number of completed on-site and off-site specialty consults ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months.	22	
		Specialty Diets		
		Outcome Measures		
	(9)	Number of juveniles receiving special medical (therapeutic) diets in the past 12 months divided by the number of special medical (therapeutic) diets prescribed in the past 12 months.		100%
	(10)	Number of juveniles receiving a special medical diet in the past 12 months divided by the average daily population in the past 12 months.		9%
		Data Collection		
		Number of juveniles prescribed a special medical (therapeutic) diet in the past 12 months.	8	
		Number of juveniles receiving a special medical (therapeutic) diet in the past 12 months.	8	
		Pregnancy Testing		
		Outcome Measures		
	(11)	Number of females' juveniles with a positive pregnancy test in the past 12 months divided by the number of pregnancy test administered in the past 12 months.		0%

	(12)	Number of female juveniles with a positive pregnancy test in the past 12 months divided by the average daily population (female) in the past 12 months.		0%
		Data Collection		
		Number of female juveniles with a positive pregnancy test in the past 12 months.	0	
		Number of pregnancy test administered in the past 12 months.	0	
		HIV		
		Outcome Measures		
	(13)	Number of HIV positive juveniles who are being treated with antiretroviral treatment of for opportunistic infection in the past 12 months divided by the total number of HIV positive juveniles in the past 12 months.		0%
		Data Collection		
		Number of known HIV positive status juveniles admitted to the facility in the past 12 months.	0	
		Number of youth testing positive for HIV in the past 12 months.	0	
		Number of HIV positive juveniles who are being treated with antiretroviral treatment or for opportunistic infection in the past 12 months.	0	
		Number of AIDS cases upon admission to the facility in the past 12 months.	0	
		Number of AIDS cases diagnosed by the facility in the past 12 months.	0	
		Tuberculosis (TB)		
		Outcome Measures		
	(14)	Number of juveniles with a known positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months divided by the number of admissions (intersystem) in the past 12 months.		0%

	(15)	Number of juveniles with a positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months divided by the number of admissions (intersystem) in the past 12 months.		0%
	(16)	Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months divided by the number of tuberculin skin test given in the past 12 months.		3%
	(17)	Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.		0%
	(18)	Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.		30%
		Data Collection		
		Number of juveniles with a known positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months	0	
		Number of juveniles with a positive tuberculin (TB) skin test administered upon admission (intersystem) to the facility in the past 12 months.	0	
		Number of admissions (intrasystem) within the past 12 months.	105	
		Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months.	3	
		Number of tuberculin skin tests administered in the past 12 months.	111	
		Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months.	0	
		Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months.	33	
		Hepatitis A,B, and C		
		Outcome Measures		

	(19)	Number of juveniles testing positive for Hepatitis A,B, and C in the past 12 months divided by the number of tests administered in the past 12 months.		0%
	(20)	Number of juveniles testing positive for Hepatitis A,B and C in the past 12 months divided by the average daily population in the past 12 months.		0%
		Data Collection		
		Number of Hepatitis A test administered in the past 12 months.	0	
		Number of Hepatitis B test administered in the past 12 months.	13	
		Number of Hepatitis C test administered in the past 12 months.	13	
		Number of juveniles testing positive for Hepatitis A in the past 12 months.	0	
		Number of juveniles testing positive for Hepatitis B in the past 12 months.	0	
		Number of juveniles testing positive for Hepatitis C in the past 12 months.	0	
		Methicillin Resistant Staphylococcus Aureus (MRSA)		
		Outcome Measures		
	(21)	Number of juveniles testing positive for MRSA in the past 12 months divided by the number of tests administered in the past 12 months.		0%
	(22)	Number of juveniles testing positive for MRSA in the past 12 months divided by the average daily population in the past 12 months.		0%
		Data Collection		
		Number of MRSA test administered in the past 12 months.	0	
		Number of juveniles testing positive for MRSA in the past 12 months.	0	
		Health Education		
	(23)	Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months divided by the number of admissions in the past 12 months.		100%
		Data Collection		

		Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months.	105	
		Number of juvenile admissions (intersystem and/or intrasystem in the past 12 months.	105	
		Pharmaceutical Management		
		Outcome Measures		
	(24)	Number of pharmacy dispensing errors in the past 12 months divided by the number of prescriptions dispensed by the pharmacy in the past 12 months.		0%
	(25)	Number of nursing medication administration errors in the past 12 months divided by the number of medications administered in the past 12 months.		N/A
	(26)	Number of juveniles on psychotropic medications in the past 12 months divided by the average daily population in the past 12 months.		44%
		Data Collection		
		Number of total prescriptions dispensed by pharmacy in the past 12 months.	2220	
		Number of pharmacy dispensing errors in the past 12 months.	1	
		Number of medications administered in the past 12 months.	N/A	
		Number of medication administrations errors in the past 12 months.	651	
		Number of incidents involving pharmaceuticals as contraband in the past 12 months.	43	
		Number of juveniles on psychotropic medication in the past 12 months.	458	
B		Quality Review		
		Outcome Measures		
	(1)	Number of health care issues/problems identified by internal review that were corrected in the past 12 months divided by the number of problems identified by internal review in the past 12 months.		0%
		Data Collection		

		Number of issues/problems identified by internal review in the past 12 months.	0	
		Number of issues/problems identified by the internal review in the past 12 months that were corrected.	0	
		Grievances Related to Health Care		
		Outcome Measures		
	(2)	Number of juvenile health related grievances found in favor of the juvenile in the past 12 months divided by the number of health related grievances filed in the past 12 months.		14%
		Data Collection		
		Number of juvenile health related grievances filed in the past 12 months.	21	
		Number of juvenile health related grievances found in favor of the juvenile in the past 12 months.	3	
		Health Related Lawsuits		
		Outcome Measures		
	(3)	Number of health related lawsuits filed by or on behalf of juveniles found in favor of the juvenile in the past 12 months divided by the number of lawsuits filed in the past 12 months.		0%
		Data Collection		
		Number of juvenile health related lawsuits filed in the past 12 months.	0	
		Number of juvenile health related lawsuits found in favor of the juvenile in the past 12 months.	0	
C		Death in Custody		
		Outcome Measures		
	(1)	Number of juvenile deaths in custody in the past 12 months divided by the average daily population in the past 12 months.		0%
		Data Collection		
		Number of juvenile deaths that were medically expected in the past 12 months.	0	

		Number of juvenile deaths that were medically unexpected other than injury, suicide and /or homicide in the past 12 months.	0	
		Number of juvenile deaths due to injury in the past 12 months.	0	
		Number of juvenile deaths due to suicide in the past 12 months.	0	
		Sexual Assaults		
		Outcome Measures		
	(2)	Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.		25%
		Data Collection		
		Number of juvenile(s) alleging sexual assault in the past 12 months.	22	
D		Health Care Staffing		
		Outcome Measures		
	(1)	Number of vacant positions for full-time equivalents for each health care staff category in the past 12 month period divided by the full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months.		0%
		Data Collection		
		Number of physician full-time equivalent position(s).	0	
		Number of physician vacancies in the past 12 months .	0	
		Number of full-time equivalent practitioner position(s).	0	
		Number of practitioner vacancies in the past 12 months.	0	
		Number of full-time equivalent dentist position(s).	0	
		Number of dentist vacancies in the past 12 months.	0	
		Number of full-time equivalent nursing (RN) positions(s).	3	
		Number of nursing (RN) vacancies in the past 12months.	1	

		Number of full-time equivalent nursing (LPN, LVN) position(s).	1	
		Number of nursing (LPN, LVN) vacancies in the past 12 months.	0	
		Number of full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months.	14	
		Qualified Staff		
		Outcome Measures		
	(2)	Number of staff with lapsed licensure and/or certification in the past 12 months divided by the number of licensed and/or certified staff in the past 12 months.		0%
	(3)	Number of specified health care positions with a written job description divided by the number of specified health care positions in the past 12 months.		100%
		Data Collection		
		Number of staff requiring a license and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., L.P.N., psychologist, et. al. therapists requiring licensure in the past 12 months.	13	
		Number of lapsed licensure and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., dentist, psychologist, et al. therapist requiring licensure) in the past 12 months.	0	
		Number of specified health care positions in the past 12 months.	14	
		Number of specified health care position with a written job description in the past month.	14	
		Fair Treatment of Staff		
		Outcome Measures		
	(4)	Number of health care staff grievances decided in favor of staff in the past 12 months divided by the total number of health care staff grievances filed in the past 12 months.		0%

	(5)	Number of health care staff terminations demotion hearings in which administrative decision was upheld in the past 12 months divided by the number of health care staff terminations or demotion hearings held in the past 12 months.		0%
		Data Collection		
		Number of health care staff grievances filed in the past 12 months.	0	
		Number of health care staff grievances decided in favor of the health care staff in the past 12 months.	0	
		Number of health care staff terminations and demotion hearings in which the program decision was upheld in the past 12 months.	0	
		Number of health care staff terminations or demotion hearings held in the past 12 months.	0	
		Employee Health		
		Outcome Measures		
	(6)	Number of new employees who were administered a tuberculin (TB) skin test in the past 12 months divided by the number of employees hired in the past 12 months.		100%
	(7)	Number of employees with a positive tuberculin skin test conversion in the past 12 months.		0%
		Data Collection		
		Number of new employees hired in the past 12 months.	71	
		Number of new employees who were administered a tuberculin (TB) skin test in the past 12 months.	71	
		Number of employees administered tuberculin (TB) skin test in the past 12 months.	7	
		Number of employees with a positive tuberculin (TB) skin test conversion in the past 12 months .	0	
E		Mental Health		
		Outcome Measures		

	(1)	Number of intake mental health screenings (intersystem or intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.		98%
	(2)	Number of juveniles receiving a mental health appraisal in the past 12 months divided by the number of admissions in the past 12 months.		98%
	(3)	Number of juveniles with a Mental Health Treatment Plan in the past 12 months divided by the number of youth requiring ongoing mental health intervention in the past 12 months.		100%
	(4)	Number of suicide attempts divided by the average daily population in the past 12 months.		0%
	(5)	Number of completed suicides divided by the average daily population in the past 12 months.		0%
		Data Collection		
		Number of juveniles receiving a mental health screening at admission (intrasystem and intersystem) in the past 12 months.	103	
		Number of juveniles receiving mental health appraisals within the past 12 months.	103	
		Number of intrasystem transfers within the past 12 months.	0	
		Number of intersystem transfers within the past 12 months.	0	
		Number of juveniles requiring ongoing mental health intervention in the past 12 months.	53	
		Number of juveniles with a mental health treatment plan in the past 12 months.	53	
		Number of suicide attempts in the past 12 months.	0	
		Number of completed suicides in the past 12 months.	0	
F		Substance Abuse		
		Outcome Measures		

	(1)	Number of juveniles receiving a substance abuse screening in the past 12 months divided by the number of admissions (intersystem or intrasystem) in the past 12 months.		95%
	(2)	Number of juveniles referred to a chemical dependency program divided by the number of youth identified as requiring a chemical dependency program in the past 12 months.		13%
	(3)	Number of juveniles completing an alcohol and drug abuse education program in the past 12 months divided by the number of admissions in past 12 months.		95%
		Data Collection		
		Number of intersystem transfers in the past 12 months.	0	
		Number of intrasystem transfers in the past 12 months.	0	
		Number of juveniles identified as requiring a chemical dependency program in the past 12 months.	82	
		Number of juvenile placed in a chemical dependency program in the past 12 months.	11	

.

Facility Staffing Information

Staffing Levels

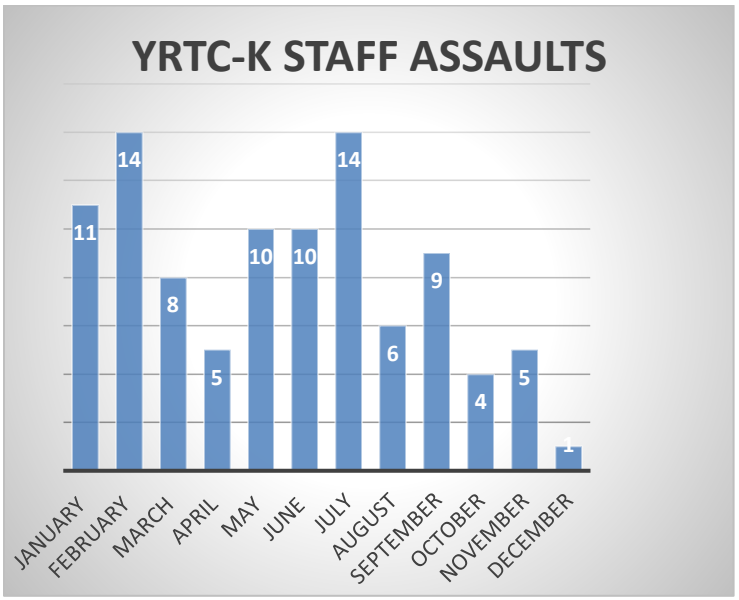
Staff Assaults

Attachment K2

Nebraska Department of Health and Human Services (NEDHHS) - YRTC-K Data
as of 1/1/2021

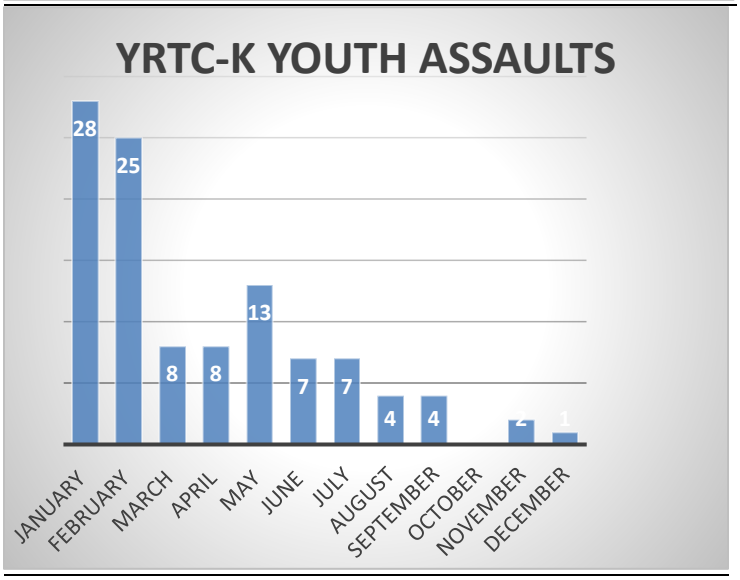
Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
A19211	ACCOUNTANT I	1	0	1	0%	0%
S19112	ACCOUNTING CLERK II	1	0	1	0%	0%
V09121	ADMINISTRATIVE ASSISTANT I	1	0	1	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	0%	0%
V09212	BUSINESS MANAGER II	1	0	1	0%	0%
V72460	CLINICAL PROGRAM MANAGER	1	0	1	0%	0%
K76410	COMPLIANCE SPECIALIST	2	0	2	0%	0%
S05712	CORR CANTEEN OPERATOR	1	0	1	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	2	0	2	0%	50%
N78560	DHHS FACILITY ADMINISTRATOR	1	0	1	0%	0%
N00750	FACILITY OPERATING OFFICER	1	0	1	0%	0%
R80122	FOOD SERVICE ASSISTANT	0	1	1	100%	
M80123	FOOD SERVICE COOK	3	3	6	50%	40%
V80311	FOOD SERVICE DIRECTOR I	1	0	1	0%	0%
M80124	FOOD SERVICE LEADER	1	1	2	50%	50%
M79112	LAUNDRY WORKER	1	0	1	0%	0%
I75013	LICENSED PRACTICAL NURSE (NEW)	1	0	1	0%	0%
H72431	MENTAL HEALTH PRACTITIONER I	1	0	1	0%	20%
H72432	MENTAL HEALTH PRACTITIONER II	8	2	10	20%	13%
V72433	MENTAL HLTH PRACTITIONER SUPERVISOR	1	0	1	0%	0%
R01113	OFFICE CLERK III	0	1	1	100%	
S01113	OFFICE CLERK III	1	3	4	75%	20%
V01120	OFFICE SUPERVISOR	1	0	1	0%	0%
G11900	PRINCIPAL	0	1	1	100%	50%
N74823	PSYCHOLOGIST/LICENSED	0	1	1	100%	
I77042	RECREATION ASSISTANT	3	1	4	25%	20%
V77045	RECREATION MANAGER	1	0	1	0%	0%
H75014	REGISTERED NURSE (NEW)	1	1	2	50%	50%
C79920	RELIGIOUS COORDINATOR	1	0	1	0%	0%
S01411	SECRETARY I	1	0	1	0%	0%
S01841	STAFF ASSISTANT I	1	0	1	0%	0%
V01842	STAFF ASSISTANT II	1	0	1	0%	0%
T11360	TEACHER (SCATA CONTRACT)	20	4	24	17%	24%
R11370	TEACHER/SUBSTITUTE	1	0	1	0%	0%
R11380	TEACHER/TEMPORARY	0	10	10	100%	
M05221	WAREHOUSE TECHNICIAN	1	0	1	0%	0%
C72481	YOUTH COUNSELOR I	13	1	14	7%	17%
V72483	YOUTH COUNSELOR SUPERVISOR	8	0	8	0%	0%
P76752	YOUTH SECURITY SPECIALIST II	49	59	108	55%	42%
R76752	YOUTH SECURITY SPECIALIST II	5	11	16	69%	30%
V76753	YOUTH SECURITY SUPERVISOR	15	2	17	12%	18%
		153	**102**	**255**	**40%**	**32%**

Youth Rehabilitation & Treatment Center - Kearney
2020



INJURY SEVERITY - STAFF

Month	#1	#2	#3	#4	#5	#6	Total
January	6	5	0	0	0	0	11
February	4	5	0	5	0	0	14
March	5	3	0	0	0	0	8
April	2	3	0	0	0	0	5
May	6	4	0	1	0	0	10
June	7	2	0	1	0	0	10
July	6	6	1	1	0	0	14
August	2	3	0	1	0	0	6
September	6	3	0	0	0	0	9
October	2	1	1	0	0	0	4
November	4	0	0	1	0	0	5
December	1	0	0	0	0	0	1



INJURY SEVERITY - YOUTH

Month	#1	#2	#3	#4	#5	#6	Total
January	19	8	1	0	0	0	28
February	9	4	0	12	0	0	25
March	8	0	0	0	0	0	8
April	5	1	0	2	0	0	8
May	7	6	0	0	0	0	13
June	3	4	0	0	0	0	7
July	2	5	0	0	0	0	7
August	4	0	0	0	0	0	4
September	2	2	0	0	0	0	4
October	0	0	0	0	0	0	0
November	2	0	0	0	0	0	2
December	1	0	0	0	0	0	1

January 2021 monthly breakdown of major incidents

Attempted Escape	**1**	Refusal to Submit to a Search	**1**
Destruction of Property over $500	**0**	Sexual Abuse/Touching	**3**
Drug or Intoxicant Abuse	**0**	Sexual Activities	**0**
Drug paraphernalia	**0**	Sexual Assault	**0**
Escape	**0**	Sexual Harassment	**1**
Escape Paraphernalia	**0**	Threatening Language or Gestures/Fighting	**6**
False Reporting	**0**	Youth on Staff Assault	**9**
Gang Related Behavior	**0**	Youth on Youth Assault/Fighting	**8**
Medication Abuse	**4**	Youth on Youth Assault	**6**
Mutinous Acts	**0**		
Possession/Manufacture of Weapons	**0**	**Total Major Violations – January 2021**	**39**

RATING	DEFINITION
#1	No visible injury or pain
#2	Injury or pain requiring first aid treatment only
#3	Injury or pain requiring on-campus medical treatment beyond first aid
#4	Injury or pain requiring assessment/treatment as an outpatient off-campus
#5	Injury or pain requiring assessment/treatment as an inpatient off-campus
#6	Injury resulting in death

Food Establishment Inspection Report

Attachment K3

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health
FOOD ESTABLISHMENT INSPECTION REPORT

Firm: West Kearney High (YATC)	Firm ID: 10-15 / Inspector Code: ZS
Address: 2402 30th Ave.	Facility Codes: / Inspection Date: 3-12-20
City: Kearney, NE	

Good Retail Practices

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

	Safe Food and Water	C	R
28	Pasteurized eggs used where required		
29	Water & ice from approved source		
30	Variance obtained for specialized proessing methods		
	Food Temperature Control		
31	Proper cooling methods used; adequate equipment for temperature control		
32	Plant food properly cooked for hot holding		
33	Approved thawing methods used		
34	Thermometers provided & accurate		
	Food Identification		
35	Food properly labeled; original container		
	Prevention of Food Contamination		
36	Insects, rodents, & animals not present; no unauthorized persons		
37	Contamination prevented during food preparation, storage, & display		
38	Personal cleanliness; hair restraints		
39	Wiping cloths; stored in sanitizing solution and properly used		
40	Washing fruits & vegetables washed prior to use		

	Proper Use of Utensils	C	R
41	In-use utensils; properly stored		
42	Utensils, equipment, & linens; properly stored, dried & handled		
43	Single-use & single-service articles; properly stored & used		
44	Gloves used properly		
	Utensils, Equipment, and Vending		
45	Food & non-food contact surfaces cleanable, properly designed, constructed & used		
46	Warewashing facilities; installed, maintained, & used; test strips		
47	Non-food contact surfaces clean		
	Physical Facilities		
48	Hot & cold water available; adequate pressure		
49	Plumbing installed, proper backflow devices		
50	Sewage & waste water properly disposed		
51	Toilet facilities; properly constructed, supplied & cleaned		
52	Garbage & refuse properly disposed, facilities maintained		
53	Physical facilities installed, maintained, & clean		
54	Adequate ventilation & lighting; designated areas used		

Critical X	Item #	Code Reference	Violation Description/Remarks/Corrections
			Refrigeration logs - current on Clipboard - prior in folder/file
			Dishwasher temp log - current on clipboard. prior in folder/file
			Food temps Recorded on Daily Production Records for Breakfast/Lunch/Dinner. Found some days missing. Binder organized oddly. New mgmt will start keeping chronologically.
			Cooling logs. not saving any TCS foods at this time
			Currently not maintaining a Receiving log. Thermometer Calibration log or Damaged Discarded log. New mgmt will start using/maintaining these
*			

Unless otherwise stated, violations cited in this report shall be corrected within a period not to exceed 10 calendar days for critical items (§8-405.11) or 90 days for noncritical items(§8-406.11).

Received by: _____ Inspected by: _____

Nebraska Department of Health and Human Services
PO Box 95026, Lincoln, NE 68509-5026 | 402/471-0903
Distribution: WHITE – Lincoln; YELLOW – Local Office; PINK - Customer

PHA-43 10/2018

* LEFT C.A.R. *
SEND IN MISSING forms for March

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health
FOOD ESTABLISHMENT INSPECTION REPORT

Firm: West Kearney High (YRTC)
Address: 2202 30th Ave
City: Kearney NE

Firm ID:	Inspector Code:
10-15	ZS
Facility Codes:	Inspection Date:
	3-12-20

Unless otherwise stated, violations cited in this report shall be corrected within a period not to exceed 10 calendar days for critical items (§8-405.11) or 90 days for noncritical items (§8-406.11).

VIOLATIONS: CRITICAL: 1 **NONCRITICAL:** —

Purpose	
Regular: 1	Investigation: 4
Follow-up: 2	Other: 5
Complaint: 3	

Temperature Observations

Food Product	Food ~~Product~~ temp	Location	Food Product	Product Temp.	Location
Beef/noodles	188.2	Steam table			

Foodborne Illness Risk Factors and Public Health Interventions

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable

Mark "X" in appropriate box for C and/or R
C=corrected on site during inspection R=repeat violation

	Compliance Status		C	R
	Demonstration of Knowledge			
1	(IN) OUT	Certification by accredited program, compliance with code, or correct responses		
	Employee Health			
2	(IN) OUT	Management awareness; policy present		
3	(IN) OUT	Proper use of reporting, restriction & exclusion		
	Good Hygienic Practices			
4	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
5	(IN) OUT N/O	No discharge from eyes, nose & mouth		
	Preventing Contamination by Hands			
6	(IN) OUT N/O	Hands clean & properly washed		
7	(IN) OUT N/A N/O	No bare hand contact with RTE foods		
8	(IN) OUT	Adequate handwashing facilities supplied & accessible		
	Approved Source			
9	(IN) OUT	Food obtained from approved source		
10	IN OUT N/A (N/O)	Food received at proper temperature		
11	(IN) OUT	Food in good condition, safe & unadulterated		
12	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
13	(IN) OUT N/A	Food separated & protected		
14	(IN) OUT N/A	Food-contact surfaces; cleaned & sanitized		
15	(IN) OUT	Proper disposition of returned, previously served, recondition, unsafe food		

	Compliance Status		C	R
	Potentially Hazardous Food Time/Temperature			
16	IN OUT N/A (N/O)	Proper cooking time & temperature		
17	(IN) OUT N/A (N/O)	Proper reheating procedures for hot holding		
18	(IN) OUT N/A (N/O)	Proper cooling time and temperatures		
19	(IN) OUT N/A N/O	Proper hot holding temperatures		
20	(IN) OUT N/A	Proper cold holding temperatures		
21	IN OUT N/A (N/O)	Proper date marking and disposition		
22	IN OUT (N/A) N/O	Time as a public health control; procedures & record		
	Consumer Advisory			
23	IN OUT (N/A)	Consumer advisory provided for raw or under cooked foods		
	Highly Susceptible Populations			
24	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Chemical			
25	(IN) OUT N/A	Food additives; approved & properly used		
26	(IN) OUT	Toxic substances properly identified, stored & used		
	Conformance with Approved Procedures			
27	(IN) OUT N/A	Compliance with variance, specialized process, & HACCP plan		X
	(IN) OUT N/A	Ventilation adequate in dry storage to maintain ideal temperatures		
	(IN) OUT N/A	Thermometer in dry storage areas		
	(IN) OUT N/A	Locks on all storage areas to prevent pilferage		

Critical X	Item #	Code Reference	Violation Description/Remarks/Corrections
			* HACCP RECORDS CHECK *
X	27	3-201.14	MISSING PARTS OF HACCP REQUIRED PAPERWORK
			HACCP Binder with Food Safety Program.
			Program / Facility Overview + S.O.P.'s
			Food Safety checklist - MANAGEMENT REQUIRES WEEKLY
			WAS DONE FOR JAN, FEB 2020 - HARD TO TELL PRIOR MONTHS
			HACCP REQUIRES AT LEAST ONCE PER MONTH.

Follow-up
Yes 1 No 2

Received by: [signature] Inspected by: [signature]

Nebraska Department of Health and Human Services
PO Box 95026, Lincoln, NE 68509-5026 | 402/471-0903
Distribution: WHITE – Lincoln; YELLOW – Local Office; PINK - Customer

PHA-43 10/2018

After our Food Establishment Inspection Report on 03/12/2020, we were found to be deficient with regards to three logs:

1. Receiving Log
2. Thermometer Calibration Log
3. Damage/Discard Log

These logs were immediately created and put into use. They remain in active use.

3/12/2020

James Orme, Food Service Director — Date