# State of Nebraska Office of Public Counsel/Ombudsman

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## 1ST ANNUAL REPORT

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

March 15, 2021

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#### 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<sup>1</sup> 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. <sup>2</sup> 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.

<sup>&</sup>lt;sup>1</sup> 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.

<sup>&</sup>lt;sup>2</sup> "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.<sup>3</sup> 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

<sup>&</sup>lt;sup>3</sup> "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 dormstyle 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:

STREET ADDRESS,
CITY, ZIP:

Lake Street

Lake Street

667 31st St, Apt 103, 104, 205, 206 Beatrice, NE 68310

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-

#### **PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG #

CITED TAG	# REFERENCED TO THE APPROPRIATE DEFICIENCE)	57112
	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	
K 0225	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.	8/14/202
	Committee on of 14/20 day are used from out to	
	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.	8/7/202
	and it was continued on 6/7/20 that the door will deen within the door will	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	B. THE PROCEDURE FOR INITIAL TOTAL CONTROL OF THE PROCEDURE FOR THE PROCEDURE	
	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.	8/14/202
	Confirmed on 8/14/20 that the door now closes and locenes within the door market	
	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.	8/7/202
	and it was commined on 6/7/20 that the door will later within the door waller	
	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.	8/14/202
	The Facility Maintenance Manager will monitor and ensure compliance.  2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020
	Z. The Facility Maintenance Manager win monitor and ensure compliance.	-,,,
	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.	8/14/2020
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/2020

	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	
K 0321	TO THE CITED DEFICIENCY:	
, U321	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.	8/7/202
	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.	8/7/202
	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	8/14/202
	will latch within the door frame.	0/14/202
	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.	8/7/202
	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.	8/7/202
	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.	8/14/202
	2. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/202
	3. The Facility Maintenance Manager will monitor and ensure compliance.	8/7/202
	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.	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.	

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**BSTA27-TRANSITION APARTMENTS** 3000 LINGOLN BLVD. BEATRICE, NE 68310

DUE BY 8/17/2020 8:00 AM NOT TO EXCEED \$6.00

REGULAR

WO# BETA272066

STATUS COMPLETED

AGENCY

Name

Contact

Mike Baklerson

Address

3000 LINCOLN BLVD. BEATRICE, NE

68310

Phone/E-tnail

Phone

BASIC

DATE CREATED 8/5/2020 7:52 AM

K0305

Interior Repair Fire Marshall - 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, Sleve

Skill

General Maintenance

Mobile

Appointment

N/A

Email

sleve.robertson@nebraska.gov

Start Time

PO#

COMPLETION

REQUIRED SIGNATURE

Work Completed

9/14/2020 1:56 PM

Name (print)

Repair Category/Code

Doors And Look Systems Repaired/replaced door

Signature

Signed

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

#### DETAIL

CATEGORY

DESCRIPTION

QUANTITY

RATE

AMOUNT

Labor

Robertson, Steve - Regular

Labor

Wieden, Dan - Regular



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

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

NEGULAR

WO# BGTA272087 STATUS COMPLETED

AGENCY

Name

Address

3000 LINCOLN BLVD. BEATRICE, NE

68310

Contact

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 hadroom 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** 

Mobile

Email

Skill

General Maintenance

**Appointment** 

N/A

Start Time PO#

COMPLETION

Work Completed

Repair Category/Code

8/14/2020 1:39 PM

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

Labor

Labor

QUANTITY

RATE

THUOMA





**BSTA27- TRANSITION APARTMENTS** #27 3000 LINCOLN BLVD. BEATRICE, NE 60318

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 junitor closel door will not close with positive latch. This door is equipped with a door closer.

ASSIGNMENT

Assigned To

Mobile

**Emall** 

Skill

General Maintenence

Appointment

NA

Start Time

PO#

COMPLETION

REQUIRED SIGNATURE

Work Completed

8/14/2020 1:45 PM

Name (print)

Repair Category/Code

Doors And Lock Systems Repaired/replaced door

Signature

Signed

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

DETAIL

CATEGORY

DESCRIPTION

QUANTITY

RATE

AMOUNT

Labor



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

DUE BY 8/17/2020 8:00 AM

REGULAR

WO# 65TA272089

NOT TO EXCEED \$0.00

STATUS COMPLETED

AGENCY

Name Address

3000 LINCOLN BLVD.

BEATRICE, NE

Contact

Phone/E-mail

Phone

Fax

68310

BASIC

DATE CREATED 8/5/2020 7:58 AM

KOJJS Interior Repair Fire Maishal - Apt. #205: South stainwell door at the tup of the stairs will not close with positive latch. This door is equipped with a door closer. - South jenitor closet door will not close with positive latch. This door is equipped with a door closer. **K631**/

ASSIGNMENT

**Assigned To** Mobile Email

Skill

General Maintenance

Appointment

N/A

Start Time

COMPLETION

REQUIRED SIGNATURE

Work Completed

8/14/2020 1:52 PM

Name (print)

Doors And Lock Systems Repair Category/Code Repaired/replaced door

Signature Signed

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

DETAIL

CATEGORY

DESCRIPTION

QUANTITY

RATE

AMOUNT

Labor

	a		

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

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION 01 - LAKE STREET ICFAD	(X3) DATE SURVEY COMPLETED	
		28G116	B, WING_	_		08/05/2020	
	ROVIDER OR SUPPLIER			ε	STREET ADDRESS, CITY, STATE, ZIP CODE 867-31ST ST. APT 103, 104, 205, 206 BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
K0225	applicable provisions Life Safety Code of the Association. This fact 33, Existing Resident Occupancies of the 2 Fire Protection Association Associatio	o12 Edition of the National inition [NFPA], Chapter 101:  a two story Type II (000) approved on 2013 and is fire alarm.  illed certified beds. At the exensus was 16.  the facility was found to be the requirements for the requirements for the initial at 42 CFR from Fire, and the related on Association (NFPA) addition.  approof Enclosures	К0:	225			
	shall be enclosed with Section 8.3 having resistance rating. Sta 7.2.2.5.3. The entire shall be arranged so the occupants to passiower story unless the spaces on that story	mpt) s a primary means of escape h fire barriers in accordance ng a minimum 1/2-hour fire					
		SUDDITIED REPRESENTATIVE'S SIGNATURE			TITLE		(X8) 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.

Facility ID: ICFDD18

18/2020

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 14 - LAKE STREET ICFID	(X3) DATE SURVEY COMPLETED	
		28G116	B. WING	B. WNG		08.	05/2020
	ROVIDER OR SUPPLIER	667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310			00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K0225	buildings of construct Type III (200), or Type construction shall be prequired fire resistant wall.  1. Stairs that conne only one other story s to the story that is not 2. In Prompt Evacus stair enclosures shall of three or fewer storic an approved automat accordance with 33.2. response or residentia shall be permitted only escape from each sle does not pass through unless that route is se that floor by construct resistance rating. 3. In Prompt Evacus stair enclosures shall of two or fewer stories residents and are prof automatic sprinkler sy 33.2.3.5 that uses qui sprinklers. The require 33.2.2.3.3, 33.2.3.4.6 permitted to be used i 4. In Prompt Evacus three or fewer stories automatic sprinkler sy 33.2.3.5, stairs shall b the topmost story only of escape of which the separated from all por Stairs shall comply with	ion other than Type II (000), a V (000), the supporting protected to afford the arrating of the supported ct a story at street level to shall be permitted to be open at at street level. The attention Capability facilities, not be required in buildings es protected throughout by ic sprinkler system in 3.5 that uses quick all sprinklers. This exception by if a primary means of eping area still exists that in a portion of a lower floor, aparated from all spaces on ion having a 1/2-hour fire attention Capability facilities, not be required in buildings with not more than eight acted by an approved attention approved attention Capability facilities, of protected by an approved attention Capability facilities, of protected by an approved stem in accordance with the permitted to be open at a stairs are a part shall be	КО	225			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - LAKE STREET ICFID		COMPLETED	
		28G116	B. WNG_		<del></del>	08/	05/2020
NAME OF PROVIDER OR SUPPLIER  LAKE STREET ICF/ID			,6	STREET ADDRESS, CITY, STATE, ZIP CODE 167 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310			
(X4) IID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
K0321	be protected against I within the building. 33.2.2.4, 33.2.2.6 This STANDARD is r Based on observation failed to assure fire rawithin the doorframe. Would allow the stainwifer and gasses during would delay egress. I for 24 beds with a cersurvey.  Findings are: Observations on 8-5-revealed: 1. The basement stallatch within the doorframe. Within the doorframe. During an interview of 1:58 pm, Facility Staffailed to latch within the Hazardous Areas - Er CFR(s): NFPA 101  Hazardous Areas - Er 2012 EXISTING (Production of the stand is in or abut, a protection shall be resistance rating of ne self-closing or automatics.	mitted. Exterior stairs shall blockage caused by fire not met as evidenced by: In and interview, the facility sted stair doors latched. This deficient practice wells to be filled with smoke, gran emergency, which he facility has the capacity issus of 16 on the day of 20 at 1:26 pm and 1:58 pm in door failed to close and ame. Buth stair door failed to latch in 8-5-20 at 1:26 pm and f A confirmed the stair doors he frame.	Коз	321			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LAKE STREET ICF/ID			(X3) DATE SURVEY COMPLETED	
		28G116	B. WING	8. WING		08/05/2020	
NAME OF PROVIDER OR SUPPLIER  LAKE STREET ICF/ID					STREET ADDRESS, CITY, STATE, ZIP CODE 567-315T ST, APT 103, 104, 205, 206 BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K0321	protection, in accordar smoke partition, in accordance when the hazardous area or primary escap separation shall be seclosing in accordance. Other hazardous area accordance with 33.2. following:  1. An enclosure have of not less than 1/2 ho automatic-closing doo that is equivalent to not control thick, solid-bonde. 2. Automatic sprinkle with 33.2.3.5, regardle Areas with approved, maintained furnaces a cooking and laundry for hazardous areas solel equipment. Standard response spror use in hazardous at 33.2.3.2.  33.2.2.2.4, 33.2.3.2, 3. This STANDARD is in Based on observation Based on observation deficient practice woulfill with smoke, fire and emergency, which wo facility has the capacit of 16 on the day of sur Findings are:	3/4 hour. e automatic sprinkler nce with 33.2.3.5, and a cordance with 8.4 located us area and the sleeping be route. Any doors in such elf-closing or automatic with 7.2.1.8. us shall be protected in 3.2.5 by one of the sing a fire resistance rating our, with a self-closing or or in accordance with 7.2.1.8 tot less than a 13/4 inch (4.4 did wood core construction. er protection in accordance eass of enclosure. properly installed and and heating equipment, and actilities are not classified as by on basis of such wrinklers shall be permitted areas in accordance with 3.2.3.2.5 of met as evidenced by: and interview, the facility azard area doors would the doorframes. This did allow the exit corridors to did gasses during an uld delay egress. The by for 24 beds with a census	KO	321			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28G116	(X2) MULTIPLE CONSTRUCTION  A. BUILDING O1 - LAKE STREET ICFAD  B. WING		(X3) DATE SURVEY COMPLETED 08/05/2020		
				_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	-
NAME OF PROVIDER OR SUPPLIER  LAKE STREET ICF/ID			667 31ST ST, APT 103, 104, 205, 206  BEATRICE, NE 68310				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR 1		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO T			(XS) COMPLETION DATE	
K0321	device, in the hall of the doorframe.  2. Janitor closet door device in the hall of the doorframe.  3. Janitor closet door device in the hall of the doorframe.  During an interview of and 1:52 pm, Facility	r equipped with closing Unit 103 failed to latch within r equipped with closing Init 104 failed to latch within r equipped with closing Init 205 failed to latch within In 8-5-20 between 1:39 pm Staff A confirmed the janitor latch within the doorframe.	КО	0321			

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/11/2020 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	NSTRUCTION		COMPLETED		
		28G116	B. WING		08	/05/2020		
	ROVIDER OR SUPPLIER		667 :	STREET ADDRESS, CITY, STATE, ZIP CODE 667 31ST ST, APT 103, 104, 205, 206 BEATRICE, NE 68310				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
E 000			€ 000					
	Preparedness regu	ompliance with Emergency plations at E41 [483.73(e)].						
ABORATORY	DIRECTOR'S OR PROVIDE	ERISUPPLIER REPRESENTATIVE'S SIGNATU	IRE	TCFA	8/18/	(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.

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### **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
۸	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD16

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG#

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	
	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.  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.  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.  A monitoring system (internal observation) will be developed to ensure availability and informed choice of eye glasses to enhance vision.  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.  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.  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	
1	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

PRINTED: 08/11/2020 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY O(2) MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER  LAKE STREET ICF/ID  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA  W 436  SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)  The facility must furnish, maintain in good and teach clients to use and to make inform choices about the use of dentures, eyeglas hearing and other communications aids, brand other devices identified by the interdisciplinary team as needed by the clients of the communication of the clients in the communication of the clients interdisciplinary team as needed by the clients of the clients in the clients is not met as evidenced.	STRI 667 BEA  ES ID PREFIX	EET ADDRESS, CITY, STATE, ZIP CODE 316T 6T, APT 103, 104, 205, 206 ATRICE, NE 68310  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	08/06/2020  (X5)  COMPLETION  DATE
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA  W 436  SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)  The facility must fumish, maintain in good and teach clients to use and to make information choices about the use of dentures, eyeglas hearing and other communications aids, brand other devices identified by the interdisciplinary team as needed by the clients.	ES ID PREFIX TAG	316T 6T, APT 103, 104, 206, 206 ATRICE, NE 68310  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
W 436  SPACE AND EQUIPMENT  CFR(s): 483.470(g)(2)  The facility must fumish, maintain in good and teach clients to use and to make inform choices about the use of dentures, eyeglas hearing and other communications aids, brand other devices identified by the interdisciplinary team as needed by the clients.	( FULL PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
CFR(s): 483.470(g)(2)  The facility must furnish, maintain in good and teach clients to use and to make information choices about the use of dentures, eyeglas hearing and other communications aids, brand other devices identified by the interdisciplinary team as needed by the clients.	W 436		
Based on record review, interview and observation, the facility failed to ensure trafor 1 of 1 client (Client 2) who refused to witheir prescribed corrective lenses. This definanciate had the potential to affect all client utilized adaptive or supportive equipment. 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 and 5/13/2020 Individual Support Plan (ISI revealed Client 2 utilized corrective lenses.  Observations throughout the survey (8/3/2) from 4:25pm-6:25pm, 8/5/2020 from 9:30am-9:55am) identified Client 2 failed to their prescriptive eye glasses and when as Client 2 stated they did not have glasses to Interview with Client 2's Coverage Qualifie Intellectual Disability Professional (QIDP) / 8/6/2020 at 11:00am confirmed Client 2 ref	inned isses, praces, ient.  d by:  aining wear efficient nts who ion nt list, sP) s. 2020  to wear sked, to wear. ed A, on efused	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 perticipation.

If continuation sheet Page 1 of 2

Facility ID: ICFDD16

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

08	8/06/2020
D BE	(X5) COMPLETION DATE
L	ION LO BE IPRIATE

PRINTED: 08/11/2020 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ B. WING 08/05/2020 28G116 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 867 31ST ST, APT 103, 104, 205, 206 LAKE STREET ICF/ID BEATRICE, NE 68310 (KB) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) E 000 E 000 | Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].

TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE busehor Any deficiency statement ending with an esterisk (\*) 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 disclosuble 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.

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION  L BUILDING		(X3) DATE SURVEY COMPLETED	
		28G116	B. WING_			08.	/06/2020
	ROWIDER OR SUPPLIER			667 3181	ADDRESS, CITY, STATE, ZIP CODE T 8T, APT 103, 104, 205, 208 CE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DISTICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Health conducted a F 8/3/2020-8/6/2020 in compliance with Federal Z, Emergency Preparation of the incompliance was 1 found to be in compliance was 1	TREE DHHS, Division of Public Recertification survey on order to determine eral regulations at Appendix redness. The facility was ance with regulations. 6 at the time of the survey.	RE	000	TITLE		(XS) DATE
PECINION	10-400 CO	libuschok			ICFA	8/18	8/2020

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.

æ		

### 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

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From: Brandt, Sharon K

Sent: Thursday, December 10, 2020 3:53 PM

To: Urbaschek, Dawn <

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.

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

Sharon.brandtesfm.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

Confidentiality Notice: This e-mail, including attachments if any, is intended for the exclusive use of the person or entity to which it is addressed and may contain confidential or privileged information. All unauthorized dissemenation, distribution or copying of this e-mail is prohibited. If you believe you have received the e-mail in error, please advise the sender by reply email and delete this e-mail immediately. Thank you

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/10/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				AVID INC.	0000-0001	
STATEMENT AND PLAN O				TIPLE CONS		COM	(X3) DATE SURVEY COMPLETED	
		28G116	B. WING				R 26/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
LAKE ST	REET ICF/ID				T ST, APT 103, 104, 205, 206 CE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X CI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE	
{E 000}	Initial Comments		{E 0	00}				
	This facility is in co Preparedness regu	empliance with Emergency elations at E41 [483.73(e)].						
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S S	IGNATURE		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.

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PRINTED: 12/10/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION		E SURVEY		
	FCORRECTION	DENTIFICATION NUMBER:	A, BUILDING 01 - LAKE STREET ICF/ID				COMPLETED		
		28G116	B. WING				R <b>26/2020</b>		
NAME OF F	PROVIDER OR SUPPLIER	250110	1		EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	ZOTZOZO		
	REET ICF/ID				31ST ST, APT 103, 104, 205, 206 ATRICE, NE 68310				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
{K 000}	INITIAL COMMENT  42 CFR 483.470 A revisit survey was ICF/ID on 8/26/20 f cited on 8/5/20. Al corrected, and no n The facility is in cor provisions of Chapt Board and Care Oc of the National Fire		{K 0	00}	DEFIGIENCY)				

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.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

# 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, COMPANY: DATE: January 8, 2020 FAX NUMBER: 402.742.2326 TOTAL PAGES INCLUDING COVER: 3 PHONE NUMBER: PHONE NUMBER:

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

☐ PLEASE REPLY

☐AS REQUESTED

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

Please advise if further information is needed.

FOR REVIEW

Thank You

**URGENT** 

Attached pages within this transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

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
	(V4) becy/inco/supplies/suppli	

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	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	
Ï	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):	
	It was a discolor interesting	
	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	
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	For all individuals residing within Solar Cottages ICF, an IDT assessment will be completed to	
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	needed to ensure compliance.	
	TO THE SAME OF STREET IN THE SAME IT IS SECURED IN	
	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.	

40	
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,
	As stated in the facility policy titled "Emergency Preparedness and Planning "dated 5/20/15,
	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
	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
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	Cherits.
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	completely.
	berng.serj.
	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.	

PRINTED: 01/02/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	0	(3) DATE SURVEY COMPLETED
		ICFDD17	B. WING_			12/17/2019
–	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3082 3066 3060 PET BLV 753 743 723 715 BEATRICE, NE 68310	SOLAR	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
W 249	PROGRAM IMPLEMICFR(s): 483.440(d)(1) As soon as the interd formulated a client's inclient must receive a program consisting of services in sufficient in support the achievem in the individual program.  This STANDARD is in Based on observation review, the facility fail programs were imple individual Support Plathe sample (Client 3) to affect all clients rescensus was 67 at the FINDINGS:  Review of Client 3's lincluded three programs training of the basic signasping and the pick these training program and frequency for impart and frequency for impart of the sample clients and frequenc	isciplinary team has individual program plan, each continuous active treatment if needed interventions and number and frequency to lent of the objectives identified am plan.  Interviews and record led to ensure client training mented as outlined in the lans (ISPs) for 1 of 6 clients in This failure had the potential siding at the facility. Facility time of the survey.  SP, dated 7/3/19, revealed it ms which focused on the kills of making a choice, ling up of items. All three of ms specified the schedule olementation of training e practiced whenever there is	W			
I AROBATORY	to sleep (eyes closed leaning forward or to of time during schedu	the survey identified Client 3 with their head down, the side) a significant period tled daily activities. SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		/ (XS) 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.

PRINTED: 01/02/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(90),000	TE SURVEY MPLETED
		ICFDD17	B. WING	-	1	2/17/2019
.,	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3062 3066 3060 PET BLV 753 743 723 715 SC BEATRICE, NE 68310	LAR	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
W 249	engage Client 3 in a r sleeping and reengag taking place. Specifical 1) Observations on 12 identified Client 3 to a Chapel. From 3:05pm observed to have their leaning forward and timot open their eyes of 35 minutes. Staff A, sc Client 3, did not attent this time.  2) Observations on 12 12:40pm identified Client 3, did not attent this time.  2) Observations on 12 12:40pm identified Client own identified Client own identified Client own identified Client area where a painting Staff B spoke to Client painting but did not proposed and their head leaning when another staff es.  3) Observations on 12 identified Client 3 to be living room, sitting in for The TV was on, but Cotheir eyes closed, with At 4:14pm Staff C entrasked Client 3 if they the evening meal. Client	taff failed to wake Client 3 or nanner that interrupted the ed Client 3 in the activities	W	249		

PRINTED: 01/02/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL*	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		ICFDD17	B. WING			12/17/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3052 3056 3060 PET BLV 753 3 BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRI (CIENCY)	DATE
W 249	4:18pm, Client 3 was area with their eyes of forward. Staff D and Intellectual Disability observed to verbally ithis time and were und. At 4:45pm, Client to rest prior to the every observations on 1:2:00pm identified Client 3:00pm identified Client 3 was observed have their eyes open Staff E was gluing ite sacks. At 11:33am Client 3 was observed their head leaning to yawning. Both Staff E Client 3 by talking dir Client 3's arm and purhand. From 11:34am observed have their seleaning to the right.  Interviews with Staff I 12/12/19 observation room) confirmed Clie and was every difficus sleepy. Staff E stated "through anything". Sto have Client 3 sleep sling and personal call.	observed to be in the kitchen losed and their head hanging Client 3's Qualified Professional (QIDP) were interact with Client 3 during successful in waking Client 3 was taken to their bedroom ening meal.  2/12/19 from 11:30am - ient 3 to be the Pay It Client 3 was at observed to and seated next to Staff E. iens on to small white paper ient 3 was observed to eyes and began to yawn. It is observed to eyes and began to yawn. It is observed to eyes and began to wake et is and Staff F tried to "wake" early to Client 3, rubbing titing an item in Client 3's in 12:00pm, Client 3 was eyes closed with their head.  E and Staff F (during the in the Pay It Forward home in the Pay It Forward home in the was sleepy on most days It to keep awake when I Client 3 could sleep taff F stated it was common in through lift transfers in a	W	249		

PRINTED: 01/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATÉ SURVEY COMPLETED	
	ICFDD17	B. WING_		12/17/2019
NAME OF PROVIDER OR SUPPLIER SOLAR COTTAGES ICF			STREET ADDRESS, CITY, STATE, ZIP CODE 3052 3056 3060 PET BLV 753 743 723 715 SOL BEATRICE, NE 68310	AR
PREFIX (ÉACH DEFICIÉ	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
Solar home and st keep Client 3 awal Client 3 was sleep activities times, sta	idient 3 was new to the 753 aff were still learning how to te. The QIDP confirmed when by or sleeping during scheduled off would not be able to programs in accordance with	Wa		

PRINTED: 01/03/2020 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	100	E SURVEY PLETED
		ICFDD17	B. WING_		12	/17/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3052 3056 3060 PET BLV 753 743 723 715 SO BEATRICE, NE 68310	LAR	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 018	CFR(s): 483.475(b)(2 [(b) Policies and procedure policies and procedure plan set forth in paragand the communication this section. The policies and update (annually for LTC).] A procedures must add [(2) or (1)] A system ton-duty staff and she (facility's) care during staff and sheltered pathe emergency, the (fapecific name and locor other location.  *[For PRTFs at §441. ICF/IIDs at §483.475. Policies and procedulocation of on-duty staff and after an emerger sheltered residents a emergency, the [PRT must document the sthe receiving facility of the procedures.  (ii) Safe evacuation frincludes consideration needs of evacuees; stages and procedures of evacuees; stages and procedures.	edures. The [facilities] must and emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of the sand procedures must be did at least every 2 years at a minimum, the policies and ress the following:]  To track the location of the tered patients in the an emergency. If on-duty stients are relocated during facility] must document the cation of the receiving facility  184(b), LTC at §483.73(b), (b), PACE at §460.84(b):]  Tes. (2) A system to track the aff and sheltered residents in F/IID or PACE] care during frow. If on-duty staff and re relocated during the F's, LTC, ICF/IID or PACE] pecific name and location of or other location.  The at §418.113(b)(6):] Policies from the hospice, which in of care and treatment.	EO			(XS) 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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		ICFDD17	B. WNG	B. WING		12/17/2019	
NAME OF PROVIDER OR SUPPLIER SOLAR COTTAGES ICF				305	REET ADDRESS, CITY, STATE, ZIP CODE 52 3056 3060 PET BLV 753 743 723 715 SOLAR EATRICE, NE 68310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
E 018	transportation; identification(s) and primare communication with eassistance.  (v) A system to track the employees' on-duty a hospice's care during on-duty employees or relocated during the edocument the specific receiving facility or othe tracking facility, and primare communication with eassistance.  *[For OPOs at § 486.3 procedures. (2) A system documentation that procedures. (2) A system documentation that procedures and maintains.  *[For ESRD at § 494.6 procedures. (2) Safe of facility, which includes needs of the patients. This STANDARD is making the tracking failed to implement potential and record revisiting the tracking failed to implement potential and record revisiting the tracking failed to implement potential on the tracking failed to im	cation of evacuation by and alternate means of external sources of the location of hospice and sheltered patients in the an emergency. If the exheltered patients are emergency, the hospice must chame and location of the ner location.  1920(b):] Policies and evacuation from the CMHC, deration of care and treatment that responsibilities; cation of evacuation ry and alternate means of external sources of the serves potential and actual exerces potential and actual exerces confidentiality of conor information, and is the availability of records.	E	018			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		ICFDD17	B, WING			12/17/2019	
NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF				STREET ADDRESS, CI 3052 3056 3060 PET ( BEATRICE, NE 68:	BLV 753 743 723 715 SOLAR		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
E 018	full scale emergency the potential to affect facility and all staff en facility census was 67 Findings: Review of the facility's Preparedness and Pl the policy revealed du testing exercises, the of clients and on-duty transfer locations, and Review of the facility's documents titled, "Ind "Individual Supported (dated 11/04/2019) fa departure and arrival relocation destination to specific clients.  Interview on 12/16/20 Administrator verified was incomplete and f	exercises. This failure has all clients residing at the imployed by the facility. The rat the time of survey.  Is policy titled, "Emergency anning," (dated 05/20/2019) uring an emergency and/or facility will document names a staff, vehicle transportation, id medical needs.  Is Emergency Preparedness cident Action Plan (IAP)" and I Evacuation Tracking Log, "ailed to identify client time, transportation, in, and on-duty staff assigned at 2:15 pm, the lithe evacuation tracking log railed to document the y tracking information for	E	018			

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# NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

January 3, 2020





Pete Ricketts, Governor

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;
- The procedure for implementing the corrective action(s);
- 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;
- 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 - Program Manager II

DHHS Public Health - Licensure Unit

Office of DD and Behavioral Health

Mark Jugar

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

H-	✓ FOR REVIEW	□ PLEASE REPLY	□AS REQUESTED				
PHONE NUMB	ER:	PHON	NE NUMBER: 402.223.6827				
FAX NUMBER:	402,742.8319	TOTAL PAGES INCLUDING COVER: 9					
COMPANY:		DATE	E: January 31, 2020				
TO: DHHS	AcuteCare Facilities	FROM	1: Russell Fralin,				

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

Attached pages within this transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

3000 Lincoln Boulevard Beatrice, NE 68310-3319

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING	B. WING			13/2020
NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF					RESS, CITY, STATE, ZIP CODE 60 PET BLV 763 743 723 715 SOLAR NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 (OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
E 000		pliance with Emergency tions at E41 [483.73(e)].	E	000			
ABOBATODY	DIRECTOR'S OR PROMOCES	SUPPLIER REPRESENTATIVE'S SIGNATUR	₹€		ПТТЕ		(XB) DATE

Any deficiency/statement ending with an asteriek (\*) denotes a deficiency which the inetitution 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.

Event (D; GWJI21

Fadility ID: ICFOD17

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 16 - SOLAR 3052	(X3) DATE COMP	SURVEY PLETED
		ICFDD17	B, WING			01/	13/2020
	ROMIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 1962 3066 3060 PET BLY 753 743 723 716 SOLAR BEATRICE, NE 68310		
(X4) IU PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		к	000			
K0511	the 2012 Edition of the National Fire Protecti is governed by Chapit Board and Care Occord the National Fire P Chapter 101: Life Sat Soler Cottage, 3052 i Type V (000) constru 2011 and is fully sprint. The facility has 12 sk time of the survey the Utilities - Gas and Ek CFR(s): NFPA 101  Utilities - Gas and Ek Equipment using gas complies with NFPA electrical wiring and NPFA 70, National E 32.2.5.1, 33.2.5.1, 9. This STANDARD is Based on observational allowed storage to observational disconnect practice could cause turning off the power emergency. The fact beds with a census of Findings are:	is a single story building of ction that was constructed in nikled.  Illied certified beds. At the a census was 9.  actric  ac	K	<b>:51</b> 11			

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.

Event (D: GWJI21

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (IDENTIFICATION NUMBER: A. BUILDING 06 - SOLAR 3052		300000	(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING			01/13/2020
	ROVIDER OR SUPPLIER OTTAGES ICF			STREET ADDRESS, CITY, STATE 3052 3066 3060 PET BLV 763 1 BEATRICE, NE 68310	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFU TAG	( (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
K0511	contractor ladder street the Electrical room.  During an interview Maintenance Staff A front of the panel both NFPA Standard: 2011 NFPA 70, 65.2 Sufficient access an provided and maintenance of succession of the panel both staff operation and requipment. Where a staff operation and requipment. Where a the minimum clear with the floor or platform; wide (measured par depth shall be as recases, the work spa	oned in front of panel boxes in on 1-13-20 at 12:33 pm, a confirmed the items stored in exes.  6 d working space shall be ained about all electrical ready and safe operation and the equipment.	KO	511		

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ECONSTRUCTION 17 - SOLAR 3056	(X3) DATE COMP	SURVEY LETED
		(CFDD17	B. WING			01/	13/2020
	ROVIDER OR SUPPLIER DTTAGES ICF			3	STREET ADDRESS, CITY, STATE, ZIP CODE 062 3066 3060 PET BLV 753 743 723 715 SOLAR B <b>eatrice, ne</b> 68340		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
K 000	INITIAL COMMENTS  42 CFR 483.470 The facility must meet the 2012 Edition of th National Fire Protecti is governed by Chapit Board and Care Occi of the National Fire P Chapter 101: Life Sat Solar Cottage, 3056 if Type V (000) construe 2011 and is fully spring. The facility has 10 sk time of the survey the 42 CFR 483.470 The with the applicable processing Residential I of the 2012 Edition of	et the applicable provisions of the Life Safety Code of the lon Association. This facility ter 33, Existing Residential upancies of the 2012 Edition protection Association [NFPA], fety Code.  Is a single story building of ction that was constructed in incled.		000	DEFICIENCY		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		_	TITLE		(X6) DATE

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NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF  SOLAR COTTAGES I	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION 16 - SOLAR 3060	(X3) DATE SURVEY COMPLETED	
SOLAR COTTAGES ICF  SOLAR COTTAGES ICF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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  3052 3056 3090 PET BLV 763 743 723 716 SOLAR BEATRICE, NÉ 88910  PROVIDER'S PLAN OF CORRECTION (FACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  K0321  K0321			ICFDD17	B. WNG			01/	13/2020
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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					3	052 3058 2080 PET BLV 753 743 723 716 SOLAR		
as storage and was over 50 square feet and that the facility failed to provide a self-closing device on	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	K0321	as storage and was o the facility failed to pr	ver 50 square feet and that	КО	321			

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PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · ·		CONSTRUCTION 8 - SOLAR 3060	(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING_		<del></del>	01/	13/2020
l	ROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 082 3066 3060 PET BLV 753 743 723 715 SOLAR REATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(%) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
K0321	the 2012 Edition of the National Fire Protection is governed by Chapt Board and Care Occur of the National Fire P Chapter 101: Life Safe Solar Cottage, 3060 in Type V (000) construte 2011 and is fully spring. The facility has 10 sk time of the survey the Hazardous Areas - E CFR(s): NFPA 101.  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous areas and is in or abut, a proseeping room shall be following means:  1. Protection shall be resistance rating of not less than 2. Protection, in accordance with 7.2. rating of not less than 2. Protection, in accordance partition, in accordance partition, in accordance or primary escape roof the National Protection of the Protection of the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition, in accordance with Pazardous primary escape roof the National Resistance partition and Pazardous primary escape roof the National Resistance partition and Pazardous primary escape roof the National Resistance partition and Pazardous primary escape roof the National Resistance page 100 primary escape 100 primary escape pag	s a single story building of ction that was constructed in okled.  illed certified beds. At the econsus was 8. inclosure mpt) that is on the same floor as, firmary means of escape or a se protected by one of the ot less than 1 hour, with a atic closing fire door in 1.8 that has a fire protection	коз	321			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	1	(Xe) DATE

Any deficiency statement ending with an asteriak (\*) 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.

Event ID; GWJI21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - SOLAR 3060	(X3) DATE COMP	SURVEY PLETED
		ICFDD17	B. WING			01/	13/2020
	ROVIDER OR SUPPLIER			30	REET ADDRESS, CITY, STATE, ZIP CODE 52 3056 3060 PET BLY 763 743 723 715 SOLAR EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K0321	accordance with 33.2  1. An enclosure have not less than 1/2 hour automatic-closing docthat is equivalent to nuch thick, solid-bonde  2. Automatic sprinkl with 33.2.3.5, regards. Areas with approved, maintained furnaces a cooking and laundry fit hazardous areas sole equipment. Standard response spuse in hazardous area 33.2.3.2.  33.2.2.2.4, 33.2.3.2, 3  This STANDARD is in Based on observation failed to assure that a installed on a room us deficient practice wou gasses to escape the exit corridor, which we facility has the capacit of 8 on the day of sum. Findings are:  Observations on 1-13 office near the dining room and the door fail device.	with 7.2.1.8.  Its shall be protected in  3.2.5 by one of the following:  ring a fire resistance rating of  r, with a self-closing or  or in accordance with 7.2.1.8  ot less than a 13/4 inch (4.4  od wood core construction.  er protection in accordance  ass of enclosure.  properly installed and  and heating equipment, and  acilities are not classified as  by on basis of such  crinklers shall be permitted for  as in accordance with  3.2.3.2.5  for met as evidenced by:  and interview, the facility  self-closing device was  sed as storage. This  Id allow smoke, fire and  hazard room and enter the  build delay egress. The  ty for 10 beds with a census  vey.  -20 at 1:20 pm revealed the  room was used as a storage  led to provide a self-closing	Ko	321			

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,, , , , ,		E CONSTRUCTION D5 - SOLAR 715	(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING			01/	13/2020
	ROVIDER OR SUPPLIER DTTAGES ICF	·		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3052 3056 3060 PET BLV 753 743 723 715 SOLAR BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X8) COMPLETION DATE
	INITIAL COMMENTS  42 CFR 483.470 The facility must mee the 2012 Editlon of th National Fire Protecti- is governed by Chapt Board and Care Occu of the National Fire P Chapter 101: Life Sal  Solar Cottage, 715 is Type V (000) constru- 2011 and is fully sprir  The facility has 16 sk time of the survey the  42 CFR 483.470 Th with the applicable pr Existing Residential E of the 2012 Edition of	at the applicable provisions of the Life Safety Code of the on Association. This facility ter 33, Existing Residential aparcies of the 2012 Edition rotection Association [NFPA], fety Code.  a single story building of ction that was constructed in inkled.		000	DEFICIENCY)	ATE	
ABOBATORY	DIRECTOR'S OR PROMPER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TILE		(%6) DATE
		C					, ,

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 pien 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.

Event ID: GWJ121

Facility ID: ICFD017

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PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OIVID IN	0. 0000-0001
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	PLE CONSTRUCTION G 04 - SOLAR 723	0.0000	E SURVEY PLETED
		ICFDD17	B. WING_		01	/13/2020
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CODE 3052 3066 3060 PET BLV 763 743 723 716		
SOLAR CO	OTTAGES ICF			BEATRICE, NE 68310	- GOLAN	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		KO	00		
K0211	the 2012 Edition of th National Fire Protecti is governed by Chapi Board and Care Occo of the National Fire P Chapter 101: Life Sat Solar Cottage, 723 is Type V (000) construe 2011 and is fully sprist. The facility has 16 sk time of the survey the Means of Egress - Grand CFR(s): NFPA 101  Means of Escape - Grand Designated means of maintained clear of the facility instant use in the sat of the exit would not implied to assure that the removed from the side the exit would not implied to a capacity of 16 at the time of the survey Findings are:	a single story building of ction that was constructed in akled.  illed certified beds. At the secensus was 11.  seneral  fescape shall be continuously betructions and impediments he case of fire or emergency.  Into the met as evidenced by: In and interview, the facility the snow and ice was lewalks, so that egress from pede it to full instant use in wer emergency. The facility and a census of 11 patients	К02	11		
						NA 8122
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(XB) 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.

Event ID: GWJI21

Facility ID: ICFDD17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING <b>04 - SOLAR 723</b>	(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING		01/1	3/2020
	ROWIDER OR SUPPLIER  OTTAGES ICF			STREET ADDRESS, CITY, STATE, 3052 3056 3060 PET BLV 783 74 BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
K0211	sidewalks from 2 of 2 south patios were covered an interview of Administration Staff A covered sidewalk.  NFPA Standard: 2012 NFPA 101, 7.1.1  Means of egress shall free of all obstructions	exit door on the north and vered with snow and ice. In 1-13-20 at 12:53 pm, I confirmed the snow and ice	ко	211		

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SOLAR 743			(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING_			01/	13/2020
NAME OF PROVIDER OR SUPPLIER SOLAR COTTAGES ICF				30	TREET ADDRESS, CITY, STATE, ZIP CODE 052 3056 3060 PET BLV 753 743 723 715 SOLAR EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(76) COMPLETION DATE
K 000	INITIAL COMMENTS		κo	юо			
K0211	the 2012 Edition of the National Fire Protective governed by Chapter Board and Care Occupied from National Fire Protective Governed by Chapter 101: Life Saff Solar Cottage, 743 is Type V (000) construe 2011 and is fully spring. The facility has 16 sk time of the survey the Means of Egress - George CFR(s): NFPA 101  Means of Escape - George Governed Gov	a single story building of ction that was constructed in aided.  illed certified beds. At the exensus was 9, eneral  eneral  escape shall be continuously betructions and impediments he case of fire or emergency.  not met as evidenced by: n and interview, the facility he snow and ice was ewalks, so that egress from bede it to full instant use in er emergency. The facility and a census of 9 patients at	коз	211			
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATURE			ппе		(X6) DATE

Any deficiency statement ending with an exterisk (\*) 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.

Event ID: GWJI21

Facility ID: 1CFDD17

STATEMENT OF DEPLORENCES  (AC.) PORTOCORNIAMENER  (DEPLOY OF THE COMPTICATION INMERIES  (DEPLOY OF THE COMPTICATION INFO DEPLOY OF THE COMPTICATION INFO D	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  KO211  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							1500 C	
NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  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			ICFDD17	B. WNG			01/	13/2020
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					34	062 3066 3060 PET BLV 783 743 723 716 SOLAR		
sidewalks from 2 of 2 exit door from the north and south patlos 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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP			COMPLETION
	K0211	sidewalks from 2 of 2 south patios were covered an interview of Administration Staff A covered sidewalk.  NFPA Standard: 2012 NFPA 101, 7.1.1 Means of egress shall free of all obstructions	exit door from the north and vered with snow and ice.  In 1-13-20 at 12:35 pm, It confirmed the snow and ice.  If the continuously maintained are impediments to full	КО	211			

PRINTED: 01/24/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SOLAR 753			(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING			01/1	13/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3052 3066 3060 PET BLV 763 743 BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFII TAG	·	ACTION SHOULD B TO THE APPROPRI		(X6) COMPLETION DATE
K 000	INITIAL COMMENTS		к	000			
K0211	applicable provisions Safety Code of the No Association. This fact 33, Existing Resident Occupancies of the 2: Fire Protection Association	a single story building of ction that was constructed in akled.  iilled certified beds. At the census was 9.  eneral  i escape shall be continuously betructions and impediments are case of fire or emergency.  not met as evidenced by: n and interview, the facility he snow and ice was ewalks, so that egress from one or emergency. The facility and a census of 9 patients at	КО	211			

Any deficiency statisment 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.

Event ID: GWJI21

Facility IO: ICFDD17

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 92 <b>- SOLAR 753</b>		(X3) DATE SURVEY COMPLETED	
ICFDD17			B. WING_		0	1/13/2020
NAME OF PROVIDER OR SUPPLIER  SOLAR COTTAGES ICF				STREET ADDRESS, CITY, STATE, ZIF 3052 3066 3080 PET BLV 753 743 3 BEATRICE, NE 68310	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
K0211	sidewalks from 2 of 2 south patios were con During an Interview of Administration Staff Acovered sidewalk.  NFPA Standard: 2012 NFPA 101, 7.1.  Means of egress shall free of all obstructions	exit door on the north and vered with snow and ice. In 1-13-20 at 12:15 pm, confirmed the snow and ice	Ko	211		

## **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

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG #

K 0211		1/13/2020
V ATT	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
	The radiity Maintenance Manager Will Market and Charles and Charles	
	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
	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	1/13/2020
K 0211	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):	

Maintenance was contacted to remove all snow and ice from the sidewalks leading to north and south patios and exit doors of 743 Solar (420) so that egress would not be ided.  BE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN RECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE IT THIS DEFICIENCY:  Facility Maintenance Manager will monitor and ensure compliance.  BE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Facility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD THE CITED DEFICIENCY:	1/13/2020
RECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE ITHIS DEFICIENCY:  Cacility Maintenance Manager will monitor and ensure compliance.  IE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Cacility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	1/13/2020
RECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE ITHIS DEFICIENCY:  Cacility Maintenance Manager will monitor and ensure compliance.  IE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Cacility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	1/13/2020
Eacility Maintenance Manager will monitor and ensure compliance.  IE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Facility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	1/13/2020
IE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Facility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	1/13/2020
PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Facility Maintenance Manager will monitor and ensure compliance.  CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A  RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD  HE CITED DEFICIENCY:	
CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	
RIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD HE CITED DEFICIENCY:	1
	1/13/2020
Maintenance was contacted to remove all snow and ice from the sidewalks leading to orth and south patios and exit doors of 753 Solar (418) so that egress would not be ded.	1/13/2020
E PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
Maintenance was contacted to remove all snow and ice from the sidewalks leading to orth and south patios and exit doors of 753 Solar (418) so that egress would not be ded.	1/13/2020
	1/15/2020
E MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN RECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE I THIS DEFICIENCY:	1
acility Maintenance Manager will monitor and ensure compliance.	1/13/2020
E TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN PLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
acility Maintenance Manager will monitor and ensure compliance.	1/13/2020
CTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A	
	1/13/2020
P	LIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).  Incility Maintenance Manager will monitor and ensure compliance.

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator immediately removed the contractor's ladder from in-front of the	. 5000555
	electrical panel boxes in the mechanical room of 3052 Peterson (416).	1/13/2020
	The second of th	
	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.	




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.

Solar Cottages ICF Page 2 January 22, 2020

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,

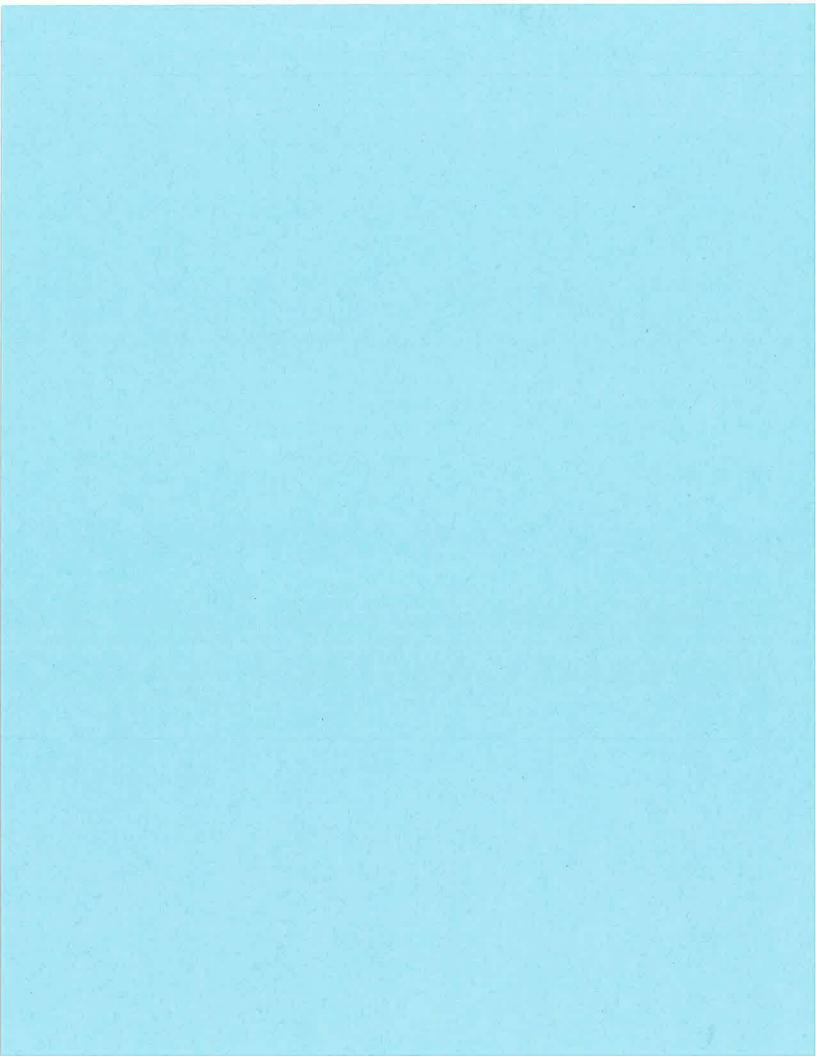
Mark Luger - Program Manager II

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 Penner, Greg From: Friday, March 20, 2020 4:24 PM Sent: Harrison, Corina; Fralin, Russell; Bratt, Julie To: Subject: Fwd: Solar Cottages Revisit Survey with Complaint 3-18-2020 Solar Cottages Revisit 3-18-20.pdf; Solar Cottage Revisit 3-18-2020.pdf; Solar Cottage Attachments: 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 Date: 3/20/20 9:16 AM (GMT-06:00) To: "Penner, Greg" Cc: "Luger, Mark" Subject: Solar Cottages Revisit Survey with Complaint 3-18-2020 PLEASE NOTE: We are moving toward a more paperiess 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: Sincerely,

Tiffany Isley

OFFICE: 402-471-9

Nebraska Department of Health and Human Services

cebook | Twitter | Linkedin



# Pete Ricketts, Governor

DEPT. OF HEALTH AND HUMAN SERVICES

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 - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94986, Lincoln, NE 68509-4986

Mark Juger

Email:



## Good Life. Great Mission.

### DEPT. OF HEALTH AND HUMAN SERVICES

March 20, 2020



Pete Ricketts, Governor

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:

The facility falls 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.

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 - Program Manager II DHHS Public Health - Licensure Unit

Mark Jugar

Office of DD and Behavioral Health PO Box 94986, Lincoln, NE 68509-4986

Email:

PRINTED: 03/19/2020 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		ICFDD17	B. WING			1	₹ 18/2020
NAME OF PE	OVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
601 40 00	TTACED ICE			30	062 3056 3060 PET BLV 753 743 723 715 SOLAR		
SOLAR CO	OTTAGES ICF			В	EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		w	000			
	Health conducted a re 3/18/2020 to the 12/1 determine compliance at 42 CFR 483, Cond Intermediate Care Fa Intellectual Disabilities 66 at the time of the r	ne DHHS, Division of Public evisit on 3/16/2020 through 7/19 Certification survey to e with the federal regulations altitions of Participation for cilities for Individuals with s. The facility census was evisit. The facility was found with these regulations.					
31							

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.

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE

PRINTED: 03/19/2020 FORM APPROVED OMB NO: 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		ICFDD17	B, WNG	B. WNG		R 03/18/2020	
	NOVED OF BUILDING			T 8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	TOTALOZO
NAME OF P	ROVIDER OR SUPPLIER				062 3066 3060 PET BLV 753 743 723 715 SOLAR		
SOLAR CO	OTTAGES ICF			1	EATRICE, NE 68310		
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E 000	Initial Comments  Representatives of the Health conducted a realth conducted a realth conducted and 3/18/2020 to the 12/1 order to determine configurations at Appendic Preparedness. The fatime of the revisit. The deficiencies were confound to be in compliant.	ne DHHS, Division of Public evisit on 3/16/2020 through 7/19 Certification survey in impliance with Federal dix Z, Emergency acility census was 66 at the expression previously cited rected and the facility was ance with regulations.	E	000	TITLE		(X6) DATE
LABURATURY	PINEC LOKA OK KKONIDEKS	SUPPLIER REPRESENTATIVE'S SIGNATUR	-		****		15-17)

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.

Event ID: GWJ112

PRINTED: 03/19/2020 FORM APPROVED

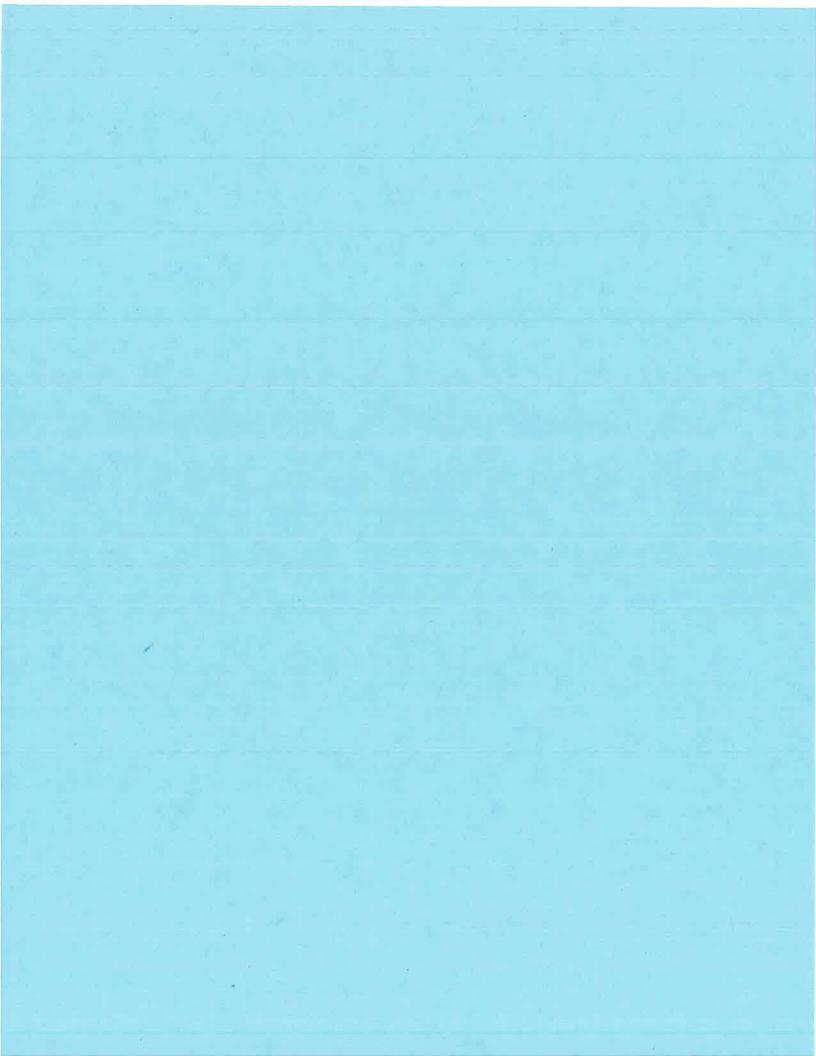
CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-03					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING				/18/2020			
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE				
SOLAR COTTAGES ICF					2 3066 3060 PET BLV 753 743 723 715 SOLJ Atrice, ne 68310	AR .			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRĒFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(XS) 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		W	000					
	Certification survey to The facility census wa	determine compliance, as 66 at the time of the s found to be in compliance							

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XB) DATE



## NEBRASKA

Good Life, Great Mission.

### DEPT. OF HEALTH AND HUMAN SERVICES

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.

Pete Ricketts, Governor

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:

PRINTED: 09/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		20/2144				С		
28G114  NAME OF PROVIDER OR SUPPLIER			B. WIING	STREET ADDRESS, CITY, STATE, ZIP CODE			09/23/2020	
					052,3054,3056,3060 PET BLV 753,743,723,715 SOI	.DR		
SOLAR C	OTTAGES			벼	EATRICE, NE 68310			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		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.							

Any deficiency statement ending with an esterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XII) DATE

# DHHS Public Health – Licensure Unit C. State Building Surveys

Attachment B3



### Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

March 4, 2020



Pete Ricketts, Governor

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 guldelines, 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

Mark Jugar

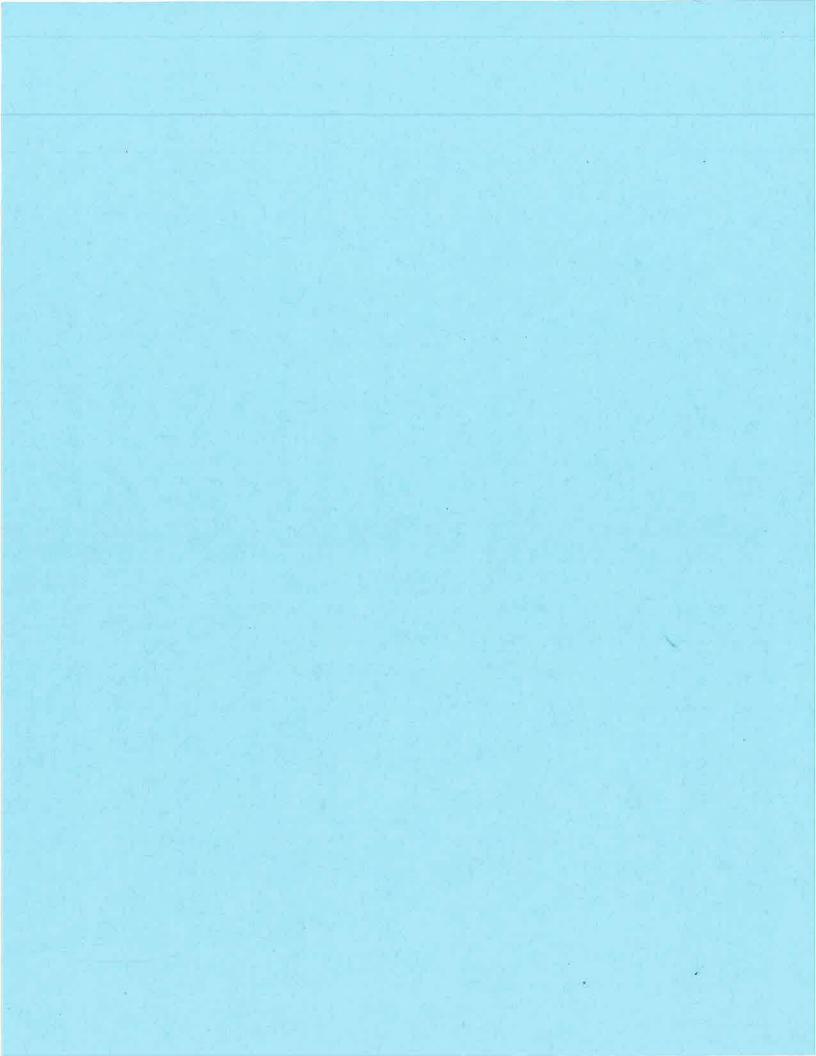
PO Box 94986, Lincoln, NE 68509-4986

Email:

PRINTED: 03/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
					С			
28G107			B. WING	B. WING			03/03/2020	
NAME OF PROVIDER OR SUPPLIER  400 STATE BUILDING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETION DATE	
W 000	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		w	000	DEPIGENCY			
LABORATORY I	DIRECTOR'S OR PROVIDER/S	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,  COMPANY:  DATE: March 5, 2020  TOTAL PAGES INCLUDING COVER: 10  PHONE NUMBER:  PHONE NUMBER:	- IIR	GENT	✓ FOR REVIEW	□ PLEASE REPLY	☐AS REQUESTED
COMPANY:  DATE: March 5, 2020	PHON	E NUMBER	i.	PHON	NE NUMBER:
COMPANY:	FAX N	UMBER:		TOTA	AL PAGES INCLUDING COVER: 10
TO: DHHS AcuteCare Facilities FROM: Russell Fralin,	COMP	ANY:		DATE	E: March 5, 2020
Control of the Contro	TO:	DHHS Ac	uteCare Facilities	FROM	A: Russell Fralin,

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

Attached pages within this transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

3000 Lincoln Boulevard Beatrice, NE 68310-3319

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### **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-	4\$E121

#### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG #

CITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	DI 112
3070 State		
	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	
K0321	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	2/21/2020
	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
	of the and security completed the historical security of the	
	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
	The Facility Maintenance Manager will thomself did about 000000000000000000000000000000000000	
400 State		
	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	
КО200	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	2 /22 /222
	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	2/11/2020
	the east slide lock was removed on 2/11/20.	2, 11, 2020

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	B. THE PROCEDURE FOR HAIF ELIMENTING THE CONNECTIVE ROTTONIO).	
	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.	2/20/202
	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.	2/11/202
	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.	2/20/202
	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).	
	The Facility Maintenance Manager will monitor and ensure compliance.	2/20/202
	2. The Facility Maintenance Manager will monitor and ensure compliance.	2/11/202
	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	
K0222	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	2/20/202
	door.	2,20,202
	8. 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.	2/20/202
	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
	The Fucility Multicondition to an age.	
	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
	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	
K0321	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	2/11/2020
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.	2/10/2026
	2/10/2020
2. The entry rug was moved immediately by the Safety Coordinator to allow the hallway door	2//0/2026
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	- 4 4
Home Managers were notified of the deficiency.	2/10/2020
s A and and an annual submitted to the Maintenance Department to install a deer closer on the	
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.	2/11/2020
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	0/44/2020
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
a door closer has been installed and the door will close with positive laten.	2,12,2020
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).	
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	2/10/2020
	monitor and ensure compliance.	2/11/2020
	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
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A	
коз53	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 Shoridan		
200 Sheridan	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	
K0321	TO THE CITED DEFICIENCY:  1. A work order was submitted to the Maintenance Department to repair/adjust the 2nd floor	
	1. A work order was submitted to the Maintenance Department to repair/adjust the 2nd most	
	shower room door that failed to close and latch properly. It was confirmed on 2/26/20 that	2/26/2020
	the door will close and latch properly.	2, 20, 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	2/26/2020
	and latch properly.	2/20/2020

	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:	
	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).	
	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	ALONG WITH A	
	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	
K0321	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.	- 10 - 10 - 00
		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
		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.	2/26/2020
	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		
козоо	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:	
ROSOO	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).	
	ICANOPEIANCE WITH THE CITED DEFICIENCY (LVV NV) WIS 34FIT HOWAY!	

	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	
(0511	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.	2/28/202
	electrical pariet boxes were not obstructed.	
	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.	2/28/202
	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.	2/28/202
	The raciney manifestance manager was	
	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		
D Bullunig	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A	
V0224	DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
K0321	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.	2/26/202
	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
	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	
K0511	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	2/21/2020
	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.	2/21/202
	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:	2/21/2020
	The Facility Maintenance Manager will monitor and ensure compliance.	2/22/202
	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.	2/21/202
Admin		
Building		
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A	
1	DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD	
K0321	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
	THE PROCESSION FOR MAIN CHARACTERS THE CORRECTIVE ACTIONICS.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

- <del>,                                   </del>	
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	
	2 /25 /202/
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
A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A	
that were removed by contractors be replaced/installed. It was confirmed on 3/2/20 that the	
	3/2/2020
eem 8 mer na a na	
B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
A work order was submitted to the Maintenance Department requesting that the celling 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	
	3/2/2020
D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN	
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.	_
	_
	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.  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.  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.  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.  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.  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.

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PRINTED: 02/26/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 12 - 3070 STATE AVENUE			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/10	0/2020
NAME OF PE	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
400 STATE	BUILDING			3104, 3070, 3071 STATE AVE BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K	000			
	applicable provisions Safety Code of the No Association. This fact 33, Existing Resident Occupancies of the 2 Fire Protection Association Life Safety Code.  400 State Building - 3 building of Type V co 1970 and is fully spring	2012 Edition of the National ciation [NFPA], Chapter 101: 3070 State is a single story natruction that was built in					
K0321	the survey the census 400 State Building - 3 not in compliance wit participation in Medic 483.470 Life Safety t National Fire Protecti Standard 101 - 2012 Hazardous Areas - E CFR(s): NFPA 101  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous area; and is in or abut, a pre	s was 8 residents.  3070 State was found to be the the requirements for the real state of the related from Fire, and the related from Association (NFPA) edition.  Inclosure  In	ко	121			
LABORATORY	sleeping room shall be following means:  1. Protection shall be resistance rating of nearest-closing or automaccordance with 7.2.	be protected by one of the be an enclosure with a fire not less than 1 hour, with a atic closing fire door in 1.8 that has a fire protection		ππε		(X	(6) 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 80 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.

Tubrochek

Facility ID: ICFMR07

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 12 - 3070 STATE AVENUE			(X3) DATE SURVEY COMPLETED				
		28G107	B. WING			02/	02/10/2020	
	ROMDER OR SUPPLIER E <b>BUILDING</b>				STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K0321	rating of not less than 2. Protection shall be protection, in accorda smoke partition, in accordance or primary escape rouseparation shall be sectosing in accordance. Other hazardous area accordance with 33.2.  1. An enclosure have not less than 1/2 hour automatic-closing docthat is equivalent to norm) thick, solid-bonde. 2. Automatic sprinkl with 33.2.3.5, regardle Areas with approved, maintained furnaces accooking and laundry finazardous areas sole equipment. Standard response spuse in hazardous area 33.2.3.2.  33.2.2.2.4, 33.2.3.2, 3. This STANDARD is not be accorded to provide a smith parameter as to set the facility. This definant amoke to migrate the exit corridor which facility census was 8. Findings are:	a 3/4 hour.  The automatic sprinkler ince with 33.2.3.5, and a cordance with 8.4 located us area and the sleeping area afte. Any doors in such aff-closing or automatic with 7.2.1.8.  The shall be protected in 1.3.2.5 by one of the following: ring a fire resistance rating of the cordance with 7.2.1.8 at less than a 13/4 inch (4.4 and wood core construction. The protection in accordance are protection in accordance are properly installed and and heating equipment, and acilities are not classified as by on basis of such prinklers shall be permitted for as in accordance with	КО	321				

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 12 - 3070 STATE AVENUE			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	10/2020
	ROVIDER OR SUPPLIER E BUILDING			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1404, 2070, 3074 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				(XB) CUMPLETION DATE
KD321	The south fire rate mechanical room and self-closing device fai the doorframe.  During an interview of		ко	321			

		e e
6		

PRINTED: 02/26/2020 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING 02 - 400 STATE BUILDING AND PLAN OF CORRECTION 02/10/2020 B. WNG 28G107 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3104, 3070, 3071 STATE AVE 400 STATE BUILDING BEATRICE, NE 68310 (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K DOD 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. K0200 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 (X6) DATE TITLE

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.

moch

Facility ID: ICFMR07

TCFA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ADDITION NUMBER: A BUILDING 02 - 400 STATE BUILDING			(X3) DATE SURVEY COMPLETED			
		28G107	B. WING			02/	10/2020
	ROVIDER OR SUPPLIER E <b>BUILDING</b>				STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRYCE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K0200	from the exit doors an locks were not used. delay agress in the exit facility census was 100 Findings are:  Observations on 2-10 revealed:  1. Four of four living the exits, the magnetic been removed from the 2. A slide lock on 2 or between rooms 3 and During an interview or pm, Facility Staff A counter slide locks.	xit buttons were removed and failed to assure that slide. This deficient practice would went of an emergency. The last slide.  -20 at 1:54 pm and 2:24 pm units provided exit buttons at cally locked function had be door.  f 2 doors for the restroom		200			
K0222	1. Doors complying permitted. 2. Doors within indivicements shall be permited. 3. No door in any mithose complying with against egress when 4. Delayed-egress if 7.2.1.6.1 shall be permited. 4. Access-controlled accordance with 7.2.1	ress shall be as follows:  with 7.2.1 shall be  ridual rooms and suites of ted to be swinging or sliding, eans of egress, other than (4) or (5), shall be locked the building is occupied, ocks in accordance with mitted.	KU	222			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 400 STATE BUILDING		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/10/2020	
	ROVIDER OR SUPPLIER E BUILDING			STREET ADDRESS, CITY, STATE 3104, 3070, 3071 STATE AVE BEATRICE. NE 68310	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)	I DATE	
K0222	latching hardware ampermitted. Lockups at regulation. 33.3.2.2.2, 33.3.2.11.  This STANDARD is in Based on observation failed to assure that the door signage was appractice would cause during an emergency.  Findings are: Observations on 2-10 delayed egress signated 406, the magnetic local functional.  During an interview of Staff A confirmed the signage posted on the not functional.  Emergency Lighting CFR(s): NFPA 101  Emergency Lighting 2012 EXISTING (Proferegency lighting in provided in facilities we capability having mor room has a direct exit at finished ground leving 33.3.2.9  This STANDARD is in the signage posted on the si	the provided with positive of roller latches are not be not permitted by 2, 42 CFR 483.470 and met as evidenced by: In and interview, the facility the magnetically locked exit propriate. This deficient confusion and delay egress. The facility census was 10.  10-20 at 2:38 pm revealed, ge on the exit door for unit the kind been removed and not an 2-10-20 at 2:38 pm, Facility exit door had delayed egress a door and the magnet was a door and the magnet was accordance with 7.9 shall be with prompt or slow evacuation at than 25 rooms, unless each at to the outside of the building	Коз				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D2 - 400 STATE BUILDING	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02	/10/2020
	ROVIDER OR SUPPLIER  E BUILDING			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) IID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K0291	failed to maintain eme stainway. The deficiel operation of the light of that could delay egree facility census was 10	ergency light in the basement int practice would not ensure upon loss of normal power as during an emergency. The	КО	1291			
	emergency light in the Office, failed to operal depressed.  During an interview or	20 at 2:02 pm revealed the shall on first floor near Nurse lite when the test button was an 2-10-20 at 2:02 pm, Facility nonfunctioning emergency					
K0321	Hazardous Areas - Er CFR(s): NFPA 101  Hazardous Areas - Er 2012 EXISTING (Pror Rooms containing hig refrigerating machiner service equipment sul shall not be located us such rooms shall be e other parts of the build 8.7.  Hazardous areas shall construction of a minimuith openings protected or have an automatic smoke partition in accidization areas shall the following: boiler or	inclosure mpt and Slow) gh-pressure boilers, ry, transformers, or other bject to possible explosion inder or adjacent to exits. All effectively separated from ding as specified in section will be separated with imum of 1-hour fire resistance ited with self-closing fire doors extinguishment system and cordance with 8.4. It include but not be limited to r heating rooms, laundries, storing combustibles in	KO	3321			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1. /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 400 STATE BUILDING				(X3) DATE SURVEY COMPLETED	
	7.	28G107	8. WING		02/	10/2020		
	ROVIDER OR SUPPLIER E BUILDING			310	REET ADDRESS, CITY, STATE, ZIP CODE 14, 3070, 3071 STATE AVE ATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL! LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE .	(XS) COMPLETION DATE	
K0321	Based on observation failed to provide a smith azardous areas to sith efacility. This definand smoke to migrate the exit corridor which facility census was 7.  Findings are: Observation on 2-10-pm revealed: General Area  1. The fire rated Conwith a self-closing dechair. 2. A rug obstructed to Conference Room, with a self-closing device fail doorframe. Unit 402 3. The Medication roself-closing device, with 408 4. The south west Orroom and the facility is device on the door. 5. The Laundry Room self-closing device, fail doorframe. Unit 408 6. Room 5, was used facility failed to provide door.	not met as evidenced by: on and interview, the facility noke resistant enclosure for eparate them from the rest of cient practice would allow fire a out of the hazard areas into h could delay egress. The	Ko	321				

	OF DEFICIENCIES CORRECTION	(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 400 STATE BUILDING			SURVEY PLETED
		28G107	B, WING			02	/10/2020
	RÖVIDER OR SUPPLIER E BUILDING			3	TREET ADDRESS, CITY, STATE, ZIP CODE 1104, 3070, 3071 STATE AVE BEATRICE, NE 68310		s
(X4) IÓ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Æ	(XS) COMPLETION DATE
K0321 K0353	and 2:46 pm, Facility findings.			321 353			
	CFR(s): NFPA 101  Sprinkler System - Ma 2012 EXISTING (Proi Automatic sprinkler arinspected, tested, and with NFPA 25, Standa and Maintaining of Wa Systems. Records of maintenance, inspectimaintained in a securavailable.  a) Date sprinkler system b) Who provided systems. Based on observation failed to assure that fill foreign material. This affect the operating tesprinklers and increas sprinkler system would during a fire. The facil Findings are: Observation on 2-10-21. Sprinkler to the left door was covered in fee	sintenance and Testing mpt and Slow) and standpipe systems are if maintained in accordance and for the Inspection, Testing ster-based Fire Protection system design, ion and testing are e location and readily stem was last checked stem test  oply  7, 8.7.8, NFPA 25 of met as evidenced by: and interview, the facility are sprinklers were free of deficient practice would imperature of the fire and the potential that the difficient practice as designed ity census was 7.					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 02 - 400 STATE BUILDING		COMPLETED	
- 5		28G107	B. WING_		02/	10/2020	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 3104, 3070, 3071 STATE AVE REATRICE, NE 68310	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI						
коз53	Continued From page		+		=#/ ( <b>4</b> %)		

2	v		
9	e		
e e	State or any season		

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	ON CONTRACTOR OF THE PROPERTY		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 03 - 200 SHERIDAN NON-RES (X9) DATE SURVEY					
l			28G107	B. WANG			02	10/2020
	,,,	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(KB) COMPLETION DATE
	K 000	INITIAL COMMENTS		K	000			
	K0321	applicable provisions Safety Code of the Na Association. This fac 39, Existing Business Edition of the National [NFPA], Chapter 101: 400 State Building - 2 building of Type II cor in 2002 and is fully sp 400 State Building - 2 not in compliance with participation in Medic 483.470 Life Safety to National Fire Protects Standard 101 - 2012 Hazardous Areas - E CFR(s): NFPA 101  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous area to and is in or abut, a prospection shall to resistance rating of re- self-closing or automatic accordance with 7.2.1 rating of not less than 2. Protection shall to protection, in accordance which records smoke partition, in accordance with in accordance with records smoke partition, in accordance with recordance	200 Sheridan is a two story instruction that was approved brinkled. 200 Sheridan was found to be in the requirements for are/Medicaid at 42 CFR from Fire, and the related on Association (NFPA) edition. Inclosure mpt) that is on the same floor as, imary means of escape or a see protected by one of the one an enclosure with a fire of less than 1 hour, with a stic closing fire door in 1.8 that has a fire protection in 3/4 hour. The same automatic sprinkler ance with 33.2.3.5, and a ecordance with 8.4 located	Ka	321			OWN DATE
L	ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(XIS) 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 citad, an approved plan of correction is requisite to continued program participation.

Event ID: 4SE121 Fedity ID: ICFMR07

TCFA

3-5-20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 03 - 200 SHERIDAN NON-RES			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING_		02/	110/2020	
	ROVIDER OR SUPPLIER E BUILDING			STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE	
K0321	or primary escape rouseparation shall be secondance of their hazardous area accordance with 33.2.  1. An enclosure have not less than 1/2 hour automatic-closing doc that is equivalent to nome thick, solid-bonde 2. Automatic sprinkle with 33.2.3.5, regardle Areas with approved, maintained furnaces a cooking and laundry finandard response spuse in hazardous area 33.2.3.2.  33.2.2.2.4, 33.2.3.2, 3 This STANDARD is not Based on observation failed to assure the dollatch within the doorfor would allow fire, smooth the exit corridor.  Findings are:  Observation on 2-10-2 pm revealed:  1. 2nd floor Staff Sho with a self-closing deviation the doorframe.  2. The fire rated door	us area and the sleeping area ate. Any doors in such slf-closing or automatic with 7.2.1.8. In shall be protected in 3.2.5 by one of the following: ring a fire resistance rating of each of each of the ring and heating equipment, and acilities are not classified as ly on basis of such or rinklers shall be permitted for as in accordance with	к03	21	8.5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION (X3) DATE SUF LDING 93 - 200 SHERIDAN NON-RES COMPLET			
		28G107	B. WING			02/	10/2020
	ROVIDER OR SUPPLIER			3104, 3	TADDRESS, CITY, STATE, ZIP CODE 1970, 3071 STATE AVE RICE, NE 68310		
(X4) ID PREPIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		(X5) COMPLETIUM DATE
K0321	crawl space failed to pand the failed to close  During an interview o	thin the frame. r to the non-sprinkled south provide a self-closing device	ко	321			

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						e.	

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - CHAPEL NON-RES	(X3) DATE	SURVEY
		28G107	B. WING_			02	10/2020
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 14, 3070, 3071 STATE AVE		
400 STATE	BUILDING			BE	ATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATFMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
К0300	applicable provisions Safety Code of the N Association. This fac 13, Assembly Occupi the National Fire Prot Chapter 101: Life Saf 400 State Building - 0 building of Type V co in 2002 and is not sp 400 State Building - 0 compliance with the r in Medicare/Medicaid Safety from Fire, and	Chapel is a single story nstruction that was approved	Ko	300			
	CFR(s): NFPA 101  Protection - Other 2012 EXISTING List in the REMARKS 33.2.3 Protection reg addressed by the pro- deficient. This inform applicable Life Safety citation, should be in- This STANDARD is Based on record rev failed to conduct mor extinguisher. This co- potential that a fire ex- operate during a fire.	y Code or NFPA standard cluded on Form CMS-2567. not met as evidenced by: iew and interview, the facility athly inspections of the fire andition increased the atinguisher would fail to					(VEL DATE
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.

Event ID: 45E121

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING 06 - CHAPEL NON-RES 28@107 B. WING 02/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE 400 STATE BUILDING BEATRICE, NE 68310 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K0300 | Continued From page 1 K0300 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. K0511 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

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER 400 STATE BUILDING  SUMMANY STATEMENT OF DEPICIENCIES  OVA ID PROVIDER FLAN OF CORRECTION REGOLATIONY OR LSC IDENTIFYING INFORMATION)  K0511  Continued From page 2 pm, Facility Staff A confirmed the items obstructing the panel boxes.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NNG 06 - CHAPEL NON-RES	O	X3) DATE SURVEY COMPLETED
400 STATE BUILDING  3104, 3070, 3071 STATE AVE BEATRICF, NF 68310  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K0511  Continued From page 2 pm, Facility Staff A confirmed the items			28G107	B. WING			02/10/2020
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K0511  Continued From page 2 pm, Facility Staff A confirmed the items					3184, 3878, 3871 STATE AVE		
pm, Facility Staff A confirmed the items	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AL	HOULD BE	COMPLETION
		Continued From page	e 2 infirmed the items	КО			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) NULTIPLE CONSTRUCTION (X3) DATE SURVE  A BUILDING 04 - CARSTENS CENTER- NON-RES COMPLETED					
		28G107	B. WNG			02	/10/2020
	ROVIDER OR SUPPLIER E BUILDING			31	REET ADDRESS, CITY, STATE, ZIP CODE 04, 3076, 3071 STATE AVE EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
K 000	K 000 INITIAL COMMENTS		к	000			
K0321	applicable provisions Safety Code of the N. Association. This fact 13, Assembly Occupithe National Fire Prof Chapter 101: Life Safe 400 State Building - County building of Type II con in 2002 and is fully sp 400 State Building - Con in 2002 and is fully sp 400 State Building - Con in compliance with the participation in Medic 483,470 Life Safety in National Fire Protecti Standard 101 - 2012 Hazardous Areas - E CFR(s): NFPA 101  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous area in and is in or abut, a pr sleeping room shall be following means:  1. Protection shall be resistance rating of no self-closing or autom accordance with 7.2. rating of not less than 2. Protection, in accordance	Carstens is a single story instruction that was approved prinkled.  Carstens was found to be not e requirements for are/Medicaid at 42 CFR from Fire, and the related on Association (NFPA)  Inclosure Inclosu	КО	321			
LABORATORY		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:	1 ' '	ULTIPLE CONSTRUCTION (X3) DATE SU  LDING 04 - CARSTENS CENTER- NON-RES COMPLET			
		28G107	e, WING	_		02	10/2020
	ROVIDER OR SUPPLIER E <b>BUILDING</b>			3'	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE JEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K0321	or primary escape rouseparation shall be secondance. Other hazardous area accordance with 33.2.  1. An enclosure have not less than 1/2 hour automatic-closing doc that is equivalent to not that is equivalent to not the secondary of the secondar	us area and the sleeping area ute. Any doors in such elf-closing or automatic with 7.2.1.8. It is shall be protected in 3.2.5 by one of the following: ving a fire resistance rating of cr., with a self-closing or or in accordance with 7.2.1.8 ot less than a 13/4 inch (4.4 ed wood core construction. Her protection in accordance less of enclosure.  properly installed and and heating equipment, and facilities are not classified as ly on basis of such prinklers shall be permitted for as in accordance with	Ко	321			

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 04 - CARSTENS CENTER- NON-RES			(X3) DATE SURVEY COMPLETED	
		28G107	p. WNG			02/	10/2020
	ROMDER OR SUPPLIER			31	REET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE FATRICF, NF 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K0321	Continued From page within the doorframe.	2		321	DEFICIENCY		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		E CONSTRUCTION DE - D BLDG NON-RES	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			0:	2/10/2020
	ROVIDER OR SUPPLIER B <b>UILDING</b>			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1904, 3070, 3071 STATE AVE SEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) LUMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
K0321	applicable provisions Safety Code of the Na Association. This fac 39, Existing Business Edition of the Nationa [NFPA], Chapter 101: 400 State Building - E building of Type II cor in 2002 and is fully sp 400 State Building - E not in compliance with participation in Medic 483.470 Life Safety if National Fire Protecti Standard 101 - 2012 Hazardous Areas - E CFR(s): NFPA 101  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous area: and is in or abut, a pr sleeping room shall is following means: 1. Protection shall is resistance rating of n self-closing or autom accordance with 7.2. rating of not less than 2. Protection, in accordance	D Building is a three story instruction that was approved prinkled.  D Building was found to be in the requirements for are/Medicaid at 42 CFR from Fire, and the related on Association (NFPA) edition.  Inclosure inclosure in the same floor as, rimary means of escape or a see protected by one of the oteless than 1 hour, with a atic closing fire door in 1.8 that has a fire protection	K0:	321			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	_	(X6) DATE

Any deficiency statement ending with an asterlask (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other antequarks provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90

Any desicency statement enough with an abbitant ( ) desicus a desicustion.) 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION DIBLOG NON-RES	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	/10/2020
	ROMDER OR SUPPLIER E BUILDING			3104,	ET ADDRESS, CITY, STATE, ZIP CODE 3070, 3071 STATE AVE TRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
K0321	between the hazardous or primary escape rot separation shall be seclosing in accordance Other hazardous area accordance with 33.2.1. An enclosure have not less than 1/2 hour automatic-closing doc that is equivalent to norm thick, solid-bonde 2. Automatic sprinkl with 33.2.3.5, regardle Areas with approved, maintained furnaces a cooking and laundry finazardous areas sole equipment. Standard response spuse in hazardous areas 33.2.3.2.  33.2.3.2.3.2.3.2.3.2.3.2.3.2.	us area and the sleaping area ute. Any doors in such elf-closing or automatic with 7.2.1.8, as shall be protected in 3.2.5 by one of the following: ving a fire resistance rating of r, with a self-closing or or in accordance with 7.2.1.8 ot less than a 13/4 inch (4.4 ed wood core construction. Her protection in accordance ess of enclosure. properly installed and and heating equipment, and facilities are not classified as ely on basis of such prinklers shall be permitted for as in accordance with 33.2.3.2.5 not met as evidenced by: In and interview, the facility oke resistant enclosure for separate them from the rest of cient practice would allow fire a out of the hazard areas,	KO	321			

CENTERS FOR MEDICARE & MEDICAID SERVICES

<b>-</b>	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 06 - D BLDG NON-RES			COMPLETED	
		28G107	B. WING			02/10/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3104, 3070, 3071 STATE AVE REATRICE, NE 68310	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD B THE APPROPRIA		
K0321	pm, Facility Staff A codor was not operating. Utilities - Gas and Electrical wiring and electrical electrical electrical electrical energency. Findings are:  Observations on 2-10 electrical panel box Delectrical room was electrical room was electrical operations on and the puring an interview of the codor of the	ectric ectric ectric ectric ectric ectric er related gas piping equipment complies with ectric Code. 1.1, 9.1.2 ent met as evidenced by: en and interview, the facility expace in front of electrical expractice could cause a delay end off the power during an expression of the pow		321 511			

PRINTED: 02/26/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR AND PLAN OF CORRECTION (X2) MULTIPLE CONSTR A BUILDING 10 - ADMIN		CONSTRUCTION 0 - ADMINISTRATION BLDG NON-RES	(X3) DATE COMP	SURVEY PLETED		
		28G107	B, WING		4.	02/10/2020	
' '	ROWDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE NFATRICF, NF 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
K0321	applicable provisions Safety Code of the N. Association. This fac 39, Existing Business Edition of the Nationa [NFPA], Chapter 101: 400 State Building - A building of Type II co in 2002 and is fully sp 400 State Building - A be not in compliance participation in Medic 483.470 Life Safety ( National Fire Protecti Standard 101 - 2012 Hazardous Areas - E CFR(s): NFPA 101  Hazardous Areas - E 2012 EXISTING (Pro Any hazardous area and is in or abut, a pr sleeping room shall to following means: 1. Protection shall to resistance rating of m self-closing or autom accordance with 7.2. rating of not less than 2. Protection, in accordance	Administration is a two story instruction that was approved prinkled.  Administration was found to with the requirements for sare/Medicaid at 42 CFR from Fire, and the related on Association (NFPA) edition.  Inclosure mpt) that is on the same floor as, rimary means of escape or a see protected by one of the protected by one of the ot less than 1 hour, with a atic closing fire door in 1.8 that has a fire protection	Kos	321			
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 ere 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.

Event ID:4SE121

CENTERS FOR MEDICARE & MEDICAID SERVICES

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/BUPPLIER/CUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 10 - ADMINISTRATION BLDG NON-RES		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING	_		02	/10/2020
	NAME OF PROVIDER OR SUPPLIER  400 STATE BUILDING			1	STREET ADDRESS, CITY, STATE, ZIP CODE 3164, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K0321	or primary escape rouseparation shall be seclosing in accordance. Other hazardous area accordance with 33.2.  1. An enclosure have not less than 1/2 hour automatic-closing doc that is equivalent to not more thick, solid-bonded. Automatic sprinkly with 33.2.3.5, regardled Areas with approved, maintained furnaces a cooking and laundry finazardous areas sole equipment. Standard response spuse in hazardous area 33.2.3.2.  33.2.2.2.4, 33.2.3.2, 33.2.3.2.3.2.  This STANDARD is in Based on observation failed to assure the doself-closing. This deficitie, smoke and gasse corridor.  Findings are: Observation on 2-10-2.  The 1 ½ hour fire in Computer Lab failed to device.  During an interview or	us area and the sleeping area ate. Any doors in such off-closing or automatic with 7.2.1.8. Its shall be protected in 3.2.5 by one of the following: fing a fire resistance rating of the in accordance with 7.2.1.8 of less than a 13/4 inch (4.4 of wood core construction. For protection in accordance assort enclosure. Properly installed and and heating equipment, and accilities are not classified as ally on basis of such prinklers shall be permitted for as in accordance with 3.2.3.2.5 of met as evidenced by:  In and interview, the facility for to a hazardous area was cleent practice would allow as to migrate into the exit are provide a self-closing	KO	321			
		self-closing device had been					

CENTERS FOR MEDICARE & MEDICAID SERVICES

MAKE OF PROMIDER OR SUPPLIER  409 STATE BUILDING  (PAPID PRETEX GACH SOFT OF LOCATION SINGLE DEPOSITION INFORMATION)  (PAPID PRETEX TAGGES AND FORMATION INFORMATION)  (ROAD DEPOSITION OF LOCATE OF PRECIDENCIES (GACH DEPICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  (K0321 Continued From page 2 removed.  (K0323 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt)  NFPA 13 and 13R Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintenance in accordance with NFPA 13D Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintenance of Sprinkler Systems in State of in accordance with NFPA 13D Systems Sprinkler systems in Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintenance of Sprinkler Systems in One - and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintenance of NFPA 25.  1. Control valves inspected monthly (NFPA 25, section 13.3.2.71).  3. Alarm devices inspected quarterly (NFPA 25, section 5.3.3).  5. Valve supervisory switches tested semiannually (NFPA 25, section 5.3.3.5).  6. Wables sprinklers inspected annually ((NFPA 26).		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG 10 - ADMINISTRATION	BLDG NON-RES	COMPLETED
A99 STATE BUILDING  SUMMARY STATEMENT OF DERICIENCES (EACH DEPICIENCE VALIETY OF DERICIENCE) BY PILL REQUILIDED CONTROL OF CORRECTION (EACH DEPICIENCY MAST BE PRECEDED BY PILL REQUILIDED CORS-REFERENCE) TO THE APPROPRIATE DEFICIENCY OR LSC IDENTIFYING INFORMATION)  K0321  Cortinued From page 2 removed.  K0323  Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt)  NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13R, 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 maintenance in Residential Occupancies Up To Systems in Residential Occupancies Up To Application of Sprinkler systems installed in accordance with NFPA 25, Standard for frapection, Testing and Maintenance of Water Based Fire Protection Systems.  NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 25, Standard for the Installation of Sprinkler systems in One- and Two-Family Dwellings and Manufactured Hornes, 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 53.3).  5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.5).			28G107	B. WING			02/10/2020
SMAMAY STATE ACTION SHOULD BE CACH DEPICIENCY MUST BE PRECEDED BY PILL REQULATORY OR LIST IDEMTIFYING INFORMATION)  K0321  Continued From page 2 removed.  K0353  Sprinkler System - Maintenance and Testing CFR(s): NFPA 10.  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, 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 maintenance of Water Based Fire Protection Systems.  NFPA 13D Systems  Sprinkler systems in one- and Two-Family Dwellings and Maintenance of Water Based Fire Protection Systems.  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 NFPA 25, section 13.3.2.1  1. Control valves inspected monthly (NFPA 25, section 13.2.71).  3. Alarm devices inspected quarterly (NFPA 25, section 5.3.3).  5. Valve supervisory switches tested semiannually (NFPA 25, section 5.3.3).					3104, 3070, 3071 STATE	E AVE	
removed.  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 Hornes, 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 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).	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH COR	RRECTIVE ACTION SHOULD B RENCED TO THE APPROPRI	E LUMPLETION DATE
25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2).		removed. Sprinkler System - M. CFR(s): NFPA 101  Sprinkler System - M. 2012 EXISTING (Pro NFPA 13 and 13R Sy Ali sprinkler systems NFPA 13, Standard for Systems, and NFPA Installation of Sprinkle Occupancies Up To a Height, are inspected accordance with NFF Testing and Maintena Protection System. NFPA 13D Systems Sprinkler systems ins NFPA 13D, Standard Sprinkler systems ins NFPA 13D, Standard Sprinkler Systems in Dwellings and Manuf inspected, tested and with the following req 1. Control valves in section 13.3.2). 2. Gauges inspecte 13.2.71). 3. Alarm devices in section 5.2.6). 4. Alarm devices te section 5.3.3). 5. Valve supervisor semiannually (NFPA 6. Visible sprinklers 25, section 5.2.1). 7. Visible pipe insp	aintenance and Testing mpt) stems installed in accordance with or the Installation of Sprinkler 13R, Standard for the er Systems in Residential and Including Four Stories in I, tested and maintained in PA 25, Standard for Inspection, ance of Water Based Fire  stalled in accordance with for the Installation of One- and Two-Family factured Homes, are d maintained in accordance quirements of NFPA 25; espected monthly (NFPA 25, set of monthly (NFPA 25, set of section 13.3.3.5). Inspected annually (NFPA 25, I				

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	10/2020
5.11.25 (2.54) S. 11.5 (2.54) S. 11.5 (2.54)	
400 STATE BUILDING 3104, 3070, 3071 STATE AVE BEATRICE, NE. 68310	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 Continued From page 3 K0353	
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 5.3.1.1.15). 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 is thecked 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	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 10 - ADMINISTRATION BLDG NON-RES		COMPLETED
		29G107	B. WING			02/10/2020
	ROMDER OR SUPPLIER E <b>BUILDING</b>			STREET ADDRESS, CITY, STATE, 2IP COD 2104, 3070, 3071 STATE AVE BEATRICE, NE 68310	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		SHOULD BE	(X5) LUMPLETION DATE
K0353	penetrations. This def allow the sprinkler syst designed and fire work egress corridor.  Findings are: Observation on 2-10- 1. The ceiling grid in several open penetral missing.	icient practice would not stem to activate as it was all spread throughout the 20 at 2:40 pm revealed: the tunnel corridor had tions where ceiling tiles were	KO	353		

3		

### NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



#### BEATRICE STATE DEVELOPMENTAL CENTER

#### FACSIMILE TRANSMITTAL SHEET

TO: DHI	HS AcuteCare Facilities	FROM	1: Russell Fralin			
COMPANY:		DATE	3: March 5, 2020			
FAX NUMB	ER:	TOTA	AL PAGES INCLUDING COVER: 10			
PHONE NUI	MBER:	PHONE NUMBER:				
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

Attached pages within this transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

3000 Lincoln Boulevard Beatrice, NE 68310-3319

x x			
	5		

	PLAN OF CORRECTION	
ovider/Supplier me:	400 State Building	Survey Date
REET ADDRESS, TY, ZIP:	3104, 3070, 3071 State Ave Beatrice, NE 68310	2/11/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	4\$E111
	PROVIDER'S PLAN OF CORRECTION	COMPLETIO
	(EACH CORRECTIVE ACTION SHOULD BE CROSS-	DATE
ITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	DAIL
	TO CORDECT THIS DEFICIENCY, ALONG WITH A	
	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	
.97	TO THE CITED DEFICIENCY: For Client 2: Client 2 was discharged from the Beatrice State Developmental Center (BSDC) on	
	2/21/20.	2/21/20
	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.	3/27/20
	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	

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".

mental health crisis, drug abuse, or other circumstances are struggling in their community

placement".

3/27/2020

3/27/2020

	BSDC facility administration is working with the DHHS Department of Developmental	1101/401-142014/2012
	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
	D 1995 III 1	
	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.	3/27/202
	Disabilities in regards to options to visiting.	
	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.	3/27/202
	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	
W249	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.	3/27/202
	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).	3/27/202
	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.	3/27/202
	F0	
	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	
of the Individual Support Plan (ISP) program "Dining Etiquette" dated 11/27/19, to ensure staff	
Of the marked an explorer rain (i.e. ) broken and a series and a serie	
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	
labbiobioco:	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	
	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.	

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PRINTED: 02/26/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		28G107	B, WING			02/	14/2020
	ROVIDER OR SUPPLIER			3104,	ET ADDRESS, CITY, STATE, ZIP CODE 3070, 3071 STATE AVÉ IRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
<b>W</b> 197	maintain generally ind able to function with li- absence of a continue This STANDARD is r Based on observation	s not include services to dependent clients who are little supervision or in the lous active treatment program.  not met as evidenced by:	w	197	C. Ionard J		
	sampled clients admit developmental needs treatment services. T all clients residing at t	failed to ensure that 2 of 4 tted to the facility had requiring continuous active his had the potential to affect the facility. The facility time of the recertification					
	2/4/2020 (11:40am-1: (7:15am-7:45am) revindependently participal required little to no stability living and developservations identified.  a. Verbally communication wants and needs	2/3/2020 (4:50pm-6:25pm), 2:25pm), and 2/5/2020 ealed Client 2 actively and pated in their environment and aff interventions related to opmental skills. These d Client 2: cated clearly and effectively is and asked direct and at to direct support staff and					
LABORATORY	the surveyor.	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement enting 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 pien 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.

35-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		34 33 3 3 K	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING		0	2/14/2020	
	ROVIDER OR SUPPLIER E <b>BUILDING</b>	·		STREET ADDRESS, CITY, STATE, 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVA CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D'TO THE APPROPRIATE CIENCY)	(XS) COMPLETION DATE	
W 197	using the stove, oven breakfast- cooked oar and honey; made toa and juice; (2) lunch-archeese sandwich, and vegetables and drinks baked burritos, a bow Client 2 independently verified said temperatives and due temperatures and due Client 2 was knowled oven mitts to prevent pans.  c. Client 2 ate independently come in size swallowing, and either the plate between bite their drink(s) between with food in their mour of gagging or coughin or difficulties with drink d. Possessed the bas toileting, maintaining and personal hygiene independence.  e. Independently come care tasks.  f. Used leisure time appersonal phone calls,	pared meals and snacks it, microwave, and toaster: (1) timeal and mixed with banana st and prepared coffee, milk, ssisted staff to cook a grilled diprepared their own s; (3) supper-prepared 3 if of blue berries, and drinks, by took food temperatures and tures with staff to ensure food it 2 asked staff for assistance did oven for correct cooking to fear of hot surfaces, geable about and utilized burns from hot pots and indently. Client 2 took single to, chewed bite before in paused or set fork down on the client took sips of the bites. The client did not talk th. Client 2 had no episodes the grade of the surfaces of the transfer of the surfaces of the client took sips of the transfer of the surfaces of the client took sips of the transfer of the surfaces of the client took sips of	W	197			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02	/14/2020
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1994, 3070, 3071 STATE AVE SEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X8) COMPLETION DATE
W 197	completed personal s (with 2 staff), played of watched television (g. channels). Client 2 waregarding current new staff and the surveyor  g. Was able to read, it skills. Client 2 would it "quiet time" between time in order for the clattorney, a local judge involving Client 2, loc surveyor.  h. Possessed basic to skills, including access music entertainment times.  i. Observations reveal 2 with two to one staft times during waking ! 11:00pm. Constant vi 15-minute checks we utilized the bathroom leisure time on the liv from the living unit, w tasks, and when in th positioned directly on behavioral risks.  j. During observations (11:40am-12:26pm) a Client 2 displayed an physical aggression to	shopping in the community cards/board games, and arne shows and news as able to have conversations as events with direct support.  Itell time, and had writing request they be provided work activities and leisure slient to write letters to their expressions over a case all politician(s), and the slephone and computer sing internet websites for during meal and leisure slied the facility provided Client fing supervision levels at all hours from 6:00am to issual supervision and are provided when Client 2, slept in their room, and fing unit. During transitions then completing janitorial job in either side of Client 2 due to	W	197			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTA A. BUILDO	IPLE CONSTRU	(X3) DATE SURVEY COMPLETED				
		28G107	B. WNG				02	14/2020
	ROWDER OR SUPPLIER  E BUILDING			3104, 3070,	ORESS, CITY, STATE, ZIP CO 3071 STATE AVE , NE 68310	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CA (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO THI DEFICIENCY	XN SHOULD BI IE APPROPRIA		(X8) COMPLETION DATE
W 197	(3) Using profanity, racalling, belittling and of (4) Invading direct carlinging at staff in an inarms out at their sides chest forward), and the (5) Punching a table at while yelling and curs (6) Flipped over their and metal) table across caused three chairs to miscellaneous items of hand sanitizer, Kleen day room and hallway (7) Kicked and tipped the loveseat toward the inthe living-room area.  2) Record review of the identified Client 2 (add 11/22/19) was independently in the client's health needs.  a. Review of the "Assa Admission/Discharge" Client 2 was independently and independently and independently and independently and independently was independently and indep	ning in a loud voice ng to do staff bodily harm dists comments, name derogatory remarks re staffs personal space, intimidating manner (flaying is and posturing by thrusting ireatening physical harm and walls with a closed fist ing at direct support staff shoved an eight foot (wood is the day room. This to be flipped over and on the table (paper, pens, ex, etc.) to be strewn in the direct support staff in the table (paper, pens, ex, etc.) to be strewn in the direct support staff in the following documents mitted to the facility on indent and required no training ill acquisition to address expendited deficits. The active treatment services was as behavioral and mental desired to the following skills: oming, dressing, bathing, ind receptive/expressive dient was able to: read	W	97				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		28G107	B. WNG			02/	14/2020
·	ROVIDER OR SUPPLIER			3,	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 197	related to time period make small purchase checks, or use of a dechecks, and emergency to aggressive behavior significant safety concinvolvement in the condays after admission) emergency protective enforcement and trantlincoln Crisis Center concerns, threats, marmental health evaluation of the concerns	(and associated events s), perform errands, and s with cash money, writing ebit card.  I Support Plan (ISP, dated and subsequent meetings 2/19/19) identified that Client placement at the facility due ors, property demage, cerns, and law enforcement minunity. On 11/25/19 (three client 2 was placed in a custody (EPC) with law isferred from the facility to the due to significant safety sladaptive behaviors, and for tion.  ed the client was able to a wants and needs. Client 2 ed (used a disposable razor	v	197			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ V - J			(X3) DATE SURVEY COMPLETED	
	28G107	B, WANG_			2/14/2020	
NAME OF PROVIDER OR SUPPLIER 400 STATE BUILDING			STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL, LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APPL  DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
Client 2 identified the published author, pot and completing cust with great detail. The that the facility had in training and teaching identified above) for Further review of the skill maintenance produced in the skill maintenance produced in the skill maintenance independent in these facility developed six Client 2's behaviors increase pro-social decrease property diphysical aggression, ideations.  The ISP identified mespecific to behavioral suicidal/homicidal propsychotropic medical Quietiapine), 2:1 supchecks, all sharps lo access to fire starting scheduled phone cal internet, no horror or safety plan addressing restraints.  c. Review of the "Ani Assessment Summa Client 2 was independent."	as. The ISP documented that bey were most proud of being a litical advocate, being athletic, odial jobs and cleaning cars a ISP included no evidence emplemented active treatment of daily living skills (as Client 2.  ISPs identified Client 2 had ograms for medication by management, and bedroom be, even though Client 2 was a skills. The ISP identified the is behavior programs to address which included a goal to communication and goals to communication and goals to communication, verbal aggression, and suicidal and homicidal cultiple rights restrictions I, safety, and ecautions including: tions (Prazosin and cervision, 15-minute visual cked unless in use, limited	W1				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED			
		28G107	B. WING			02/	14/2020
	ROVIDER OR SUPPLIER E BUILDING			3104, 3	ET ADDRESS, CITY, STATE, ZIP CODE 18070, 3071 STATE AVE RICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(KS) COMPLETION DATE
W 197	washing, bathing, appropriate while eati Client 2 was independently skills including dining clean up, clothing car putting away items), a The assessment identified of the washing windows/mindevelopmental skills identified Client 2 enji socializing with other engage with other engage with other whise audity needs. The areas of safety skills, and cognitive skills of utilization of numbers numbers, etc.), time of and identified Client 2's in needed to address that take responsibility for and in appropriate so d. Review of the "Tra Risks, Protections, S. 12/19/19) identified Crecognizing hazardouindependently ambuly vehicles, and independing properties and independently ambuly vehicles, and independing processing hazardouindependently ambuly vehicles, and independently with the safety and independently ambuly vehicles, and independently ambuly vehi	plying lotion, oral hygiene, indressing, eating, being ing, and mealtime activities. Ident in areas of home living ing, meal preparation, meal-time in (washing, drying, and and household care chores. It if it is the client needed of it is when utilizing the it ing tasks such as it is emptying garbage, and it is estion of the assessment over being around and it is client 2 had skills to be socializing and human in client was independent in all it is medication administration, if money management, it is concepts, reading, writing, colors. Client 2 was action/leisure, community pling skills. The assessment dependent living skills eaching the client how to it their eggressive behaviors icial actions.  Instition Planning: Individual upports and Services" (dated client 2 was capable of us environments, ated and transferred in/out of indentity completed all daily essment identified Client 2.	W	197			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING_		02/14/2020	
	ROVIDER OR SUPPLIER E <b>BUILDING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
W 197	Client 2 was employe completing custodial j staffing (6:30am - 11:1 living unit) for training be immediately availal redirection and intervolution of the management of the ma	cialty healthcare therapies. d and paid by the facility for obs. Client 2 had two to one DOpm and when off of the Isafety needs, and for staff to ble to provide needed antion for behavioral risks. afety plan, and crisis iddress the client's verbal and property destruction, dal and homicidal his document identified that is, "sometimes they are not ing me and others when I am itional Evaluation" (dated lient 2 ate independently. express food preferences and arred to and independently asis. The client assisted with reparation, table setting and diagnosed with GERD flux disease).  Post Admission Report," iffied that from 11/22/19 - no incidents of property ingage in suicidal and and no attempts to elope. hat Client 2 was independent be successful in community was implemented to provide it 2 would be able to manage ental health symptoms and	W 1	97		

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B, WNG			02/	14/2020	
	ROVIDER OR SUPPLIER		•	31	TREET ADDRESS, CITY, STATE, ZIP CODE 184, 3070, 3071 STATE AVE EATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE	
W 197	g. Review of the "Eva (admission history an identified Client 2 was spectrum disorder (hi disability), mood diso GERD. The physicia a full scale IQ of 86. (identified in 7/29/15 c assessment received at the time of Client 2 h. Review of the "Anr (dated 12/11/19) reve Client 2 was independent. [Client 2] does to good."  i. Review of Client 2's Assessment" (dated following diagnoses: history and without in generalized anxiety disorder, and paranofacility's Psychologist assessment that basing psychological testing not and does not mer intellectual disability" Autism spectrum disc Client 2 eligible for deservices.  j. Review of the docu facility's Psychiatrist Management" (dated 1/9/2020, and 1/24/2020, and 1/24/2020)	dustion and Management" d physical, dated 12/31/19) s diagnosed with autism story of developmental rder, personality history, and in identified that Client 2 had This IQ diagnosis was comprehensive IQ evaluation as collateral documentation 's admission.)  unal Dental Examination" haled that the dentist identified dent and had "Very good oral rloss. Periodontal health very  a "Admission Psychological rl2/6/19) identified the Autism spectrum disorder (by tellectual impairment), lisorder, post-traumatic stress and personality disorder. The identified in this and on the cognitive and results that Client 2 "would bet the criteria for an is but due to the identified brider (by history) deemed evelopmental disability  ments completed by the kitled "Evaluation and	W	197				

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  AG	(X3) DATE SURVEY COMPLETED			
		28G107	B. WING		02/14/2020			
	ROVIDER OR SUPPLIER  BUILDING			STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFU TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
<b>W</b> 197	Quietiapine for behav documents identified a Autism spectrum diso intellectual impairmen disorder, post-traumar generalized anxiety disorder anxiety disorder anxiety disorder anxiety disorder anxiety disorder d	ior management. These Client 2's diagnoses to be rder (by history and without t), paranoid personality tic stress disorder, and sorder.  eneral Event Reports (GERs) ments identified Client 2's	W 1	97				
	involvement in incider staff and law enforcers at a few enforcers.  a. Review of a GER at (PERs) revealed an in in which Client 2 was. Health Crisis Center in GER and PER, due to made to staff and Clie participate in medicati beyond their current of Administrator contacte (NSP). Client 2 was determined to the mergency protective Client 2 to the Mental b. Review of a GER at communication log) re on 2/10/2020 in which staff. According to the supervisor was deliver from nursing staff and enforcement surfaced Client 2 shoved the supervisor's phone.	ats of physical aggression to ment involvement.  and Preliminary Event Review acident occurred on 11/25/19 transferred to the Mental action. According to the safety concerns, threats at 2's unwillingness to on changes or medication agimen, the Clinical Services and the Nebraska State Patrol etermined to be a risk to a and the NSP initiated custody and transported Health Crisis Center.  and T-Logs (electronic vealed an incident occurred Client 2 physically attacked a GER and T-Log, a ring a message to Client 2						

	[ W					(X3) DATE SURVEY COMPLETED	
	28G107	B. WING			02/	14/2020	
			STREET ADDRESS, CITY, STATE, ZIP 3104, 3079, 3071 STATE AVE BEATRICE, NE 68310	CODE			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFII TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIA		(X5) COMPLETION DATE	
supervisor with closed aggress toward the sit to physically intervended and resided at the fact mental health needs.  a. During interviews of presence of Staff F at (in the presence of Staff F at (in the presence of Staff Health had been in sincidentified they had to incident at one of the Client 2 reported they enforcement to a local admitted to the facility aggressive.  Client 2 reported they cleaning their bedroot tasks, showering/batt shaving, eating, drink flossing, dressing, and they earned pay for juindependently utilize purchase personal ite were able to communion the phone with face	d fists. Client 2 continued to uppervisor, requiring three staff a with Client 2's aggression.  ent 2 and facility staff verified dent in or capable of epimental and daily living skills cility due to behavioral or  ent 2/3/2020 at 5:10pm (in the end J) and 2/5/2020 at 7:18am taff B and I) Client 2 cility was the fifth placement as May 2019. Client 2 go to court because of an former service providers.  If were taken by law all crisis center after being y because they were being of were independent in m and the living unit, laundry hing, personal hygiene, ting, tooth brushing and ad grooming. Client 2 reported anitorial work and were able to money/debit card to ems. Client 2 identified they nicate verbally, in writing, and cility staff, their attorney,	W					
	Continued From page supervisor with close aggress toward the sito physically intervended and resided at the fact mental health needs.  a. During interviews of Staff Fact (in the presence	CORRECTION  IDENTIFICATION NUMBER: 28G107  ROVIDER OR SUPPLIER  BUILDING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	CORRECTION  IDENTIFICATION NUMBER: 28G107  B. WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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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	ROWDER OR SUPPLIER  286107  286107  286107  28700ER OR SUPPLIER  28UILDING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 B and 1) Client 2 continued 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 were she 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	CORRECTION  IDENTIFICATION NUMBER:  28G107  SITECT ADDRESS, CITY, STATE, ZIP CODE  3164, 8976, 3971 STATE AVE  BEATRICE, NE 68310  SUMMARY STATEMENT OF DEPCIENCIES (EACH DEPRICINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 B) 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 star 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 takes, 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 2016 about being	COMPETITION    DENTIFICATION NUMBER:   A BUILDING   B. WING     2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	14/2020	
	ROVIDER OR SUPPLIER  E BUILDING			3194,	ET ADDRESS, CITY, STATE, ZIP CODE 3070, 3071 STATE AVE TRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		0(5) COMPLETION DATE	
W 197	Client 2 confirmed the preparations, cooking the meal. Client 2 reprecipes and menus pr 2 verified they know h toaster, stove, and ow Client 2 reported they leisure time and didn't to do. Client 2 liked to basketball and lift weig against staff, watch the family members, compand/or hang out on the Client 2 verified they in behaviors and medical Client 2 revealed their check off the electronial admitted to refusing to because the client alremedications. According independently take the names of medications use, times, and how to b. Interview with Staff and 2/5/2020 at 3:20p independent and did a completing personal his showering, toileting, did and floss teeth, shavir if added that Client 2 times per day because appearance. Client 2 is electric razor to shave	ey were independent in meal , serving, and clean-up after orted being able to follow rovided by the facility. Client row to use the microwave, en.  planned their recreation and t like staff telling them what go the facility's gym to play ghts, play video games elevision, play cards, call plete personal errands, e living unit.  In ad training programs for ation administration programs. In medication program was to ic medication program was to ic medication sheet. Client 2 to participate in the program eady knew how to take their and to Client 2 they could eir medications and knew the ta, dosage, the rationale for to take the medications.  F on 2/4/2020 at 4:52 pm om, confirmed Client 2 was an excellent job with	W	197				

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		26G107	B, MNG			02/	14/2020
	ROMDER OR SUPPLIER E BUILDING				STREET ADDRESS, CITY, STATE, 2IP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIÉS Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X6) COMPLETION DATE
W 197	stove/oven. Client 2 work independently a community doing suc medication administration but wanted staff to de medications. Client 2 wants and needs verified they had read 2 authored and publis Client 2 had behavior verbal and physical a suicidal thoughts. Achad a hard time contribution caused the cliestaffs face, use lots of harm staff and propereported that Client 2 wanted a reason to a dollars as Client 2 had Nebraska Corrections Staff F, Client 2 tried by using verbal aggreciient could get a rea for Client 2 to become during incldents of agrepeatedly talk about and that Client 2 knew did not know why Client client was identified that Client 3 other clients that need daily living skills.  c. Interview with Staff		W	197	7		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING	_		02/	14/2020
	ROVIDER OR SUPPLIER E BUILDING			3	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE SEATRICE, NE 68310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(XS) COMPLETION DATE
W 197	or the regional center independent in showe hygiene, dressing/und grooming/shaving, eath ad skills to complete cooking, serving, eath staff I identified Client own catmeal and coff their own snacks and communicated independents. Client 2 wrote various providers, polifacility. Staff I verified addressing medication and safety plans. Acc knew their medication could independently to document on the facility (medication administriction 2 was at the facility and was physically ag 2's behaviors were un Staff I reported they behaviors and skills the mental health needs to needs.  d. Interview with Staff identified Client 2 was behavioral problems in which resulted in Client Staff A confirmed Client Staff A confirmed Client Staff A confirmed Client Staff A confirmed Client Cli	staff I verified Client 2 was ering, toileting, personal literssing, brushing teeth, ting, and drinking. Client 2 steps for meal preparation, and, and completing clean-up. It 2 independently made their ele each morning and got drinks. Client 2 endently verbally and in several letters per week to iticians, judges, and the Client 2 had programs and administration and behavior ording to Staff I, Client 2 s, why they were prescribed, ake them, and how ity's electronic MAR ation record). Staff I reported cility for their anger According to Staff I, Client 2 seatened harm, made insulting ace with staff and screamed, igressive toward staff. Client predictable and aggressive. elieved based on Client 2's neat the client had more than developmental disability.  A on 2/6/2020 at 11:38am, at the facility due to a community based services at 2 being in legal trouble. Int 2 was independent with sileting, personal hygiene,	w	197			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	14/2020	
ľ	ROVIDER OR BUPPLIER E BUILDING			310	REET ADDRESS, CITY, STATE, ZIP CODE 14, 3070, 3071 STATE AVE L'ATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 197	medications. Client 2 independently with a was able to speak the verbally and in writing 2 had programs for money management, plans. However, Clie the medication programs to get the client's the documentation. So their medications and confirmed Client 2 was destroyed property, peloped one time from campus. Staff A reposaggression and threat would posture and get white screaming and punched walls, and titems from tables. Staff to a local crisis of and for evaluation and admitted to the facility treatment skills were A replied that Client 2 treatment skills. Staff belong at the facility, facility's help for skill living skills. According not have the supports behavioral or mental e. Interview with Staff confirmed Client 2 has said to the supports the supports of the support	ating, drinking, and taking their was able to cook few staff prompts. Client 2 eir mind and communicate g. Staff A identified that Client nedication administration, and behavior and safety ent 2 refused to participate in am and told staff it was their medications and complete staff A verified Client 2 knew d how to take them. Staff A as verbally aggressive, and at the facility but not off of the red Client 2 displayed verbally tened staff daily. Client 2 et nose to nose with staff using profanity. Client 2 hrew chairs/furniture and aff A verified that Client 2 was center due their aggressions couple of days after being y. When asked what active being taught to Client 2, Staff 2 was not being taught active f A reported Client 2 did not as the client did not need the acquisition of basic daily g to Staff A, the facility did is to meet Client 2's specific health needs.  If B on 2/6/2020 at 12:51pm, ad programs to address ce/cleaning, medication	W	197				

Event |D:48E111

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	/14/2020
	ROVIDER OR SUPPLIER  E BUILDING			310	REET ADDRESS, CITY, STATE, ZIP CODE M. 3070, 3071 STATE AVE ATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 197	behavior/safety plans and physical aggress did very well with cleaknew how to take the use money. Staff B coindependent in launditoileting, showering, cothemselves haircuts, brushing/flossing. Clie skills, cooked well, us microwave. But Client cook so that staff wou verified Client 2 cooke lunch each day. Staff behavior/safety plans verbal (screaming and aggression, threatening getting face to face w belittling, property desthrowing objects) and (cursing and eloping). knew right from wrong behaviors. According facility supports and to with their anger mana B stated, "We can't te help." Staff B reported the facility could do to aggressive behaviors Staff B identified that supports or treatment equipped to meet Clief health needs.  f. Interview with Client Disabilities Profession	to address the clients verbal ions. Staff B verified Client 2 aning and room maintenance, ir medications, and how to onfirmed Client 2 was ry tasks, eating, drinking, dressing/undressing, gave	W	197			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		28G107	B. WING			02/	14/2020
	ROWIDER OR SUPPLIER		•	310	REET ADDRESS, CITY, STATE, ZIP CODE 04, 3070, 3074 STATE AVE EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
W 197	cleaning' and (b) six p 2's social communica physical aggression, suicidal and homicida  QIDP-B verified Clien grooming/shaving, to shower/bathing, toilet eating/drinking, comm and basic meal prepar reported Client 2 was and needed minimal meal preparations. S Client 2 to complete C Client 2 usually refus was very independer day to day living activ  QIDP-B confirmed th intellectual disabilities clients Autism diagno services. The facility Client 2 since being a developmental disab Client 2 was involved behavioral/assaultive their vehicle at the po provider where Client asked why Client 2 w ICFIID facility, QIDP- help with their menta facility provided a mo QIDP-B verified that health services and	ns for medication y management, and bedroom programs to address Client tion, verbal aggression, property destruction, and al ideations.  It 2 was independent in oth brushing/oral cares, ting, dressing/undressing, nunicating wants and needs, arations skills. QIDP-B is not confident using the stove everbal prompting when doing taff also provided prompting to clean up tasks after meals as ed. QIDP-B reported Client 2 at and capable of completing	w	197			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING		02/	14/2020	
	ROVIDER OR SUPPLIER E <b>BUILDING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE 3194, 3070, 3071 STATE AVE BEATRICE, NE 68310			
(X4) IID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE	
W 197	mental health stabilize recommended by the Additionally, Client 2 v. coping mechanisms to According to QIDP-B, mental health and agg have an independent asked if Client 2 belon ICFIID level care, QIDB. Client 3  1) Observations on 2/3 (2/4/2020 (11:30arn-11 (8:13am-8:15am and 9 (1:00prn-1:45pm) and revealed Client 3 to according to the interventions reladevelopmental skills. Client 3:  a. Verbally communicate with direct support stab. Possessed the basi (eating/drinking, toileti grooming/hygiene) net and privacy.  c. Used leisure time ald. Independently maddicleaned kitchen areas e. Used a microwave tread/interpreted food pf. Was able to read, idepossessed rudimentar	medication changes for ation and treatment as facility's physicians. Was not open to learning new to address their aggressions. If Client 2 could get their gression stabilized they could life in the community. When aged and was in need of IP-B replied "No."  3/2020 (5:00pm-6:00pm), :50am), 2/5/2020 (7:45am - 8:20am) 2/5/2020 (7:45am - 8:20am) atively and independently irronment requiring little to no ted to daily living and Observations identified ated clearly and effectively ff, peers and the surveyor. In control of the community is a coffee, set the table, and loaded the dishwasher to reheat food and preparation directions entify numbers and	W	197			

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING\_ 02/14/2020 B, WNG 28G107 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3104, 3070, 3071 STATE AVE 400 STATE BUILDING BEATRICE, NE 68310 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION BHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 197 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 in familiar areas and was

used the restroom

small amounts of money.

skills.

capable of demonstrating many independent living

- As able to withdraw, secure, carry and spend

- Completed custodial, recycling and vehicle detailing work, earning \$305.90 over the last 30

- Had three skill training programs: to document

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02	14/2020
	ROMDER OR SUPPLIER			3104	REET ADDRESS, CITY, STATE, ZIP CODE 4, 3070, 3071 STATE AVE ATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(XS) COMPLETION DATE
W 197	Continued From page	± 19	w	197			
	the taking of their me- medication administra Therap (an electronic task analysis for keep current, and a prograt analysis of their groon  - Had a Behavior Sup address coping skills, and pro-social behavior verbal aggression, ph self-injurious behavior and comments, arguin  -With many rights resibehavioral, safety and precautions identified Safety Plan and Ment Intervention Plan (MH  b. Review of Client 3: Assessment (updated could complete the ba bathing, eating, hygie hygiene. Client 3 need items/materials or to a task/skill. This assess 11/10/18 Independent competed at the time to the facility. Accord	dications on their electronic ation record (MAR) located in records system), to follow a sing their money ledger on to complete a task ming/hygiene routine.  Sport Program (BSP) to participation in daily routine ors while working to decrease ysical aggression, as, disrespectful bounderies on and lying.  Intrictions specific to a suicidal/homicidal in Client 3's Individualized all Health Behavioral Crisis BCIP)  In Independent Living Skills (6/27/19) identified Client 3 is sic skills of toileting, in e/grooming, and oral ided verbal prompts to gather ensure Client 3 performed the sment was updated from an Eliving Skills Assessment of Client 3's first admissioning to the 6/27/19 update, are unchanged from the		187			
	c. Review of Client 3's document dated 2/3/2	transitional planning 020 Identified Client 3 did not ces or supports related to			•		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	14/2020
	ROVIDER OR SUPPLIER E BUILDING			3104	EET ADDRESS, CITY, STATE, ZIP CODE 1, 3070, 3071 STATE AVE ATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
W 197	d. Client 3's Psycholo 6/18/19 identified the Intellectual Disabilitie Disorder associated vexposure, Posttraum: Conduct Disorder, Ur of empathy type.  e. Client 3's 5/28/19 I address Client 3's "taphysical and verbal a behaviors and suicida Behaviors included p forms, along with the to harm others. The physical restraint as if. Client 3's 12/16/19 addressed safety corphysical and verbal a behaviors and suicida safety plan outlined a the occurrence of befollowing restrictions:  - Increased staff rations are used to safety and are to sharps	regical Assessment dated following diagnoses: Mild s, Neurodevelopmental with prenatal alcohol atic Stress Disorder and respecified Onset, callous/lack MHBCIP outlined a plan to reget program behaviors" of ggression, self-injurious al/homicidal precautions, hysical violence in various use of sharp or blunt objects plan also included the use of meeded.  Individualized Safety Plan recens related to behaviors of regression, self-injurious al/homicidal ideation. The supervision levels based on haviors and identified the	w	197			

Facility ID: ICFMR07

	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		28G107	B. WING_	<del></del>	02	/14/2020
	RÖVIÐER OR SUPPLIER E <b>BUILDING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE 3164, 3076, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X9) COMPLETION DATE
W 197	g. Client 3's record in the facility administrat Client 3's arrest and p identified Client 3 had Stabilization Unit (CS) could be readmitted to facility's letter describe "treatment and hability has been designed to psychiatric and medic Nebraskanswho have developmentally disebmental health crisis, dicroumstances are struplacements."  h. Client 3's record in Probation resulting from Assault in the Third De Misdemeanor committ Further review of the conditions Client 3 to "follow all properties the CSU and Developmental Centers as demonstrating developmental developmental Centers as demonstrating developmental health needs. Since the conditions confirmed Client 3 as it demonstrating developmental health needs. Since the conditions confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs. Since the confirmed Client 3 as it demonstrating developmental health needs.	cluded a 5/24/19 letter from or to an attorney regarding ending charges. The letter been at the facility's Crisis U) from 10/31/19-4/1/19 and of the facility on 5/28/19. The ed the services provided as ative care in the CSU, which provide behavioral, all interventions to been determined to be olded and who, by reason of rug abuse, or other auguling in their community cluded a 9/20/19 Order of the Client 3's conviction of the end on or about 5/12/19. Idea at 100 State Building It is located at Beatrice State independent in or capable of ormental and daily living skills lity due to behavioral or	W1	97		

	S FOR WILDIOARL W		(X2) MI II	TIPLE CON	ASTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''	ING		COMPLETED	
		28G107	B. WING		<del>_</del>	02/	14/2020
	ROVIDER OR SUPPLIER E BUILDING			3104,	ET ADDRESS, CITY, STATE, ZIP CODE 3070, 3071 STATE AVE RICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 197	the presence of Staff in jail prior to returnin stated they were sent probation as they "att punching them in the was a staff person the group home operated Client 3 reported they eating/drinking, comm bathroom, dressing a Client 3, they knew hof their dentures, but the tasks as they wer mood". Client 3 reported they nearly to cook on a Client 3 reported they Depakote stating the "needed the most" as behaviors. According facility psychologist on how to talk about and emotions. Client 3 rejupset and "go overboth client 3, they had alretheir medication and modication in their Miknew how to do all the program and the	N) confirmed they had been g to the facility. Client 3 to the facility to do their tacked someone" by face. Client 3 reported it ey punched while living in a I by a community provider.  If were independent in nunication, using the and grooming. According to ow to shower and take care often choose not to complete re "tired" or "not in the red they could make their rowave or crock pot and was stove top.  If took Risperdal and se were the medications were for g to Client 3, they saw a me time per week to learn if express feelings and ported they could get rather pard" in how they reacted.	W	197			

	TEMENT OF DEFICIENCIES  OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		O	(X3) DATE SURVEY COMPLETED		
		28G107	B. WANG		j	02/14/2020
	ROVIDER OR SUPPLIER E <b>BUILDING</b>			STREET ADDRESS, CHY, STATE, ZIP CO. 3164, 3070, 3071 STATE AVE BEATRICE, NE 68310	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI TAG		ON SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
W 197	Continued From page money program and a behaviors.  Client 3 reported they until they completed to their interdisciplinary of find an "EFH" (extend take Client 3.  b) Interview with Staff during an observation Creek) confirmed Client 3 stated their present required supervision I should Client 3 rush to step in the cleaning pool of the client 3 was eating/drinking, communications, and denture Client 3 would lie about the client 3 would lie about th	had a program to help with  were to remain at the facility heir probation at which time team would see if they could led family home) that would  N (on 2/5/2020 at 9:10pm of Client 3 cleaning at Bear out 3 required little to no te the custodial tasks. Staff be was due to Client 3's evels and to redirect Client 3 hrough the task and miss a rocess.  I (on 2/6/2020 at 11:05am) is independent in				
	the facility was due to jail. Staff I reported Cl based and lead to phy d) Interview with Staff 12:30pm) confirmed C facility due to anger is women. Staff H report complete their probatito Staff H, Client 3 was eating/drinking, committed to the complete the complet	f H (on 2/10/2020 at Client 3 readmission to the sues, particularly directed at ted Client 3 was ordered to ion at the facility. According is independent in				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
STATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/	14/2020
	ROYIDER OR SUPPLIER E BUILDING			3104,	ET ADDRESS, CITY, STATE, ZIP CODE 3070, 3071 STATE AVC TRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ION SHOULD BE COMI THE APPROPRIATE	
W 197	Staff H reported Clier but had the skills to d 3 completes both the programs without star Client 3 had a BSP a came from anger.  e) Interview with Star confirmed Client 3 was a last and a money needed assistance to the skills and a money need	at 3 does not always shower, to so. Staff H reported Client in medication and money if assistance. Staff H stated is Client 3's behaviors all stated is Client 3's behaviors all stated is Client 3's needs were related arily physical aggression and G (a female staff) confirmed ked" by Client 3 and Client 3 angry. Staff G reported ity to work on anger skills, medication oney skills. Staff G as independent in munication, ressing, denture care and would refuse to complete garding the completion of the staff of t	W	197			
	eating/drinking, com	munication, toileting, dressing the QIDP reported Client 3					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B, WING			02	/14/2020
	ROVIDER OR SUPPLIER E BUILDING			SYREET ADDRESS, CITY, STATE, ZIP C 3104, 3079, 3071 STATE AVE BEATRICE, NE 68310	<b>OPE</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUIL SC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the s	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
W 197	grooming and hygiend showering.  According to Client 3's the facility as they we arrested after attackin community based gro Client 3's probation of 2020 and was to take QIDP stated Client 3 in health needs which resupervision.  Interview with the faci 2/11/2020 at 1:30pm of 1) Client 2 was admit emergency placement in a community based identified that Client 2's aggmental health needs. Administrator, Client 2 daily living skills, medirequired little to no stand personal shopping that Client 2's plan at Stabilization Unit" (CS address Client 2's sociand communications, medication oversight.	ensure they completed a tasks and would lie about a solution of the property o	W	197			
	medication oversight.  2) Client 3 was readman emergency situation	itted to the facility based on					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1	
1	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02/14/2020	
	ROVIDER OR SUPPLIER E BUILDING			31	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3470, 3071 STATE AVE EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLÉTION DATE
W 197	group home. The adicommunity based prosupports or treatment required. According to required structure and by CSU to address C.  The Administrator representation of the Administrator representation of the Administrator reported situation were different as a continuous control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation were different as a control of the Administrator reported situation as a control o	nt 3's community based ministrator reported the evider did not have the exider which Client 3 to the administrator, Client 3 d extra supervision provided lient 3's behavioral needs.  Forted admission to the extracted by the State of the Administrator, the	w	197			
W 249	client must receive a program consisting o services in sufficient	isciplinary team has ndividual program plan, each continuous active treatment f needed interventions and number and frequency to nent of the objectives identified	w	249			

Event (D: 4SE111

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			02	/14/2020
	ROVIDER OR SUPPLIER <b>E BUILDING</b>			:	STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE. 60310		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	·	ot met as evidenced by:	w	249			
	review, the facility fails programs were impler Individual Support Pla the sample. This failur	mented as outlined in the in (ISP) for 1 of 2 clients in re had the potential to affect he facility. Facility census					16
	using a napkin to wipe or snack time when ea program specified the	program which focused on Client 1's face during meal ating or drinking. The training frequency for Id occur at every given					
	Observations identifies "Dining Etiquette" ISP during 3 of 4 meals.  Observation on 2/3/20 identified Staff C did n	d staff did not implement program, dated 11/27/2019 120 from 5:19pm - 5:46pm ot offer a napkin or prompt 1's face during or after the					
	identified Staff D did n	20 from 12:33pm - 1:00pm ot offer a napkin or prompt 1's face during or after the					
		20 from 11:55am - 12:54pm Staff D did not offer a napkin					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		28G107	B. WING_			02/	14/2020
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE DEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	or prompt Client 1 to after the meal, during to have saliva drippin Interviews with Staff I Staff E on 2/11/2020 were not able to ident implemented during a checking Client 1's re Interview on 2/11/202 Intellectual Disabilities confirmed: 1) Staff sh prompting Client 1 to eating or taking a drinnapkin available at ex-	wipe Client 1's face during or which Client 1 was observed g of their face multiple times.  O on 2/6/2020 at 12:55pm and at 10:36am revealed staff lifty a program that was to be meal and snack times without cord.  O at 11:37am with Qualified is Professional (QIDP) A lould be offering napkins and wipe Client 1's face whenever lik, 2) Client 1 should have a very meal or snack, and 3) as not implemented correctly	W	249			

PRINTED: 02/26/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING_			02/11/2020
<u> </u>	ROWIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X\$) COMPLETION DATE
E 000	Initial Comments		EO	00		
	Health conducted a R 2/3/2020 - 2/11/2020 compliance with Fede	eral regulations at Appendix redness. The facility was				
LABORATORY		supplier representative's signatur Uwaschek	RE.	TITLE TCFA	.3-5	(XS) 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 safeguerds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 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.

2 2		







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

Page 2 February 26, 2020

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,

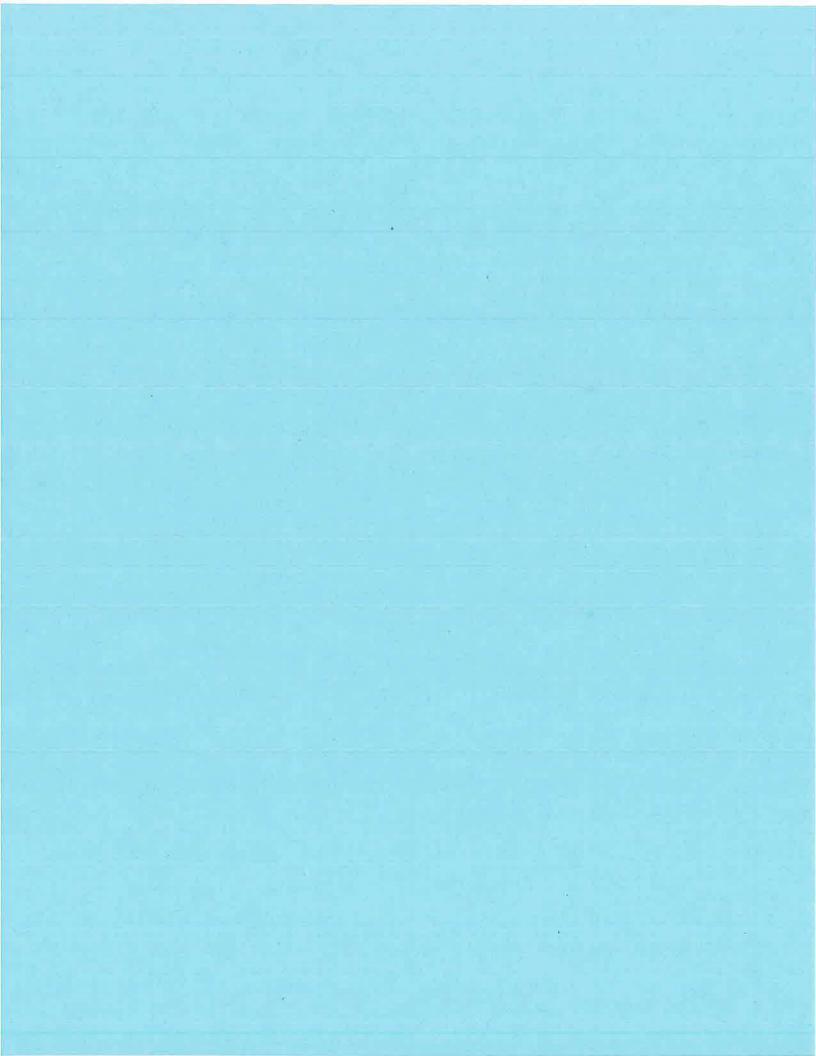
Mark Luger - Program Manager II

DHHS Public Health - Licensure Unit

Office of DD and Behavioral Health

PO Box 94986, Lincoln, NE 68509-4986

Email:



CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) DATE SU COMPLE		
		28G107	B. WING			02	10/2020
	RÖVIDER OR SUPPLIER BUILDING			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
K 000	INITIAL COMMENTS	ne facility must meet the	K	000			
	applicable provisions Life Safety Code of th Association. This fact 33, Existing Resident Occupancies of the 2 Fire Protection Association Safety Code.	of the 2012 Edition of the ne National Fire Protection will be governed by Chapter ial Board and Care 012 Edition of the National ciation [NFPA], Chapter 101:					
	building of Type V co. 1970 and is fully sprin. The facility has 12 ce the survey the census 400 State Building - 3 not in compliance with participation in Medic 483.470 Life Safety National Fire Protecti Standard 101 - 2012	rtified beds. At the time of s was 0 residents.  8071 State was found to be the three requirements for the transfer are/Medicaid at 42 CFR from Fire, and the related on Association (NFPA) edition.	KO	345			
K0345	CFR(s): NFPA 101  Fire Alarm System - 2012 EXISTING (Pro A fire alarm system is accordance with an a with the requirements Electric Code, and NI and Signaling Code. acceptance, maintenavailable.  9.7.5, 9.7.7, 9.7.8, ar This STANDARD is a	s tested and maintained in approved program complying as of NFPA 70, National FPA 72, National Fire Alarm Records of system ance and testing are readily	KO	345			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			ππε		(X6) DATE

Any deficiency statement ending with an asteriek (\*) 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 deya following the date thase documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	(X2) MULTIPLE CONSTRUCTION A. BUILDING 11 - 3071 STATE AVENUE		(X3) DATE SURVEY COMPLETED	
		28G107	B. WING	_		02/10/2020	
	ROVIDER OR SUPPLIER  E BUILDING			3	TREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE BEATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
K0345	failed to assure that a labeled. I his deficient potential that the fire a smoke from a fire, who occupants in all smok facility census was 0 of Findings are:  Observations on 2-28 smoke detector in the labeled or identified.  During an interview or	all fire alarm devices were the practice increased the alarm would fail to detect alich would affect all the compartments. The on the day of survey.  20 at 1:00 pm revealed, the Laundry Room failed to be an 2-28-20, at 1:00 pm, and the smoke detector	КО	345			

## **PLAN OF CORRECTION**

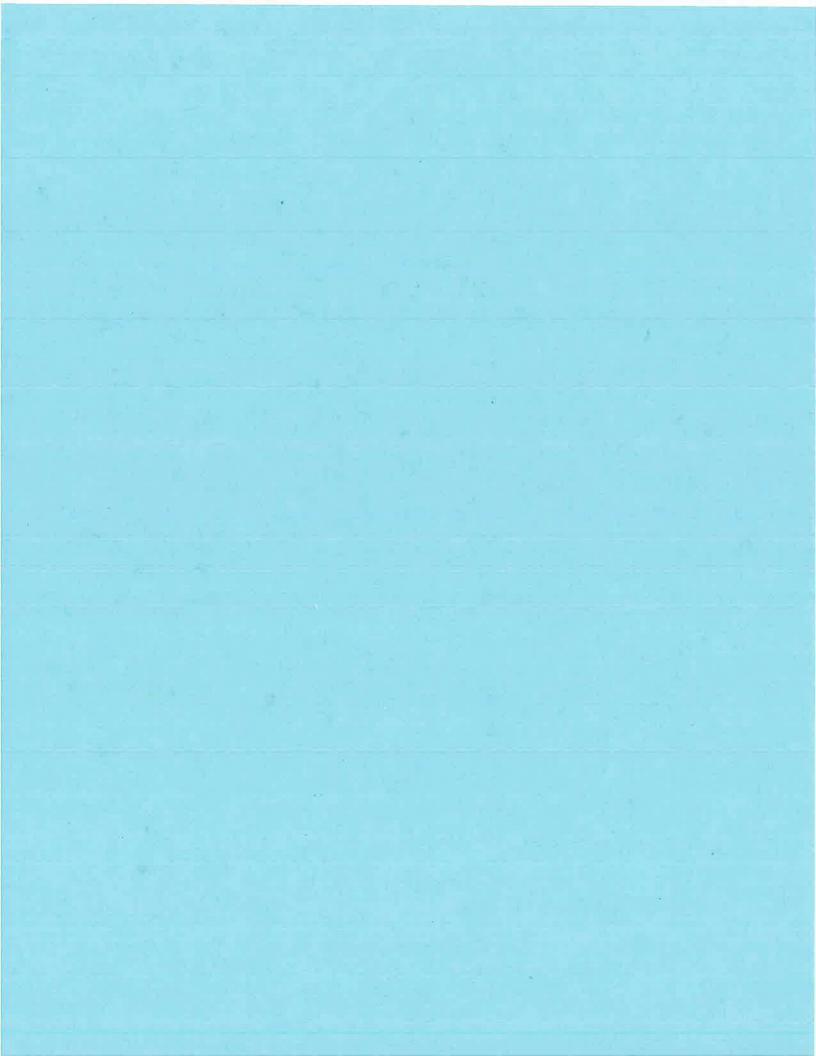
Provider/Supplier Name:	400 State Building	Survey Date
STREET ADDRESS, CITY, ZIP:	3071 State Ave Beatrice, NE 68310	2/11/2020
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	4SE111

#### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

CITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	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	
(0345	TO THE CITED DEFICIENCY:	
(0343	TO THE CITED DELICITION	
	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 detectors on 30/1 state / 411. Of residually 14, 2020, it was determined that the smoke detector should be labeled as #3 to coincide with the inspection report. The Safety	
	smoke detector should be labeled as #5 to conficult with the inspection report. The savety	
	Coordinator placed the appropriate #3 label on the smoke head in the laundry room of 3071	2/14/202
	State / 411 on February 14, 2020.	2/14/2020
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	B. THE PROCEDURE FOR ITAL SELECTION OF THE SELECTION OF T	
	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 detectors on 30/1 state / 411. On replically 14, 2020, it was determined the smoke detector should be labeled as #3 to coincide with the inspection report. The Safety	
	smoke detector should be labeled as #5 to coincide with the inspection report. The safety	
	Coordinator placed the appropriate #3 label on the smoke head in the laundry room of 3071	2/14/202
	State / 411 on February 14, 2020.	2/21/2021
	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.	2/14/202
	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.	2/14/202
	The Facility Wallitenance Wanager with Monteor and Close Company	
	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:	ű.
D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
<u>NOTE:</u> Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	



09/10 13:26

01'09

OK

## NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM BEATRICE STATE DEVELOPMENTAL CENTER FACSIMILE TRANSMITTAL SHEET FROM: Russell Fralin, DHHS.DDBHFacilities@nebraska.gov TO: COMPANY: DATE: September 10, 2020 TOTAL PAGES INCLUDING COVER: FAX NUMBER: PHONE NUMBER: PHONE NUMBER: PLEASE REPLY ☐AS REQUESTED ✓ FOR REVIEW **□**URGENT Attached are the signed front page(s) for the 2567's received for State Building ICF at the

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

Beatrice State Developmental Center for the Public Health survey.

Please advise if further information is needed.

ST. TIME TX/RX TIME

PGS.

RESULT

Thank You



NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



## BEATRICE STATE DEVELOPMENTAL CENTER

# TO: DHHS.DDBHFacilities@nebraska.gov FROM: Russell Fralin, COMPANY: DATE: September 10, 2020 FAX NUMBER: TOTAL PAGES INCLUDING COVER: PHONE NUMBER: PHONE NUMBER: □ 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

Attached pages within this transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

3000 Lincoln Boulevard Beatrice, NE 68310-3319

a .			

## 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

## PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

CITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	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.	10/15/202
	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.	10/15/202

C. THE MONITORING OR TRACKING CORRECTING THE DEFICIENCY AND WITH THIS DEFICIENCY:	PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN TO ENSURE THE FACILITY REMAINS IN COMPLIANCE	
(CFA) has been reviewed to determine treatment essential for privacy and in personal hygiene, dental hygiene, ear basic needs). Should any review indicate the provision of active treatment, fire Facility Administrator discussed with and any others applicable to the situ	e Building ICF, the Comprehensive Functional Assessment ne specific developmental deficits requiring active independence (including, but not limited to: toileting, ting, bathing, dressing, grooming, and communication of cate that an individual did not meet the requirement for adings were submitted to the Facility Administrator.  Director, Deputy Director of Developmental Disabilities ations to develop plans for referral out of BSDC.  Administrator, QDDP and Service Coordinator.	<b>1</b> 0/15/2020
Administration met with Service Coo Health to discuss options for Client 5	rdination, Community Based Services and Behavioral to find and secure alternative, less restrictive living entified, a 60 day transition period will begin with a er 2, 2020.	10/15/2020
meet eligibility for the Nebraska Dev disability as defined by Nebraska Sta developmental disability present bef	O assessment by a psychiatrist, stating Client 5 "does not elopmental Waiver due to not having a developmental tute". This is based on the fact there is no evidence of a ore the age of 22. The Facility Administrator met with the tcome of Level of Care Review and instructed to begin the services.	10/15/2020
B. THE PROCEDURE FOR IMPLEMEN	TING THE CORRECTIVE ACTION(S):	
arrangements on 9/4/2020. Once id tentative discharge date of November For all indivdiuals residing in the Stat (CFA) has been reviewed to determine treatment essential for privacy and in personal hygiene, dental hygiene, ea basic needs). Should any review indicate provision of active treatment, fin Facility Administrator discussed with and any others applicable to the situ	entified, a 60 day transition period will begin with a	10/15/2020
Administration met with Service Coo	e Beatrice State Developmental Center (BSDC) rdination, Community Based Services and Behavioral to find and secure alternative, less restrictive living	<b>3</b>

	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.	10/15/20
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN	
	COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
		10/15/26
	The ICF Administrator is the responsible person for monitoring and to ensure compliance.	10/13/2
	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:	
	TO THE CITED DETICIENCY.	
-		
	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:	
	THE PARTY OF THE P	
	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.	
	additing tools, new or revised penales and present sy	
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PRINTED: 09/03/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		R		
		28G107	B. WING			1	31/2020
NAME OF PROVIDER OR SUPPLIER				_	TREET ADDRESS, CITY, STATE, ZIP CODE		
AND STATE	BUILDING			ı	104, 3070, 3071 STATE AVE		
TOUSINE					EATRICE, NE 68310		px51
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{W 197}	maintain generally inc	) s not include services to dependent clients who are little supervision or in the	<b>{W</b> 1	197}			
	Based on observation interviews the facility sampled clients (Cliental developmental nactive treatment servipotential to affect all of	not met as evidenced by:  ns, record review, and failed to ensure that 1 of 4 int 5) admitted to the facility eeds requiring continuous ices. This failure had the clients residing at the facility. 6 at the time of the revisit to fication survey.					
	12:10pm, 2:40pm -3: 8/28/2020 from 8:37a 5 to actively and inde environment requiring interventions related						
AROBATOR	with direct support st b. Possessed basic of (eating/drinking, dres grooming/hygiene) no privacy.	levelopmental skills			TITLE		(XS) 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.

PRINTED: 09/03/2020 FORM APPROVED

CLIVILI	15 I ON WEDICARE &	WEDICAID SERVICES				OMB N	IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTIONS	ON		TE SURVEY MPLETED
		28G107	B. WING_			01	R 8/31/2020
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
ADD STAT	'E BUILDING			3104, 3070, 3071	1 STATE AVE		
				BEATRICE, NE	E 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{W 197}	c. Used lelsure time a d. Independently set t from the cupboard e. Used a microwave items in the dishwash f. Was able to read ar g. Accurately convers direct support staff Observations identifie 5 with supervision leve	appropriately the table, retrieving items to reheat food and put her nd identify numbers sed on current events with ed the facility provided Client vels ranging from constant time alone in Client 5's	(W 18	17]			
	as independent or cap developmental and de focus of facility's servi or mental health need a. Review of Client 5's (ISP) dated 2/21/2020 - As an effective verb	s Individual Support Plan					
	utterances. Client 5's language skills, as we skills, all fall within nor informal assessment.  - Possessed strength; independent fiving skill utilized the restroom in hands, bathed and ate capable of demonstrate.	receptive and expressive all as cognitive linguistic armal limits based on as/abilities in all areas of alls. Client 5 independently in familiar areas, washed e/drank. Client 5 was atting other independent					
	living skills, occasiona reminders to ensure c	ally needing verbal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	
		28G107	B. WING	_	<del></del>	08/	31/2020
NAME OF PROVIDER OR SUPPLIER 400 STATE BUILDING				aı	IREET ADDRESS, CITY, STATE, ZIP CODE 104, 3070, 3071 STATE AVE EATRICE, NE 68310		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 197}	- As able to make sm change, identify coins in the past 30 days (fi ISP.)  - Had skill training pranalysis (TA) for: 1) training pranalysis and training product the independently aworked independently aworked independently aworked independently address inappropriate physical aggression, elopement, stealing, suicidal/homicidal idewere being address treplacement behaviors. Review of Client 5's could complete the bathing, eating, hygicoral hygiene indepenprompt from staff to gensure completion of c. Review of Client 5's document dated 2/11 not currently require to speech and langual occupational therapy d. Client 5's Psycholog 2/26/2020 identified to	nall purchases, make and bill and made \$150.92 rom admission to annual regrams to complete the task aking medications ding and identifying correct ck daily caloric intake, 3) eparation, 4) arriving to work and appointment on and 5) increasing the time y.  pport Program (BSP) to a verbal/gestural behavior, property destruction, self-injurious behavior, property destruction, self-injurious behavior, bations and lying. Behaviors through pro-social rs.  Is Independent Living Skills of 2/12/2020) identified Client basic skills of toileting, ane/grooming, dressing and dently or with a verbal pather items/materials or to ithe task/skill.	(vv 1	197)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  28G107			(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		28G107	B. WNG			R	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	08/31/2020	
				3104, 3070, 3071 STATE AVE	• •		
400 STATE	E BUILDING			BEATRICE, NE 68310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFU TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
{W 197}	O STATE BUILDING  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		{W 1				
	"does not meet eligibit Developmental Waive	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		28G107	B. WING			R 06/31/2020	
	_	250101	10	STREET ADDRESS, CITY, STATE, ZIP CO 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	DOE	, 00	31/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		ON SHOULD 19 HE APPROPRI		O(S) COMPLETION DATE
{W 197}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.		(W 1	197}			
	self-care needs and (	nd the skills to complete all Client 5 put a lot of appearance. Staff L reported					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  28G107				TPLE CONSTRUCTION		(X3) DATÉ SURVEY COMPLETED	
		B. WING_		4	R <b>08</b> /31/2020		
NAME OF PROVIDER OR SUPPLIER  400 STATE BUILDING				STREET ADDRESS, CITY, STATE, ZIP CO 3104, 3070, 3071 STATE AVE BEATRICE, NE 68310		<b>00</b> 73 172020	
(X4) ID PREF(X TAG	REF(X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) 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.		{W 15	37}			
	8/31/2020 at 1:00pm received an assessment stating that Client 5 di requirements for servi Nebraska Department Disabilities. (A copy or obtained from the faci According to the Administrativas scheduled on 9/4 State of Nebraska De Human Services were	ices through the State of					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/03/2020 FORM APPROVED OMB NO. 0938-0391

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			_	. 0938-039
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	.ETED
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400 STATE	BUILDING		I .	BEATRICE, NE 68310		
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(W 197)	Continued From page Client 5's services.	÷ 5	{W 197			

# NEBRASKA

Good Life. Great Mission.

### DEPT. OF HEALTH AND HUMAN SERVICES

September 3, 2020

Pele Ricketts, Governor

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 <a href="mailto:DBHFacilities@nebraska.gov">DBHFacilities@nebraska.gov</a> 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 - Program Manager II

DHHS Public Health - Licensure Unit

Mark Jugar

Office of DD and Behavioral Health PO Box 94986, Lincoln, NE 68509-4986

Email:

(40)			
		*	

# **2020 Facility Staff Information**

Staff levels
Staff Injuries
Staff planning

Attachment B4





Per your request

Skirry, Sarah
To: "Moreland, Jerall"

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 as #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: CELL:

DHHS.ne.gov | Facebook | Twitter | LinkedIn

### 7 attachments

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

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

C. All ICF Licensure Renewal 2020.pdf

C. Lake Street Surveys FM-PH 2020.pdf

C. Solar Cottage Surveys FM-PH 2020.pdf

C. State Building Surveys FM-PH 2020.pdf

Staffing plan.pdf 508K

Jerall Moreland

To: "Skirry, Sarah"

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

Jerall

[Quoted text hidden]

--

Jerall Moreland, Deputy Ombudsman for Institutions Nebraska Legislature- Ombudsman's Office Wed, Feb 24, 2021 at 1:31 PM

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.		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 escalated individuals. right wrist / forearm.		Emergency Room	М
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	М
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.	lated and exhibited physical aggression and Be mindful of body positioning. erty destruction. Staff was blocking and Review de-escalation and verbal communication techniques to rs or additional property. The individual punched continue to try.		М
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.		Emergency Room	М
D/L	1/24/2020	1715 Hrs.	DT Crisis	406 State	ndividual was having an escalated behavior. Individual stacked 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.		Emergency Room	М
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.		Emergency Room	М
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	М

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.		Emergency Room	М
D/L	2/2/2020	1745 Hrs.	DT Crisis	406 State Ind. Bedroom	statt down to the tlear Statt tell and hit her lett knee		No Medical Treatment	М
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.		Emergency Room	М
D/L	2/10/2020	1415 Hrs.	DT Crisis	406 State Safe Room			No Medical Treatment	М
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.	d spitting at staff. Individual lowered herself rand continued hitting and kicking.  Better redirection and body blocking.		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		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	М
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	М

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	dividual was in crisis behavior when he hit staff twice and attempted to bite. Another staff escorted dividual backwards when he lunged forward and bit taff on her upper right arm above the elbow. dividual also punched staff in the right side of the ead 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	М
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.	irst floor of "F" building talking to clock-out. Staff was standing next to individual was being escorted through vidual stopped and punched staff / forehead. Staff's head jerked back		М
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	М
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	М
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

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.		No Medical Treatment	М
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.		No Medical Treatment	М
7/5/2020	1700 Hrs.	DT Crisis	406 State	I the mouth and enitting contacting statt's tare arm		No Medical Treatment	М
7/8/2020	2000 Hrs.	DT Crisis	402 State Kitchen Area	prabbing at staff. Staff was redirecting the individual but of the kitchen area when the individual hit staff in he head. Staff and individual fell down to the floor with		No Medical Treatment	F
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.		No Medical Treatment	М
7/18/2020	1520 Hrs.	DT Crisis	406 State	couraged individual to use his coping skills.  ividual would not listen and verbally threatened  iff. Individual suddenly attacked staff. Staff  empted to hold individual when the individual bit  iff's left forearm (breaking skin) and also scratched		Emergency Room	М
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	М
	7/5/2020 7/5/2020 7/8/2020 7/17/2020	7/5/2020 1700 Hrs.  7/5/2020 1700 Hrs.  7/8/2020 2000 Hrs.  7/17/2020 1400  7/18/2020 1520 Hrs.	7/17/2020 1700 Hrs. Crisis  7/5/2020 1700 Hrs. DT Crisis  7/8/2020 2000 Hrs. DT Crisis  7/17/2020 1400 DT Crisis  7/18/2020 1520 Hrs. DT Crisis	7/1/2020         2122 Hrs.         Crisis         Hallway           7/5/2020         1700 Hrs.         DT Crisis         406 State           7/5/2020         1700 Hrs.         DT Crisis         406 State           7/8/2020         2000 Hrs.         DT Crisis         402 State Kitchen Area           7/17/2020         1400         DT Crisis         406 State           7/18/2020         1520 Hrs.         DT Crisis         406 State	7/1/2020 1700 Hrs. DT Crisis Hallway bedroom when the individual shammed the bedroom door on staff's foot jerking her lower back.  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.  1700 Hrs. DT Crisis 406 State Individual was having an escalated behavior and grabbing at staff. Staff was redirecting the individual was having an escalated behavior and grabbing at staff. Staff and individual fit staff in the head. Staff and individual fit staff in the head. Staff and 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.  17/18/2020 1520 Hrs. DT Crisis 3RD Floor Crisis individual was fluid seeking (behavior.) Staff encouraged individual was heaving an escalated behavior. Staff encouraged individual to use his coping skills. Individual was having an escalated behavior. Staff encouraged individual was having an escalated behavior. Staff encouraged individual to use his coping skills. Individual was having an escalated behavior. Staff encouraged individual was fluid seeking (behavior). Staff escorted individual was fluid seeking (behavior). Staff escorted individual to asfa area. Individual towered himself to the mat on the floor. Individual towered himself to the mat on the floor. Individual towered himself to the mat on the floor. Individual towered himself to the mat on	7/5/2020 1700 Hrs. OT Crisis Hallway  7/5/2020 1700 Hrs. OT Crisis 406 State Hallway  7/5/2020 1700 Hrs. OT Crisis 406 State  1. 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 scretch on his right thumb during a behavioral episode.  1. Individual bit his tongue at lunch and had been in and out of behavior all day. Individual was bleeding from the muth and spitting contacting staff is face, arm, chest, nuck, etc.  1. Individual was having an escalated behavior and grabiting at staff. Staff was redirecting the individual spit blood mixed with saliva on staff.  1. Individual was having an escalated behavior and grabiting at staff. Staff was redirecting the individual beak to the floor with staff landing on her left knee.  1. Individual was upset and started hitting staff in the face. Staff and individual fell down to the floor with staff landing on her left knee.  1. Individual was upset and started hitting staff in the face. Staff and individual grabbed PPC mask that staff was vering and pulled. The mask caught staff's ear (ripped earing) then grabbed staff by the heir and pulled hurting staff's neck.  1. Individual was having an escalated behavior. Staff encouraged individual to use his coping skills. Individual wad her the staff was vering and pulled. The mask caught staff's later (ripped earing) then grabbed staff by the heir and pulled hurting staff's neck.  1. Individual was having an escalated behavior. Staff encouraged individual to use his coping skills. Individual wad have the individual bit staff's later part of the later and verbally threatened staff. Individual wad the little was fluid seeking (behavior). Staff escorted individual bit staff's leg hit the little was the floor with him	7/15/2020   1700 Hrs.   DT   Crisis   406 State   Mallway   Discharge and provided in the modern of the modern o

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.		Emergency Room	М
D/L J.F.	7/28/2020	1955 Hrs.	DTSS Crisis	406 State			No Medical Treatment	М
D/L G.O.	7/30/2020	0105 Hrs.	DT Solar North	3052 Peterson Ind. Bedroom			No Medical Treatment	М
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	М
<b>D/L</b> 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.	Individual was in behavior and fluid seeking. Staff redirected individual as he was trying to hit, kick and		М
<b>D/L</b> 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.	ndividual became upset and punched the ion. Staff went to move individual away from the ion when individual punched staff in the left jaw ck area causing staff's head to whip back fast		М
<b>D/L</b> J.K.	12/15/2020	1200 Hrs.	ZYTA	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	М

#### Stats as of 02/11/2021

Home	IDD Level	Age	Wheelchair			Acuity	
				Braden Risk	Enteral Feeding	PNM Risk	Health Ris
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	moderat
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	moderat
	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	moderat
3060 Peterson Blvd 413	Severe	37				high	moderat
3060 Peterson Blvd 413	Mild	33				moderate	moderat
3060 Peterson Blvd 413	Moderate	65				moderate	moderat
3060 Peterson Blvd 413	Severe	40				moderate	moderat
3060 Peterson Blvd 413	Mild	49				moderate	moderat
413 # of individuals	Average age	45.4	7			moderate	moderat
3056 Peterson Blvd 414	Mild	63				moderate	high
3056 Peterson Blvd 414	Profound	83	yes	mild		high	high
3056 Peterson Blvd 414	Profound	64	700			low	moderat
3056 Peterson Blvd 414	Mild	66				moderate	high
3056 Peterson Blvd 414	Profound	61				moderate	moderat
3056 Peterson Blvd 414	Severe	64				moderate	moderate
3056 Peterson Blvd 414	Profound	63				moderate	moderate
3056 Peterson Blvd 414	Profound	54				high	moderat
3056 Peterson Blvd 414	Profound	53	yes	mild		moderate	high
3056 Peterson Blvd 414	Moderate	71	700			low	moderat
414 # of individuals	Average age	64.2	10				
3052 Peterson Blvd 416	Profound	58	yes			moderate	moderati
3052 Peterson Blvd 416	Profound	73	yes			moderate	high
3052 Peterson Blvd 416	Mild	72	ves			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	moderat
3052 Peterson Blvd 416	Profound	55				moderate	moderat
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
		<ul> <li>1 safety plans requires 1 to 1 when in community</li> <li>1 safety plan requires 1 to 1 supervision if alarm is not functioning</li> <li>1 safety plan requires 1 to 1 supervision when exhibiting precursors, safety concerns or target behaviors</li> </ul>

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			moder	ate moderate
422 # of individuals	Average age	64.5	9			
715 Solar - 424	Severe	66			moder	ate low
715 Solar - 424	Mild	71	yes	high	high high	high
715 Solar - 424	Severe	36			moder	ate moderate
715 Solar - 424	Severe	67	yes		moder	ate moderate
715 Solar - 424	Moderate	64	yes	mild	moder	ate high
715 Solar - 424	Mild	57			low	moderate
715 Solar - 424	Profound	63			moder	ate moderate
715 Solar - 424	Moderate	56	yes	high	high moder	ate high
715 Solar - 424	Severe	60	yes	mild	moder	ate high
	Average age	60	9			
424 # of individuals						
Lake Street ICF						
Lake Street Homes - 103	Mild	52	yes	mild	moder	ate high
Lake Street Homes - 103	Mild	61			moder	ate low
Lake Street Homes - 103	Mild	54			low	moderate
Lake Street Homes - 104	Moderate	47			low	low
Lake Street Homes - 104	Moderate	70			moder	ate moderate
Lake Street Homes - 104	Severe	58			low	moderate
Lake Street Homes - 104	Moderate	61			low	moderate
Lake Street Homes - 205	Mild	61			moder	ate 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

# 2020 ICF Licensure Renewals

**Attachment B5** 



### Good Life. Great Mission.

### DEPT. OF HEALTH AND HUMAN SERVICES



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			



### 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

LIDENT	IFYING 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: (#02) 223-6192 ADMINISTRATOR: DAWN URBASCHEK	
3. FEDERAL EMPLOYER IDENTIFICATION NUMBER 4. TOTAL NUMBER OF BEDS TO BE LICENSED:	
OWNE	ERSHIP INFORMATION
	RASKA, DEPT OF HEALTH & HUMAN SERVS ndividual or Business Organization)
MAILING ADDRESS:  POBOX 95044  LINCOLN, NE 685  7. BUSINESS ORGANIZATION: (Check one):	509
Sole Proprietorship Partnership Limited Partnership Corporation Limited Liability Company	trict, County, City or Municipal)
I/we have read the Rules and Regulations issued by the Nebs	CERTIFICATION  raska Department of Health and Human Services and will comply with them your 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:  (1) the owner, if the applicant is an individual or partn.  (2) two of its members, if the applicant is a limited liat.  (3) two of its officers, if the applicant is a corporation,  (4) the head of the governmental unit having jurisdicting overnmental unit.  Corina Harrison, Facility Administrator  AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	Applications shall be signed by sership, sellity company,
ALITHODIZED DEDDESENTATIVE - TYPE OR PRINT	SIGNATURE DATE

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

Co.B (full



## **POST IN PROMINENT PLACE**



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

Co.B (full



## **POST IN PROMINENT PLACE**

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

(b.B (full



## **POST IN PROMINENT PLACE**





### 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 I	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: (402) 223-6192 ADMINISTRATOR: DAWN URBASCHEK	
3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE	FACILITY: 470481200
4. TOTAL NUMBER OF BEDS TO BE LICENSED: 24	. <del></del>
OWNERSHIP I	NFORMATION
6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA, D	DEPT OF HEALTH & HUMAN SERVS
(Legal Name of Individual or	
MAILING ADDRESS: P O BOX 95044	
MAILING ADDRESS: POBOX 95044 LINCOLN, NE 68509	
7. BUSINESS ORGANIZATION: (Check one):	
Sole Proprietorship Partnership Limited Partnership Corporation Limited Liability Company Governmental ( _XXx State, District, Other (Please Specify) Non-profit	County, City or Municipal)
	FICATION
I/we have read the Rules and Regulations issued by the Nebraska Depa should a license be issued. I/we certify that to the best of my/our knowle correct and I/we hereby apply for a renewal license.	rtment of Health and Human Services and will comply with them edge, all information and statements on the application are true and
PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applicatio (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability comp (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the governmental unit.	алу,
)	AH = 2/11/2020
Corina Harrison, Facility Administrator	NATURA DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT SIG	, and the same
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT SIG	ENATURE DATE

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:

Co.B (Full

State Fire Marshal



## **POST IN PROMINENT PLACE**





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

3/31/2021

## Intermediate Care Facilities for the Mentally Retarded Licensure Renewal Application

IDENTIFYING INFORMATION
1. NAME AND ADDRESS OF FACILITY:  Sheridan Cotteges  3054 PETERSON BLVD BEATRICE, NE 68310  2. PRFFFRRED 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: FAX NUMBER: (402) 223-6192 ADMINISTRATOR: GREG PENNER  3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY:
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
MAILING ADDRESS: POBOX 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  DATE
AUTHORIZED REPRESENTATIVE - TIPE ON PRINT
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT SIGNATURE DATE

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:

Co.B. Gull

State Fire Marshal



### POST IN PROMINENT PLACE





### DOSMETS THE SERVICES 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 IN	FORMATION
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: (402) 223-6192 ADMINISTRATOR: GREG PENNER	
FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FA     TOTAL NUMBER OF BEDS TO BE LICENSED:	ACILITY:
OWNERSHIP INI	FORM ATION
6. OWNERSHIP OF FACILITY: STATE OF NEBRASKA-DHI- (Legal Name of Individual or B	HS
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, Other (Please Specify) Non-profit	County, City or Municipal)
CERTIFIC  I/we have read the Rules and Regulations issued by the Nebraska Departr should a license be issued. I/we certify that to the best of my/our knowleds	ment of Health and Human Services and will comply with them
correct and I/we hereby apply for a renewal license.	
PLEASE NOTE: Neb.Rev.Stat. Section 71-433 requires: Applications (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability compan (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the f governmental unit.	y,
Corina Harrison, Facility Administrator	3/16/2000
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT SIGNA	ATURE DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT SIGN	ATURE DATE

Certificate Number: 10270

Name of Facility: Solar Cottages ICF 715

Type of Facility: **ICF/MR** 

Location: 715 Solar Dr, Beatrice

Maximum

14 Beds Persons

Occupancy: Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By:

State Fire Marshal



## POST IN PROMINENT PLACE

Certificate Number: 10269

Name of Facility:

Solar Cottage ICF 723

Type of Facility:

ICF/MR

Location:

723 Solar Dr. Beatrice

Maximum

14 Beds Persons

Occupancy: Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By:

State Fire Marshal



## **POST IN PROMINENT PLACE**

Certificate Number: 10268

Name of Facility:

Solar Cottage ICF 743

Type of Facility:

ICF/MR

Location:

743 Solar Dr, Beatrice

Maximum

14 Beds Persons

Occupancy: Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By:

**State Fire Marshal** 



## POST IN PROMINENT PLACE



Certificate Number: 10267

Name of Facility:

Solar Cottage ICF 753

Type of Facility:

ICF/MR

Location:

753 Solar Dr. Beatrice

Maximum

16 Beds Persons

Occupancy: Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By:

State Fire Marshal



## **POST IN PROMINENT PLACE**

Certificate Number: 10265

Name of Facility: Solar Cottage ICF 3052

Type of Facility: ICF/MR

Location: 3052 Peterson Blvd, Beatrice

Maximum

12 Beds Persons

Occupancy: Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By:

State Fire Marshal



## **POST IN PROMINENT PLACE**

Certificate Number: 10264

Name of Facility: Solar Cottage IFC 3056

Type of Facility: ICF/MR

ype of Lability: 101 miles

Location: 3056 Peterson Blvd, Beatrice

Maximum

12 Beds Persons

Occupancy:
Date Issued:

2/20/2020

Inspected By: Susen Lindner

**Deputy State Fire Marshal** 

Approved By: OB

State Fire Marshal



## **POST IN PROMINENT PLACE**

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

Approved By: State Fire Marchal

Deputy State Fire Marshal State Fire Marshal



### POST IN PROMINENT PLACE





DEPT. OF HEALTH AND HUMAN SERVICES



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.

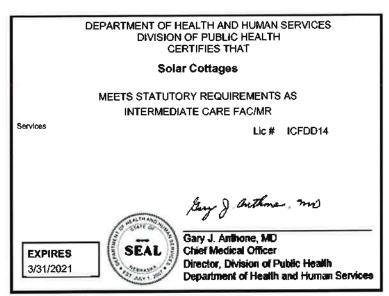
This will increase the licensed beds in the Solar Cottages ICF/IDD from 79 to 87. We would like this merger to become official on June 29, 2020.

If you ha

Greg Penner, ICF/DD Manager Solar Cottages ICF/IDD

1		

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



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 4<sup>th</sup> Quarter Fire Drill Times

Attachment B6

	2019 -	2020 FIF	RE DRILI	LTIMES	- 4TH Q	TR. 2020	
Building	Chapel 3065 Carstens Drive	Carstens Center 3000 Carstens Drive	West Wing 834 Sheridan	Admin. 843 Wallman	<b>"D" Bldg.</b> 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 DTR 2019 VACANT 4TH DTR 2019 VACANT IST DTR 2020 VACANT 2ND DTR 2020 VACANT 3RD DTR 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				•	•	•	02/19/2020
2019 - 2020							0527 Hrs. 05/18/2020 0436 Hrs. 08/18/2020 2302 Hrs. 4TH Qtr 2020 COVID
Follow up needed							
Follow up Completed							
Building	<b>402</b> 3104 State	<b>404</b> 3104 State	<b>406</b> 3104 State	<b>408</b> 3104 State	<b>411</b> 3071 State	<b>412</b> 3070 State	<b>413</b> 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		<u>ı</u>	<u> </u>	1			<u> </u>
2019 - 2020	QTR 2020	03/12/2020 VACANT 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH QTR 2020	03/12/2020 2026 Hrs. 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH Qtr 2020	03/12/2020 2026 Hrs. 06/10/2020 1717 Hrs. 09/11/2020 1620 Hrs. 4TH Qtr 2020	03/17/2020 VACANT 06/17/2020 VACANT 09/17/2020 VACANT 12/30/2020	01/06/2020 2032 Hrs. 04/06/2020 1723 Hrs. 07/07/2020 1824 Hrs. 10/06/2020	01/15/2020 1934 Hrs. 04/17/2020 2035 Hrs. 07/20/2020 1622 Hrs. 10/20/2020
	QTR 2020 COVID	QTR 2020 COVID	4TH Qtr 2020 COVID	4TH Qtr 2020 COVID	12/30/2020 1546 Hrs.	10/06/2020 1610 Hrs.	10/20/202 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	415	416	418	420	422	424
1st Shift	3056 Peterson	3054 Peterson	3052 Peterson	753 Solar	743 Solar	723 Solar	715 Solar
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		

I			
]			

# 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



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



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.

# <u>DHHS Letter</u> <u>Regarding launch of Litigature project</u>

Attachment L2





#### **DEPT. OF HEALTH AND HUMAN SERVICES**

**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 look forward to partnering with you all in these planning efforts.

Chief Operating Officer

Department of Health and Human Services

Sheri Dawson, RN, BS

Director

Division of Behavioral Health

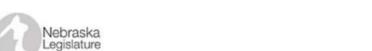
Department of Health and Human Services

# **Facility Staff Information**

# Staffing Levels Number of Assaults on Staff

Attachment L3

	<b>-</b>					
Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
A19211 S19112	ACCOUNTANT I	1 1	0	<u> </u>	0% 0%	0% 0%
H77023	ACCOUNTING CLERK II ACTIVITY SPECIALIST	17	0	17	0%	0%
V77024	ACTIVITY SPECIALIST 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%
179510	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%
174110	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 1	0% 0%	0%
G75017 N00750	DIRECTOR OF NURSING (NEW) FACILITY OPERATING OFFICER	1 2	0	2	0%	0% 25%
M80121	FOOD SERVICE AIDE	3	0	3	0%	0%
M80123	FOOD SERVICE AIDE	23	1	24	4%	18%
R80123	FOOD SERVICE COOK	0	1	1	100%	10 /0
V80312	FOOD SERVICE COOK  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%	
175013	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 R74731	OFFICE SERVICES MANAGER I PHARMACIST	0	2	2	0% 100%	0%
N74740	PHARMACIST/CLINICAL	3	0	3	0%	0%
174712	PHARMACY INVENTORY TECHNICIAN	1	0	1	0%	0%
N74732	PHARMACY MANAGER	1	0	1	0%	0%
174711	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 STATISTICAL ANALYST II	4	0	<u>4</u> 1	0% 0%	17%
A13252		1	0	1	0%	0% 0%
V13253 S05211	STATISTICAL ANALYST III 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%
				-		



Jerall Moreland <imoreland@leg.ne.gov>

#### **Ombudsman's Contact**

Snyder, Peter To: "Moreland, Jerall"

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

3. The number of positions needed in your HR staffing plan for FY21

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** 

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Jerall Moreland <imoreland@leg.ne.gov>

#### **Ombudsman's Contact**

Snyder, Peter < Peter To: "Moreland, Jerall Cc: "Vogel, Barbara"

Mon, Feb 8, 2021 at 4:56 PM

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** 

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# **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

			ion

Building: Lincoln Regional Center Contact: Kurt -

Address: 801 W Prospector Pl Phone:

Address: Fax:

City/State/Zip: Lincoln, NE 68522 Mobile:
Country: United States of America Email:

#### **Inspection Performed By**

Company: General Fire & Safety Inspector: Ron Fox

Address: 2431 Fairfield Street Phone:

Address: Fax:

City/State/Zip: Lincoln, NE 68521 Mobile:

Country: United States of America Email:

#### **Inspection Summary**

Cataman	Total	Items	Serv	riced	Pas	sed	Failed	/Other
Category	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 Building: Lincoln Regional Center

Inspector: Ron Fox Contact: Kurt -

Signed: 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
	I	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,	Building 14 1st-Hall-Rm 138	ZP736943	Hydro Test	09/29/20 2:52:10 PM
A.B.C.		ZP736943		
Fire Extinguisher, 5 Lbs,	Building 14 1st-Hall-Rm 148a	AZ497634	Inspected	09/09/20 9:34:04 AM
A.B.C.	3	AZ497634	•	
Fire Extinguisher, 5 Lbs,	Building 14 1st-Hall-Rm 153	YF864122	Inspected	09/09/20 9:32:43 AM
A.B.C.	3	YF864122	•	, ,
Fire Extinguisher, 5 Lbs,	Building 14 1st-Hall-Rm 189	SP535641	Inspected	09/09/20 9:28:48 AM
A.B.C.	2aag	SP535641		03/03/20 3.20.10 /
Fire Extinguisher, 5 Lbs,	Building 14 2nd-Hall-Rm 212	XA51018	Inspected	09/09/20 9:51:51 AM
A.B.C.	banang i i zna man mi ziz	XA51018	mspeered	03/03/20 3.31.31 /
Fire Extinguisher, 5 Lbs,	Building 14 2nd-Hall-Rm 240	V69213	Inspected	09/09/20 9:46:07 AM
A.B.C.	building 14 Zhu-Hall-Kill Z40	V69213	iiispecteu	09/09/20 9.40.07 AW
	Building 14 2nd-Hall-Rm 252	YC301458	Inchested	09/09/20 9:44:36 AM
Fire Extinguisher, 10 Lbs,	Building 14 Zilu-Hall-Kill 232		Inspected	09/09/20 9.44.30 AW
A.B.C.	Duilding 14 2nd Hall Due 201	YC301458	Ulvalua Taak	00/20/20 2.22.2C DM
Fire Extinguisher, 10 Lbs,	Building 14 2nd-Hall-Rm 281	ZU118735	Hydro Test	09/29/20 3:23:36 PM
A.B.C.	B !!!! 140 !!! B 200	ZU118735		00/00/00 0 00 00 00
Fire Extinguisher, 10 Lbs,	Building 14 2nd-Hall-Rm 290	XG-467364	Inspected	09/09/20 9:39:31 AM
A.B.C.		XG-467364		
Fire Extinguisher, 5 Lbs,	Building 14 2nd-Rm 217	XM79553	Inspected	09/09/20 9:49:32 AM
A.B.C.		XM79553		
Fire Extinguisher, 5 Lbs,	Building 14 2nd-Rm 230	AK349954	Inspected	09/09/20 9:47:57 AM
A.B.C.		AK349954		
Fire Extinguisher, 6 Ltr,	Building 14 2nd-Rm	AC817615	Inspected	09/09/20 9:42:48 AM
Class K	271-Kitchen	AC817615		
Fire Extinguisher, 5 Lbs,	Building 14 3rd-Hall-Middle	ZP736936	Hydro Test	09/29/20 3:27:06 PM
A.B.C.	Stairs	ZP736936		
Fire Extinguisher, 5 Lbs,	Building 14 3rd-Hall-Rm 319	ZP724320	Hydro Test	09/29/20 3:26:10 PM
A.B.C.		ZP724320		
Fire Extinguisher, 5 Lbs,	Building 14 3rd-Hall-Rm 331	ZP736994	Hydro Test	09/29/20 3:28:26 PM
A.B.C.		ZP736994		
Fire Extinguisher, 10 Lbs,	Building 14 3rd-Hall-Rm 359	ZZ-182844	Inspected	09/09/20 9:55:05 AM
A.B.C.		ZZ-182844		
Fire Extinguisher, 10 Lbs,	Building 14 3rd-Office-Rm	C98789954	Inspected	09/09/20 9:57:46 AM
A.B.C.	348	C98789954	·	
Fire Extinguisher, 10 Lbs,	Building 14 LL-Elev Mech	K884527	Inspected	09/09/20 9:17:53 AM
A.B.C.	Rm-Rm 039	K884527	.,	,,
Fire Extinguisher, 5 Lbs,	Building 14 LL-Hall-Rm 029	ZP724348	Hydro Test	09/29/20 3:42:02 PM
A.B.C.	2aag 0_3	ZP724348	,	03/23/20 31 12102 1111
Fire Extinguisher, 5 Lbs,	Building 14 LL-Hall-Rm 041	ZP724373	Hydro Test	09/29/20 3:43:16 PM
A.B.C.	bananig i i EE i ian i iii o i i	ZP724373	11,410 1630	03/23/20 3. 13.10 1111
Fire Extinguisher, 5 Lbs,	Building 14 LL-Hall-Rm 056	ZP715804	Hydro Test	09/29/20 3:35:24 PM
A.B.C.	banding 14 LE Han Kin 050	ZP715804	riyaro rest	03/23/20 3.33.24 TW
Fire Extinguisher, 5 Lbs,	Ruilding 14 LL Mach Pm 014	BS730257	Inspected	09/09/20 9:10:39 AM
A.B.C.	Building 14 LL-Mech Rm 014	BS730257	Inspected	03/03/20 3.10.33 AM
	Puilding 14 LL NW Us!!		Hydro Tost	00/20/20 2:47:40 084
Fire Extinguisher, 5 Lbs,	Building 14 LL-NW Hall	ZW989049	Hydro Test	09/29/20 2:47:40 PM
A.B.C.	Duilding 1411 NIM/MI-	ZW989049	lnenoete d	00/25/20 11:15:10 444
Fire Extinguisher, 6 Ltr,	Building 14 LL-NW Mech	AB110001	Inspected	09/25/20 11:15:19 AM
Class K	Room-Spare	AB110001	In an art I	00/25/20 11 10 20 434
Fire Extinguisher, 10 Lbs,	Building 14 LL-NW Mech	57605861	Inspected	09/25/20 11:19:28 AM
A.B.C.	Room-Spare	WT-363452		00/05/00 15 55 55
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,	Building 14 LL-NW Mech	XL914520	Inspected	09/25/20 11:17:26 AM
A.B.C.	Room-Spare	XL914520		
Fire Extinguisher, 5 Lbs,	Building 14 LL-NW Mech	WU105507	Inspected	09/25/20 11:24:45 AM
A.B.C.	Room-Spare	WU105507		
Fire Extinguisher, 5 Lbs,	Building 14 LL-NW Mech	AU800350	Inspected	09/25/20 11:27:49 AM
A.B.C.	Room-Spare	AU800350		
Fire Extinguisher, 5 Lbs,	Building 14 LL-NW Mech	AV616821	Inspected	09/25/20 11:28:12 AM
A.B.C.	Room-Spare	AV616821		
Fire Extinguisher, 5 Lbs,	Building 14 LL-NW Mech	AW981212	Inspected	09/25/20 11:30:30 AM
A.B.C.	Room-Spare	AW981212		
Fire Extinguisher, 5 Lbs,	Building 14 LL-Rm 029	VZ498987	Inspected	09/09/20 9:12:41 AM
A.B.C.		VZ498987		
Fire Extinguisher, 5 Lbs,	Building 14 LL-Rm	ZP724307	Hydro Test	09/29/20 3:36:42 PM
A.B.C.	056-Storage	ZP724307		
Fire Extinguisher, 5 Lbs,	Building 14 LL-Rm 056b	XL938807	Inspected	09/09/20 9:23:00 AM
A.B.C.		XL938807		
Fire Extinguisher, 5 Lbs,	Building 14 LL-Rm	ZP724331	Hydro Test	09/29/20 3:40:47 PM
A.B.C.	062-Storage	ZP724331		
Fire Extinguisher, 5 Lbs,	Building 14 LL-Shop-Rm 054	AW981252	Inspected	09/09/20 9:20:44 AM
A.B.C.		AW981252		
Fire Extinguisher, 5 Lbs,	Building 14 LLNW Mech	AT713959	Inspected	09/25/20 11:24:53 AM
A.B.C.	Room-Spare	AT713959		
Fire Extinguisher, 5 Lbs,	Building 3 1st-By Elevator	A40076392	Inspected	09/11/20 10:36:18 AM
A.B.C.		A40076392		
Fire Extinguisher, 5 Lbs,	Building 3 1st-East	BS798461	Inspected	09/11/20 10:33:44 AM
A.B.C.		BS798461		
Fire Extinguisher, 10 Lbs,	Building 3 1st-Kitchen	W-425773	Inspected	09/11/20 10:31:02 AM
A.B.C.		W-425773		
Fire Extinguisher, 5 Lbs,	Building 3 1st-West	AU371289	Inspected	09/11/20 10:27:53 AM
A.B.C.		AU371289		
Fire Extinguisher, 5 Lbs,	Building 3 2nd-By Elevator	BN438136	Inspected	09/11/20 10:39:29 AM
A.B.C.		BN438136		
Fire Extinguisher, 5 Lbs,	Building 3 2nd-East	BN438033	Inspected	09/11/20 10:42:54 AM
A.B.C.		BN438033		
Fire Extinguisher, 5 Lbs,	Building 3 2nd-Kitchen	AW981794	Inspected	09/11/20 10:45:21 AM
A.B.C.		AW981794		
Fire Extinguisher, 5 Lbs,	Building 3 2nd-West	S758439	Inspected	09/11/20 10:48:55 AM
A.B.C.		S758439		
Fire Extinguisher, 5 Lbs,	Building 3 LL-East	BV748715	Inspected	09/11/20 10:08:49 AM
A.B.C.		BV748715		
Fire Extinguisher, 5 Lbs,	Building 3 LL-Elevator Mech	AK346420	Inspected	09/11/20 10:13:43 AM
A.B.C.	Room	AK346420		
Fire Extinguisher, 10 Lbs,	Building 3 LL-Maintenance	BF-142204	Inspected	09/11/20 10:06:03 AM
A.B.C.	Shop	BF-142204		
Fire Extinguisher, 5 Lbs,	Building 3 LL–Rec	YB784137	Inspected	09/11/20 10:20:00 AM
A.B.C.	Room-Kitchen	YB784137		
Fire Extinguisher, 5 Lbs,	Building 3 LL-Rec Room-West	BK191555	Inspected	09/11/20 10:16:49 AM
A.B.C.	Wall	BK191555		
Fire Extinguisher, 10 Lbs,	Building 3 LL-Rm 008-Mech	AT-018360	Inspected	09/11/20 10:23:06 AM
A.B.C.	Room	AT-018360		
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,	Building 3 LL-West	AZ499964	Inspected	09/11/20 10:25:41 AM
A.B.C.		AZ499964		
Fire Extinguisher, 5 Lbs,	Building 5 1st-Lobby	XL938806	Inspected	09/09/20 2:53:01 PM
A.B.C.		XL938806		
Fire Extinguisher, 5 Lbs,	Building 5 1st-Rec Room-RT	XB816431	Inspected	09/09/20 3:09:04 PM
A.B.C.	Office	XB816431		
Fire Extinguisher, 5 Lbs,	Building 5 1st-S2-Tech	XL914486	Inspected	09/09/20 2:44:28 PM
A.B.C.	Station	XL914486		
Fire Extinguisher, 5 Lbs,	Building 5 LL-Gym Storage	XF876503	Inspected	09/09/20 2:03:04 PM
A.B.C.		XF876503		
Fire Extinguisher, 5 Lbs,	Building 5 LL-West Electrical	XS048693	Inspected	09/09/20 2:59:20 PM
A.B.C.	Room	XS048693		
Fire Extinguisher, 5 Lbs,	Building 5	ZP737022	Hydro Test	09/28/20 3:48:17 PM
A.B.C.	1st-Canteen-Breakroom	ZP737022		
Fire Extinguisher, 6 Ltr,	Building 5	A-35484808	Hydro Test	09/28/20 3:38:39 PM
Class K	1st-Canteen-Kitchen	A-35484808		
Fire Extinguisher, 5 Lbs,	Building 5 1st-H.I.M. Office	ZT900966	Inspected	09/09/20 1:56:39 PM
A.B.C.		ZT900966		
Fire Extinguisher, 10 Lbs,	Building 5 1st-Kitchen	ZP896214	Hydro Test	09/28/20 3:48:52 PM
A.B.C.		ZP896214		
Fire Extinguisher, 5 Lbs,	Building 5 1st-Rec Room	AW981247	Inspected	09/09/20 2:08:28 PM
A.B.C.		AW981247		
Fire Extinguisher, 10 Lbs,	Building 5 1st-Rec	RX-783016	Inspected	09/09/20 2:11:53 PM
A.B.C.	Room-Library	RX-783016		
Fire Extinguisher, 5 Lbs,	Building 5 1st-S1-Fire Exit	VS-479556	Inspected	09/09/20 2:25:07 PM
A.B.C.		VS-479556		
Fire Extinguisher, 5 Lbs,	Building 5 1st-S1-Tech Room	SJ-230294	Inspected	09/09/20 2:23:27 PM
A.B.C.		SJ-230294		
Fire Extinguisher, 5 Lbs,	Building 5 1st-S2-Fire Exit	AT713834	Inspected	09/09/20 2:41:32 PM
A.B.C.		AT713834		
Fire Extinguisher, 5 Lbs,	Building 5 1st-S3-Fire Exit	AY719620	Inspected	09/09/20 2:27:26 PM
A.B.C.		AY719620		
Fire Extinguisher, 5 Lbs,	Building 5 1st-Security Office	RH-020799	Inspected	09/09/20 1:57:52 PM
A.B.C.		RH-020799		
Fire Extinguisher, 5 Lbs,	Building 5 2nd-S3-Tech	WU095774	Inspected	09/09/20 2:31:44 PM
A.B.C.	Station	WU095774		
Fire Extinguisher, 5 Lbs,	Building 5 2nd-S4-Fire Exit	AW981253	Inspected	09/09/20 2:39:48 PM
A.B.C.		AW981253		
Fire Extinguisher, 5 Lbs,	Building 5 2nd-S4-Tech	RH-020810	Inspected	09/09/20 2:36:44 PM
A.B.C.	Station	RH-020810		
Fire Extinguisher, 5 Lbs,	Building 5 2nd-S5-Tech	R988783	Inspected	09/09/20 2:51:18 PM
A.B.C.	Station	R988783		00/00/00 0 00 00
Fire Extinguisher, 5 Lbs,	Building 5 2nd–South Elev	AT713841	Inspected	09/09/20 2:33:42 PM
A.B.C.	Mech Room	AT713841		00/00/00 0 40 00 04
Fire Extinguisher, 10 Lbs,	Building 5 Annex-Hall	ZP896220	Hydro Test	09/28/20 3:49:20 PM
A.B.C.	Duilding E Anney Mach Darre	ZP896220	Inconceto d	00/00/20 2:15:02 04
Fire Extinguisher, 5 Lbs,	Building 5 Annex-Mech Room	WA-658121	Inspected	09/09/20 3:15:03 PM
A.B.C.	Puilding E.H. Fact Floo Boom	WA-658121	Inchested	00/00/20 2:00:55 884
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,	Ruilding 5 LL -Floy Mach Poom		Inspected	00/00/20 2:02:12 DM
rife extiliguistier, 5 LDS,	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,	Building 5 LL-Gym-Work Out	VP-622356	Inspected	09/09/20 2:05:45 PM
A.B.C.	Room	VP-622356		
Fire Extinguisher, 5 Lbs,	Building 5 LL-Mech Room	AZ621013	Inspected	09/09/20 2:56:14 PM
A.B.C.		AZ621013		
Fire Extinguisher, 10 Lbs,	Building 7 LL-Elev Mech Room	BR334948	Inspected	09/09/20 11:16:48 AM
A.B.C.		BR334948		
Fire Extinguisher, 5 Lbs,	Building 7 LL-Loading Dock	XS122493	Inspected	09/09/20 11:14:25 AM
A.B.C.		XS122493		
Fire Extinguisher, 10 Lbs,	Building 9 Basement Mech	X863229	Inspected	09/09/20 11:13:22 AM
Carbon Dioxide	Room	X863229		
Fire Extinguisher, 5 Lbs,	Building 9 Basement-Stairs	BN340978	Inspected	09/09/20 10:58:42 AM
A.B.C.		BN340978		
Fire Extinguisher, 5 Lbs,	Building 9 East Hall	AK379543	Inspected	09/09/20 10:54:17 AM
A.B.C.		AK379543		
Fire Extinguisher, 5 Lbs,	Building 9 East Hall	AK347330	Inspected	09/09/20 10:56:35 AM
A.B.C.		AK347330		
Fire Extinguisher, 5 Lbs,	Building 9 South Lobby	M613495	Inspected	09/09/20 10:47:01 AM
A.B.C.		M613495		
Fire Extinguisher, 20 Lbs,	Maintenance/Grounds Boiler	ZR267659	Hydro Test	09/28/20 3:17:40 PM
A.B.C.	Room-South Wall	ZR267659		
Fire Extinguisher, 5 Lbs,	Maintenance/Grounds	ZP715802	Hydro Test	09/28/20 3:23:03 PM
A.B.C.	Carpenter Shop-North	ZP715802		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds	AH-333035	Inspected	09/28/20 3:18:27 PM
A.B.C.	Carpenter Shop-South	AH-333035		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds Cave	BF-142219	Inspected	09/28/20 3:19:08 PM
A.B.C.		BF-142219		
Fire Extinguisher, 20 Lbs,	Maintenance/Grounds Gas	V897464	Inspected	09/09/20 11:41:42 AM
B.C.	Pump	V897464		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds	K901376	Inspected	09/28/20 3:20:16 PM
A.B.C.	Grounds Shop-Entry	K901376		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds Shop	YU18673	Inspected	09/09/20 12:01:01 PM
A.B.C.		YU18673		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds Shop	ZP896247	Hydro Test	09/28/20 3:26:01 PM
A.B.C.		ZP896247		
Fire Extinguisher, 10 Lbs,	Maintenance/Grounds West	ZP896238	Hydro Test	09/28/20 3:23:55 PM
A.B.C.	Shed-Entry	ZP896238		

# 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		
3001112		Due in 2021	,	2.0000111	2410		
		down/Maintenar	nce				
Eiro Evti	nguisher, A.B.C., 10 Lbs						
		102017500	00/00/27	00/11/21	00/00/15		
A92847699	Building 10 LL-Kitchen Office	A92847699	09/09/27	09/11/21 Fire Extinguisher, A	09/09/15		
	H	Iydrostatic Test	Total	The Extinguisher, A	A.B.C., TO LDS. T		
Fire Exti	nguisher, 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		
			· · ·	l 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		
			Tota	l Fire Extinguisher,	Class K, 6 Ltr: 1		
	I	Due in 2022					
	Break	down/Maintenar	nce				
Fire Exti	nguisher, A.B.C., 5 Lbs						
WK692500	Building 10 LL-Elev	WK692500	09/09/28	09/11/22	09/09/04		
			Tota	l Fire Extinguisher	, A.B.C., 5 Lbs: <b>1</b>		
	H	lydrostatic Test					
Fire Exti	nguisher, 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 Exti	nguisher, 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		
			Tota	l Fire Extinguisher	, A.B.C., 5 Lbs: <b>2</b>		
Fire Exti	nguisher, B.C., 20 Lbs						
V897464	Maintenance/Grounds Gas Pump	V897464	09/09/22	09/09/28	09/09/10		
			Tot	al Fire Extinguishe	r, B.C., 20 Lbs: 1		
Fire Exti	nguisher, Class K, 6 Ltr						
AC817615	Building 14 2nd-Rm 271-Kitchen	AC817615	09/09/22		09/09/12		
			Tota	l 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	
Fire Extinguisher		Fire	100.00%	115
	Qt			
Type	у	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**

1313 Farnam, Rm. 233 Omaha, NE 68102

sfm.Conveyances@nebraska.gov Office: 402-595-3184

Fax: 402-595-1360

Building Name: h neo n legons Cut	Building Address:		北			
Elevator No.: State ID Number: 40 7	<b>Elevator Type</b> :		Eleva	ntor Use	: # of Landings:	
Last Annual Insp. Date: 5-8-2019 Elevator Speed:	Elevator Capacity:	C	Code Ye	ar:	Manufacturer:	
ELEVATORS Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes	
1 Must make door reopening device operable.	1.1.1	ĊXI"				
2 Must make car and floor sill's level.	1.3.1.1	12				
3 Must make emergency light operable.	1.5.1(b)	X				
4 Must make emergency Alarm Bell/Phone operable.	1.6.1	2				
5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1	<u> 2</u> 2				
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	1				
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	ĮΣŕ			granden and the second	
12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	X		ā	TESTED April 2002l	
13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)	f.		(X)	· · · · ·	
14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	F		KZ KZ		
15 Must make car top stop switch operable.	3.1.1	T I	ΙĦ	ñ		
16 Must make car top inspection station operable.	3.3.1	120	ΗĒ	Ħ		
17 Must make car top light and GFCI outlet operable.	3.2.1	N	ΙĦ	T		
18 Must make hoist way venting clear and louvers operable.	3,11,1	Ä	H	M		
19 Check that a standard railing is provided where required.	3.4.3.1 (b)	Ħ	ΙĦ	V		
20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1	Ħ	li	P		
21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3	Z		Ħ		
22 Must maintain monthly fire service testing log in control room.	6.1.1	M	ΙĦ	H		
23 Must maintain door closing foot pound pressure within limits.	1.8.1	X X	<del>                                      </del>	H		
24 Must properly adjust door equipment on car & hall doors.	3.17.1	A		Ħ		
25 Must maintain door gibs and retainers if provided to code.	1.7.1	X		H		
26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	M	片片	H		
27 Must provide pit ladder on all pits over 30", on P.U. side of door.		1	┝╞┼╌	H	7	
28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(b)	Z	<del>   - </del> -	H		
29 Must make pit stop switch operable, locate adjacent to ladder.		<u> </u>	- -	H		
30 Must make pit stop switch operable, locate adjacent to ladder. 30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(c)		<del>   - </del> -	뭐		
		M	닏	부		
31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	N N	<u> </u>	Ш	6	
32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	ľΑ				
ESCALATORS						
33 Must keep handrails free from cuts, cracks, pinch points and oth						
34 Must keep covers secure, no tripping hazards, maintain open ar						
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 whi	ch mesh 7.7.1				ĵe.	
7 Must maintain gap between moving step and stationary skirt par						
38 Must keep excessive play or rocking movement in steps to a min	nimum. 7.9.1(b,1)	n	M	Ħ		
39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up gu			Ы	Ħ		
	pector Signature:	3	10	53	mhs Date: 08 25 2	
College Control Name		- Ca	4 0	400	Date: 00. 40 B	
Building Contact Name: Tom / Con	tact Signature:					

1313 Farnam, Rm. 233

Omaha, NE 68102

sfm.Conveyances@nebraska.gov Office:

402-595-3184 Fax: 402-595-1360

Building Name: Lincoln Resignation	TF Building Address:	#	_5		
Elevator No.: State ID Number: 40 1	/ Elevator Type: 🔑	rDr C	Eleva	ntor Us	e: 4 of Landings: 2
ast Annual Insp. Date: 5' -8-2019 Elevator Speed:	Elevator Capacity:	C	ode Ye	ar:	Manufacturer: TRE
ELEVATORS Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
Must make door reopening device operable.	1.1,1				
2 Must make car and floor sill's level.	1.3.1.1	2			
B Must make emergency light operable.	1.5.1(b)	M			
Must make emergency Alarm Bell/Phone operable.	1,6.1				
Must make restrictors work outside 18" zone to 4" max open.	1.18.1	K			
Ensure permanent/unobstructed access to machines/controls.	11.1.3	X			
7 Must provide ample, guarded, machine room lighting.	2.3.1				
B Must provide sufficient heating/cooling for equipment	2.6.1	X			
Must provide lockable mainline and lighting disconnects.	2.11,1	32			
10 Must have fire extinguisher adjacent to controls/machine areas	2.7	Z			
1 Clear of non-elevator storage, flammables, from oil, grease, dirt		A			
2 Current relief test records tag/plate for pressure testing 1 year	2.31.1	X	Π	Π	40rl 2020
3 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)	T		X	
4 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	Ī		X	
5 Must make car top stop switch operable.	3.1.1	মি	Ħ		
6 Must make car top inspection station operable.	3.3.1	N	Ħ		
7 Must make car top light and GFCI outlet operable.	3.2.1	Ĭ.		Ħ	
8 Must make hoist way venting clear and louvers operable.	3.11.1	#	Ħ	k	
9 Check that a standard railing is provided where required.			H	玄	
	3.4.3.1 (b)	屵	-		
0 Must keep all ropes free from rust/kinks/broken strands.	3.23.1		$\vdash \vdash$	Ø	
1 Must test Fire Service Phase One & Two monthly.	6.5,2 & 6.5.3	N/A			
2 Must maintain monthly fire service testing log in control room.	6.1.1	ĮŽI			
3 Must maintain door closing foot pound pressure within limits.	1.8.1	2			
4 Must properly adjust door equipment on car & hall doors.	3.17.1	X			
5 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			
7 Must provide pit ladder on all pits over 30°, on P.U. side of door.	. 5.1.1(b)	M			
8 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	X			
9 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	X			
0 Must make pit light operable, switch adjacent to ladder, 18" high		X	F	Ħ	
1 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1 (e)	-	Ħ	一	
2 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14		H	H	
ESCALATORS	J. 10-14	لكل		L	
	<u> </u>			_	
3 Must keep handrails free from cuts, cracks, pinch points and oth		$\perp$	Щ.		
4 Must keep covers secure, no tripping hazards, maintain open ar		Ц.	_Ц_	Ш	
5 Must keep safety decals or signs in good shape for passengers	to read, 7.6	ᆜᆜ	Щ_	Ш	
S Must keep stationary comb plates and escalator step edges white				Ш	
Must maintain gap between moving step and stationary skirt pan					
B Must keep excessive play or rocking movement in steps to a mir					
Current MCP tasks w/dates, tests, repairs, callbacks, start-up gu	ide. 2013+ 7.19/1				1
spector Name: Insp utiding Contact Name: 16 M	oector Signature:	lin	B	S	Londo Date: 08-25-2

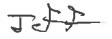


1313 Farnam, Rm. 233 Omaha, NE 68102

sfm.Conveyances@nebraska.gov Office: 402-595-3184

Fax: 402-595-1360

Building Name: Am	colm RagionalC	Building Address:	- <del></del>	5		0
Elevator No.:	State ID Number: 640	ろ Elevator Type: <i>H</i>	402	<i>O</i> Eleva	itor Us	e: 1455 # of Landings:
Last Annual Insp. Date:	S-8-50 Elevator Speed:	Elevator Capacity:	C	ode Ye	ar:	Manufacturer: TRE
<b>ELEVATORS</b> De	evices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
1 Must make door reopening	The state of the s	1.1.1	টাব			
2 Must make car and floor s		1.3.1.1	M			
3 Must make emergency light		1.5.1(b)	Z			
4 Must make emergency Al		1.6.1	Z			
	rk outside 18" zone to 4" max open.	1.18.1	X X			
	tructed access to machines/controls.	11.1.3	X			
7 Must provide ample, guar	ded, machine room lighting.	2.3.1	X X			
	eating/cooling for equipment	2.6.1	<b>24</b>			
	inline and lighting disconnects.	2.11.1	ZI'			
10 Must have fire extinguis	her adjacent to controls/machine areas	2.7	K			
	orage, flammables, from oil, grease, dirt.		<b>A</b>			
	s tag/plate for pressure testing 1 year	2.31.1	X			TESTED MOVE (202
13 Must provide current go	vernor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			V	
	s, repairs, callbacks, oil usage. 2013+	2.40.1			X	
15 Must make car top stop		3.1.1	M			
To Must make car top mspe		3.3.1	M			
17 Must make car top light a	NAME AND ADDRESS OF THE PARTY O	3.2.1	Z			
	nting clear and louvers operable.	3.11.1			X	
19 Check that a standard ra	iling is provided where required.	3.4.3.1 (b)			M	
	from rust/kinks/broken strands.	3.23.1			N	
21 Must test Fire Service P		6.5.2 & 6.5.3	X	985		
E	ire service testing log in control room.	6.1.1	À	ĪП	Ī	23
	ng foot pound pressure within limits.	1.8.1	<b>A</b>	Ħ	Ħ	***
24 Must properly adjust do	or equipment on car & hall doors.	3.17.1	12		Ħ	
25 Must maintain door gibs	and retainers if provided to code.	1.7.1	Z			
26 Escutcheons intact, secu	ure. Access switches & limits work OK,	4.5.1	74			
27 Must provide pit ladder of	n all pits over 30", on P.U. side of door.	5.1.1(b)	W			,
28 Must maintain a dry pit, o	clean and paint pit equipment.	5.1.1(e)	X			
15	h operable, locate adjacent to ladder.	5.1.1(c)	127		П	
	able, switch adjacent to ladder, 18" high		Į.	Ħ	Ħ	
	ited or 5-2" holes to allow water inside	5.1.1 (e)	TXT		ī	
	rust free, clean to bare metal, paint	5.10-14		H	H	
ESCALATORS	rust nee, clean to bare metal, paint	0.10-14	LSI.		<u> </u>	
	from cuts, cracks, pinch points and other					
	, no tripping hazards, maintain open are		+		H	
35 Must keen safety decale	or signs in good shape for passengers t	to read, 7,6	H	- -	H	
36 Must keep stationary con	or signs in good snape for passengers in nb plates and escalator step edges which	to read, 7,6	H	-  -	H	
			-	-	片	
	en moving step and stationary skirt pan y or rocking movement in steps to a min		Η	H	H	
	10/2007/04		ᆜ	⊢∺	님	
	es, tests, repairs, callbacks, start-up gui	ide. 2013+ 7.19-1		4	Щ	
Inspector Name:	Insp	ector Signature:	and	1/3	37	Bonks Date: 08-25-20
Building Contact Name:	10m' Cont	act Signature:				



1313 Farnam, Rm. 233 Omaha, NE 68102

sfm.Conveyances@nebraska.gov Office:

402-595-3184 Fax: 402-595-1360

Building Name:	Lincol	on Designal Com	F Building Address:	B	the	10	0
Elevator No.:	# 2_	State ID Number: 1/83	Elevator Type:	22	Eleva	ator Use	$\times$ $Y_{4Se}$ # of Landings: $3$
Last Annual Insp	o. Date:5 8	Elevator Speed:	Elevator Capacity:	C	ode Ye	аг:	Manufacturer: て 大 医
ELEVATORS	Device	es Tested/Test Requirement	ASME A17.2 Item #	Rass	Fail	N/A	Results/Notes
1 Must make doo			1.1.1	X			
2 Must make car			1.3.1.1	X			
3 Must make em			1.5.1(b)	N/			
		Bell/Phone operable.	1.6.1				
		utside 18" zone to 4" max open.	1.18.1			[ <del>Z</del> ]	
		ted access to machines/controls.	11.1.3	<u> 7</u>			
		, machine room lighting.	2.3.1	Z			
8 Must provide si	ufficient heatin	g/cooling for equipment	2.6.1	<b>Z</b>			
		e and lighting disconnects.	2.11.1	[X]			
		adjacent to controls/machine areas	2.7	X			
11 Clear of non-e	elevator storage	e, flammables, from oil, grease, dirt.		<u>V</u> ,			
12 Current relief t	test records ta	g/plate for pressure testing 1 year	2.31.1	M			TESTED April 2021
		or test tag/plate 1/5 year.	2.13.2.1 (b) (6)	$\sqcup$		VZI	
		pairs, callbacks, oil usage. 2013+	2.40.1	<u> </u>		[X]	
15 Must make ca			3.1.1	[X]			
		n station operable.	3.3.1	K		Ш	
		GFCI outlet operable.	3.2.1	<u>Z</u>			
V 3		g clear and louvers operable.	3.11.1	_Ļ_		[X]	
19 Check that a s	tandard railing	is provided where required.	3.4.3.1 (b)	ĽΧ			
		n rust/kinks/broken strands.	3,23,1			M	
21 Must test Fire	Service Phase	One & Two monthly.	6.5.2 & 6.5.3	M M			
		ervice testing log in control room.	6.1.1	মি			
23 Must maintain	door closing for	oot pound pressure within limits.	1.8.1	ग्रि	F		
24 Must properly	adjust door ed	quipment on car & hall doors.	3.17.1	X ,Z	T		
25 Must maintain	door gibs and	retainers if provided to code,	1.7.1	M			
		Access switches & limits work OK.	4.5.1	X			
27 Must provide p	it ladder on all	pits over 30", on P.U. side of door.	5.1.1(b)	X			
28 Must maintain	a dry pit, clear	n and paint pit equipment.	5.1.1(e)	A			
29 Must make pit	stop switch op	erable, locate adjacent to ladder.	5.1.1(c)	(X)		F	
		switch adjacent to ladder, 18" high	5.1.1(d)	V X	H		
		or 5-2" holes to allow water inside	5.1.1 (e)		H	H	
		free, clean to bare metal, paint	5.10-14	X	-	H	
ESCALATORS	adnibilient rast	nee, dean to bare metal, paint	3,10-14	لكوا	Ш	U	
	desila fesa fusu	and analysis about a lateral deli-	1 70				
		n cuts, cracks, pinch points and other				$\vdash$ $\vdash$ $\vdash$ $\vdash$	
35 Must keep cov	the decele or of	tripping hazards, maintain open are	ea for access, 7.4	H			<del></del>
		igns in good shape for passengers t		片	-#-		
		lates and escalator step edges which		무			
or wust mathtain (	yap vetween n	noving step and stationary skirt pane		닏	닏	닏	
		rocking movement in steps to a min ests, repairs, callbacks, start-up gui		井	井	片	
nspector Name:				/		0	N
		Insp	ector Signature:	un	13	150	unle Date: 08-15-20:
Building Contact	Name: 4	Cont	act Signature:				

1313 Farnam, Rm. 233 Omaha, NE 68102

sfm.Conveyances@nebraska.gov Office: 402-595-3184

Fax: 402-595-1360

Building Name: Linedy Ros onal Can		BI	do	10	2
Elevator No.: 5 State ID Number: 71 8					
ast Annual Insp. Date 5-8-2019 Elevator Speed:	Elevator Capacity:		code Ye	ar.	Manufacturer: TRE
<b>ELEVATORS</b> Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
1 Must make door reopening device operable.	1.1.1	Ì			
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	M			
5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1				
6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	X			
7 Must provide ample, guarded, machine room lighting.	2.3.1	<b>X</b> 1			
8 Must provide sufficient heating/cooling for equipment	2.6.1	21			
9 Must provide lockable mainline and lighting disconnects.	2.11.1	K			
10 Must have fire extinguisher adjacent to controls/machine areas		[2]			
11 Clear of non-elevator storage, flammables, from oil, grease, di	rt. 2.5,1	X			
12 Current relief test records tag/plate for pressure testing 1 year		X			TESTED April 2000
13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			X	25 3 h 2
14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+				Z	
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	4		Q	
18 Must make hoist way venting clear and louvers operable.	3.11.1			12	
19 Check that a standard railing is provided where required.	3.4.3.1 (b)	)\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{			
20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1			K	
21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3			F	
22 Must maintain monthly fire service testing log in control room.	6.1.1	X X	H	Ħ	
23 Must maintain door closing foot pound pressure within limits.	1.8.1	M	H	H	
24 Must properly adjust door equipment on car & hall doors.	3.17.1	<u>(Z</u> )	H	H	
25 Must maintain door gibs and retainers if provided to code.	1.7.1	X	Ħ	H	
26 Escutcheons intact, secure, Access switches & limits work OK		<u> </u>	Ħ	H	
27 Must provide pit ladder on all pits over 30°, on P.U. side of doo		Ž	H	H	
28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	X	H	H	
9 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	<b>\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{</b>	H	H	
30 Must make pit light operable, switch adjacent to ladder, 18" hig		(X	片	H	
31 Sump cover must be grated or 5-2" holes to allow water inside		NZI.	片	H	
		_124	닉	닏	
2 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	A		L L	
ESCALATORS				<u> </u>	
3 Must keep handrails free from cuts, cracks, pinch points and ot					
34 Must keep covers secure, no tripping hazards, maintain open a		ᆜ		Ш	
5 Must keep safety decals or signs in good shape for passengers		$\Box$			
6 Must keep stationary comb plates and escalator step edges wh					
7 Must maintain gap between moving step and stationary skirt pa					
8 Must keep excessive play or rocking movement in steps to a m					2:
9 Current MCP tasks w/dates, tests, repairs, calibacks, start-up g	puide. 2013+ 7.19,1				
nspector Name: Ins	spector Signature:	te e	1	3/3	world Date: 08-2520.
	ntact Signature:		_		25 0100)2.
9 < 7 1	i ilati Sigilaluiti.				

#### 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: )	incoln Dogsomust Cnt	Building Address:	B	168	w 1	4
Elevator No.:	State ID Number: 1005			Eleva	itor Use	e: # of Landings:
Last Annual Insp.	Date:5'-8-3019 Elevator Speed:	Elevator Capacity:	С	ode Ye	ar:	Manufacturer:
ELEVATORS	Devices Tested/Test Requirement	ASME A17.2 Item#	Pass	Fail	N/A	Results/Notes
	reopening device operable.	1.1.1	取区			
2 Must make car ar		1.3.1.1				
	gency light operable.	1,5,1(b)	IXI			
	gency Alarm Bell/Phone operable.	1.6.1	W			
	ctors work outside 18" zone to 4" max open.	1.18.1	[]			
	nt/unobstructed access to machines/controls.	11.1.3	M			
	ple, guarded, machine room lighting.	2.3.1	(A)			
8 Must provide suff	icient heating/cooling for equipment	2.6.1	<u> </u>		$\sqcup$	
	able mainline and lighting disconnects.	2.11.1	M			
	xtinguisher adjacent to controls/machine areas	2.7	Z			
11 Clear of non-ele	vator storage, flammables, from oil, grease, dirt.		<b>2</b>			
12 Current relief tes	st records tag/plate for pressure testing 1 year	2.31.1	M		<u>U</u>	TESTED April 2020
	ment governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			[2]	10.00
	ites, tests, repairs, callbacks, oil usage. 2013+	2.40.1			团	
	op stop switch operable.	3.1.1				
	op inspection station operable.	3.3.1	ŪŽ.		Ш	
	op light and GFCI outlet operable.	3.2.1	12			
18 Must make hoist	way venting clear and louvers operable.	3.11.1	<b>Z</b>			
19 Check that a sta	ndard railing is provided where required.	3.4.3.1 (b)	<b>Ž</b> a			
20 Must keep all roj	pes free from rust/kinks/broken strands.	3.23.1			DXI	
21 Must test Fire Se	ervice Phase One & Two monthly.	6.5.2 & 6.5.3	X			
22 Must maintain m	nonthly fire service testing log in control room.	6.1.1	X			
	oor closing foot pound pressure within limits.	1.8.1	X	n	T	
	djust door equipment on car & hall doors.	3.17.1	<u> </u>			
25 Must maintain do	oor gibs and retainers if provided to code.	1.7.1				
	act, secure. Access switches & limits work OK.	4.5.1	X X			
27 Must provide pit	ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	X			
	dry pit, clean and paint pit equipment.	5.1.1(e)	Tri -			
	op switch operable, locate adjacent to ladder.	5.1.1(c)	<b>1</b> X1			
	tht operable, switch adjacent to ladder, 18" high		হিব	Ħ	F	
	st be grated or 5-2" holes to allow water inside	5.1.1 (e)	Ā	<u> </u>	늗	
	uipment rust free, clean to bare metal, paint	5.10-14	<b>A</b>	H	H	
ESCALATORS	dipriners rust nee, clear to bare metal, paint	3.10-14	JДU			
	atta for form 2012 and the state of the state of the	1 70		r		
	ails free from cuts, cracks, pinch points and other		뷔		片	
	s secure, no tripping hazards, maintain open an		井	井	片	
	decals or signs in good shape for passengers t		#	⊢⊢	-	
	nary comb plates and escalator step edges which				님	
	p between moving step and stationary skirt pan		닏	부	닏	
	sive play or rocking movement in steps to a min		Ц.	Ш	ᆜᆜ	
	ks w/dates, tests, repairs, callbacks, start-up gui	de. 2013+ 7.19.1				
nspector Name:	Insp	ector Signature	In	2>	530	only Date: 08-25-30
Building Contact N	lame: Cont	act 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

 $Generated\ by:\ Building Reports.com$ 

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:				
Address:	Fax:				
City/State/Zip: Lincoln, NE 68522-1701	Mobile:				
Country: United States of America	Email: j				
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 regi	onal center B 3						
FC 02 03 05 FP 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 fir	e alarm requi	rements relat	ted 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 au	tomatic extin	guishing req	uirements 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		
<b>Total Device Count: 17</b>							

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, Pailed=F, Pailed=F

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	I 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	Basement Center room 008		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	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 Cente	r 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 Q4/2	0 Teste	d YTD (2020	)) Tota	Total Quantity	
Drain		1	1	0		1		1	
Device Type	Location		ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20	
Drain	Basement C	enter 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			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	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 Q4/2	20 Fail Q4/	/20 Tes	ted YTD (202	0) Tota	l Quantity
Control Valve		1	1	0		1		1
Device Type	Location		ScanID	Address	Q1/20	Q2/20	Q3/20	Q4/20
Control Valve	2nd Cente	er rom 216	59342407	1	03/02-F	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 indicatin	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.	jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.)								
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 Co	enter 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

2

3

2

Tamper Switch

Tamper Switch

Waterflow Switch

Waterflow Switch

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
	Qt				
Device Type	у	Model #	Type	Description	Install Date
		In Servi	ice - 90 Days	s - 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

Control Valve

Vane

Supervisory

Alarm

Alarm

03/02/2020

03/02/2020

03/02/2020

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

 $Generated\ by:\ Building Reports.com$ 

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:	
Address:	Fax:	
City/State/Zip: Lincoln, NE 68522-1701	Mobile:	
Country: United States of America	Email:	
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 regi	onal center B 5						
FC 02 03 05 FP 02	ix-month testing of tampe esting of mechanical water-						
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		
FC 07 03 05 FP 09	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 fir	e alarm requi	rements rela	ted 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							
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		
<b>Total Device Count: 24</b>							

Certification

Company: NIFCO Mechanical Systems Building: Lincoln regional center B 5

Inspector: Jerad Baxter Contact: tiffany na

Signed: Signed:

T 1	<b>D</b>	~ · · · ·	
Terad	Raxter	Certifications	1

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, Pailed=F, Pailed=F

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	d 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	1 st Closet center	closet by reception	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 Close cliset	t s4 housekeeping	59342388	1	03/02-P	06/08-P	09/08-P	
Tamper Switch	2nd Close cliset	t s4 housekeeping	59342390	1	03/02-P	06/08-P	09/08-P	
Tamper Switch	2nd Close	t 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	I 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	1 st Closet center	closet by reception	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 Close cliset	t s4 housekeeping	59342391	1	03/02-P	06/08-P	09/08-P	
Waterflow Switch	2nd Close cliset	t s4 housekeeping	59342392	1	03/02-P	06/08-P	09/08-P	
Waterflow Switch	2nd Close	t 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 center	closet by reception	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 Close cliset	t s4 housekeeping	59342387	1	03/02-P	06/08-P	09/08-P	
Supervisory Signal	2nd Close cliset	t s4 housekeeping	59342389	1	03/02-P	06/08-P	09/08-P	
Supervisory Signal	2nd Close	t 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 indicatin	g and outsi	de screw and yoke valv	es shall be backed	a one-quarter tu	ırn from the f	ully open pos	ition to preve	ent
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 o	itside 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

6

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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
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
	Qt				
Device Type	у	Model #	Type	Description	Install Date
		In Serv	ice - 90 Da	ys - 1 Year	
Control Valve	1				03/02/2020
Drain	1		Main		03/02/2020
Post Indicator Valve	1				03/02/2020

Control Valve

Vane

Supervisory

Alarm

03/02/2020

03/02/2020

03/02/2020

03/02/2020

03/02/2020

Download Date: 01/12/2021

Supervisory Signal

Tamper Switch

**Tamper Switch** 

Waterflow Switch

Waterflow Switch

## 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	Туре	ScanID
		Control Panel 1		
Zone/A	ddress: 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

 $Generated\ by:\ Building Reports.com$ 

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:	
Address:	Fax:	
City/State/Zip: Lincoln, NE 68522-1701	Mobile:	
Country: United States of America	Email:	
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									
FC 02 03 05 FP 02	ix-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly esting of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.								
Devices	Tested This Quarter	Fested This Quarter Pass Fail Tested YTD (2020) Total Quantity							
Tamper Switch	7	7	0	7	7				
Waterflow Switch	3 3 0 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	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:

T 1	<b>D</b> (	C	
Terad	Raxter	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, Pailed=F, Pailed=F

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 r	oom 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	d 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 r	oom 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 (20		(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	

#### 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 6 Address **Device Type** Location ScanID Q1/20 Q2/20 Q3/20 Q4/20 Supervisory Signal Basement Center room 013 59342342 03/02-P 06/08-P09/08-P12/07-P Supervisory Signal Basement Center room 013 59342346 03/02-P 06/08-P 09/08-P 12/07-P 1 06/08-P Supervisory Signal Basement Center room 013 59342348 03/02-P 09/08-P12/07-PSupervisory Signal Basement Center room 013 59342351 03/02-P 06/08-P09/08-P12/07-P Supervisory Signal 1st Center room 147 59342410 03/02-P 06/08-P 09/08-P 12/07-P

03/02-P

06/08-P

09/08-P

Download Date: 01/12/2021

12/07-P

59342341

Supervisory Signal

Device Total: 6

2nd East room 234

LS 02.01.35 EP	14	4 All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5									
	g and outsi	pened until spring or to de screw and yoke valv 13.3.3.2/13.3.3.3)		,							
Devices		Tested Q4/20	Pass Q4/20	Fail Q4/20	Tested YTD (2020) Total Quantity		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

	Qt				
Device Type	у	Model #	Type	Description	Install Date
		In Servic	e - 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

 $Generated\ by:\ Building Reports.com$ 

Building Information		
Building: Lincoln regional center B 14	Contact: Kurt Na	
Address: 801 west prospector	<b>Phone:</b> 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:	
Address:	Fax:	
City/State/Zip: Lincoln, NE 68522-1701	Mobile:	
Country: United States of America	Email:	
Monitoring		
Company:	Phone:	Account #:
Central Station Signal Verification		
Type:	Mfg:	Model #:
Test Time/Date:	Restore Time:	Note:

Inspection Completion	Date: Dec 7, 20	)20						
Building: Lincoln regi	onal center B 14							
FC 03 03 05 ED 03		-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly ting 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			
FC NO NO NO FD NO	nnual test of main drains a able 13.1.1.2; Table 13.8.1	•	point or at a	ll system risers. NFPA 25-2	011: 13.2.5; 13.3.3.4;			
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 fi	re departmen	t water supp	ly connections. NFPA 25-20	011: 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	II other Life Safety Code fir	e alarm requi	rements rela	ted 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	II other Life Safety Code au	itomatic extir	iguishing req	uirements 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	11	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:

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Terad	Raxter	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 I	Room 42	59342430	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement I	Room 42	59342432	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement I	Room 42	59342437	1	03/02-P	06/08-P	09/08-P	12/07-P
Tamper Switch	Basement I	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 ceiling	Room 135 above	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	d 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 ceiling	Room 135 above	59342414	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	2nd Cente ceiling	r Room 247 above	59342417	1	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	3rd Cente	r Room 340	59342422	1-3rd floor	03/02-P	06/08-P	09/08-P	12/07-P
Waterflow Switch	3rd Cente	r 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	Tested YTD (2020)		ed YTD (2020) Total Quan		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	Tested YTD (2020) Total Quan		Quantity
Fire Dep't Connection	า	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 ceiling	Room 135 above	59342413	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	2nd Cente ceiling	er Room 247 above	59342415	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	3rd Cente	r Room 340	59342418	1	03/02-P	06/08-P	09/08-P	12/07-P
Supervisory Signal	3rd Cente	r 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 Co	de automatic exti	nguishing require	ments related	d to NFPA 101	-2012 18/19	9.3.5
All backflow preven	ters installe	d in fire protection sys	tem piping shall be	e tested annually	by conductin	g a forward flo	ow test of the	9
system at the desig	ned flow rat	e, including hose strea	m demand, where	hydrants or insid	le hose statio	ns 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
<b>Backflow Prevention</b>		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 Co	ode automatic exti	nguishing require	ments relate	d to NFPA 101	-2012 18/1	9.3.5
· ·	•	em riser check valves s	•				ponents sha	ll be
Devices	s riecessary i	Tested Q4/20	Pass Q4/20	Fail Q4/20		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 Cente ceiling	r Room 247 above	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 Co	ode automatic exti	nguishing require	ments related	to NFPA 101	-2012 18/19	9.3.5
	g and outsi	pened until spring or to de screw and yoke valv 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 So building	outh In yard south of	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.

		Ai	larms				
Waterflow Swit	ch						
Туре	Manufacturer	Model #	Sec	Size	Zone/Address	ОК	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

	Qt				
Device Type	у	Model #	Туре	Description	Install Date
		In Servic	ce - 90 Days -	1 Year	
<b>Backflow Prevention</b>	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	Туре	ScanID
		Control Panel 1		
Zone/A	ddress: 3rd floor			
	Tamper Switch	3rd Center Room 340	Control Valve	59342421
	Waterflow Switch	3rd Center Room 340	Vane	59342422

# Alarm system



#### 2020 INSPECTION

## LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



<u>DISCLAIMER:</u> 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.

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1. PROPERTY INFORMATION Account Name or Property Name

**Shipping Street** 

#### **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

Inspection Date: 8/21/2020

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL.

Property Address: 801 West Prospector PL.

Lincoln, NE 68506

Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
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	
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln NE 68508
Monitoring Org Phone	
Monitoring Org Email	_
Monitoring Acct Number	Customer Provided
Phone Line one or IP	Customer Supplied

Phone Line two or IP

Means Of Transmission

Customer Supplied

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?

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 Tiffany Fitzpatrick If the Auto Field is not correct who is the responsible party who is accepting the Test report? Title: Phone: Date: 8-10-2020



#### 2020 INSPECTION

## LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



<u>DISCLAIMER:</u> 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.

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1. PROPERTY INFORMATION Account Name or Property Name

#### **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

Inspection Date: 8/18/2020

LRC Bldg. # 5- Lincoln Regional

Property Address: 801 West Prospector PL.

Lincoln, NE 68506

	Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
AHJ Phone Number	
Description of property	Hospital
Scope of this instance of inspection	Full 100%
2. TESTING AND MONITORING INFORMATION	
2. TESTING AND MONITORING INFORMATION  Testing Organization	Protex Central
	Protex Central  1239 N Minnesota Ave, Hastings, NE, 68901
Testing Organization	1239 N Minnesota Ave, Hastings,
Testing Organization Address	1239 N Minnesota Ave, Hastings,
Testing Organization Address Phone	1239 N Minnesota Ave, Hastings, NE, 68901
Testing Organization  Address  Phone  Monitoring Organization	1239 N Minnesota Ave, Hastings, NE, 68901 Midwest Alarm Services
Testing Organization Address  Phone Monitoring Organization Address	1239 N Minnesota Ave, Hastings, NE, 68901 Midwest Alarm Services
Testing Organization Address  Phone Monitoring Organization Address Monitoring Org Phone	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services
Testing Organization Address  Phone Monitoring Organization Address Monitoring Org Phone Monitoring Org Email	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services  141 M St Lincoln NE 68508

Phone Line two or IP

Means Of Transmission

Customer Supplied

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?

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	
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



#### 2020 INSPECTION

## LRC Bldg. #9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

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1. PROPERTY INFORMATION

### **Protex Central** 1239 N Minnesota Ave, Hastings, NE, 68901 Office: (800) 274-0888 Fax: (402) 463-6057

### NFPA72 2010 Testing and Inspection Form

LRC Bldg. # 9 - Lincoln Property:

Regional Center

Property Address: 801 West Prospector PL.

Lincoln, NE 68522

Inspection Date: 8/14/2020

Full 100%

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	
Main Account Email	
Authority Having Juristiction	Nebraska state fire marshall
AHJ Phone Number	
Description of property	Hospital

#### 2. TESTING AND MONITORING INFORMATION

Scope of this instance of inspection

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	
Monitoring Organization	Midwest Alarm Services
Address	141 M St Lincoln, NE 68508
Monitoring Org Phone	
Monitoring Org Email	kurt.anderson@nebraska.gov
Monitoring Acct Number	
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?

If the location is not indicated as YES above give description of location here

#### 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	✓	<b>√</b>	
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	
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:	



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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### **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. PR	OPERTY	INFORM	1ATION
--	-------	--------	--------	--------

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

Monitoring Org Email

**Authority Having Juristiction** Nebraska State Fire Marshalls

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

Midwest Alarm Services Monitoring Organization

141 M St Lincoln, NE 68508 Address

Monitoring Org Phone

Monitoring Acct Number **Customer Supplied** 

Phone Line one or IP Customer supplied Phone Line two or IP

Means Of Transmission

Customer supplied

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?

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

Ī	Description	Yes	No	Time	Comments
Ī	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					
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				



# LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL. Power Plant, Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

1. PROPERTY INFORMATION Account Name or Property Name

### **Protex Central** 1239 N Minnesota Ave, Hastings, NE, 68901 Office: (800) 274-0888 Fax: (402) 463-6057

### NFPA72 2010 Testing and Inspection Form

LRC Bldg. # 11 - Lincoln Property:

Regional Center

Property Address: 801 West Prospector PL. Power

Plant

Lincoln, NE 68522

Inspection Date: 8/21/2020

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	
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	
Description of property	Hospital
Scope of this instance of inspection	Full 100%
2. TESTING AND MONITORING INFORMATION	
Testing Organization	Protex Central
Testing Organization Address	Protex Central  1239 N Minnesota Ave, Hastings, NE, 68901
	1239 N Minnesota Ave, Hastings,
Address	1239 N Minnesota Ave, Hastings,
Address Phone	1239 N Minnesota Ave, Hastings, NE, 68901
Address  Phone  Monitoring Organization	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services
Address  Phone  Monitoring Organization  Address	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services
Address  Phone  Monitoring Organization  Address  Monitoring Org Phone	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services

Phone Line one or IP	Customer supplied
Phone Line two or IP	Customer supplied
Means Of Transmission	POTS

No

#### 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?

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	✓	✓	
Domete annunciatore			

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.	9.40.2020
	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	
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



# LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

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1. PROPERTY INFORMATION

### Protex Central 1239 N Minnesota Ave, Hastings, NE, 68901 Office: (800) 274-0888 Fax: (402) 463-6057

## NFPA72 2010 Testing and Inspection Form

Property: Decision 10 and 10 a

Regional Center

Property Address: 801 West Prospector PL.

Lincoln, NE 68522

Inspection Date: 8/21/2020

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	
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	
T 11 O 1 11	
Testing Organization	Protex Central
Address	Protex Central  1239 N Minnesota Ave, Hastings, NE, 68901
	1239 N Minnesota Ave, Hastings,
Address	1239 N Minnesota Ave, Hastings,
Address Phone	1239 N Minnesota Ave, Hastings, NE, 68901
Address  Phone  Monitoring Organization	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services
Address  Phone  Monitoring Organization  Address	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services
Address  Phone  Monitoring Organization  Address  Monitoring Org Phone	1239 N Minnesota Ave, Hastings, NE, 68901  Midwest Alarm Services

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?

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	
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



# LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522



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Account: LRC ANNEX #5 - Lincoln Regional Center

Address: 801 West Prospector Plaza, 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	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	Туре	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



# LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

# Address: 801 West Prospector Plaza, Lincoln, NE 68522

Account: LRC ANNEX #5 - Lincoln Regional Center

## TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

#### Result Totals

	1 Court 1 Otalo
Devices	
Passed	
Mitigated	
New - Passed	
Failed	
Removed	
Not Inspected	
Total	
	Supercomponent Information
Туре	1 - FACP
	1st Floor
	Main Entrance
Model	-
Voltage/Current	120VAC
s/Communication	

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	Туре	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	Туре	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	



# LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522



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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	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.

Account: LRC ANNEX #5 - Lincoln Regional Center

Address: 801 West Prospector Plaza, Lincoln, NE 68522

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



# LRC ANNEX #5 - Lincoln Regional Center

801 West Prospector Plaza, Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

# Address: 801 West Prospector Plaza, Lincoln, NE 68522

Account: LRC ANNEX #5 - Lincoln Regional Center

## **TJC - Fire Alarm 2020 Annual Inspection Summary**

#### Result Totals

Devices	
Passed Mitigated New - Passed Failed	
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

### **Protex Central** 1239 N Minnesota Ave, Hastings, NE, 68901 Office: (800) 274-0888 Fax: (402) 463-6057

## NFPA72 2010 Testing and Inspection Form

LRC ANNEX #5 - Lincoln Property:

Regional Center

Property Address: 801 West Prospector Plaza

Lincoln, NE 68522

Inspection Date: 8/18/2020

Customer supplied

Lincoln, INC 00022	
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	
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	
Description of property	Hospital
Scope of this instance of inspection	Full 100%
2. TESTING AND MONITORING INFORMATION	
Testing Organization	Protex Central
L	

resting organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	
Monitoring Organization	Midwest Alarm Services
Address	141 M Street Lincoln, NE
Monitoring Org Phone	
Monitoring Org Email	kurt.anderson@nebraska.gov
Monitoring Acct Number	Customer Supplied

Phone Line one or IP

Phone Line two or IP

Means Of Transmission

Customer supplied

POTS

No

#### 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?

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	✓			<del>-</del>
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 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: Kurt Anderson Property Rep Auto Field Tiffany Fitzpatrick If the Auto Field is not correct who is the responsible party who is accepting the Test report? Title: Maintenance Phone: Date: 8-11-2020



# LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg # 3- Lincoln Regional Center

## **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

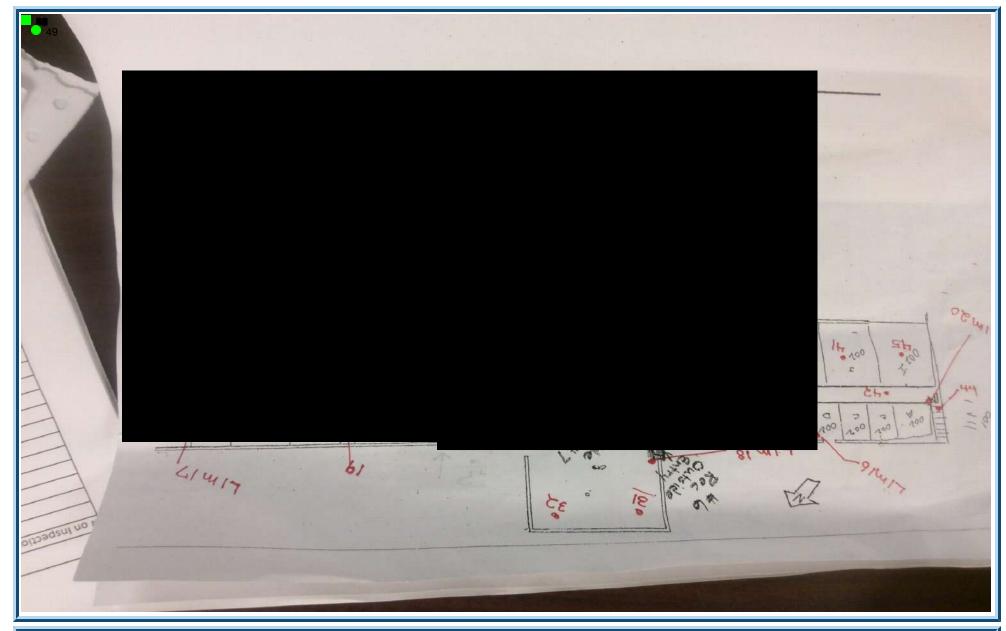
This inspection was performed on 8/12/2020 in accordance with applicable requirements.

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	Comments	8/24/2020 12:01 PM
2	Manual Pull Station	L1M17	Notifier	101 001	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

Passed = Green

O Heat Detector

Mitigated = Green

■ Manual Pull Station

Failed = Red

Smoke Detector

Not Tested = Blue



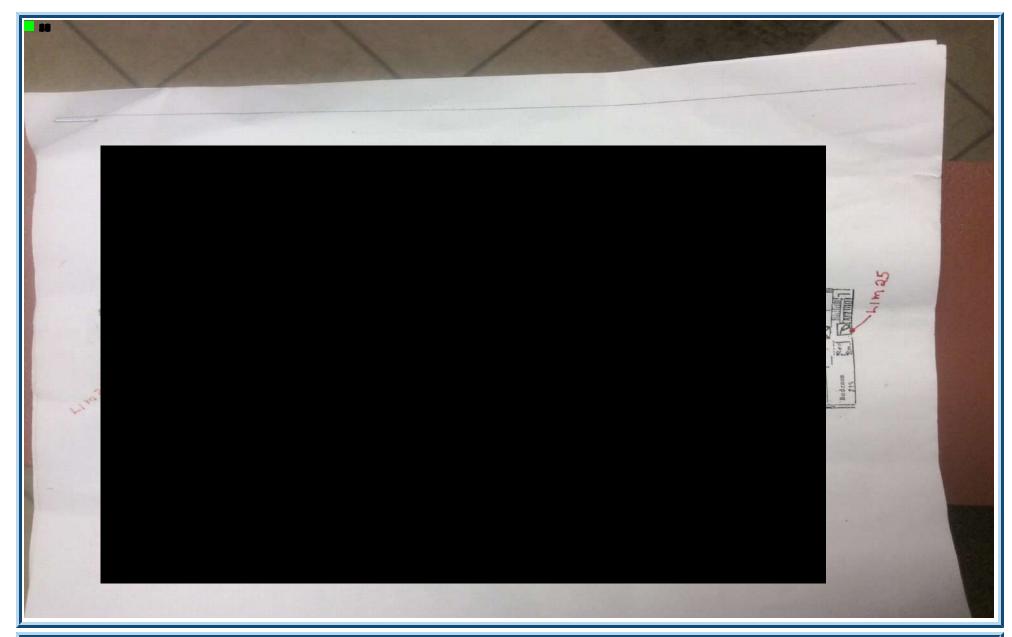
BASEMENT
TJC EP3 Initiating Devices



Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE

## 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

Passed = Green

O Heat Detector

Mitigated = Green

■ Manual Pull Station

Failed = Red

Smoke Detector

Not Tested = Blue



1st FLOOR
TJC EP3 Initiating Devices

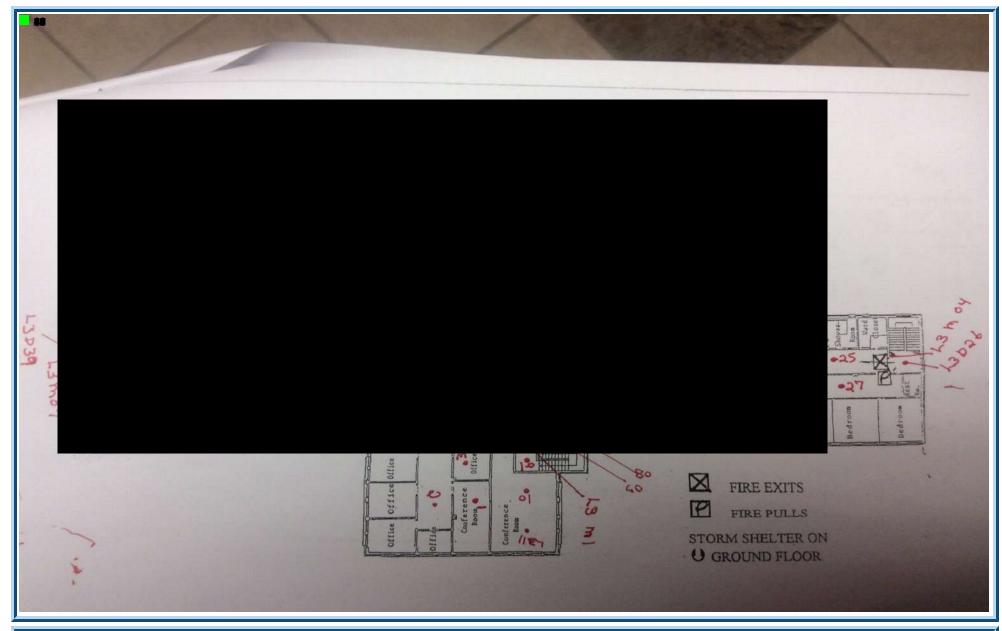


Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE

## 2nd FLOOR TJC EP3 Initiating Devices Results

Number  1 2 3	Type Smoke Detector	Zone/address	Make	Model	Location	Result	Comments	Date
	Smoke Detector	1.00.07						
•		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	Туре	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 Passed = Green O Heat Detector

Mitigated = Green

■ Manual Pull Station

Failed = Red

Smoke Detector

Not Tested = Blue



2nd FLOOR
TJC EP3 Initiating Devices



Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE



### 2020 INSPECTION

# LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



<u>DISCLAIMER:</u> 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.

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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	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.

Account: LRC Bldg. # 5- Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68506

### **1st Floor TJC EP4 Notification Results**

Number	Туре	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	ОТ	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	Туре	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	Туре	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



### 2020 INSPECTION

# LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg # 3- Lincoln Regional Center

## **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	Туре	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	Туре	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



### 2020 INSPECTION

# LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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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	0021	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	Туре	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	Туре	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



### 2020 INSPECTION

# LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central

Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual Account

Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg # 3- Lincoln Regional Center

## **TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary**

### Result Totals

			1 Count 1 Otalo
Devices	Annuciator	Power Supply	
Passed	-	-	
Mitigated	-	-	
New - Passed	-	-	
Failed	-	-	
Removed	-	-	
Not Inspected	3	3	
Total	3	3	
			Supercomponent Information
Туре	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	Туре	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	Туре	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	Туре	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	



### 2020 INSPECTION

# LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg # 3- Lincoln Regional Center

## **TJC EP19 Shutdown 2020 Annual Inspection Summary**

### Result Totals

Devices	Fan	Relays
Passed	-	22
Mitigated	-	-
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	Туре	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	Туре	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	Туре	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	<u> </u>	_	AHU 2 Fan control	BASEMENT	Not Inspected	



#### 2020 INSPECTION

# LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg. # 5- Lincoln Regional Center

# **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** 

Niconale au	T				la action	Decult	0	Dete
Number	Туре	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
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Number	Туре	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	Туре	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

	<u> </u>				tiating Devices Results			5 /
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	Туре	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	Туре	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	Туре	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	Туре	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	<u>-</u>	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**

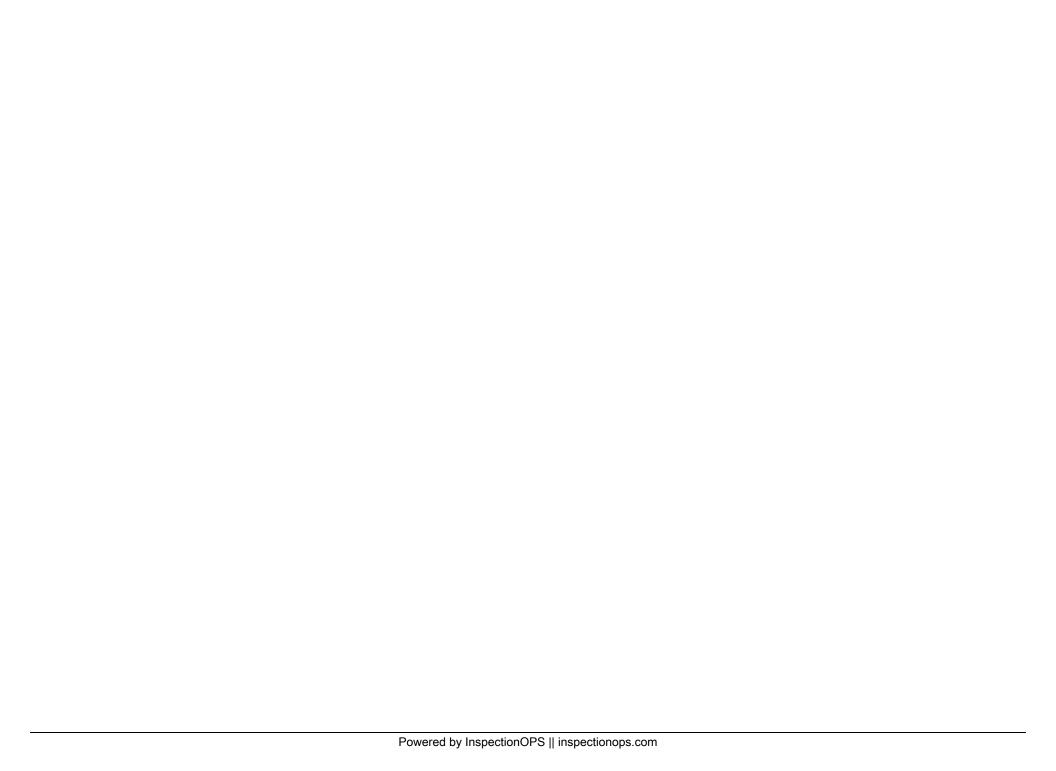
Number	Туре	Zone/address	Make	Model	Location	Result	Comments	Date
1	Duct Detector	L1D29	Notifier		Duct Det. Canteen Roof	Passed		8/11/2020 11:01 AM
2	Duct Detector	L2D41	Notifier		Duct Det RTU-5	Passed		8/11/2020 12:40 PM
3	Duct Detector	L2D42	Notifier		Duct Det RTU-5 return	Passed		8/11/2020 12:44 PM
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

					<u> </u>			
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
20	Smoke Detector	L2D58	Notifier	FSP-851	S-3 Rm 10	Passed		

1st floor continued TJC EP3 Initiating Devices Results

	ist noor continued 130 LF3 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				





#### 2020 INSPECTION

# LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



<u>DISCLAIMER:</u> 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.

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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

## Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg. # 5- Lincoln Regional Center

# **TJC EP2 Tampers Waterflows 2020 Annual Inspection Summary**

### Result Totals

Dovisos	Control Valve	PIV	Standpipe Water	Water Flow
Devices	Switch	PIV	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	Туре	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	Туре	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



#### 2020 INSPECTION

# LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100%

Frequency: 2020 Annual

Account Manager: (800) 274-0888

Address: 801 West Prospector PL., Lincoln, NE 68506

Account: LRC Bldg. # 5- Lincoln Regional Center

# **TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary**

#### Result Totals

			1 Count 1 Otalo
Devices	Annuciator	Power Supply	
Passed	5	6	
Mitigated	-	-	
New - Passed	-	-	
Failed	-	-	
Removed	-	-	
Not Inspected	-	-	
Total	5	6	
			Supercomponent Information
Туре	1 - FACP		
Location	1st Floor		
	Control room		
Model	AFP1010		
Voltage/Current	120VAC		
s/Communication			

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	Туре	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP1010		Control room	Passed		8/18/2020
	17101	rtounoi	711 1010		Control 100m	1 40004		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	8/18/2020
	1 Ower ouppry	rvounci	1 01 0 24	LTWOO	7 bove parier	1 03300	supply might be going bad.	10:34 AM
3	Power Supply	Notifier	FCPS-24	L3M03	S2 Electrical	Passed		8/18/2020
	1 Ower Supply	Nounci	1 01 0-24	LOWIGO	Closet	1 83360		10:33 AM
5	Power Supply	Notifier	FCPS	L4M07	S-1 Closet	Passed		8/18/2020
	r ower Supply	Nounei	1010	L4IVIO7	3-1 Closet	rasseu		10:31 AM
6	Annuciator	Notifier			S1 ward	Passed		8/18/2020
	Allitadiator	Nounci			OT Ward	1 83360		10:31 AM
7	Annuciator	Notifier			S2 ward	Passed		8/18/2020
	Allitadiator	Nounci			OZ Ward	1 83360		10:30 AM
8	Annuciator	Notifier			S3 ward	Passed		8/18/2020
	Allitadiator	Nounci			O5 Ward	1 83360		10:30 AM
9	Annuciator	Notifier			S4 ward	Passed		8/18/2020
	Allitadiatol	Nounci			O+ Wald	1 83360		10:29 AM
10	Annuciator	Notifier			S5 ward	Passed		8/18/2020
	Allitudiator	Nounei			33 Walu	i asseu		10:29 AM
11	Power Supply	Notifier	FCPS24S8		s-2 closet	Passed		8/18/2020
11	Fower Supply	Notifiel	1 01 32430		3-2 0,0561	rasseu		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	Туре	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 I	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	



#### 2020 INSPECTION

# LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

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.

Account: LRC Bldg. # 5- Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68506

## 1st Floor TJC EP19 Shutdown Results

Number	Туре	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	Туре	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	Туре	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	



## LRC Bldg. #9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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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	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.

Account: LRC Bldg. #9 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

**1st Floor TJC EP3 Initiating Devices Results** 

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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	Туре	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



## LRC Bldg. #9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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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	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.

Account: LRC Bldg. #9 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

#### **1st Floor TJC EP4 Notification Results**

Number	Туре	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



## LRC Bldg. #9 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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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

	1 toodit 1 otalio	
Devices	Power Supply	
Passed	2	
Mitigated	-	
New - Passed	-	
Failed	-	
Removed	-	
Not Inspected	-	
Total	2	
	Supercomponent Information	
Туре	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.

Account: LRC Bldg. #9 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

### 1st Floor TJC EP5 FA Equipment Signals Results

Number	Туре	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	Туре	Make Mode	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier AFP101	120	Main office	1st Floor	Passed		
2		Power Supply	Notifier MPS-24	A 110	Main office	1st Floor	Passed		_
1	L1M10	Power Supply	Notifier FCPS-2	1	mech rm	BASEMENT	Passed		



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

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.

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

NFPA72, 2010 Ed.

### 1st Floor TJC EP2 Tampers Waterflows Results

Number	Туре	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	Туре	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	Туре	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



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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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	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.

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

## **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**

		- /						5.4
Number	Туре	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



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

#### Result Totals

Devices	Annuciator	Power Supply	
Passed	2	3	
Mitigated	-	-	
New - Passed	-	-	
Failed	-	-	
Removed	-	-	
Not Inspected	-	-	
Total	2	3	
			Supercomponent Information
Туре	3 - FACP		
Location	1st Floor		
	Front Entrance		
Model	AFP-1010		
	120\/AC		
Voltage/Current	120VAC		

This inspection was performed on 8/12/2020 in accordance with applicable requirements.

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

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	Туре	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	Туре	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 Mode	el 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-10	10 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		



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

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.

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

#### 1st Floor TJC EP19 Shutdown Results

Number	Туре	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	Туре	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	Туре	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	Туре	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		<u> </u>	AHU	LOWER LEVEL	Passed	<u> </u>



# LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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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	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.

Account: LRC Bldg. # 10 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

#### **1st Floor TJC EP4 Notification Results**

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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	Туре	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	Туре	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



## LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL. Power Plant, Lincoln, NE 68522



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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



## LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL. Power Plant, Lincoln, NE 68522



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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	Туре	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



## LRC Bldg. # 11 - Lincoln Regional Center

801 West Prospector PL. Power Plant, Lincoln, NE 68522



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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

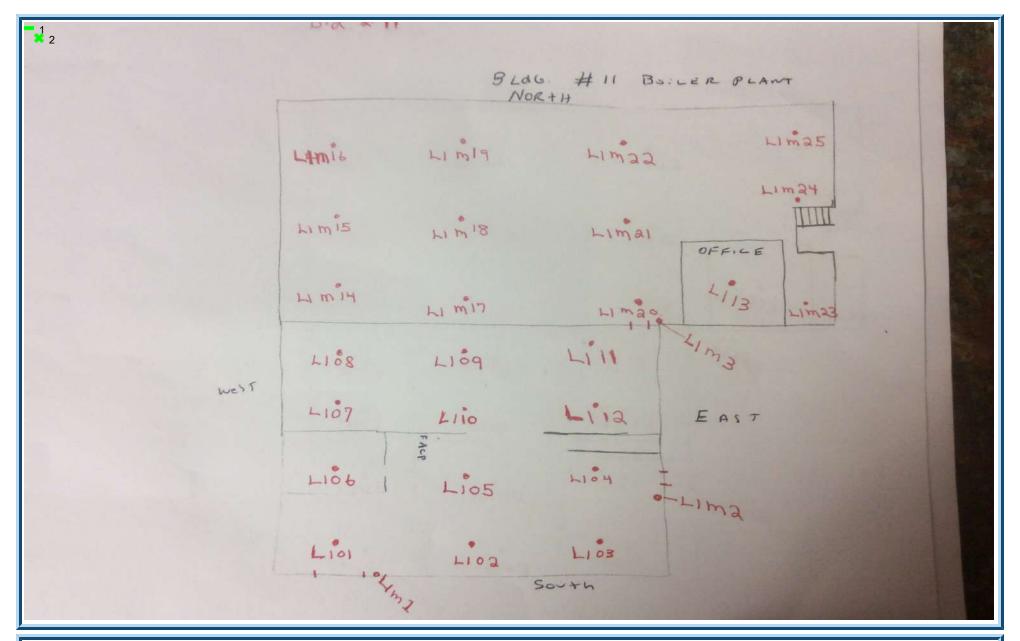
	Troom Totalo
Devices	Power Supply
Passed	1
Mitigated	
New - Passed	
Failed	
Removed	
Not Inspected	-
Total	1
	Supercomponent Information
Туре	1 - FACP
Location	1st Floor
	Boiler Room
Model	AFP1010
Voltage/Current	120
s/Communication	Yes Passed

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	Туре	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



**F**ACP

Mitigated = Green

**★** Power Supply

Failed = Red Not Tested = Blue



Passed = Green

1st Floor
TJC EP5 FA Equipment Signals



## **Subcomponent Results**

Supercomponent Number	Туре	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	Туре	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



# LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

Account: LRC Bldg. # 14 - Lincoln Regional Center Address: 801 West Prospector PL., Lincoln, NE 68522

## **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.

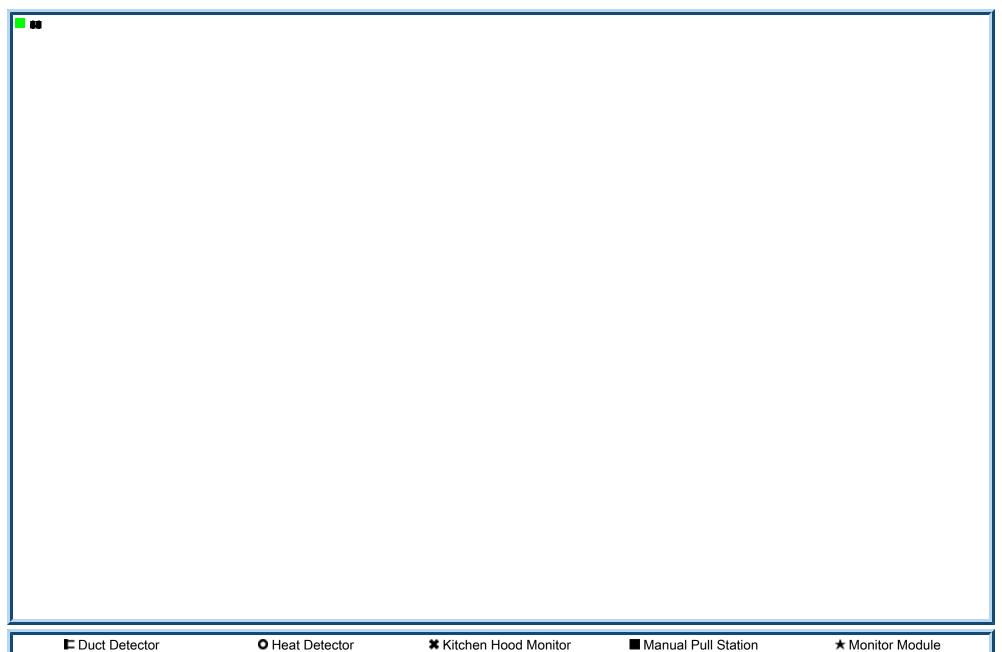
NFPA72, 2010 Ed.

### **GROUND FLOOR TJC EP3 Initiating Devices Results**

GROUND FLOOR 13C LF3 illitiating Devices Results									
Number	Туре	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	Туре	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
-							<b>*</b>	

Number	Туре	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 Ivl	Passed		8/19/2020 5:33 PM



Smoke Detector

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



**GROUND FLOOR** TJC EP3 Initiating Devices

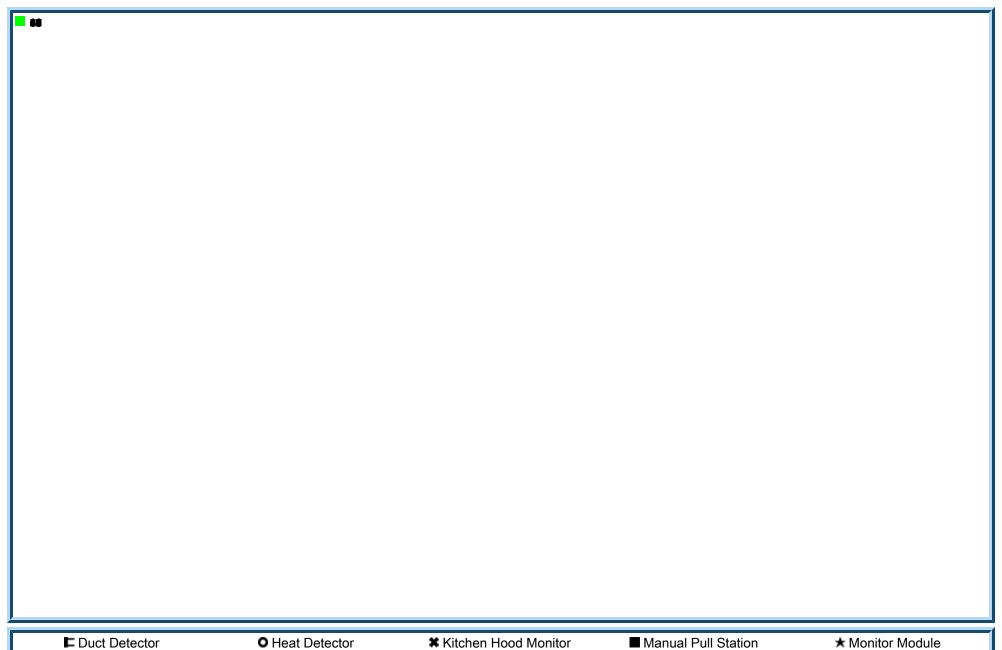


Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE

# 1st FLOOR TJC EP3 Initiating Devices Results

		1001 =0	<b>7011 100</b>	Ei o iiiitiat	ing bevices result	<u> </u>		
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	Туре	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



Smoke Detector

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



1st FLOOR TJC EP3 Initiating Devices

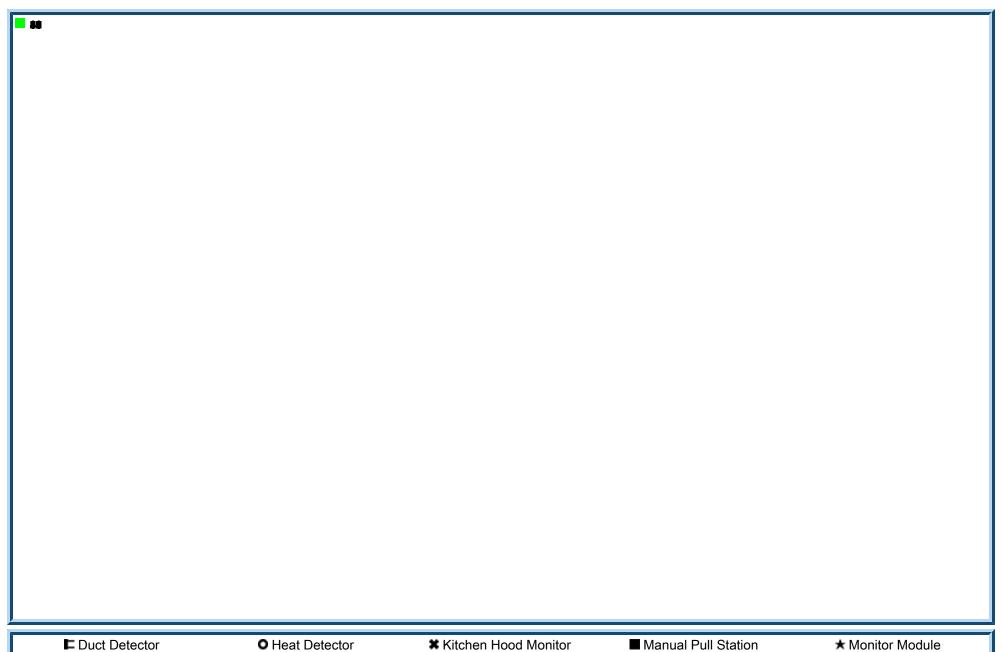


Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE

# 2nd FLOOR TJC EP3 Initiating Devices Results

					ting bevices itesuit			
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



Smoke Detector

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



2nd FLOOR TJC EP3 Initiating Devices

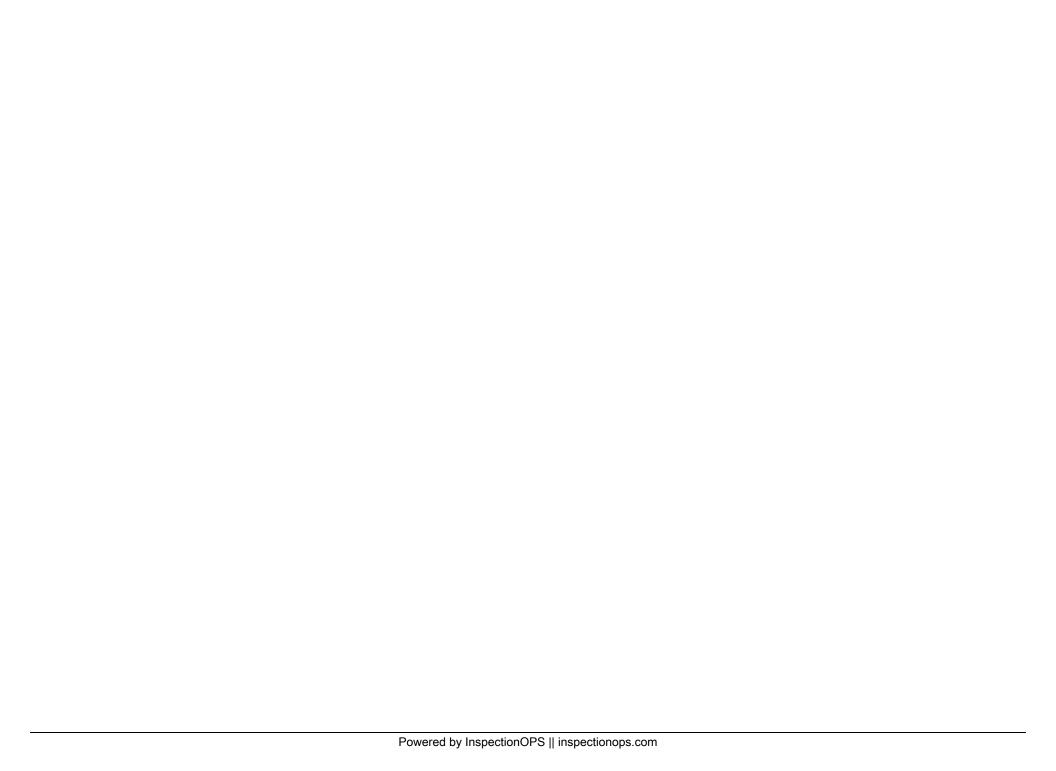


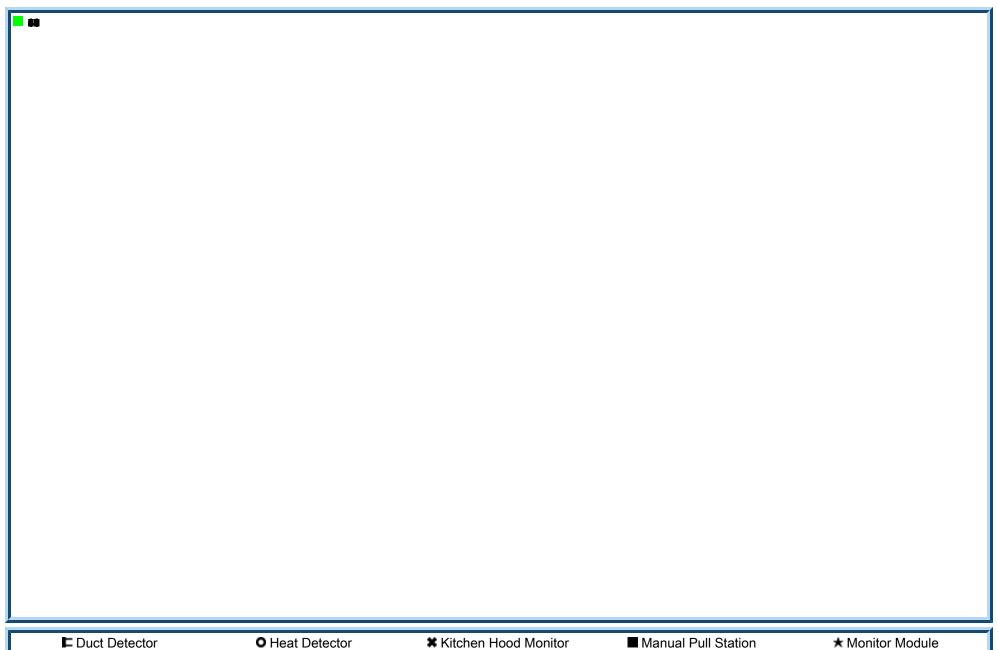
Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE

# **3rd FLOOR TJC EP3 Initiating Devices Results**

1   Smoke Detector   L4D05   Notifier   SDX-651   Tip of N Stairs   Passed   8/19/2005 5.25	Missingle au	T				danig bevices results	Desult	O a manufactural transfer	Dete
2	Number	Туре	Zone/address	Make	Model	Location	Result	Comments	Date
Hear Detector	<u> </u>					·			
Hear Detector	•					• •			8/19/2020 5:32 PM
5         Heat Detector         L4D04         Notifier         FDX-551         Office Equipment Storage         Passed         81/9/2003 5:29           7         Smoke Detector         L4D07         Notifier         SDX-551         Hall by N Stairs         Passed         81/9/2003 5:29           8         Heat Detector         L4D08         Notifier         FDX-551         Custodial Storage         Passed         81/9/2003 5:28           9         Heat Detector         L4D09         Notifier         FDX-551         Custodial Storage         Passed         81/9/2003 5:28           10         Heat Detector         L4D11         Notifier         FDX-551         Old Equipment Rm         Passed         81/9/2003 5:28           11         Smoke Detector         L4D14         Notifier         FDX-551         Hald dequipment room         Passed         81/9/2003 5:28           12         Heat Detector         L4D14         Notifier         FDX-551         Medical Records         Passed         81/9/2003 5:26           13         Heat Detector         L4D16         Notifier         FDX-551         Medical Records         Passed         81/9/2003 5:26           14         Heat Detector         L4D16         Notifier         FDX-551         Medical Records									8/19/2020 5:31 PM
6         Heat Detector         L4006         Notifier         FDX-551         Maintenance Storage         Passed         8/19/200 5:29           7         Smoke Detector         L4007         Notifier         SDX-551         Hall by N Stairs         Passed         8/19/200 5:29           8         Heat Detector         L4008         Notifier         FDX-551         Custodial Storage         Passed         8/19/200 5:28           9         Heat Detector         L4011         Notifier         FDX-551         Custodial Storage         Passed         8/19/200 5:28           11         Smoke Detector         L4012         Notifier         FDX-551         Medical Records         Passed         8/19/200 5:28           12         Heal Detector         L4014         Notifier         FDX-551         Hall by old equipment from         Passed         8/19/200 5:28           13         Heat Detector         L4015         Notifier         FDX-551         Medical Records         Passed         8/19/200 5:26           14         Heat Detector         L4016         Notifier         FDX-551         Medical Records         Passed         8/19/200 5:26           15         Smoke Detector         L4017         Notifier         FDX-551         Heal Detector									8/19/2020 5:31 PM
7         Smoke Detector         L4D07         Notifier         SDX-551         Hall by N Stairs         Passed         8192020 5:29           8         Heat Detector         L4D08         Notifier         FDX-551         Custodial Storage         Passed         8192020 5:29           9         Heat Detector         L4D19         Notifier         FDX-551         Old Equipment Rm         Passed         8192020 5:28           10         Heat Detector         L4D11         Notifier         FDX-551         Old Equipment from         Passed         8192020 5:28           11         Smoke Detector         L4D14         Notifier         FDX-551         Medical Records         Passed         8192020 5:28           13         Heat Detector         L4D15         Notifier         FDX-551         Medical Records         Passed         8192020 5:26           14         Heat Detector         L4D16         Notifier         FDX-551         Medical Records         Passed         8192020 5:26           15         Smoke Detector         L4D17         Notifier         FDX-551         Medical Records         Passed         6192020 5:26           16         Hat Detector         L4D17         Notifier         FDX-551         Hat Dyx Control Passed         6192									8/19/2020 5:30 PM
8         Heat Detector         L4D08         Notifier         FDX-551         Custodial Storage         Passed         8/19/2000 5:29           9         Heat Detector         L4D01         Notifier         FDX-551         Custodial Storage         Passed         8/19/2000 5:28           11         Smoke Detector         L4D11         Notifier         FDX-551         Hall by old equipment room         Passed         8/19/2002 5:27           12         Heat Detector         L4D14         Notifier         FDX-551         Hall by old equipment room         Passed         8/19/2002 5:26           13         Heat Detector         L4D15         Notifier         FDX-551         Medical Records         Passed         8/19/2002 5:26           14         Heat Detector         L4D16         Notifier         FDX-551         Medical Records         Passed         8/19/2002 5:26           15         Smoke Detector         L4D17         Notifier         FDX-551         Medical Records         Passed         8/19/2002 5:26           16         Heat Detector         L4D18         Notifier         FDX-551         Medical Records         Passed         8/19/2002 5:24           17         Heat Detector         L4D18         Notifier         FDX-551         Medical		Heat Detector	L4D06	Notifier		Maintenance Storage			8/19/2020 5:29 PM
9 Heat Detector L4D09 Notifier FDX-551 Custodial Storage Passed 8/19/2005-228 10 Heat Detector L4D11 Notifier FDX-551 Oil Equipment Rom Passed 8/19/2005-278 11 Smoke Detector L4D12 Notifier FDX-551 High yorld equipment rom Passed 8/19/2005-278 12 Heat Detector L4D14 Notifier FDX-551 Medical Records Passed 8/19/2005-288 13 Heat Detector L4D15 Notifier FDX-551 Medical Records Passed 8/19/2005-288 14 Heat Detector L4D16 Notifier FDX-551 Medical Records Passed 8/19/2005-288 15 Smoke Detector L4D17 Notifier FDX-551 Medical Records Passed 8/19/2005-288 16 Heat Detector L4D18 Notifier FDX-551 Hall by medical records Passed 8/19/2005-288 17 Heat Detector L4D18 Notifier FDX-551 Medical Records Passed 8/19/2005-258 18 Smoke Detector L4D19 Notifier FDX-551 Medical Records Passed 8/19/2005-258 19 Heat Detector L4D19 Notifier FDX-551 Medical Records Passed 8/19/2005-252 10 Heat Detector L4D19 Notifier FDX-551 Office Equipment Storage Passed 8/19/2005-254 19 Heat Detector L4D21 Notifier FDX-551 Office Equipment Storage Passed 8/19/2005-254 19 Heat Detector L4D21 Notifier FDX-551 Soffice Equipment Storage Passed 8/19/2005-252 20 Heat Detector L4D23 Notifier FDX-551 Junk Storage Passed 8/19/2005-252 21 Heat Detector L4D24 Notifier FDX-551 Junk Storage Passed 8/19/2005-252 22 Smoke Detector L4D24 Notifier FDX-551 Hall by Page Recycling Passed 8/19/2005-252 23 Heat Detector L4D24 Notifier FDX-551 Hall by Page Recycling Passed 8/19/2005-252 24 Smoke Detector L4D24 Notifier SDX-551 Hall by Page Recycling Passed 8/19/2005-252 25 Heat Detector L4D24 Notifier SDX-551 General Storage Passed 8/19/2005-252 26 Smoke Detector L4D28 Notifier FDX-551 General Storage Passed 8/19/2005-252 27 Heat Detector L4D28 Notifier FDX-551 General Storage Passed 8/19/2005-252 28 Smoke Detector L4D29 Notifier FDX-551 General Storage Passed 8/19/2005-252 29 Heat Detector L4D31 Notifier FDX-551 General Storage Passed 8/19/2005-252 30 Smoke Detector L4D33 Notifier FDX-551 General Storage Passed 8/19/2005-253 31 Heat Detector L4D34 Notifier FDX-551 General Fi	7	Smoke Detector	L4D07	Notifier	SDX-551	Hall by N Stairs	Passed		8/19/2020 5:29 PM
10   Heat Detector   L4D11   Notifier   FDX-551   Old Equipment Rm   Passed   8/19/2020 5:28		Heat Detector	L4D08	Notifier	FDX-551	Custodial Storage	Passed		8/19/2020 5:29 PM
11		Heat Detector	L4D09	Notifier		Custodial Storage	Passed		8/19/2020 5:28 PM
12		Heat Detector	L4D11	Notifier	FDX-551	Old Equipment Rm	Passed		8/19/2020 5:28 PM
13	11	Smoke Detector	L4D12	Notifier	SDX-551	Hall by old equipment room	Passed		8/19/2020 5:27 PM
14	12	Heat Detector	L4D14	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
15	13	Heat Detector	L4D15	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
16	14	Heat Detector	L4D16	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:26 PM
17         Heat Detector         L4D19         Notifier         FDX-551         Office Equipment Storage         Passed         8/19/2020 5:24           18         Smoke Detector         L4D20         Notifier         SDX-551         Hall by Pipe Chase         Passed         8/19/2020 5:23           19         Heat Detector         L4D23         Notifier         FDX-551         S Office Equipment Storage         Passed         8/19/2020 5:23           20         Heat Detector         L4D23         Notifier         FDX-551         Junk Storage         Passed         8/19/2020 5:22           21         Heat Detector         L4D25         Notifier         FDX-551         Paper Recycle Room         Passed         8/19/2020 5:22           22         Smoke Detector         L4D26         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:21           23         Heat Detector         L4D26         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:20           24         Smoke Detector         L4D26         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:20           25         Heat Detector         L4D28         Notifier         FDX-551	15	Smoke Detector	L4D17	Notifier	SDX-551	Hall by medical records	Passed		8/19/2020 5:25 PM
18	16	Heat Detector	L4D18	Notifier	FDX-551	Medical Records	Passed		8/19/2020 5:25 PM
19         Heat Detector         L4D21         Notifier         FDX-551         S Office Equipment Storage         Passed         8/19/2020 5:23           20         Heat Detector         L4D23         Notifier         FDX-551         Junk Storage         Passed         8/19/2020 5:23           21         Heat Detector         L4D25         Notifier         FDX-551         Paper Recycle Room         Passed         8/19/2020 5:22           22         Smoke Detector         L4D24         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:22           23         Heat Detector         L4D26         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:21           24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:20           25         Heat Detector         L4D28         Notifier         FDX-551         Top of East Stairs         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         FDX-551         Top of East Stairs         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         Genera	17	Heat Detector	L4D19	Notifier	FDX-551	Office Equipment Storage	Passed		8/19/2020 5:24 PM
20         Heat Detector         L4D23         Notifier         FDX-551         Junk Storage         Passed         8/19/2020 5:23           21         Heat Detector         L4D25         Notifier         FDX-551         Paper Recycle Room         Passed         8/19/2020 5:22           22         Smoke Detector         L4D24         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:22           23         Heat Detector         L4D26         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:22           24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:20           25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage<	18	Smoke Detector	L4D20	Notifier	SDX-551		Passed		8/19/2020 5:24 PM
21         Heat Detector         L4D25         Notifier         FDX-551         Paper Recycle Room         Passed         8/19/2020 5:22           22         Smoke Detector         L4D24         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:22           23         Heat Detector         L4D26         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:22           24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:20           25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         FDX-551         General File	19	Heat Detector	L4D21	Notifier	FDX-551	S Office Equipment Storage	Passed		8/19/2020 5:23 PM
22         Smoke Detector         L4D24         Notifier         SDX-551         Hall by Paper Recycling         Passed         8/19/2020 5:22           23         Heat Detector         L4D26         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:21           24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:22           25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         FDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         FDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         SDX-551         File Storage	20	Heat Detector	L4D23	Notifier	FDX-551	Junk Storage	Passed		8/19/2020 5:23 PM
23         Heat Detector         L4D26         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:21           24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:21           25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom	21	Heat Detector	L4D25	Notifier	FDX-551	Paper Recycle Room	Passed		8/19/2020 5:22 PM
24         Smoke Detector         L4D27         Notifier         SDX-551         General Storage         Passed         8/19/2020 5:21           25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:17           32         Smoke Detector         L4D36         Notifier         SDX-551         Hall by Legal Files <td>22</td> <td>Smoke Detector</td> <td>L4D24</td> <td>Notifier</td> <td>SDX-551</td> <td>Hall by Paper Recycling</td> <td>Passed</td> <td></td> <td>8/19/2020 5:22 PM</td>	22	Smoke Detector	L4D24	Notifier	SDX-551	Hall by Paper Recycling	Passed		8/19/2020 5:22 PM
25         Heat Detector         L4D28         Notifier         FDX-551         General Storage         Passed         8/19/2020 5:20           26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:15           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:15           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage </td <td>23</td> <td>Heat Detector</td> <td>L4D26</td> <td>Notifier</td> <td>FDX-551</td> <td>General Storage</td> <td>Passed</td> <td></td> <td>8/19/2020 5:21 PM</td>	23	Heat Detector	L4D26	Notifier	FDX-551	General Storage	Passed		8/19/2020 5:21 PM
26         Smoke Detector         L4D29         Notifier         SDX-551         Top of East Stairs         Passed         8/19/2020 5:20           27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:15           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storag	24	Smoke Detector	L4D27	Notifier	SDX-551	General Storage	Passed		8/19/2020 5:21 PM
27         Heat Detector         L4D30         Notifier         FDX-551         IMS E. Storage         Passed         8/19/2020 5:19           28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/202 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/202 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/202 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/202 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage	25	Heat Detector	L4D28	Notifier	FDX-551	General Storage	Passed		8/19/2020 5:20 PM
28         Heat Detector         L4D31         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Recor	26	Smoke Detector	L4D29	Notifier	SDX-551	Top of East Stairs	Passed		8/19/2020 5:20 PM
29         Heat Detector         L4D32         Notifier         FDX-551         General File Storage         Passed         8/19/2020 5:19           30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D36         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:13           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Off	27	Heat Detector	L4D30	Notifier	FDX-551	IMS E. Storage	Passed		8/19/2020 5:19 PM
30         Smoke Detector         L4D33         Notifier         SDX-551         File Storage         Passed         8/19/2020 5:18           31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:13           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office<	28	Heat Detector	L4D31	Notifier	FDX-551	General File Storage	Passed		8/19/2020 5:19 PM
31         Heat Detector         L4D34         Notifier         FDX-551         East Bathroom         Passed         8/19/2020 5:18           32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:13           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	29	Heat Detector	L4D32	Notifier	FDX-551	General File Storage	Passed		8/19/2020 5:19 PM
32         Smoke Detector         L4D35         Notifier         SDX-551         Hall by Legal Files         Passed         8/19/2020 5:17           33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:13           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	30	Smoke Detector	L4D33	Notifier	SDX-551	File Storage	Passed		8/19/2020 5:18 PM
33         Heat Detector         L4D36         Notifier         FDX-551         Legal File Storage         Passed         8/19/2020 5:15           34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:14           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	31	Heat Detector	L4D34	Notifier	FDX-551	East Bathroom	Passed		8/19/2020 5:18 PM
34         Heat Detector         L4D37         Notifier         FDX-551         IMS Supply Storage         Passed         8/19/2020 5:15           35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:14           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	32	Smoke Detector	L4D35	Notifier	SDX-551	Hall by Legal Files	Passed		8/19/2020 5:17 PM
35         Heat Detector         L4D38         Notifier         FDX-551         Custodian Storage         Passed         8/19/2020 5:14           36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:14           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	33	Heat Detector	L4D36	Notifier	FDX-551	Legal File Storage	Passed		8/19/2020 5:15 PM
36         Heat Detector         L4D39         Notifier         FDX-551         Personnel Records         Passed         8/19/2020 5:14           37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	34	Heat Detector	L4D37	Notifier	FDX-551	IMS Supply Storage	Passed		8/19/2020 5:15 PM
37         Smoke Detector         L4D40         Notifier         SDX-551         Hall by Cust. Office         Passed         8/19/2020 5:13           38         Heat Detector         L4D41         Notifier         FDX-551         Custodial Office         Passed         8/19/2020 5:13	35	Heat Detector	L4D38	Notifier	FDX-551	Custodian Storage	Passed		8/19/2020 5:14 PM
38 Heat Detector L4D41 Notifier FDX-551 Custodial Office Passed 8/19/2020 5:13	36	Heat Detector	L4D39	Notifier	FDX-551	Personnel Records	Passed		8/19/2020 5:14 PM
38 Heat Detector L4D41 Notifier FDX-551 Custodial Office Passed 8/19/2020 5:13	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		Passed		8/19/2020 5:13 PM
39 Heat Detector L4D42 Notifier FDX-551 Conference Rm Passed 8/19/2020 5:12	39	Heat Detector	L4D42	Notifier	FDX-551	Conference Rm	Passed		8/19/2020 5:12 PM
		Smoke Detector		Notifier		Hall by Conference Rm	Passed		8/19/2020 5:12 PM

Number	Туре	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





Smoke Detector

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



3rd FLOOR TJC EP3 Initiating Devices



Des Moines, IA Hastings, NE North Platte, NE Omaha, NE Scottsbluff, NE



#### 2020 INSPECTION

# LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

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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	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.

Account: LRC Bldg. # 14 - Lincoln Regional Center

Address: 801 West Prospector PL., Lincoln, NE 68522

#### **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

**🙏 9**8 Bell ▲ Horn Strobe ☆ Strobe

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



**GROUND FLOOR TJC EP4 Notification** 



#### 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

**\*** 99 Bell ☆ Strobe

▲ Horn Strobe

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



1st FLOOR TJC EP4 Notification



#### 2nd FLOOR TJC EP4 Notification Results

Number         Ty           1         Stro           2         Stro           3         Stro           4         Stro	be	Model SR	Location RM 298	Result Passed	Comments	Date
2 Stro 3 Stro		SR	PM 208	Doocod		
3 Stro	bbe		TAIVI 200	Passeu		8/21/2020 10:58 AM
		SR	RM 299	Passed		8/21/2020 10:58 AM
4 Stro	bbe	SR	Hall outside RM 299	Passed		8/21/2020 10:58 AM
	bbe	SR	Hall outside RM 295	Passed		8/21/2020 10:57 AM
5 Be	ell	SSM24-8	Hall outside rm 295	Passed		8/21/2020 10:57 AM
6 Stro	bbe	SR	Hall outside Rm 290	Passed		8/21/2020 10:57 AM
7 Stro	be	SR	Hall outside Rm 281	Passed		8/21/2020 10:57 AM
8 Be	ell	SSM24-8	Hall outside rm 281	Passed		8/21/2020 10:57 AM
9 Stro	be	SR	Hall outside Rm 278	Passed		8/21/2020 10:58 AM
10 Be	ell	SSM24-8	Hall outside rm 278	Passed		8/21/2020 10:57 AM
11 Stro	be	SPR	Rm 274	Passed		8/21/2020 10:57 AM
12 Stro	be	SR	Rm 273	Passed		8/21/2020 10:57 AM
13 Stro	be	SPR	Rm 272	Passed		8/21/2020 10:57 AM
14 Stro	be	SR	outside Rm 269	Passed		8/21/2020 10:56 AM
15 Stro	be	FSF204-st	RM 269	Passed		8/21/2020 10:56 AM
16 Stro	be	SR	outside Rm 270	Passed		8/21/2020 10:56 AM
17 Stro	be	SR	Rm 270	Passed		8/21/2020 10:56 AM
18 Stro	be	FSF204-st	RM 266	Passed		8/21/2020 10:56 AM
19 Stro	be	SR	outside Rm 259	Passed		8/21/2020 10:56 AM
20 Be	ell	SSM24-8	Hall outside rm 259	Passed		8/21/2020 10:56 AM
21 Stro	be	SR	Elevator lobby	Passed		8/21/2020 10:56 AM
22 Stro	be	SR	Outside Elevator lobby	Passed		8/21/2020 10:54 AM
23 Stro	be	SR	Outside 254	Passed		8/21/2020 10:53 AM
24 Stro	be	SR	Outside 241 B1	Passed		8/21/2020 10:53 AM
25 Stro	be	SR	251	Passed		8/21/2020 10:53 AM
26 Stro	be	SR	250	Passed		8/21/2020 10:53 AM
27 Stro	be	SPR	Rm 252	Passed		8/21/2020 10:53 AM
28 Stro	be	SPR	Rm 247	Passed		8/21/2020 10:53 AM
29 Stro	be	SPR	Rm 242	Passed		8/21/2020 10:52 AM
30 Stro	be	SR	Outside Rm 243	Passed		8/21/2020 10:52 AM
31 Be	ell	SSM24-8	Hall outside rm 243	Passed		8/21/2020 10:52 AM
32 Stro	be	SPR	Center Above pop machines	Passed		8/21/2020 10:52 AM
33 Stro	be	SPR	244	Passed		8/21/2020 10:50 AM
34 Stro		SS24110ADA	Outside Rm 240	Passed		8/21/2020 10:50 AM
35 Be	ell	SSM24-8	Hall outside rm 240	Passed		8/21/2020 10:50 AM
36 Stro	be	SS24110ADA	Rm 240	Passed		8/21/2020 10:50 AM
37 Stro	bbe	SS24110ADA	Outside Rm 230	Passed		8/21/2020 10:50 AM
38 Be	ell .	SSM24-8	Hall outside rm 230	Passed		8/21/2020 10:50 AM
39 Stro	bbe	SS24110ADA	Rm 232	Passed		8/21/2020 10:50 AM
40 Stro	be	SS24110ADA	Rm 231	Passed		8/21/2020 10:50 AM

Number	Туре	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

**\*** ☆ Strobe

Bell

▲ Horn Strobe

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



2nd FLOOR TJC EP4 Notification



#### **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

**🙀 9**8 Bell ▲ Horn Strobe ☆ Strobe

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue



3rd FLOOR TJC EP4 Notification





#### 2020 INSPECTION

# LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

# Address: 801 West Prospector PL., Lincoln, NE 68522

Account: LRC Bldg. # 14 - Lincoln Regional Center

# **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**

Zone	7 /   -							
	Zone/address	s Mak	ĸe N	/lodel	Location	Result	Comments	Date
L	L1M07	Notifi	ier	Door Release 038A		Passed		8/18/2020 6:35 PM
L	L1M95	Notifi	ier	Door Release RM041		Passed		8/18/2020 6:41 PM
L	L1M30	Notifi	ier		Elevator Mech Rm 039	Passed	Primary Recall	8/18/2020 6:40 PM
L	L1M31	Notifi	ier		Elevator Mech Rm 039	Passed	Alternate Recall	8/18/2020 6:40 PM
L	L1M32	Notifi	ier	Elevator Mech Rm 039		Passed	Flash Hat	8/18/2020 6:39 PM
L	L1M33	Notifi	ier	Elevator Mech Rm 039		Passed	Shunt	8/18/2020 6:39 PM
L	L1M24	Notifi	ier F	FRM-1	Mech Rm 014	Passed	AHU-1	8/18/2020 6:39 PM
L	L1M25	Notifi	ier F	FRM-1	Mech Rm 056B	Passed	AHU-2	8/18/2020 6:38 PM
L	L1M26	Smol	ke D	amper	SD-001 by 052	Passed		8/18/2020 6:38 PM
		Smol	ke D	amper	SD-002 045	Passed		8/18/2020 6:37 PM
L	L1M28	Smol	ke D	amper	SD-003 033e	Passed		8/18/2020 6:37 PM
L	L1M28	Smol	ke D	)amper	SD-004	Passed		8/18/2020 6:37 PM
					Door Holder Hallway 028	Passed	Door Holder	8/18/2020 6:36 PM
•		Smol	ke D	)amper	1 SD-014	Passed		8/18/2020 6:36 PM
		Smol	ke D	)amper )amper	SD-003 033e SD-004 Door Holder Hallway 028	Passed Passed Passed		Door Holder

#### 1st FLOOR TJC EP19 Shutdown Results

Number	Туре	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	0-004 Patient Telephone Passed		8/18/2020 6:16 PM
17	Relays	<u> </u>	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	Туре	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	Туре	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



#### 2020 INSPECTION

# LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

# Address: 801 West Prospector PL., Lincoln, NE 68522

Account: LRC Bldg. # 14 - Lincoln Regional Center

# **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	Туре	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	Туре	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	Туре	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



#### 2020 INSPECTION

## LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522



<u>DISCLAIMER:</u> 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.

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Inspection Provider: Protex Central Lead Inspector: Conner Holsclaw

Assistant Inspector:

Scope: Full 100% Frequency: 2020 Annual

Account Manager: (800) 274-0888

### Address: 801 West Prospector PL., Lincoln, NE 68522

Account: LRC Bldg. # 14 - Lincoln Regional Center

#### TJC EP5 FA Equipment Signals 2020 Annual Inspection Summary

#### Result Totals

			1 totale
Devices	Annuciator	Power Supply	
Passed	8	6	
Mitigated	-	-	
New - Passed	-	-	
Failed	-	-	
Removed	-	-	
Not Inspected	-	-	
Total	8	6	
			Supercomponent Information
Туре	1 - FACP		
Location	GROUND FLO	OR	
	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	Туре	Make Model Zone/addr	ess 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	Туре	Make Model	Zone/addres	s Location	Result	Comments	Date
1	Annuciator	Notifier		2 West Tech Station	Passed		8/21/2020 10:31
							AM
2 Applicator		N. CC		2 Outside Elevator			8/21/2020 10:47
2	Annuciator	Notifier		Lobby	Passed		AM
	A	N - CC		tb 000	December		8/21/2020 10:47
3	Annuciator	Notifier		tech 230	Passed		AM
	D 0 1	N CE FORO 0400	1.0144.0	040.01		NAC 2 and 4 not going into trouble when wires taken off NAC 4 might be	8/21/2020 10:46
4	Power Supply	Notifier FCPS-24S8	8 L3M16	242 Closet	Passed	controlling door holders	AM
	Danier Oriente	Netice FORO 04	1.01400	040 014	December		8/21/2020 10:40
5	Power Supply	Notifier FCPS-24	L3M06	242 Closet	Passed		AM

#### 3rd FLOOR TJC EP5 FA Equipment Signals Results

Number	Туре	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	Туре	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	Туре	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 <u>Occupancy Permits</u>

Attachment L5

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: (DR (4.0))

**State Fire Marshal** 



## POST IN PROMINENT PLACE



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: (DR (4.0))

State Fire Marshal



## POST IN PROMINENT PLACE



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: (DR (4.0))

**State Fire Marshal** 



## POST IN PROMINENT PLACE



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: (DR (4.0))

**State Fire Marshal** 



## POST IN PROMINENT PLACE



## DHHS Public Health Licensure Unit Survey

Attachment N1

#### Nebraska DHHS Licensure Unit

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		520003	B. WING		10/08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE	
NORFOLE	REGIONAL CENTER		1209, 1700 NOR	TH VICTORY RD	
		NORFOL	K, NE 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
1 000	Initial Comments		1 000		
	determine compliance Regulations for Hospi compliance with the re at the time of survey:	ucted a licensure survey to with 175 NAC 9, Licensure tals. The facility was out of egulations identified below			
I 470	0-006.08 Infection Co	ntrol	I 470		
	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.				

Licensure Unit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

#### Nebraska DHHS Licensure Unit

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		520003	B. WING	<del></del>	10/0	08/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORFOLK	REGIONAL CENTER	P O BOX 1 NORFOLK		RTH VICTORY RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
1 470	A. Record review of to "Infection Control Plant the responsibilities of Coordinator (ICC) who and systematic surveinfection, compiles mainfection rates, including healthcare-associated infection rates. The IC monthly/quarterly patil Infection Control Commonthly/quarterly patil Infection Control Commonthly/quarterly patil Infection Control Commonthly/quarterly patil Infection Control Commonthly Performance Important Management Committed includes mandatory redisease to local and shealth agencies. The Risk Reduction and Phonitoring and Account investigate, control strategies for healthcath The pharmacy reports in antibiotic use to the Committee. The Multil are to be monitored the chart reviews for any IC practices and educing hygiene is to be monit compliance to greater activity found was relapandemic plan that we Planning.  B. Review of data title	has the potential to affect are:  the facility document titled on last reviewed 11/18 notes the Infection Control to is responsible for ongoing illance of risk or potential for conthly/quarterly patient ing any diffections, monitors staff CC presents to the mittee, Medical Staff and to rovement/ Risk tee. The IC plan also reporting of communicable state community Public plan identifies Infection revention strategies, intability for the committee and develop prevention are-associated infections. In patient infections resulting a Infection Control Drug Resistant Organisms proughout the year with indicated cases to assess that staff as needed. Hand tored to maintain than 90 %. The only IC atted to the facility Covid 19	1470			
		otember of 2019. Data for eporting found no reports 019. A report titled				

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Licensure Unit STATE FORM

BW4911 If continuation sheet 2 of 11

#### Nebraska DHHS Licensure Unit

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		520003	B. WING		10/08/2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
NORFOLE	REGIONAL CENTER	P O BOX 1. NORFOLK		RTH VICTORY RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
1 470	by month with type of respiratory, dental, sk identify the patient or There were no surveil demonstrate IC was r (Health Care Acquired The last document titl IC was second quarter of med rooms, kitcher machines.  C. Record review of Imminutes noted that the meeting in July 2020 August, and Septemb lacked any discussion infection rates of patier monitoring of staff cor and procedures. There Stewardship meeting  D. Staff interview on Director of Nursing (Dinfection Control Coor COVID facility policies Assistant (PA #1) reviantibiotic use and docreports go to the IC coover the role as IC Conted that the previous Infection Control left in DON confirmed that the prior to July 2020. The no antibiotic stewards confirmed there has r staff compliance with	infection such as upper in. The report does not unit or any culture reports. Illance reports to monitoring the nosocomial d) infections of patients. ed "Action Taken" related to er of 2019 related to cleaning as on the units and coffee of IC committee began and had meetings for July, wer 2020. All 3 meetings a of surveillance data, ents and staff or any impliance with IC policies in were no Antibiotic minutes or reports.  10/7/20 at 9:30 AM with the individual of the reduction of the properties of the reduction of the properties. The pommittee. The DON took pordinator this summer and	1470			

Licensure Unit STATE FORM

#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1	5. GG.W.2011611	.52	A. BUILDING: _	A. BUILDING:		
		520003	B. WING		10/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORFOLE	REGIONAL CENTER		209, 1700 NOR , NE  68701	RTH VICTORY RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
1470	PM revealed being not The previous PA left of to Infection Control. The transfer of the Infection Control of the Infection Control of the Infection Control of the Infection Survey of the Infection Control of the Infection	n PA 1 on 10/7/20 at 1:15 ew on the IC Committee. 1/2/20 and did not orient me the PA identified attendance at of 2020 and was not reports. The PA stated " I ce data, no antibiotic re." The PA was aware the reports at the Medical Staff s. The PA stated "I am not role is, we are trying to revious PA did."	1470			
	Legionella, as eviden assess and promote of growth of coliform spot Legionella (as require since 2017).  Meeting with staff 11:00am, the Facility Maintenance Supervimember, revealed the aware of or establisher risk/mitigation of the final Maintenance Supervimentel Housekeeping staff flubleach but no flushing water systems had be A discussion of the DHHS (Department of Services) website whor Disease Control)	tial infections related to ced by lack of any policy to water safety to prevent the pre bacteria that promotes and for all health care facilities.  If members on 10/5/2020 at Operations Officer, sor and Compliance Staff at the facility had not been ad any plan for Legionella acility water system. Sor related that such drains weekly with gof lines or monitoring of the tool-kit available on the				

Licensure Unit STATE FORM

#### Nebraska DHHS Licensure Unit

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		520003	B. WING		10/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
NORFOL M	REGIONAL CENTER			TH VICTORY RD		
MON OL	TREGIONAL GENTER	NORFOL	K, NE 68701			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
I 470	Continued From page 4		I 470			
	use for facility to estal program to ensure the	s was reviewed for potential blish a team and begin a e safety of the facility water atients living at facility and at work in the facility.				
I 560	9-006.09G Pharmacy	Services	I 560			
	needs of patients dire agreement, and must a pharmacist licensed control, handling, comdrugs, devices and bi accordance with Neb. 71-1,147.59 and their thereunder.  9-006.09G1 Emergibiologicals as determinated be readily availal locations when an emergion of the seption of the receipt controlled substances 9-006.09G2 Current be kept on the receipt controlled substances 9-006.09G3. The subiologicals and control protected and restrict authorized purposes.  9-006.09G4 Abuses substances must be readily substance promulgated thereund 9-006.09G5. Drugs, must be stored in lock with the manufacturer temperature, light, huinstructions.	Rev. Stat. §§ 71-1,142 to egulations promulgated ency drugs, devices and ined by the medical staff able for use at designated ergency occurs. It and accurate records must and disposition of all is. pply of drugs, devices and elled substances must be ed to use for legally and losses of controlled eported in accordance with -401 to 28-445, the Uniform s Act, and the regulations der. devices and biologicals areas in accordance				

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Licensure Unit STATE FORM

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#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:				
		520003	B. WING		10	0/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
NORFOLE	REGIONAL CENTER		( 1209, 1700 NORT	H VICTORY RD			
	T		_K, NE 68701			T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
I 560	560 Continued From page 5		I 560				
	area only by personn- policies and in accord law.  9-006.09G7 The su biologicals must be of ensure expired, misla unusable products and use and are disposed hospital policies and se 9-006.09G8 Informa contraindications, sid dosage, indications fo administration for dru must be available to se  This Standard is not	e not available for patient I of in accordance with state and federal law. ation relating to interactions, e effects, toxicology, or use, and routes of gs, devices and biologicals staff. 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:						
	pharmacy, on the 5 p (Medication Cabinet I identified as containir pharmacist identified range of 32-40 degree following: -The Pharmacy medic temperature log. The 40 degrees F. -Unit 1 West medicati						

Licensure Unit STATE FORM

BW4911 If continuation sheet 6 of 11

#### Nebraska DHHS Licensure Unit

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	LIED
	<b>520003</b> B. WING			10/0	08/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
NOBEOLI	C DECIONAL CENTED	Р О ВОХ	1209, 1700 NOR	TH VICTORY RD		
NORFOLI	REGIONAL CENTER	NORFOL	K, NE 68701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
I 560	Continued From page 6		I 560			
	38 degrees FUnit 2 West medicati electronic temperatur months of daily monit temperature recorded currently read 34 deg -Unit 3 West medicati electronic temperature months of daily monit temperature recorded currently read 34 deg -Unit 3 East medicatic electronic temperature months of daily monit no temperature record currently read 24 deg the refrigerator was cand the recheck was -MCM cabinet refriger	ion refrigerator had an e log. Review of the last 4 oring showed 7 days with no d. The thermometer rees F. ion refrigerator had an e log. Review of the last 4 oring showed 4 days with no d. The thermometer rees F. ion refrigerator had an e log. Review of the last 4 oring showed 39 days with ded. The thermometer rees F. The medication in hecked and dial adjusted				
	included but are not li Injectable Ativan and	ed in these refrigerators imited to vaccines, insulin. Those medications range of 32-40 degrees F.				
	(RP A) revealed that, were not keeping logs we were but the staff to monitor it, retired s	the Registered Pharmacist "I was not aware that we s. I know in the pharmacy member that was assigned everal months ago and it eassigned. The refrigerator egrees F.				
	facility failed to ensure were removed from s	r) n and staff interview the e that expired medications tock to prevent use for crash carts/medication box.				

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Licensure Unit STATE FORM

BW4911 If continuation sheet 7 of 11

#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		520003	B. WING		10/08/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
NORFOLK	REGIONAL CENTER		1209, 1700 NOR K, NE  68701	TH VICTORY RD	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE
I 560	Continued From page 7		I 560		
	the locked emergency 3 medications were or	, •			
	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.				
	11:00 AM stated, "The is to be checked for o outdates are to be rer nurses are supposed outdated medication s job is assigned to a di "The medication box i	he Pharmacist on 10/7/20 at e crash carts/medication box utdates every week and the moved and replaced. The to notify us if there is an so we can replace it. This fferent nurse every month." s suppose to be locked and I am unsure when it was			
I 570	through written agree nutritional needs of pa	be provided directly or ment to meet the general	I 570		

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Licensure Unit STATE FORM

#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		71. 501251110			
	520003	B. WING		10/08/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORFOLK REGIONAL CENTER	P O BOX 12 NORFOLK,		TH VICTORY RD		
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
designated as full-time and is responsible for dietary services.  9-006.09H1 There is provide dietary services.  9-006.09H2 There is of trained staff to provide dietary services.  9-006.09H3 Menus and followed to meet is patients.  9-006.09H4 Meals is at appropriate interval 9-006.09H5 Each he protects, serves and cand sanitary manner as Food Code.  This Standard is not 19-006.09H2  Based on observation review, the facility failed director and sufficient staff to ensure preparameals daily for the fact.  Findings include:  Review of dietary dep and schedule reveale position had been vace Facility had not design as director during this nine (9) months. Inter Operating Officer (FO 11:15am revealed that recently been re-classifications.	dietitian, a person must be e director of dietary services the daily management of must be written policies and ed and implemented that es to meet patient needs. must be a sufficient number ride dietary services. must be planned, written the nutritional needs of must be served to patients is. ospital stores, prepares, disposes of food in a safe and in accordance with the met as evidenced by:  In, interview and record ed to employ a dietary number of dietary ration of approximately 300 cility.  In artment employee roster d the dietary director cant since January 2020. In ated an individual to serve prolonged time frame of rview with the Facility	1570			

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Licensure Unit STATE FORM

BW4911 If continuation sheet 9 of 11

#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		520003	B. WING	B. WING		08/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
NORFOLE	REGIONAL CENTER			RTH VICTORY RD		
	T		K, NE 68701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
I 570	Continued From page 9		I 570			
1070	advertising for applications classified Dietary Mar further revealed that a Dietitian was not secuse the Dietitians at E Developmental Center facility who employs to The Food Service Suphone number to call	ants to apply for the newly nager position. The FOO a contract with a Registered ured, and the staff were to Beatrice State er (BSDC) - another State hree (3) Dietitians.				
	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.					
	staff were required to meals 3 times daily w Continental Breakfast the occasional sack to meals. To meet the do service of hot meals to of 7 employees were working multiple	or the facility revealed the prepare and serve hot with the exception of the on Saturday/ Sunday and unch offering of sandwich emands of the regular menu opatients, the current staff the hours of over-time and with rom the facility. A total of				

Licensure Unit STATE FORM

Nebraska DHHS Licensure Unit

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		520003			10/0	8/2020
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	rte, zip code Rth victory RD		
NORFOLK	REGIONAL CENTER		, NE 68701	ATT VIOTORI RE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
1 570	Continued From page 323 hours of Overtime previous 6 weeks by 6	e was worked in the	1570	DELIGITION ()		

Licensure Unit STATE FORM

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	770007 B. WII		B. WING _		10/08/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OP 0 BOX 1209, 1700 NORTH VICTOR NORFOLK, NE 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	D.4.T.E.
K 000	INITIAL COMMENTS		K	000		
K 211	of the 2000 Edition of National Fire Protecti is governed by Chapt Occupancies" of the Erice Protection Associated Safety Code.  The Norfolk Regional story's with a walk out built in 1950 and is a The facility is fully spring the corridors and some the corridors and some the corridors and some the Norfolk Regional to be not in compliant participation in Medical 482.41 Life Safety National Fire Protecti Standard 101 - 2000 Means of Egress - Government of E	eneral eneral corridors, exit discharges, cesses are in accordance the means of egress is ned free of all obstructions to ergency, unless modified by 19.2.11.	K 2	211		
LABORATORY	I 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 A. BUILDING 01 - MAIN BLDG			(X3) DATE SURVEY COMPLETED	
		770007	B. WING	B. WING		10/08/2020	
	ROVIDER OR SUPPLIER			Р	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 1209, 1700 NORTH VICTORY RD IORFOLK, NE 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 211	day of survey.  Findings are:  Observations on 10-6 12:48 pm revealed: 1. A clean linen cart a were being stored (no 2nd floor west next to control room. 2. Holiday decorations in the hallway measur 4'10" to 6'4" for cleara  During an interview or pm and 12:48 pm, Ma the carts and trash ba hallway, and the lack clearance in an egres Hazardous Areas - Er CFR(s): NFPA 101  Hazardous Areas - Er Hazardous areas are having 1-hour fire res fire rated doors) or an system in accordance When the approved a system option is used separated from other partitions and doors in Doors shall be self-cle and permitted to have protective plates that from the bottom of the Describe the floor and	-20 between 12:44 pm and long with two trash bags of in use) in the hallway in the security observation shung from the ceiling grid red from the floor between ance. In 10-6-20 between 12:44 aintenance Staff A confirmed ags were being stored in the of the minimum 6'8" head is path. Inclosure Incl		321			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG			(X3) DATE SURVEY COMPLETED	
		770007	B. WING	B. WING		10/08/2020	
	ROVIDER OR SUPPLIER		•	Р	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 1209, 1700 NORTH VICTORY RD ORFOLK, NE 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 321	e. Trash Collection Ro (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if class Hazard - see K322) This STANDARD is r. Based on observation facility failed to assure was provided with a shazardous equipment room. The deficient p. smoke and gasses to corridor.  Findings are:  Observation on 10-6-11:40 am revealed the area, was being used min fire rated door fai self-closing device.  2. The pottery kiln lock West) failed to be lock separated from other with a door that is self. 3. The Custodial Storafailed to have penetral	Automatic Sprinkler  ded Heater Rooms from 100 square feet) froe, and Paint Shops s (exceeding 64 gallons) froms s) from Rooms/Spaces from	К	321			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 01 - MAIN BLDG		(X3) DATE SURVEY COMPLETED	
		770007	B. WING		1	0/08/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	PREFIX (EACH CORRECTIVE ACTION SHOU		BE COMPLETION	
K 321	and 11:40 am, Mainte findings.	ding foam. n 10-6-20 between 11:26 am enance Staff A confirmed	K 32				
K 346			K 34	6			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING <b>01 - MAIN BLDG</b>			(X3) DATE SURVEY COMPLETED	
		770007	B. WING _			10/	08/2020	
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI: TAG				(X5) COMPLETION DATE	
K 346	Continued From page		K	346				
K 353	documentation of a fir Sprinkler System - Ma CFR(s): NFPA 101	re watch policy aintenance and Testing	ĸ	353				
	Automatic sprinkler an inspected, tested, and with NFPA 25, Standa Testing, and Maintain Protection Systems. From maintenance, inspect maintained in a secur available.  a) Date sprinkler system sup b) Who provided system.  C) Water system sup Provide in REMARKS any non-required or prosystem.  9.7.5, 9.7.7, 9.7.8, and This STANDARD is represented and redeficient practices were temperature of the first the potential that the storoccupants.	ing of Water-based Fire Records of system design, ion and testing are re location and readily stem last checked stem test reply source 6 information on coverage for reartial automatic sprinkler d NFPA 25 not met as evidenced by: n and staff interview, the ain fire sprinklers free from						
	-	-20 between 11:07 am and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG		(X3) DATE SURVEY COMPLETED		
		770007	0007 B. WING			10/08/2020	
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701		O BOX 1209, 1700 NORTH VICTORY RD			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 353	with dust and lint. 3. Two sprinklers in d covered with dust and 4. A sprinkler in the w obstructed. 5. A sprinkler in the Sobstructed. 6. A sprinkler in the Mobstructed. 7. A sprinkler in the C was obstructed. In an interview on 10-11:23 am, Maintenand	e following:  In the dish room were Id lint. In the Kitchen were covered  ry storage room were Id lint.	К	353			
K 354	extent and duration of determined, areas or inspected and risks a recommendations are or designated represed department and other jurisdiction have been sprinkler system is outhours in a 24-hour per of the building affected.	ut of Service ystem is impaired, the f the impairment has been buildings involved are re determined, e submitted to management entative, and the fire r authorities having n notified. Where the ut of service for more than 10 eriod, the building or portion d are evacuated or an es provided until the sprinkler	K	354			

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BLDG</b>			(X3) DATE SURVEY COMPLETED	
	770007 B. WING			10/08/2020			
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		HOULD BE		(X5) COMPLETION DATE
K 354	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.			712	N SHOULD BE COMPLETION		

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG		(X3) DATE SURVEY COMPLETED		
	770007 B. WING			10/08/2020			
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER				Р	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 1209, 1700 NORTH VICTORY RD IORFOLK, NE 68701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
K 712	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K	712		BE COMPLETION	

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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G <b>01 - Main Bldg</b>	(X3) DATE SURVEY COMPLETED			
		770007	B. WING _		,	10/08/2020	
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 1209, 1700 NORTH VICTORY RI NORFOLK, NE 68701	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 712	Continued From pag	e 8	K 7	12			
	from a central receiv activation records.	ing station on the fire alarm					
K 753	During an interview of Maintenance Staff A Combustible Decora CFR(s): NFPA 101	confirmed the findings.	K 7:	53			
	unless one of the fol o Flame retardant fire-retardant coating product. o Decorations me o Decorations exh 100 kilowatts in accorations, surand other art are attained non-fire-rated do 18.7.5.6(4) or 19.7.5 o The decorations in such limited quant development or spreading to the such limited quant development or spreading facility failed to prohid decorations which we the exit corridor. The 150 beds with a centary survey.  Findings are:  Observations on 10-multiple decorations	cions shall be prohibited lowing is met: or treated with approved plant is listed and labeled for let NFPA 701. ibit heat release less than ordance with NFPA 289. In as photographs, paintings lached to the walls, ceilings loors in accordance with loof(4). In existing occupancies are lities that a hazard of fire					

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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BLDG</b>		(X3) DATE SURVEY COMPLETED	
		770007	B. WING			10/0	08/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD P O BOX 1209, 1700 NORTH VICTORY F NORFOLK, NE 68701			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
K 753 K 918	During an interview o Maintenance Staff A o hanging in the hallwa	ed with a flame retardant. n 10-6-20 at 12:44 pm, confirmed the decorations		753 918			
	Maintenance and Tes The generator or oth and associated equip service within 10 secc criterion is not met du process shall be prov capability for the life s Maintenance and test transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exe months for 4 continuo under load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power accordance with NFP circuit breakers are in program for periodica components is establ manufacturer requirer maintenance and test readily available. EES circuits are marked, re separate from normal	er alternate power source ment is capable of supplying onds. If the 10-second ring the monthly test, a ided to annually confirm this safety and critical branches. ing of the generator and performed in accordance  spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 hours. Scheduled test include a complete and automatic or manual ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder spected annually, and a lly exercising the					

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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG		(X3) DATE SURVEY COMPLETED		
		770007	B. WING			10/08/2020	
	ROVIDER OR SUPPLIER		•	P	TREET ADDRESS, CITY, STATE, ZIP CODE O BOX 1209, 1700 NORTH VICTORY RD IORFOLK, NE 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 918	111, 700.10 (NFPA 70 This STANDARD is r Based on documentate the facility failed to protein that all of the weekly was conducted propeincreased the potentia fail to run during loss the capacity for 150 bethe day of survey.  Findings are:  Documentation review revealed the following:  1. The facility failed to the generator monthly and documented that capacity was met.  2. The facility failed to documentation on the inspection.  a. The lubrication system documented weekly.  c. The electrical system documented weekly.  The prime mover fadocumented weekly.  The water pump fadocumented weekly.  The water pump fadocumented weekly.	resideration for new  FPA 99), NFPA 110, NFPA  (b)  not met as evidenced by: ation review and interview, ovide proper documentation and monthly load testing rly. The deficient practices al that the generator would of power. The facility has needs with a census of 87 on  (c)  (v) on 10-6-20 at 13:31 pm (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	K	918			

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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BLDG			(X3) DATE SURVEY COMPLETED	
		770007	B. WING _			10/	08/2020
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER					S, CITY, STATE, ZIP CODE 700 NORTH VICTORY RD 68701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
K 918	Continued From page and documented weeh. The radiator failed documented weekly.  During an interview of Maintenance Staff A of	kly. to be inspected and n 10-6-20 at 13:31,	ΚŞ	18			
K 920	CFR(s): NFPA 101  Electrical Equipment Extension Cords Power strips in a paticused for components patient-care-related e (PCREE) assembles by qualified personne 10.2.3.6. Power strip may not be used for relectronics), except ir rooms that do not use PCREE meet UL 136 strips for non-PCREE (outside of vicinity) m care rooms, power st standards. All power precautions. Extensic substitute for fixed with the strips of the strips of the strips for strips for non-PCREE (outside of vicinity) m care rooms, power st standards. All power precautions. Extensic substitute for fixed with the strips of the strip	ent care vicinity are only of movable lectrical equipment that have been assembled I and meet the conditions of s in the patient care vicinity con-PCREE (e.g., personal I long-term care resident PCREE. Power strips for 3A or UL 60601-1. Power in the patient care rooms eet UL 1363. In non-patient rips meet other UL strips are used with general on cords are not used as a	KS	20			
	immediately upon cor which it was installed 10.2.4. 10.2.3.6 (NFPA 99), 1 (NFPA 70), 590.3(D) This STANDARD is r Based on observatio facility failed to use el	npletion of the purpose for and meets the conditions of 0.2.4 (NFPA 99), 400-8					

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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BLDG			(X3) DATE SURVEY COMPLETED	
		770007	B. WING _			10/08/2020	
NAME OF PROVIDER OR SUPPLIER  NORFOLK REGIONAL CENTER				STREET ADDRESS, CITY, STATE, ZIP COL P O BOX 1209, 1700 NORTH VICTORY NORFOLK, NE 68701	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 920	had the potential to of the capacity for 1 50 beds with a censur Findings are:  Observation on 10-6-12:47 pm revealed the 1. An extension cord permanent wiring in the located in the basem 2. 5 sets of Holiday liand ceiling daisy chawest wing.  In an interview on 10	ause a fire. The facility has is of 87 on the day of survey.  20 between 10:58 am and it following:  was used in lieu of the maintenance office	KS	020			

PRINTED: 10/22/2020 FORM APPROVED

#### Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
					С
		520003	B. WING		10/08/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
NORFOLK	REGIONAL CENTER			TH VICTORY RD	
			K, NE 68701	DD0//DED0 D/ 44/ 05 00DD507/0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
I 000	Initial Comments		1 000		
	On 10/5-10/8/20, DHF representatives condu investigation to detern NAC 9, Licensure Represented to 9-006.04 Pa	ucted a licensure complaint mine compliance with 175 gulations for Hospitals atient Rights. The facility th the regulations related to			

Licensure Unit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

### **Plan of Correction**

	Plan of Correction	_			
Provider/Supplier Name:	Norfolk Regional Center	Survey Date			
STREET ADDRESS, CITY, ZIP:	1700 North Victory Rd, Norfolk, NE 68701				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	9/19/3323			
	PROVIDER'S PLAN OF CORRECTION				
	(EACH CORRECTIVE ACTION SHOULD BE CROSS-	COMPLETIOND			
	REFERENCED TO THE APPROPRIATE VIOLATION)	ATE			
	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				
CITED TAG #	staff during an emergency.				
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all means of egress are				
K-211	free from obstructions.				
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):				
	NRC Quality Assurance Coordinator (QAC) will update the NRC Decorations policy and procedure to ensure a				
K-211	minimum of 6' 8" clearance is maintained in all points of egress.	10/27/2020			
	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				
K-211	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			
N ZII	The will educate all staff on the revised time becordions policy.	12/10/2020			
	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:				
	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				
K-211	continue for at least 90 days of 100% compliance.	2/1/2021			
	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%				
K-346	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				
	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				
CITED TAG #	room. The deficient practices would allow fire, smoke and gasses to migrate into the exit corridor.				
CITED TAG#	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all hazardous areas are				
K-321	secured with a self-closing devise and fire rated door.				
K-3ZI	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).	11/12/2020			
N-251	NRC discontinued the use of the pottery kiln and will not use until secured in an area which is separated by	11/13/2020			
K-321	smoke partitions and a door which is self-closing.	10/27/2020			
N-321	NRC Maintenance Director will get an estimate of cost to install smoke partitions and a self-closing door	10/2//2020			
K-321	around the pottery kiln.	12/1/2020			
N-26T	around the pottery kim.	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:	
	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.	
I-470		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	
	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	
CITED TAG #	interim safety measures in the event of an emergency. This deficient practice affected all occupants.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure a Fire Watch policy and	
K-346/K-354	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 ENGLIRE THE FACILITY IS EFFECTIVE IN CORRECTING	
	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:	
	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	
K-346/K-354	discussed in Administrative Council, PIRM, EOCC and all staff meetings.	1/1/2021
	NRC QA Department will complete a survey of staff to ensure they have knowledge of the Fire Watch Process.	
K-346/K-354	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	
K 246 /K 254	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:  NRC Quality Assurance Coordinator	
K-346/K-354	INRC Quality Assurance Coordinator	
	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	
CITED TAG #	affect all occupants.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all fire sprinklers are free	
K-353	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
	NRC Maintenance Director will ensure all fire sprinklers have at least 18" clearance and are free from any	
K-353	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:	

	4	
	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	
K-353	reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
K 333	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE	2/1/2021
	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Quality Assurance Coordinator	
	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	
CITED TAG #	affect fire procedure response for all residents. The deficient practice would affect all occupants.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure fire drills are completed	
K-712	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
	NRC QAC will update the NRC Fire Drill Assessment to ensure the fire pull stations are tested within 24 hours	
K-712	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:	
	NDC OAC will audit all fire drille are completed according to the NDC Fire Drill Schodule and according to	
	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	
K-712	be reported and discussed in Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
K-712	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE	2/1/2021
	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	
	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	
CITED TAG #	allow fire spread within the exit corridor.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure combustible decorations	
K-753	will not allow fire spread within the exit corridor.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	NRC QAC will update the NRC Decorations policy to reflect the process for treating decorations with flame	
K-753	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:	

	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	
K-753	Administrative Council, PIRM, EOCC and all staff meetings.	2/1/2021
K 733	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE	2,1,2021
	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	
	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	
CITED TAG #	potential that the generator would fail to run during loss of power.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure the generator is tested	
K-918	and monitored as necessary to decrease the likelihood of generator failure during loss of power.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	NRC Maintenance Director will update the Monthly NRC Generator Testing form to ensure documentation of	
K-918	load is documented and at least 30% of the generator capacity was met.	10/28/2020
	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	
K-918	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:	
	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,	
K-918	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	
	K-920: Electrical Equipment - Power Cords and Extends CFR(s): NFPA 101- This STANDARD is not met as	
CITED TAC #	evidenced by: Based on observation and staff interview, the facility failed to use electrical wiring in a way that	
CITED TAG #	would not create a fire hazard.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all electical wiring is used	
K-920	in a way which does not increase fire hazards.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
v 020	NRC QAC will ensure the holiday lights are removed from all patient living units unless approved through the	40/20/2020
K-920	NRC Decorations policy.	10/28/2020
K-920	NPC OAC will undate the NPC Decorations policy to state "daisy chaining" of electrical items is not permitted	10/28/2020
K-920	NRC QAC will update the NRC Decorations policy to state "daisy chaining" of electrical items is not permitted.  NRC QAC will update the NRC Environment Inspection Form to monitor the use of power and electrical cords	10/28/2020
K-920	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	10/28/2020
K-920	electrical cords and ensure "daisy chaining" of electric items does not occur.	10/28/2020
N 920		10/20/2020
	TINKE MISINTENANCE DIFFETOR WILLINGTALL NERMANENT WIRING IN THE NACEMENT MAINTENANCE OFFICE and remove the Tri	
K-920	NRC Maintenance Director will install permanent wiring in the basement maintenance office and remove the	11/6/2020
K-920 K-920	extension cord.	
K-920 K-920	·	
	extension cord.  NRC will educate all staff on the revised NRC Decorations policy.	
	extension cord.  NRC will educate all staff on the revised NRC Decorations policy.  C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING	
	extension cord.  NRC will educate all staff on the revised NRC Decorations policy.  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:	
	extension cord.  NRC will educate all staff on the revised NRC Decorations policy.  C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING	11/6/2020 12/18/2020

	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	
K-920	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**

		1
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	3/13/3323
	(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.	
1-470	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
	NRC ICC will work with Quality Assurance (QA) Department to re-establish infection control reports; which will include antibiotic stewardship, staff and patient illness.	
I-470		11/13/2020
	NRC ICC will implement a Antibiotic Stewardship program.	
I-470		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:	
	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.	
I-470		12/1/2020
	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	
1.470	will be reported and discussed in Administrative Council, PIRM and all staff meetings.	2/1/2021
I-470	D. IDENTIFICATION OF THE DEDCON DESCONCIDER (By 100 TITLE mot by NAME) FOR ENGLIDING THE	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	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.	

	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will implement a Legionella				
I-470	prevention program for water safety.				
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):				
	NRC QA Coordinator (QAC) will work with NRC Maintenance Director to establish a Legionella policy and				
	procedure.				
I-470		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:				
	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				
I-470	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				
	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				
CITED TAG #	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):				
	NRC QAC will develop a refrigerator monitoring form to track refrigerator temperatures in lieu of electronic				
I-560	monitoring process.	10/27/2020			
I-560	NRC QAC will ensure all refrigerators have a temperature monitoring form.	11/6/2020			
1.500	NDC DON will oncure all staff are advected on the revised refrigerator manitoring process	11/12/2020			
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:				
	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				
I-560	in Administrative Council, PIRM and all staff meetings.	2/1/2021			
1 300	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE	2/1/2021			
	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:				
I-560	Director of Nursing				
. 555	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				
CITED TAG #	box.				
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure crash cart medications				
I-560	are removed from the crash cart.				
. 555	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):				
	NRC Pharmacy Director replaced all expired medications and added plastic lock to storage bin where				
I-560	medications are located.	10/9/2020			
I-560	NRC Medical Director reviewed medications on crash cart to assess need.	10/27/2020			
2	NRC Pharmacy Director will remove all medications from crash cart inventory per NRC Medical Director	,,			
I-560		10/27/2020			
I-560	feedback.	10/27/2020			

	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	
I-560	are not expired.	11/13/2020
I-560	NRC DON will ensure all crash cart monitoring forms are updated.	11/13/2020
1-300	INCE DON WIII elisure all crash care 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:	
	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	
I-560	Administrative Council, PIRM and all staff meetings.	2/1/2021
1 300	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE	2,1,2021
	FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	Director of Nursing	
	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	
CITED TAG #	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
	NRC Dietary Supervisor will assess current duties and hours of work for options of support from other	
I-570	departments and options to streamline.	10/16/2020
	NRC Clinical Program Manager will work with Personal Development Supervisor to implement work therapy	
I-570	in dietary for cleaning carts/dishes.	10/19/2020
	NRC Dietary Services Supervisor will Implement sack meals for dinner 2x/week to assist during staffing	• •
I-570	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
	Clinical Program Manager will assess ability to maximize use of work therapy positions including reviewing	
I-570	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
	NRC Dietary Services Supervisor will post the contact information for Beatrice State Developmental Center	
I-570	dietician in Dietary Services and ensure all staff are aware of the contact information.	11/6/2020
	NRC Hospital Administrator will assess options for assistance in getting deep cleaning in the kitchen and dish	
I-570	room completed.	11/15/2020
	NRC Human Resource Business Partner (HRBP) will expedite reclassification of two open food assistant	
I-570	positions to food cooks.	12/1/2020
	NRC HRBP will Contact community businesses to discuss work options including Liberty Center, Workforce	
I-570	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 DEDCON DECOMPLETE (D. 100 TITLE 11-1). MANY TO SHOULD THE	
	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, Dori Banks, Gorey, English, Andrew

You are viewing an attached message. Nebraska Legislature Mail can't verify the authenticity of attached message

#### 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 starts
- 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 exceptione. I am needing some help. I told Jecall I would get them him the information next week. Please know I have to run all information through fe

Denise can you please give me the info for A.

Corevican 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 | Unspital Administrator-Interior for the Norfolk Regional Center

BELLATIORAL HEALTH

#### Nebraska Department of Health and Human Services

OFFICI:: 402-370-4333 | CELL: 402-649-2760

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Jerall Moreland <jmoreland@leg.ne.gov>

#### **Ombudsman's Contact**

Wed, Feb 10, 2021 at 7:07 AM

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

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## **Inspections Reports**

Bi-Annual 1<sup>st</sup> Half 2020 Bi-Annual 2<sup>nd</sup> Half 2020 State Fire Marshall

Attachment N3

Scoring	
0 = Non-Compliant	
1 = Compliant	

Area: Wes't
Date: (1.12.20

Surveyors Signatures:

Safety/Security Management Score pillar, ohs ever , Beck room Are walls in good condition? 1 (i.e. no peeling paint, holes or patches) 0 Are ceiling tiles in place and in good condition? 2 (i.e. no water stains, dirt or mold) Ô 3 Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.) Storage areas are clean and used appropriately? 1 4 (i.e. free of clutter, no boxes stored on floor, shelving secure) 3/3 R 3/3 ţ 5 All employees are wearing ID badge in plain sight and carrying radios. 6 Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc) t 7 Confidential papers are secure and protected. 8 Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes L on floor, clothes not piled in corner) List room # if non-compliant. Patients have bed and dresser for personal possessions? Mattress on floor 1 9. is alright. 1 10. Units are free of excess staples? Are staff members belongings secured? (no purse or bags, in office area, 11. bec k Brook if found note location and unit) 12. Windows are not tampered with, not functioning, or damaged? t Percentage: §3 % Section Score: 6 / 12

Infection Control			Score		nent
1	Gloves are readily available i	n utility rooms		1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.		are	0	file hight dien chancel since 4/23/2020
3	Food is not present in medication refrigerator other then what is used in giving medication.		used in	1	
	Section Score: 2/3	Percentage: 46 %			

Life S	afety Management	Score	
1	Arc means of egress/exit doors clearly and correctly marked?	ı	
2	Exit signs working and arrows pointed in correct direction?	ı	
3	Does the fire extinguisher have a current inspection tag?	ı	
4	Are safety pins in place?	ı	
5	Are fire alarm pull stations accessible?	1	
6	Do fire doors open and security alarms sound?	(	

8	Is fire/smoke doors free of being propped/held wedged open?			
9	Sprinkler heads have 18" clears		t	
10	Means of egress are free of furniture, laundry carts, etc.			
		Percentage: 160 %		
ī	Lazardous Material Waste and	Communication Score	Comme	ent
1	Chemicals stored in appropriate	- · · · · · · · · · · · · · · · · · · ·	1	
2	EVS closet is locked when not		ı	
3		opriate labeling. (i.e. no labels faded or	ı	
4	Product labels are not altered o	r defaced.	•	
5	1200	is readily available (i.e. gloves)		
	Section Score: 5/5	Percentage: (60 %		
Emergenc	y Management/Utility Systems		Score	
1	Flash lights workextra batter	ries available	ı	
2	Two way radios charged and working properly?			
3	Weather radio plugged in and alerts when activated?			
4	Code Green buttons easily acco	essible and not blocked.	ı	- las chilf und
5	Emergency blankets easily acc	essible.	0	on top shelf, nul
6	Red Emergency Management l	Manual is readily available and up to date?	t	
7	Panel box is not block and is lo	ocked?	ı	
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	1	
	Section Score: 7/8	Percentage:%		
Medical E	quipment Management Plan		Score	,
1	Medical Equipment have any t	rayed cords?	1	
2	Sharps container no more than ¾ full?		ł	
3	Medication room is secure when not in use?		١	
4	Code Green buttons easily acc	essible and not blocked.	l	
5	No open medication container	s lying on top of medication cart.	t	
	Section Score: 5/5	Percentage: 600 %		

Scoring

0 = Non-Compliant

1 = Compliant

Area: 5 = 45+

Date: 6.29.20

Surveyors Signatures:

Safety/Security Management Are walls in good condition? a Hole (i.e. no peeling paint, holes or patches) Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold) 2 3 Is furniture arranged so area is free from tripping and falling and in good 1 working condition? (no loose screws, torn, etc.) Storage areas are clean and used appropriately? ١ 4 (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. 6 Secure areas are locked and/or access controlled when not in use. ţ (i.e. utility rooms, offices, class rooms, etc) ŧ Confidential papers are secure and protected. Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes 8 1 on floor, clothes not piled in corner) List room # if non-compliant. Patients have bed and dresser for personal possessions? Mattress on floor 1 9. is alright. ţ 10. Units are free of excess staples? Are staff members belongings secured? (no purse or bags, in office area, 11. ì if found note location and unit) 12. Windows are not tampered with, not functioning, or damaged? Percentage: \_ f ~ % Section Score: [ / 12

	Infection Control		Score Co		ent
1	Gloves are readily available in	utility rooms		7	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.			0	missing Some
3_	Food is not present in medication refrigerator other then what is used in giving medication.		is used in	1	
	Section Score: 2/3	Percentage: 66%			

Life S	afety 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?	i i	
6	Do fire doors open and security alarms sound?	)	

8	Is fire/smoke doors free of being propped/held wedged open?		I	
9	Sprinkler heads have 18" clear	ance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc.		ı	
	Section Score:// /10	Percentage: (VV) %		
H	Iazardous Material Waste and	Communication Score	Comme	ent
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	1	
2	EVS closet is locked when not	in use.	1	
3	Chemical containers have appr missing)	opriate labeling. (i.e. no labels faded or	1	
4	Product labels are not altered o	r defaced.	ı	
5	Personal Protective Equipment	is readily available (i.e. gloves)	(	
	Section Score: 5/5	Percentage: (66 %		
Emergency	ency Management/Utility Systems			
1	Flash lights workextra batteries available		!	
2	Two way radios charged and w	orking properly?	1	
3	Weather radio plugged in and alerts when activated?		ł	
4	Code Green buttons easily accessible and not blocked.		1	
5	Emergency blankets easily acc	essible.	1	
6	Red Emergency Management I	Manual is readily available and up to date?	ı	
7	Panel box is not block and is le	ocked?	ł .	
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	•	
	Section Score: 8 /8	Percentage: (68 %		
Medical E	quipment Management Plan		Score	
1	Medical Equipment have any frayed cords?		1	
2	Sharps container no more than ¾ full?		(	
3	Medication room is secure when not in use?		(	
4	Code Green buttons easily accessible and not blocked.		l.	
5	No open medication containers	lying on top of medication cart.	i	
	Section Score: 5/5	Percentage: (00 %		

6-29-20 S-14 dance Sw clent 3 East Det 7019 Kitcher - print S-8 quint W5 de the Julisto Brunedon light change W-7 point peeling of acting hole cutain rols 714 habo externation 12.26 N-9 paint-oiling Well - Pains paling Littley will 515 the rad reported 11.22 N12 - chip parot, bushle whoty S-13 pint smilletound 11.22 thought to the 11,22 5-89 Don from 5-7 punt -11.22 No pourt with at bestile the filmy U, 22 olist S-3 Print day the printing frame Saturback 5 Doty-L. Samon SI puint Malloon No hot water Food 14 fridge to 21 Biblipant print dire 5 shown the missing 11.22 9 Day lell - autin missishule point peel out vent -Broton file De Molecont yents in show landry . pint Enosl - Jun 5:1 Ches wolte 5-disty 12.24 N-5 hales show dear film soth dishill un ceiting paint, oliphand Alove print W12 Spell 11.22 Sy mad the New Speed 11.22 mi-lock-pricess 5-4 pant appelor & state H dept 3-00 1 11.22 holicog wall craft fine ES SING HIP - paint real

Scoring	
0 = Non-Compliant 1 = Compliant	

Area: 2 E - 5/
Date: 6 · 16 76

Surveyors Signatures:

		core	Comments
	Are walls in good condition?	<b>X</b>	Se affeled
1	(i.e. no peeling paint, holes or patches)		ar affect
	Are ceiling tiles in place and in good condition?		
2	(i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good	١,	
	working condition? (no loose screws, torn, etc.)	'	
	Storage areas are clean and used appropriately?		
4	(i.e. free of clutter, no boxes stored on floor, shelving secure)	(	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	B214 R114
6	Secure areas are locked and/or access controlled when not in use.		
•	(i.e. utility rooms, offices, class rooms, etc)	1	
	(not differ to state) to other, etc)		<del></del>
7	Confidential papers are secure and protected.	1	
·			
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes	٠, ١	
~	on floor, clothes not piled in corner) List room # if non-compliant.	'	
	Patients have bed and dresser for personal possessions? Mattress on floor	_	
9,	is alright.	<b>  7</b>	
		,	
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)	'	
12.	Windows are not tampered with, not functioning, or damaged?	1	
		•	
	Section Score: 10/12   Percentage: 83 %		

1	Infection Control	Score	e Comm	ent
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.		l	
3	Food is not present in medication refrigerator other then what is used in giving medication.		1	·
	Section Score: 3/3	Percentage: LOU %		

Life Sa	nfety 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?	t	
4	Arc safety pins in place?	t	
5	Are fire alarm pull stations accessible?	(	
6	Do fire doors open and security alarms sound?	ı	

8	ls 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 fur.	niture, laundry carts, etc.	1	
	Section Score: 10 /10	Percentage: (60) %		
I	Iazardous Material Waste and	Communication Score	Comme	ent
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	1	
2	EVS closet is locked when not	in use.	1	
3	Chemical containers have approxissing)	opriate labeling. (i.e. no labels faded or	1	
4	Product labels are not altered of	r defaced.	'	
5	Personal Protective Equipment	is readily available (i.e. gloves)	,	
	Section Score: 6 /5	Percentage: [60 %		
Emergenc	y Management/Utility Systems		Score	
1	Flash lights workextra batter	ries available	ı	
2	Two way radios charged and v	vorking properly?	1	
3	Weather radio plugged in and	alerts when activated?	t	
4	Code Green buttons easily acc	essible and not blocked.	1	
5	Emergency blankets easily acc	essible.	1	model net to
6	Red Emergency Management	Manual is readily available and up to date?	1	•
7	Panel box is not block and is lo	ocked?	1	,,,,,
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	,	
	Section Score: 6/8	Percentage: 100%		
Medical E	quipment Management Plan		Score	
1	Medical Equipment have any frayed cords?		t	
2	Sharps container no more than ¾ full?		t	
3	Medication room is secure who	en not in use?	1	
4	Code Green buttons easily acc	essible and not blocked.	1	
5	No open medication containers	s lying on top of medication cart.	1	
	Section Score: 5/5	Percentage:		

6-29-20 2 East SUS punt meds window corner done -Pant bette Mrs - Sow funy pant 514 Sea France -gaint Sed france Swain, F 50 pains 5.43 The four for Sy pind Nr paint 5.2 Vent Nothiase paint Sdan mil put is EVS closet Fsink Leaks -vant posted - gover stell S. Shower-missic files Buthousin Quint Bobbles SS 2-90 No pand former 5-3 Rame paid Sobble- will arace i youth Wk 1.22 bele our At dirty room Ha Vint Mossing N-11 point 1 mossy 11.27 pout missing No Bart France 516 Frame was habblegowt 11.22 South hellow hate in hal 11-82 - Soume pained

·			
·			

Scoring

0 = Non-Compliant 1 = Compliant

Surveyors Signatures:

		core	Comments
	Are walls in good condition?		
1	(i.e. no peeling paint, holes or patches)	♢	
	Are ceiling tiles in place and in good condition?		
2	(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.)	ı	
	Storage areas are clean and used appropriately?	_	***
4	(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 214 R 1/4
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	ı	
7	Confidential papers are secure and protected.	ı	
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.	ı	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	Į.	
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)		
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 16 / 12 Percentage: §3 %		

parameter 10 m.	Infection Control	Score	Com	ıment A	
1	Gloves are readily available in	utility rooms	0	in office	-
2	Refrigerator longs maintained stored on the S drive, temperat	and up to date (refrigerator temps are ure folder.	l		
3	Food is not present in medication refrigerator other then what is used in giving medication.		ι		
	Section Score: 2/3	Percentage: 66. %			

Life S	ife 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?		3		
3	Does the fire extinguisher have a current inspection tag?		1		
4	Are safety pins in place?		ì		_
5	Are fire alarm pull stations accessible?		1	· · · · · · · · · · · · · · · · · · ·	
. 6	Do fire doors open and security alarms sound?	ı	.J		

8	Is fire/smoke doors free of being propped/held wedged open?		ı	
9	Sprinkler heads have 18" clearance especially in storage areas.			
10	Means of egress are free of fur		ŧ	
	Section Score: 6 /10	Percentage: 160 %		
F	lazardous Material Waste and	Communication Score	Comme	ent
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	1	
2	EVS closet is locked when not	in use.	t	
3	Chemical containers have apprimissing)	opriate labeling. (i.e. no labels faded or	ı	
4	Product labels are not altered of	r defaced.	ı	
5	Personal Protective Equipment	is readily available (i.e. gloves)	i	
	Section Score: 5 /5	Percentage: [00] %		
Emergenc	y Management/Utility Systems		Score	
1	Flash lights workextra batte	ries available	ı	
2	Two way radios charged and v	orking properly?	1	
3	Weather radio plugged in and	alerts when activated?	t	
4	Code Green buttons easily acc	essible and not blocked.	1	
5	Emergency blankets easily acc	essible.	i	
6	Red Emergency Management	Manual is readily available and up to date?	ı	
7	Panel box is not block and is lo	ocked?	t	
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	l	
	Section Score: 8 /8	Percentage: 100 %		
Medical E	quipment Management Plan		Score	
1	Medical Equipment have any frayed cords?			
2	Sharps container no more than ¾ full?			
3	Medication room is secure when not in use?			
4	Code Green buttons easily accessible and not blocked.		i	
5		s lying on top of medication cart.	ı	
	Section Score: 6/5	Percentage: 600 %	•	

19-29-ZEZO  $2\omega$ paint office S12. Walls & Registerpaint 510-Walls Paint S-B- Walls Paint Directable / 2007 5-4-Walls, Register ZAirlenit Paint 52-Darframe paint pertly fine wee- Wein will 5.5 - Office med mysel NI strands then 1 = 12 MO-Fram pminA pre paine 149 print bibble - 122 Landy Reon - Pan & TE Total foiled of 3 repland S1- Paint-outlet box hole hear ciling 53. Door frame Paint/Plader 37 Doon frame Paint 5-15- Pegister needs point 5-16-Doon frame-wall paint 5-14 Walls Paint

Scoring

0 = Non-Compliant 1 = Compliant

Surveyors Signatures:

Area: \_

	Safety/Security Management Se	ore	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	Se utte beld
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	)	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	l	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	İ	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	Bolz R1/2
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	i	
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.	ł	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	l	
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)	(	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: [6/12   Percentage:		

	Infection Control	Score	Comm	ent
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.		ŧ	
3	Food is not present in medication refrigerator other then what is used in giving medication.		1	
	Section Score: 3/3	Percentage: <u>loo</u> %		

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	Arc safety pins in place?	1		
5	Are fire alarm pull stations accessible?			
6	Do fire doors open and security alarms sound?			

8	Is fire/smoke doors free of being propped/h	eld wedged open?	t	
9	Sprinkler heads have 18" clear	ance especially in storage areas.	1	
10	Means of egress arc free of furniture, laundry carts, etc.			
	Section Score: 16/10	Percentage: _/60 %		
1	Hazardous Material Waste and	Communication Sec	ore Comme	ent
1	Chemicals stored in appropriat	e 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 of	r defaced.	i	
5	Personal Protective Equipment is readily available (i.e. gloves)		1	
	Section Score: 5/5	Percentage: 160%		
Emergenc	y Management/Utility Systems		Score	
1	Flash lights workextra batte	ries available		
2	Two way radios charged and v	vorking properly?	1	
3	Weather radio plugged in and alerts when activated?		1	
4	Code Green buttons easily acc		1	
5	Emergency blankets easily acc	essible.	1	
6		Manual is readily available and up to dat	e? 1	
7	Panel box is not block and is lo	ocked?	1	
8		king properly? No apparent leaks.	1	
	Section Score: \$ /8	Percentage: 100%		
Medical E	quipment Management Plan		Score	-
1	Medical Equipment have any	fraved cords?	1	
2	Sharps container no more than		1	
3	Medication room is secure wh		1	, , , , , , , , , , , , , , , , , , ,
4	Code Green buttons easily acc	H - H - H - H - H - H - H - H - H - H -	· ·	
5	1	s lying on top of medication cart.	L.	
	Section Score: \$\int /5	Percentage: 100%		

6-29-20 Ked of Sort La Novo Offices - Paint Bubbling & wall Tech other- Berhoon - Det fornt puch N Bettreon - zul frinet lighty facet orisbord Rame 142 Bys in 1844 Sing to het SIL purton With N-7 paret massing Wat pringer was themed Seo part port N-7 101 tomas west & the stand Sig Smith myster purel Not part to ster non sweet was white anche from - 10 to 10 t Anun driver 11.22 Contrara Peron-Buthles part BUTTE 12-31-19 punt pel w.s. Print tolling 1/172 clinical 12-31-17 Bookwar (wold?) sy piny ancel vortelanny 11 Wir Both proof N-10 - France paint Bug of flow 11.22 ven 1 10 31 graneled punt No Credent France
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3 West East

CRITERIA	RESPONSE		Y	ES			Ŋ	Ю	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible			/	1				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	\ <u></u>			V				
Who is responsible for making fall reduction a priority?	All NRC staff.			V	/				
Identify one security sensitive area.	HfM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	<b>/</b>	/	/	<b>V</b>				
NRC has a tolerance for violence from staff and visitors.	ZERO	$\sqrt{}$			/				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.		$\checkmark$	>	V				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish		$\checkmark$	$\sqrt{}$					
What does SDS stand for?	Safety Data Sheet	250	· <b>*</b>	,		ン	<i>&gt;</i>	X	
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.			$\searrow$	V				
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,	V	V		/				
Where is the hospital incident command center located?	Room 216					بد	<b>&gt;</b> -	4	×
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	<u> </u>	<i>\( \sigma \)</i>	/					
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	1		V	V				
Do personal electrical items need inspection before use?	Yes	<b>/</b>	V	J	V				

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14



(A)

(C)

x number of employees questioned (D)

= 50 (E)

- (F)

	·		

3-Entwest

CRITERIA	RESPONSE	YES	NO
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	1 1 1	
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.	111	
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	V V V V	
NRC has a tolerance for violence from staff and visitors.	ZERO	V	
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	V . V	×
What does SDS stand for?	Safety Data Sheet	V 6 V .	+ *
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	V V V	
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,	V J J J	
Where is the hospital incident command center located?	Room 216	V V V •	8
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	1 1 1 1	
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		

MINUS N/A			

Subtotal

Subtract total number of NO answers

TOTAL NUMBER OF QUESTIONS

Divide (G) by (E) X 100

14

x \_\_\_\_\_ number of employees questioned (D)

= \_\_\_\_\_ (E)

- \_\_\_\_\_ (F)

= \_\_\_\_\_ (G)

\_\_\_\_\_ (G)

2 East

CRITERIA	RESPONSE		Y	ES			N	о	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	V/	$\sqrt{}$	V	<b>_</b>				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	V	- <b>V</b>	/	~	ļ			
Who is responsible for making fall reduction a priority?	All NRC staff.	$ \sqrt{ }$	$\sqrt{}$		<u> </u>				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	$\sqrt{}$	$\sqrt{}$	/					
NRC has a tolerance for violence from staff and visitors.	ZERO		$\checkmark$	/					
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.		$\checkmark$		/				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish		•			•	٠ ٩	+	×
What does SDS stand for?	Safety Data Sheet	1						~	7
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.			$\overline{}$	<b>1</b> /				
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	<i>\</i>	' <b>'</b>	· /	~				<b>*</b>
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	V	V		1/				ļ
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.		·/	1	V				
Do personal electrical items need inspection before use?	Yes		/	✓	1/				

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14

<u>0</u> (B)

number of employees questioned (D)

= **56** (E)

. **(**e (F)

- 50 (G)

71.0

CRITERIA	RESPONSE		YES				N	0	
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.	V	V	V	<b>/</b>				
Who is responsible for making fall reduction a priority?	All NRC staff.	V	/	V	/				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	<b>/</b>	V	-ا	<b>V</b>				
NRC has a tolerance for violence from staff and visitors.	ZERO		V	/	<b>V</b>				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	/	/	1					
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	/		<u> </u>					*
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.		/		V	<u> </u>			
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	V		\	_		ĸ		
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	V	<b>✓</b>						
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	<b>V</b>	/	>	/				

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14



(A)

X \_\_\_\_\_ number of employees questioned (D)

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$$= 56$$

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CRITERIA	RESPONSE		Y	ES		 N	Ю	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	<b>/</b>	$\sqrt{}$	<b>/</b>	J			
Who would receive a falling star logo?	Any patient that is at high risk for falls,		$\checkmark$	>				
Who is responsible for making fall reduction a priority?	All NRC staff.	\/	$\checkmark$	V	$\checkmark$			
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)		<b>/</b>	V	$\checkmark$			
NRC has a tolerance for violence from staff and visitors.	ZERO	$\checkmark$	<b>/</b>	/	<b>√</b>			
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	<b>√</b>	<b>√</b> ,		$\checkmark$			
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	<b>/</b>	<b>√</b>		<b>1</b>			
What does SDS stand for?	Safety Data Sheet		$\checkmark$				×	>
Where can you locate SDS sheet?	On the "S" drive in the SDS folder or the Building Services Manager/Safety Officers Office.	V	<b>✓</b>				4	بد
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,	$\checkmark$	✓	/	<b>✓</b>			
Where is the hospital incident command center located?	Room 216	<b>V</b>	•	/		×		×
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	$\vee$	/	✓	<b>✓</b> _			
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.		<b>/</b>	<b>/</b>	<b>/</b>			
Do personal electrical items need inspection before use?	Yes		<u> </u>	<b>√</b>				

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14

number of employees questioned (D)

(A)

:<u> Sle</u> (:

(F)

= <u>50</u> (G)

\_\_\_ %

Environmental Insp	ection	Form					
Date: (0-16-2	OHO		Area /	West Living Unit			
Indicator	Yes	No	NA	0	Comments	Corrective Action	Date Corrected
Safety		1000					24 <b>%</b> 2487
Area clean, including							
Pt rooms. Showers/	./						
bathrooms free of							
mold/mildew							
Area well lit/no lights out	V_						
Area free of slip/trip	\ /	-					
hazards and excess staples	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
Unit Restraints			<u> </u>			-	
accounted for.							
Outlet covers are	\ /						
intact.							
All employees are		,		Goffa - Bedales			
wearing ID badge in				0,0 0095			
plain sight and carrying radios.		•		6/6 - Bidges 8/6-Radius			
Electrical panel			· · · · · -	STO RADIOS			
unobstructed	V						
		3000	345 XX				
All doors secured							
Window Integrity	1/						
checked	V						
Badge Readers are							
working properly Sensitive areas are	-				<del></del>		
maintained secure/No	1./						
unusual activity	Y ,	ļ					
Code Green Buttons							
Accessible					**	<u> </u>	
Other Security		1					
Deficiencies		127-60-107-02					
Hazardous Mace		A HOTEL	***				
EVS utility rooms locked.	V						
All chemicals are	1						-
stored properly with		ţ					
appropriate labeling.	<u></u>						
Only hospital							
approved cleaning	IV						
supplies in the patient	-						
areas.			<u> </u>	l	<u> </u>		

Fire	2.00				<b>1</b>
Fire door/Alarms					
operable					
Fire door free from					
obstruction					
Corridors and exits					
are clear and	/	1			
unobstructed. Exit	$ \mathcal{M} $				
signs functioning and	"				
pointed in correct					
direction.	/	1			
Fire extinguisher pin	11/				
in place	<u> </u>	<del> </del>			
Magnetic doors (in	$\mid V \mid$				
patient area) are					
latching correctly Electrical Panel in					
staff office is not	1/				
blocked	V				
Other Fire Safety					
Deficiencies					
Facility Safety	20.00	25			
Gates are operable		845 E. CANCULATAGO	- British Charles		erreges in Fay South Mills.
and no issues with	1				
perimeter fence.	•				
Exterior doors are					
locked and working	$ \mathcal{M} $				
properly		1			
Exterior lights are	\ /				
working	$\vee$				
Additional Commen	nts:				
				·····	
				111 100 10 3/ 111	
				Mars PT 10-26-8020	
				Staff Signature/Date	
				Statt Signature/Date	

Date: $/2-13-26$ Indicator	Yes	Are No	NA	E Comments Corrective Action	Date Corrected
Safety: 4 92%		Sept Port	ESTAN SALES SALES		Confected
Area clean, including Pt	12 1200	GARAGE S	PER CONTRACTOR		
rooms. Showers/	人	į		Room S-15 is messy, Not Clean,	
bathrooms free of	$\sim$			1	İ
mold/mildew		ļ	ļ		
Area well lit/no lights out	人	<del> </del>			
Area free of slip/trip	1		1		
hazards and excess staples	<b>X</b> -				<u> </u>
Unit Restraints accounted	1				
for.	X			<u> </u>	<u> </u>
Outlet covers are intact.	7				<u> </u>
All employees are	T .	Ì		Radio also in window for staff use.	
wearing ID badge in plain	人			KONOTO OTEO IV MINDION FOR 7401, 925.	ļ
sight and carrying radios.					<del>                                       </del>
Electrical panel	X				
unobstructed	· `			the second section of the section of the section	Der Ch
Security	<b>₹</b> \$~~	73875	127	THE RESERVE OF THE PROPERTY OF	
All doors secured	X				<del> </del>
Window Integrity	X				
checked	_ ^				<del>                                     </del>
Badge Readers are	1				
working properly					
Sensitive areas are	ļ				-
maintained secure/No					
unusual activity Code Green Buttons			-:		
Accessible	X		1		
Other Security	1		,		
Deficiencies				· .	
Hazardous Mac		18.00 AS	1000		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
EVS utility rooms locked.	X	6. 4 · · ·			
All chemicals are stored	<del>                                     </del>			Chemicals are not behind locked cabinet like	
properly with appropriate				other units	
labeling.	1			Other   Whi 12	<u> </u>
Only hospital approved					
cleaning supplies in the	X				
patient areas.	l '				100+
Fire	1873		***	THE RESIDENCE OF THE PARTY OF T	747
Fire door/Alarms operable	K				
and not obstructed	/ >		<u>.</u>		<del> </del>
lo "daisy-chaining" of	,				
lectrical items,	🔪				<u> </u>

Corridors and exits are loader and unbetracted. No items are bring from ceiling or importanted. No items are bring from ceiling or importanted and understanding of clearance in hallways. Exit signs functioning and pointed in corroot direction. Fire extinguisher pin in pales. Magnetic doors (in patient X correctly). Some converting the correctly correctly. Some converting the correctly correctly. Some converting the correctly correct		Y	Ν	NIA		
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Not been as the unit, which is a set of the control		1				
clearance in hallways. Exit signs functioning and pointed in correct direction. Fire extinguishes pin in place Magnetic doors (in patient area) are alcohold for a correction of the correction	No items are nung from	'				
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place Magnetic doors (in patient area) are latching Correctly A correctly A confector Panel in staff office is not blocked A colored by a color form of the color		v				
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.  Bacinic Safets  Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	place	~		_		
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 Sep Gates are operable and no issues with perimeter fence. Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	Magnetic doors (in patient	J.				
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No objects blocking sprinklers No decorative lighting is used other than on approved artificial trees.  Facilities for the first of the		1				
sprinklers  No decorative lighting is used other than on approved artificial trees.  Facility 16  Gates are operable and no issues with perimeter fence.  Exterior doors are locked and working properly  Exterior lights are working  Additional Comments:	Office is not blocked			<b></b>		
No decorative lighting is used other than on approved artificial trees.  Faillt Side Comments:  Gates are operable and no issues with perimeter fence.  Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	sprinklers	1				
used other than on approved artificial trees  Facility Softif  Gates are operable and no issues with perimeter fence.  Exterior doors are locked and working properly  Exterior lights are working  Additional Comments:	No decorative lighting is	,		1		
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Gates are operable and no issues with perimeter fence. Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	approved artificial trees.					<del></del>
Gates are operable and no issues with perimeter fence. Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	Facility/Safetyles/1984					to C
Gates are operable and no issues with perimeter fence. Exterior doors are locked and working properly Exterior lights are working  Additional Comments:		<b>100</b>		275		<del>h</del> erika:
Exterior doors are locked and working properly Exterior lights are working  Additional Comments:	Gates are operable and no			1		
Exterior doors are locked and working properly Exterior lights are working  Additional Comments:		}		1/		
and working properly Exterior lights are working  Additional Comments:		ļ		'		
Exterior lights are working  Additional Comments:				/		
Additional Comments:	and working properly	1	<del>                                     </del>	<u> </u>		
Additional Comments:				ームー		
Jones . The RT 12-	working	<del> </del>		<del> </del>		
	Additional Comments:	<u> </u>				
Staff Signature/Date						<u> </u>
					Staff Signature/Date	

Date: 12-13-20 Indicator	Yes	Ar No	NA NA	Comments	Corrective Action	Date
					<u></u>	Corrected
Safety	19.5		( NO.			W. 4.
Area clean, including Pt			!			1
rooms. Showers/	人	ĺ		Room S-4 needs cleaned.		
bathrooms free of	/ _	ļ				
mold/mildew		1				
Area well lit/no lights out	人			Linen Closet has (2) lights out.	<u> </u>	
Area free of slip/trip			1	J.		
hazards and excess staples	<u>}</u>				<u> </u>	
Unit Restraints accounted	'	ļ				
for.	X	<u> </u>			<u> </u>	ļ <u> </u>
Outlet covers are intact.	1	}				
All employees are				Radio Also in window for staff use.		
wearing ID badge in plain	X	1		Regula 1902 (16 2 1904) (d. Clari, order		
sight and carrying radios.		<u> </u>				
Electrical panel	,					
unobstructed	Ιχ					
Security			#13755			ļ
All doors secured	X	)				<u> </u>
Window Integrity						
checked	X					<del> </del>
Badge Readers are	~					
working properly	X		ļ <u> </u>			<del>-</del> -
Sensitive areas are				Jackeding SSC and Nursing Area		
maintained secure/No	X		1	J SS and Manager		
unusual activity	/			<u> </u>	<u> </u>	<del>-</del> <del>-</del>
Code Green Buttons	1		1			
Accessible			ļ			<del>-</del> -
Other Security						
Deficiencies	<u> </u>		<b>/</b>	the second secon	And the second of the second o	
Hazardous Mat.		Section 1	1200	The state of the s	THE CONTRACT SECTION AND ASSESSMENT OF THE PROPERTY OF THE PRO	<u> </u>
EVS utility rooms locked.	*			Chemicals behind tocked cobinet	<u> </u>	<u> </u>
All chemicals are stored						
properly with appropriate						
labeling.	ļ		<del> </del>			<del>-</del> -
Only hospital approved						
cleaning supplies in the					•	
patient areas.	<del> </del>	2	Tarih Tarih	Control of the Contro		7.5
Fire	10 X 10 10		TAX X 1		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
Fire door/Alarms operable	X					į
and not obstructed			-		<u></u>	<u> </u>
No "daisy-chaining" of electrical items.	<b>x</b>					
siectricai items.	$\sim$		L		<u> </u>	L.——

	У	N	NIA	
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and	X			
pointed in correct direction.  Fire extinguisher pin in place	1			
Magnetic doors (in patient area) are latching correctly  Electrical Panel in staff	X			
office is not blocked  No objects blocking sprinklers  No decorative lighting is	1		_	
used other than on approved artificial trees.  Facility Safety.	人	250.20		office windows have papers and decor possibly obstructing view
Gates are operable and no issues with perimeter fence.			J	
Exterior doors are locked and working properly			X	
Exterior lights are working		}	人	
Additional Comments:	SS	<b>x:</b>	ERC	is located in area. Area needs cleaned + Sanatized.
				Staff Signature/Date 12-13-20

NRC Environmental Inspection Form

Date: |2/14/20 Area | St Floor

Indicator Yes No NA

active reason states of the control	Date: 12/19/20 Indicator	Yes	No	NÁ	Comments	Corrective Action	Date
There clean, including Promiss. Stawers' affirmed and the state of all districtions free of all districtions free of sighting the state well lithe lights out were free of stiphting the state of state of the state of state of the state of t							Corrected
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athrocoms free of boldmildew varies well lifting lights out varies well lifting lights out varies are of stipping agands and excess staples of the control o	Area clean, including Pt	/				}	
audi and to light out ure afree of sliphrip audi and oxess staples in Restrains accounted ox.  Ill employees are vering ID badge in plain got and carrying radios.  Ill employees are vering ID badge in plain got and carrying radios.  Ill entertial panel nobstructed ecturify di doors secured  Window Integrity eccided adage Readers are obtking properly ensitive areas are startained secure/No navaul activity obed Green Battons coessible their Security efficiencies  Dezardous Mat  WS willing rooms locked.  We willing rooms locked.  Use hermicals are stored roperly with appropriate heims guily hospital approved ecuning supplies in the diction areas  ire ire of oder/Arrans operable gin not obstructed of stays-chaining* of of stays-chaining* of of stays-chaining* of of stays-chaining* of of stays-chaining* of of stays-chaining* of	rooms. Showers/	./					
wear well lift to lights out wear free of sliphtip  azards and excess staples full Restrains accounted or.  butter covers are intact.  If employees are rearing ID badge in plain gift and cerrying radios.  Ilectrical panel nobstructed  ceurity  If doors secured  Adage Readers are orising properly necked adage Readers are orisitive areas are altafatined secure/No masual activity Dode Green Buttons coessible  Coessible  In themicals are stored roperly with appropriate being, may hospital approved evaning supplies in the diction areas.  Ire ire door/Alarias operable of and obstructed  of badsy-chaining of		~					
wear free of stipfurip  azards and excess staples  bit Restrains accounted  in employees are  gearing ID badge in plain ght and carrying radios.  lectrical panel nobstructed  excurify  all dorn's secured  Window Integrity hecked  adage Readers are ording properly enablive areas are anistitated securenyo nausual activity odo Green Buttons coessible ther Security efficiencies  Bazardous Mat.  VS stillty nome locked.  Il chemicals are stored roperly with appropriate beling.  Il chemicals are stored roperly with appropriate deciming supplies in the direct areas  ire ire ire door/Alarms operable of not obstructed  of basy-chaining' of  's dassy-chaining' of  's dassy-chaining' of	mold/mildew						
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ar.  Juillet covers are intact.  Ill employees are rearing ID badge in plain ght and carrying radios.  Jeet real panel nobstructed  recurify  Jil doors secured  Vindow Integrity hecked  Jid doors secured  Vindow Integrity hecked  Jid doors secured  Vindow Integrity hecked  Jid doors secured  Vindow Integrity hecked  Jid doors secured  Vindow Integrity hecked  Jid doors secured  Vindow Integrity hecked  Jid doors secured  Jid do	hazards and excess staples					<u> </u>	
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ight and carrying radios.  lectrical panel nobstructed  ceurity  il doors secured  Vindow Integrity hecked adage Readers are rorking properly consilive areas are naintained secure/No massa activity ode Green Buttons coessible ther Security beficiencies  lazardous Mat:  VS utility rooms locked.  Il chemicals are stored roperly with appropriate heding, naty hospital approved leaning supplies in the attent areas.  Ire  ire door/Alarms operable gin not obstructed or  o'daisy-dehaing" of	All employees are						
licetrical panel nobstructed ceurity  all doors secured vindow Integrity hecked adage Readers are rorking properly ensitive areas are adintained secure/No masual activity rode Green Buttons possessible where Security efficiencies hazardous Mat.  VS utility rooms locked. Ill chemicals are stored popely with appropriate heeling, may have been deaning supplies in the attent areas. In the first of the strength of t		´					
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adge Readers are oricking properly censitive areas are naintained secure/No nusual activity odde Green Buttons coessible wher Security deficiencies  **Lazardous Mat.**  VS utility rooms locked.**  Il chemicals are stored roperly with appropriate beling. only hospital approved leaning supplies in the attent areas.  **Ire*  Ire*		~				1	
tensitive areas are maintained secure/No musual activity ode Green Buttons coessible their Security deficiencies  Lazardous Mat:  WS utility rooms locked.  In chemicals are stored roperly with appropriate the ling. And hospital approved leaning supplies in the attent areas.  Tre  ire door/Alarms operable and not obstructed to offer the stored robstructed of offer the stored robst		/		ļ			
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nusual activity lode Green Buttons coessible where Security leficiencies  lazardous Mat.  WS utility rooms locked. Il chemicals are stored roperly with appropriate lebeling. haly hospital approved leaning supplies in the aftent areas.  Ire ire door/Alarms operable of ord obstructed io "daisy-chaining" of							
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cocessible Other Security Deficiencies  Izzardous Mat:  VS utility rooms locked. Ult chemicals are stored roperly with appropriate Deling. Deliy hospital approved leaning supplies in the attent areas.  Ire Ire Ire Ind not obstructed Io "daisy-chaining" of			1				
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Deficiencies    Iazardous Mat:							
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WS utility rooms locked.  Ill chemicals are stored roperly with appropriate abeling.  Only hospital approved leaning supplies in the atient areas.  Ire  ire door/Alarms operable and not obstructed  io "daisy-chaining" of		6.65	Paramania Paramania	Balant Makan		Charles Commence of the Commen	145
all chemicals are stored roperly with appropriate decling.  Only hospital approved leaning supplies in the attent areas.  Ire  ire door/Alarms operable and not obstructed  io "daisy-chaining" of		1	property in a	e# un gest			
roperly with appropriate abeling.  Only hospital approved leaning supplies in the attent areas.  Ire  ire door/Alarms operable ad not obstructed io "daisy-chaining" of		<u> </u>			James 1) the permy on Dark way		<u> </u>
included in the action of the			}		, ,		
only hospital approved leaning supplies in the attent areas.  Ire ire door/Alarms operable and not obstructed io "daisy-chaining" of	Inhalina	~					
leaning supplies in the attent areas.  Ire  ire door/Alarms operable and not obstructed  io "daisy-chaining" of	Only hospital approved					-	
ire door/Alarms operable and not obstructed to "daisy-chaining" of	cleaning supplies in the					1	
ire door/Alarms operable and not obstructed to "daisy-chaining" of				1			
ire door/Alarms operable ad not obstructed io "daisy-chaining" of		Stories	Star John S	7.04 (5-24)		Constitution of the Consti	
ad not obstructed  o "daisy-chaining" of				1 4 4 5 5 5	The state of the s		
io "daisy-chaining" of		į V	]	}		]	
lectrical items		<del>                                     </del>		<del> </del>			<u> </u>
	electrical items.	~					

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Corridors and exits are				<u></u> :	. <u></u>	· <b></b>	· ·				
clear and unobstructed.		1									
No items are hung from		1	•								
ceiling or impacting 8'	_	- I									
clearance in hallways.										}	
Exit signs functioning and											
pointed in correct	-										
direction.	1										
Fire extinguisher pin in	<del>                                     </del>						·		-		
place	/										
Magnetic doors (in patient	1 /				<u></u> -				·	į	
area) are latching										j	
correctly	′	[									
Electrical Panel in staff	<del> </del>				<del></del>						
office is not blocked	-										
No objects blocking	<del>  _</del>	+			<del>-</del>			-			
sprinklers	/		!								
No decorative lighting is	i										
used other than on			/								
approved artificial trees.		1	•								
Facility Safety	1 2 7 2 2 2 4	12000	- Marie 18	Total Charles and Cold The Cold Cold	and the same of the last	STEEL STATE OF THE	***	A CONTRACTOR			green g
racinty Salety	(2)										
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Gates are operable and no											
issues with perimeter	$ \checkmark $							ſ			
fence.								·			
Exterior doors are locked											
and working properly	ļ. /	1				·					
Exterior lights are											
working	ļ ·	ļ <u> </u>						<del> </del>		-	<u></u> _
	l					<del></del>					
Additional Comments:											
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							X. A.	Mes 1 17	-14-20.		
							gr!	1 / (	<u>- 11 CC</u>		
							Staff S	ignature/Date			

Date: 12-13-20 Indicator	Yes	No	ea	Comments Corrective Action	Date Corrected
and the second of the second o	con Street an	-4-6-3-1-	and the second		
	1200		1000		<u> </u>
Area clean, including Pt rooms. Showers/				South shower drain is backed up.	
bathrooms free of	X				
mold/mildew					
Area well lit/no lights out	X				
Area free of slip/trip	<del>                                     </del>	····			
hazards and excess staples	X	1		<u> </u>	
Unit Restraints accounted					
for.	X				
Outlet covers are intact.	X			bottom outlet in (N) dayhall doesn't work.	
All employees are	<del>  ^</del>		-	Radio in window for staff use	
wearing ID badge in plain	X			KOGIO IN WINDOW TO STATE WY	Į
sight and carrying radios.	<b>N</b>				
Electrical panel					
unobstructed	1				
Security	45	7 7 7 6			1 300 10 10
All doors secured	1	,			<u> </u>
Window Integrity	<del></del>				
checked	人				
Badge Readers are	.5				1
working properly	X				<u> </u>
Sensitive areas are					
maintained secure/No	X				İ
unusual activity	/\				<del></del>
Code Green Buttons	X			· ·	
Accessible			<u> </u>		<del>-</del>
Other Security			A		
Deficiencies					<u> </u>
			BEAL TON	THE RESIDENCE OF THE PARTY OF T	<u> </u>
EVS utility rooms locked.	X			Chemicals behind locked cabinet	<u> </u>
All chemicals are stored					
properly with appropriate	义				
labeling.					
Only hospital approved	$\sim$				
cleaning supplies in the	X				}
patient areas.	- (1. <u>7 _ 1, _</u> 3 + ; sa	Section of the second section is	Land Markey A		1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (
	***	7 37 3		THE PROPERTY OF THE PROPERTY O	-
Fire door/Alarms operable	$ \cdot $				1
and not obstructed	$\perp$				<del></del>
No "daisy-chaining" of	<b>V</b>				
electrical items.	١ ١				

	У	N	NIA	
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 dear on ceiling but on outside of conera lane.
Fire extinguisher pin in place	X			
Magnetic doors (in patient area) are latching correctly	7			
Electrical Panel in staff office is not blocked	1			
No objects blocking sprinklers	X			
No decorative lighting is used other than on approved artificial trees.		X		Decorative lights on beams in dayhall.
Facility Safely so 1:34				
Gates are operable and no issues with perimeter fence.			1	
Exterior doors are locked and working properly			7	
Exterior lights are working			X	
Additional Comments:	Obs	ervat	ia -	table Closest to Nursing office is unstable, screwe loose at coming

Date: 2-15-6	Yes	Aro No	NA.	Comments	Corrective Action	Date
mulcator	1 62	1310	INAL	<del></del>		Corrected
Safety:	27.5	112	W. W. S.	Text to the second seco	NAME OF TAXABLE PARTY OF TAXABLE PARTY.	S.M. A. A. A.
Area clean, including Pt			1			!
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Area well lit/no lights out			1		/ \ _	<u> </u>
Area free of slip/trip						İ
hazards and excess staples						
Unit Restraints accounted						
for.					<u> </u>	
Outlet covers are intact.						
All employees are			]			
wearing ID badge in plain						
sight and carrying radios.	<u>.</u>	<u></u> .				
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Security		A. 18.	42			
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working properly						
Sensitive areas are						
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No "daisy-chaining" of electrical items.						
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clear and unobstructed.											
No items are hung from				-							İ
ceiling or impacting 8'											
clearance in hallways.											
Exit signs functioning and	1										
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Date: 12 - 15 - 20 Indicator	Yes	No	NA C	Comments	Corrective Action	Date Corrected
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Area clean, including Pt	]				•	Į
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bathrooms free of					•	]
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Area well lit/no lights out						<u> </u>
Area free of slip/trip						Ì
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Outlet covers are intact.						
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EVS utility rooms locked.						
All chemicals are stored						
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labeling.				<u> </u>		
Only hospital approved						
cleaning supplies in the						
patient areas.	ļ.,	1.	, ,	THE SECOND SECON	1.1 . 1.4	<del> </del>
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Fire door/Alarms operable						
and not obstructed		]				
No "daisy-chaining" of	1					
electrical items.						

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Corridors and exits are													ļ	
clear and unobstructed.													į	
No items are hung from						•								
ceiling or impacting 8'			·											
clearance in hallways.													ļ	
Exit signs functioning and														
pointed in correct														
direction.														
Fire extinguisher pin in														
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Magnetic doors (in patient														
area) are latching														
correctly	ļ									l I				
Electrical Panel in staff														
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sprinklers				 •								<del></del>		
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issues with perimeter	ļ													
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									Staff S	ignature/I	)ate	_		·
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Date: 11-25-26 Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
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Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	<b>M</b>		X	Hollways Cleary perallowed on Iw		
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.			Χ			_
Outlet covers are intact.	V					
All employees are wearing ID badge in plain sight and carrying radios.	Χ,			not allowed on IW/1st floor personal are wearing Bodges!		<b> </b>
Electrical panel unobstructed	X					
Security	2.13.3	¥3776	\$5 <b>\$</b> \$5			
All doors secured	X				<u> </u>	
Window Integrity checked	X					<u>_</u>
Badge Readers are working properly	Χ		•			
Sensitive areas are maintained secure/No unusual activity	X					
Code Green Buttons Accessible	X					: 
Other Security Deficiencies		_	X	·		
Hazardous Mat.	1.0		PART COME	COMPANY TO CALL STREET AND A ST	The state of the s	1,4,2,2
EVS utility rooms locked.	Λ					
All chemicals are stored properly with appropriate labeling.	χ,					_
Only hospital approved cleaning supplies in the patient areas.	R		X	not-allowed to venture on IW	·	·
Fire	Strate in	A CASSA	特别的名	- 100 mm -		· · · · · · · · · · · · · · · · · · ·
Fire door/Alarms operable and not obstructed	χ					
No "daisy-chaining" of electrical items.	Х					

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	Χ							<u></u>		<u> </u>
Magnetic doors (in patient area) are latching correctly			χ	not allowed	on lw					
Electrical Panel in staff office is not blocked	χ	!				 				
No objects blocking sprinklers	XI						_			
No decorative lighting is used other than on approved artificial trees.	χ					 			4 1- The A- THE A	
			1							
Gates are operable and no issues with perimeter fence.	X				_					
Exterior doors are locked and working properly	X						ļ 1			
Exterior lights are working	X									
Additional Comments:		ı	l .							
						 	<u></u>		·	<del></del>
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						مر <sub>حة</sub> سب	uly	7 0		
						Staff	f Signature/D	ate		

Date: 11/16/20 Indicator Yes No Corrective Action Date Comments Corrected Safety 1.00 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 化铁铁 化氯化铁 美国遗嘱 经 Hazardous Mat. EVS utility rooms locked. All chemicals are stored properly with appropriate labeling. Only hospital approved cleaning supplies in the patient areas. Fire 一个自己的主义的主义。国际的首都也有特殊的数据的自己的主义。 机浇造 精神复形菌 Fire door/Alarms operable and not obstructed No "daisy-chaining" of electrical items.

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clear and unobstructed.		1			
No items are hung from					
ceiling or impacting 8'	! /	4			
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Exit signs functioning and				Í	
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Magnetic doors (in patient			-		
area) are latching	1				•
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Electrical Panel in staff					
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No objects blocking	V				
sprinklers	1		ļ		
No decorative lighting is					
used other than on	1/				
approved artificial trees.	"				
Facility Safety	added Sees on				
Gates are operable and no	١.				1
issues with perimeter	V				
fence.					
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and working properly	V				
Exterior lights are	V	1			
working	<i>V</i>			 	
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NRC Environmental Inspection Form

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Acea clean, including Pt comms. Shower's bathrooms free of mode/midew water with the lights out.  Area well lifting lights out.  Area with lights out.  Area fire of sliphtipity hizards and excess staples of the light of the li	Safety	\$1.00 kg	4000 4000	.¥.26.3∓		CONTROL OF THE PROPERTY OF THE PROPERTY OF	
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						<u> </u>	
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Corridors and exits are					
clear and unobstructed.					
No items are hung from	/	∤			
ceiling or impacting 8' clearance in hallways.	11/	1			
Exit signs functioning and	V				
pointed in correct		-			
direction.	1				
Fire extinguisher pin in		<del>-</del>			
place					
Magnetic doors (in patient	/		<u> </u>		ļ
area) are latching	V				
correctly	ļ ·	-	<del> </del>		<del>-</del>
Electrical Panel in staff					
office is not blocked	1	<u> </u>			<u> </u>
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No decorative lighting is	<del>                                     </del>	<del> </del>			
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Gates are operable and no			/		
issues with perimeter					
fence.		ļ			<del> </del> -
Exterior doors are locked					
and working properly	ļ.—	<del> </del>			
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Area free of slip/trip    December   Decembe		w/					_
Integrations and excess staples for the first of the firs	<b>-</b>				<u> </u>		
Coultet covers are intact.  All employees are warring to badge in plain sight and overying radios. Blectrical panel anobstructed  Security  All doors secured  Window Integrity theoled  Security sensitive areas are maintained secure/No minusual activity. Dode Green Buttons  Accessible  All chemicals are stored sporting to the sensitive areas are anobstructed. All chemicals are stored sporting that proporting the sensitive areas are anobstructed. All chemicals are stored sporting that proporting the sensitive areas are are anobstructed. All chemicals are stored sporting that proporting the sensitive areas are are alternative and the sensitive areas are are alternated secure/No minusual activity. Dode Green Buttons  Accessible  All chemicals are stored sporting that the sensitive area are alternative and the sensitive area are alternative and the sensitive area are alternative and the sensitive area are alternative and the sensitive area are alternative area area area.		V					
Dutlet covers are intact. All employees are working properly with appropriate abeling. Dutly hospital approved area.  Window Mate Studies are stored working properly before a security and some security with appropriate abeling. Dutly hospital approved teams are marked and some sources.  All chemicals are stored working properly with appropriate abeling. Dutly hospital approved teams are marked and source with the stricture area.  Wire with the stricture area are marked and the stricture area are marked and the stricture area are marked and the stricture area.  All chemicals are stored woperly with appropriate abeling. Dutly hospital approved teams supplies in the aftent areas.  Wire with the stricture area are marked and the stricture area.  Wire with the stricture area are marked and the stricture area.  Wire with the stricture area are marked and the stricture area.  Wire with the stricture area are marked and the stricture area.  Wire with the stricture area are marked and the stricture area.		. /			UI		
Julied covers are intact.  All employees are waring ID badge in plain ights and carrying radios.  Discrited panel mobstructed  Security  All doors secured  Window Integrity hecked  adage Readers are working properly  sensitive areas are maintained secureNo musual activity  Dade Green Buttons hocked.  All chemicals are stored woperly with appropriate who provided and the stored woperly with appropriate who provided and the stored woperly with appropriate ability rooms locked.  All chemicals are stored woperly with appropriate ability rooms locked.  All chemicals are stored woperly with appropriate who provided and not obstructed to of offsiary-chaining of the stored woperly with appropriate ability.		V	<u> </u>		To they are		
ident and carrying radios.  Electrical panel mobstructed  Security  All doors secured  Window Integrity tecked tecked sadge Readers are working properly  Sensitive areas are maintained secure/No musual activity  Dode Green Buttons Accessible Under Security  Deficiencies  Taxardous Mat  UN sopital approved leaning supplies in the aftent areas.  Wine the door/Alarms operable and not obstructed  No "disity-chaining" of the statement of the statement areas.  Wine the statement of the statement of the statement of the statement areas.  Wine the statement of the stat		V					
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Other Security Deficiencies  Hazardous Mat:  EVS utility rooms locked. All chemicals are stored properly with appropriate abeling. Only hospital approved eleaning supplies in the partient areas.  Fire  Orice door/Alarms operable and not obstructed  No "daisy-chaining" of							
Deficiencies  Hazardous Mat:  VS utility rooms locked.   V	Accessible	V			<u></u>		. <u> </u>
Hazardous Mat  IVS utility rooms locked.  All chemicals are stored properly with appropriate abeling.  Only hospital approved leaning supplies in the atient areas.  Fire  I're door/Alarms operable and not obstructed  Io "daisy-chaining" of	Other Security						
VS utility rooms locked.  All chemicals are stored roperly with appropriate abeling.  Only hospital approved leaning supplies in the atient areas.  Vire  ire door/Alarms operable and not obstructed  Io "daisy-chaining" of			<i>V</i>		The second of th	No. 1991 Company of the Company of t	<del>.</del>
All chemicals are stored roperly with appropriate abeling. Only hospital approved leaning supplies in the atient areas.  Pire  ire door/Alarms operable and not obstructed  Io "daisy-chaining" of		_	3. 3. Acres 5.	(Regulary)	The state of the s	前の大力をはいるがあるとというはよるではなどではないない。このでは、「「「あます」」	···.
roperly with appropriate abeling. Only hospital approved leaning supplies in the atient areas.  Pire ire door/Alarms operable and not obstructed Io "daisy-chaining" of	<u>-</u>	V					
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Only hospital approved leaning supplies in the attent areas.  Vire  ire door/Alarms operable and not obstructed  lo "daisy-chaining" of		u					
leaning supplies in the atient areas.  Fire  ire door/Alarms operable and not obstructed  lo "daisy-chaining" of		_			· · · · · · · · · · · · · · · · · · ·	-	_
Fire Vire door/Alarms operable Ind not obstructed Vire "daisy-chaining" of	leaning supplies in the	V		i			ļ
Tire door/Alarms operable and not obstructed  To "daisy-chaining" of				<u> </u>	And the same state of the same	1 Section 1997 Sec	
nd not obstructed  To "daisy-chaining" of		Çiya sar	5 12	\$4.75 (\$1)	10.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.		· .
To "daisy-chaining" of		1/					
o and stating of   / /			~			-	
lectrical items. $ V $	lectrical items.	V					_

Corridors and exits are			· <del>-</del>		
clear and unobstructed.					
No items are hung from	,	.		·	
ceiling or impacting 8'	/	}	•		
clearance in hallways.					
Exit signs functioning and					
pointed in correct					
direction.	٠,				
Fire extinguisher pin in	1				
place	V				
Magnetic doors (in patient					
area) are latching					
correctly	\ \ \				<u></u>
Electrical Panel in staff					
office is not blocked			🗸		
No objects blocking	_	1			
sprinklers	V				
No decorative lighting is	1		-		
used other than on	./		.		
approved artificial trees.	🗸				<del> </del>
Facility Safety	in way	441 20			
Gates are operable and no	1	İ	_		
issues with perimeter	1		\/		
fence.					
Exterior doors are locked			1/		
and working properly					<del></del>
Exterior lights are			\/		
working			V		
	<u> </u>				
Additional Comments:					
				Monoto 1-18-2000	
				1 Mars 14 11-18-2007)	
				04-06 d:	
				Staff Signature/Date	

Date: // - 18 -2 -		Are		East	Clause Anna Anti-	Date
Indicator	Yes	No	NA	Comments	Corrective Action	Corrected
Safety	罗克德	MI COLD	13 (1) 32°		THE RESERVE OF THE PROPERTY OF	20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	Х			ON this unit many Patients have "Staile vooms, Cleanliness is not on issue.		
Area well lit/no lights out	乂	<u> </u>				
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					_
Outlet covers are intact.	X				<u> </u>	
All employees are wearing ID badge in plain sight and carrying radios.	X			Remindes needed at times.		
Electrical panel unobstructed	X					- -
Security			4.00			<u> </u>
All doors secured	人					_
Window Integrity checked	人	! [				
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X			All Staff areas properly Secured		
Code Green Buttons Accessible	人					_
Other Security Deficiencies		X				
Hazardous Mat.	1.50	<b>分為於</b>	New York	CONTRACTOR OF CONTRACTOR CONTRACT	AND THE THE PROPERTY OF THE PA	1,14 1
EVS utility rooms locked.	人					
All chemicals are stored properly with appropriate labeling.	X			Straige is correct but lock was not on straige Shelf within closet.		
Only hospital approved cleaning supplies in the patient areas.	X					
Fire	34.14	5 mg	#Begiven		11. 计自然的 12. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	Х					<u> </u>

	У	Ν	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								<u> </u>			
Magnetic doors (in patient area) are latching correctly	X											
Electrical Panel in staff office is not blocked	X											
No objects blocking sprinklers	X						<u></u>					
No decorative lighting is used other than on approved artificial trees.	X										*	<del></del>
Facility Safety	74 /s					Territoria.					()	
Gates are operable and no issues with perimeter fence.	X											
Exterior doors are locked and working properly	1											
Exterior lights are	7							ļ				
working												<u>-</u>
Additional Comments:				all lights an			ng propert	y and	ERC	is loca	ted.	
	<u></u>		<i>y</i> 644		1470 74-0-3							
							Staf	grad f Signature	Date	)o	11-,	18-20
											2-	<del>1</del> -

## NRC Environmental Inspection Form

Date: //-/8 - 6 Indicator	Yes	No Are	NA	3Eas+ Comments	Corrective Action	Date Corrected
Safety			- <del> </del>			15k9 (1)
Area clean, including Pt				Section 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1		
rooms. Showers/	X					
bathrooms free of			! 			
mold/mildew	<u> </u>					
Area well lit/no lights out	ベ				<u> </u>	
Area free of slip/trip	X					
hazards and excess staples Unit Restraints accounted						
for.	X					
Outlet covers are intact.	X					
All employees are	<b>— ` ~</b>			Reminders Needed		
wearing ID badge in plain	X			terminas lackon		
sight and carrying radios.	/ \					_
Electrical panel					,	ļ
unobstructed	X			A STATE OF THE STA	The company of the contract of	
Security		1. 17.	N 9740			<u> </u>
All doors secured	*			<u></u>		<del>-</del>
Window Integrity checked	X				<u> </u>	
Badge Readers are	<b>X</b>					
working properly Sensitive areas are	/					_
maintained secure/No	<b>√</b> :					
unusual activity	X	}				
Code Green Buttons Accessible	X					
Other Security Deficiencies			X			
Hazardous Mat.	v 1984	1386	والأثار الأسطيرع	CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CARLO DE LA CAR	京都中心中央の大学を表現的では、1915年 1966日	5.0
EVS utility rooms locked.	7				····	
All chemicals are stored						
properly with appropriate labeling.	X					
Only hospital approved						
cleaning supplies in the	1					
patient areas.	ļ. '				· · · · · · · · · · · · · · · · · · ·	1
Fire	Page 1	Property of	إأ هم إلاَّ إنهابيِّة	· · · · · · · · · · · · · · · · · · ·		
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	NIA	4	
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  Magnetic doors (in patient area) are latching correctly	メ				
Electrical Panel in staff office is not blocked No objects blocking	メイ				
sprinklers  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 Avec - Frankfon (Vec	15	> Cla	ed ≠	well lit - No issues.  clear:  omes hsu 1/-18-  Staff Signature/Date	

NRC Environmental Inspection Form

Date: 11-18-2020 Indicator	Yes	No	NA NA	Living A	Comments		Corrective Action	Date
						<del>-</del>		Corrected
	2.3.0		TO SERVE				THE RESERVE THE PROPERTY OF TH	
Area clean, including Pt	,							
rooms. Showers/								
bathrooms free of mold/mildew	~							
Area well lit/no lights out								
Area free of slip/trip	V	<del></del>						
hazards and excess staples	~							
Unit Restraints accounted			1					
for.	١٧,		ļ					
Outlet covers are intact.								
All employees are		/		515-12				f
wearing ID badge in plain	-	V		515-B 315-R				
sight and carrying radios.		-		315-16			<u> </u>	
Electrical panel unobstructed	V							
Security	1.5		\$2.0 Age	* Programme			1000 1000 1000 1000 1000 1000 1000 100	
All doors secured			1					
Window Integrity	1/							
checked								
Badge Readers are	$ \nabla $							ĺ
working properly Sensitive areas are			-					<u> </u>
maintained secure/No				1				
unusual activity	'		}					
Code Green Buttons	1	<u>.                                    </u>						
Accessible	.~		-			ı		
Other Security		V						
Deficiencies		, T						
Hazardous Mat:		1. T. C. C. C. C. C. C. C. C. C. C. C. C. C.	A Comment	1. <b>1986年</b> 1. 1000年	TO A CONTRACT OF THE PARTY OF T	A STATE OF THE STA	The secretary of the second of	·
EVS utility rooms locked.	V,							
All chemicals are stored	V					ı		
ргорегly with арргортiate labeling.						ı		
Only hospital approved	-							
cleaning supplies in the	V		} 			ı		
patient areas.							·	
Fire	2.8%	(1) (4) (4)	944044.			TARREST STATE OF THE STATE OF T	The second secon	
Fire door/Alarms operable	. / .			<u></u>	The state of the s	*		
and not obstructed	4/							<u> </u>
No "daisy-chaining" of								
electrical items.	\ \					l l		

Due to Quality Assurance Department by the 15th of each month

Corridors and exits are clear and unobstructed.				<u>.</u>													
No items are hung from	1	Į															
ceiling or impacting 8'	/	1								•							
clearance in hallways.	$\mathbb{N}/$																
Exit signs functioning and	V																
pointed in correct			ţ								1						
direction.		<i>\</i>								_	.		_				
Fire extinguisher pin in place	$\vee$					_											
Magnetic doors (in patient	/	┨ .															
area) are latching																	
correctly														· <del>-</del> ·			
Electrical Panel in staff																	
office is not b <u>locked</u>		-									-				<del>-</del> -	<u> </u>	
No objects blocking	/		Ì								}						
sprinklers	V,																
No decorative lighting is	/																
used other than on	k /																
approved artificial trees.	\ <u>\</u>	1					Audelina er leiter i sentra ser	on and the second section of the second	ristra :		: 9 .22	sa Valvesia	S & Colored March	Sala (Sa)	August and a st	74.75.15.1	
Facility Safety				****									***				<u>:</u> :
Gates are operable and no	/	[									ļ						
issues with perimeter																	
fence.		1			<u> </u>						<del>   </del>		<del></del> -		<del></del>		
Exterior doors are locked	$\mathbf{k} \mathbf{Z}$	.															
and working properly	<u> </u>		ļ	ļ													_
Exterior lights are	$\mathcal{M}$	ĺ															
working												<del>-</del>		·	_	<u> </u>	
												_				<u> </u>	—
Additional Comments:																	
-																	
									-	-							
	<del></del>				<del></del> -					<del></del>		<del></del> -					
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										Staff	Signa	ture/Date	Э				

Scoring	
0 = Non-Compliant 1 = Compliant	

	Safety/Security Management	Score	Comments
	Are walls in good condition?	,	
1	(i.e. no peeling paint, holes or patches)	į,	
	Are ceiling tiles in place and in good condition?	1 o	5 graphed Allient the one
2	(i.e. no water stains, dirt or mold)		1 2) Le
_			1 *
3	Is furniture arranged so area is free from tripping and falling and in good	1 1	
	working condition? (no loose screws, torn, etc.)		
	Storage areas are clean and used appropriately?		BONDER VERN VIII
44	(i.e. free of clutter, no boxes stored on floor, shelving secure)	υ U	JA I H. W.
_	411 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	(	
6	Secure areas are locked and/or access controlled when not in use.		
O		1	
	(i.e. utility rooms, offices, class rooms, etc)		
7	Confidential papers are secure and protected.	į	
	Confidential papers are secure and protected.	<del></del>	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes	1 1	
U	on floor, clothes not piled in corner) List room # if non-compliant.	,	
	Patients have bed and dresser for personal possessions? Mattress on floor		+
9.	is alright.	į	
10.	Units are free of excess staples?	,	
11.	Are staff members belongings secured? (no purse or bags, in office area,	<u> </u>	<del>-  </del>
	if found note location and unit)	Y Y	
12.	Windows are not tampered with, not functioning, or damaged?	,	
		· · · · · · · · · · · · · · · · · · ·	
	Section Score: 10 / 12 Percentage: \( \frac{\mathcal{3}}{3} \) \( \text{\parameters} \)		

_	Infection Control	Sco	Score			
1	Gloves are readily available in	atility rooms		ŧ		
2	Refrigerator longs maintained stored on the S drive, temperat	nd up to date (refrigerator temps are re folder.		0	futes	missig
3	Food is not present in medicating giving medication.	on refrigerator other then what is used in		i		
	Section Score: 2/3	Percentage: (666 %				

Life S	afety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?		
2	Exit signs working and arrows pointed in correct direction?	3	
3	Does the fire extinguisher have a current inspection tag?	,	
4	Are safety pins in place?		
5	Are fire alarm pull stations accessible?		
6	Do fire doors open and security alarms sound?	A	

	T			_	
8	Is fire/smoke doors free of being propped/he	eld wedged open?	1		
9	Sprinkler heads are clear of lin in storage areas.	t/debris and have 18" clearance especially	ŧ		
10	Means of egress are free of fur 8' clearance and no items can l	niture, laundry carts, etc. Halls must have be hanging from ceiling.	ł		
	Section Score: 16 /10	Percentage: (W) %			
	L Tazardous Material Waste and	Communication Score	Comme	ent	
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	i		
2	EVS closet is locked when not		ł		
3	Chemical containers have appr missing)	opriate labeling. (i.e. no labels faded or	ı		
4	Product labels are not aftered of	r defaced.	į		
5	Personal Protective Equipment	is readily available (i.e. gloves)	ŀ		
	Section Score: 5/5	Percentage: (OO %			
Emergenc	y Management/Utility Systems		Score		
1	Flash lights workextra batter	ries available	l		
2	Two way radios charged and w	orking properly?	ı		
3	Weather radio plugged in and	alerts when activated?	ŧ		
4	Code Green buttons easily acco	essible and not blocked.	l		<i>r ii</i>
5	Emergency blankets easily acc	essible.	•	top mekind	lemmen
6	Red Emergency Management 1	Manual is readily available and up to date?	i		
7	Panel box is not block and is lo	ocked?	1		<u> </u>
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	1		
	Section Score: 7 /8	Percentage: 48 %			
Medical E	quipment Management Plan		Score		
1	Medical Equipment have any f	rayed cords?	i		
2	Sharps container no more than		Ł		
3	Medication room is secure when not in use?				
4	Code Green buttons easily accessible and not blocked.				
5	No open medication containers	lying on top of medication cart.	ţ		
	Section Score: 5/5	Percentage: <u>660</u> %			

CRITERIA	RESPONSE		Y	ES		NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	/	V	V	<b>√</b>				
Who would receive a falling star logo?	Any patient that is at high risk for falls.		1	V	/				
Who is responsible for making fall reduction a priority?	All NRC staff.	V	V	52/	1				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	V	1/	V	V				
NRC has a tolerance for violence from staff and visitors.	ZERO	V	V	V	Qu'				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	V		1/	1/				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish		$\checkmark$		1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100		V	
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL,	W	V.	V	3.7				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	$\vee$	V	V					1,000
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,	V	V	U.	U			:	
Where is the hospital incident command center located?	Room 216	V		V					
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	V	$\sqrt{}$	1	3.200				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	V		V.					
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	V	V					V	V

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14



(A)

(C)

number of employees questioned (D)

(G)

Scoring	
0 = Non-Compliant 1 = Compliant	

Amaa

Area: Date: 3 (N4) 12-21-20

Surveyors Signatures:

re walls in good condition?  e. no peeling paint, holes or patches)  re ceiling tiles in place and in good condition?  e. no water stains, dirt or mold)  furniture arranged so area is free from tripping and falling and in good orking condition? (no loose screws, torn, etc.)	<u>0</u> a	Comments See is He Cen
e ceiling tiles in place and in good condition?  e. no water stains, dirt or mold)  furniture arranged so area is free from tripping and falling and in good orking condition? (no loose screws, torn, etc.)		
orking condition? (no loose screws, torn, etc.)	1	
orage areas are clean and used appropriately? e. free of clutter, no boxes stored on floor, shelving secure)	l l	
l employees are wearing ID badge in plain sight and carrying radios.	1	
cure areas are locked and/or access controlled when not in use. e. utility rooms, offices, class rooms, etc)	(	
onfidential papers are secure and protected.		
re patient rooms free of clutter, debris and excess linens? (i.e. no boxes floor, clothes not piled in corner) List room # if non-compliant.	)	
Patients have bed and dresser for personal possessions? Mattress on floor is alright.		
Units are free of excess staples?		
Units are free of excess staples?  Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)		
indows are not tampered with, not functioning, or damaged?	i	
t a train	employees are wearing ID badge in plain sight and carrying radios.  oure areas are locked and/or access controlled when not in use.  utility rooms, offices, class rooms, etc)  infidential papers are secure and protected.  patient rooms free of clutter, debris and excess linens? (i.e. no boxes floor, clothes not piled in corner) List room # if non-compliant.  ients have bed and dresser for personal possessions? Mattress on floor dright.  its are free of excess staples?  estaff members belongings secured? (no purse or bags, in office area, bound note location and unit)	cmployces are wearing ID badge in plain sight and carrying radios.  cure areas are locked and/or access controlled when not in use.  dutility rooms, offices, class rooms, etc)  infidential papers are secure and protected.  e patient rooms free of clutter, debris and excess linens? (i.e. no boxes floor, clothes not piled in corner) List room # if non-compliant.  ients have bed and dresser for personal possessions? Mattress on floor clright.  its are free of excess staples?  e staff members belongings secured? (no purse or bags, in office area, bound note location and unit)  indows are not tampered with, not functioning, or damaged?

_	1	Infection Control		Score	Comr	ment
	11	Gloves are readily available in	utility rooms		Ĺ	
	2	Refrigerator longs maintained stored on the S drive, temperat	and up to date (refrigerator temps are ure folder.	;	6	dites missing
	3	Food is not present in medicat giving medication.	ion refrigerator other then what is use	ed in	;	7
		Section Score: 2 /3	Percentage: 66 %			

Life Sa	fety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?		
2	Exit signs working and arrows pointed in correct direction?		
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?	!	
6	Do fire doors open and security alarms sound?	1	

8	Is fire/smoke doors free of being propped/ho	eld wedged open?	i	
9	Sprinkler heads are clear of lin in storage areas.	t/debris and have 18" clearance especially	t	
10	Means of egress are free of fur 8' clearance and no items can be	niture, laundry carts, etc. Halls must have be hanging from ceiling.	i	
	Section Score: 10/10	Percentage: 600 %		
	L Hazardous Material Waste and	Communication Score	Comme	J ent
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	ť	
2	EVS closet is locked when not	in use.	ì	
3	Chemical containers have appr missing)	opriate labeling. (i.e. no labels faded or	t	
4	Product labels are not altered o	r defaced.	i	
5	Personal Protective Equipment	is readily available (i.e. gloves)	1	
	Section Score: 5/5	Percentage: <u>(00</u> %		
Emergency	y Management/Utility Systems		Score	
1	Flash lights workextra batter	ries available	1	
2	Two way radios charged and w	orking properly?	i	
3	Weather radio plugged in and a	ilerts when activated?	l	
4	Code Green buttons easily acce	essible and not blocked.	ì	
5	Emergency blankets easily acc	essible.	t	
6	Red Emergency Management I	Manual is readily available and up to date?	t	
7	Panel box is not block and is lo	ocked?	1	and the declar
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	0	nuls reprind
	Section Score: 7 /8	Percentage: 88 %		
Medical E	quipment Management Plan		Score	
1	Medical Equipment have any f	rayed cords?	i	
2	Sharps container no more than	% full?	1	
3	Medication room is secure whe	en not in use?	(	
4	Code Green buttons easily acce	essible and not blocked.	- (	
5	No open medication containers	lying on top of medication cart.	i	
	Section Score: 5/5	Percentage: (00) %		

CRITERIA	RESPONSE		Y	ES		N	(O	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	./	/	1	V			
Who would receive a falling star logo?	Any patient that is at high risk for falls.	1		U.	$\sqrt{}$			
Who is responsible for making fall reduction a priority?	All NRC staff.	* V	$\checkmark$	S	V			
identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	/	V	V	$\sqrt{}$			
NRC has a tolerance for violence from staff and visitors.	ZERO	$\sqrt{}$	v'	J				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	1	\ \J_	<b>√</b>				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	1	Ĭ,	V _	Ų		ļ	
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	V	J.	✓ _	Ŕ			W
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	V				1		V
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,	V	$\sim$	V	<u> </u>			
Where is the hospital incident command center located?	Room 216	0			V			
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.			<u> </u>				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.		V	V	V			
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor		V	V	V			

Divide (G) by (E) X 100

Scoring	Scoring
0 = Non-Compliant 1 = Compliant	•

Area: 2 E 45 + Date: 12 20 20

Surveyors Signatures:

walls in good condition? no peeling paint, holes or patches) ceiling tiles in place and in good condition? no water stains, dirt or mold)  rniture arranged so area is free from tripping and falling and in good king condition? (no loose screws, torn, etc.) age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure)  employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use. utility rooms, offices, class rooms, etc)  fidential papers are secure and protected.	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	Luc i the bet
ceiling tiles in place and in good condition? no water stains, dirt or mold)  rniture arranged so area is free from tripping and falling and in good king condition? (no loose screws, torn, etc.) age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure)  employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	i i	with the set the more taken
no water stains, dirt or mold)  rniture arranged so area is free from tripping and falling and in good cing condition? (no loose screws, torn, etc.)  age areas are clean and used appropriately?  free of clutter, no boxes stored on floor, shelving secure)  employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	i 1 3	
rniture arranged so area is free from tripping and falling and in good king condition? (no loose screws, torn, etc.) age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure) employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	i 1 3	
cing condition? (no loose screws, torn, etc.) age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure) employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	(	
cing condition? (no loose screws, torn, etc.) age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure) employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	(	
age areas are clean and used appropriately? free of clutter, no boxes stored on floor, shelving secure) employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use, utility rooms, offices, class rooms, etc)	l G	
employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use.  utility rooms, offices, class rooms, etc)	Ö	
employees are wearing ID badge in plain sight and carrying radios.  are areas are locked and/or access controlled when not in use.  utility rooms, offices, class rooms, etc)	Ö	
are areas are locked and/or access controlled when not in use. utility rooms, offices, class rooms, etc)		
are areas are locked and/or access controlled when not in use. utility rooms, offices, class rooms, etc)		R M
utility rooms, offices, class rooms, etc)	3	
utility rooms, offices, class rooms, etc)		
· · · · · · · · · · · · · · · · · · ·	- '	
fidential papers are secure and protected.	ł	
fidential papers are secure and protected.	(	
Confidential papers are secure and protected.		
patient rooms free of clutter, debris and excess linens? (i.e. no boxes	:   1	
on floor, clothes not piled in corner) List room # if non-compliant.		
Patients have bed and dresser for personal possessions? Mattress on floor is alright.		
Units are free of excess staples?		
Arc staff members belongings secured? (no purse or bags, in office area,		
if found note location and unit)		
dows are not tampered with, not functioning, or damaged?	.	
. * \$-2		
	staff members belongings secured? (no purse or bags, in office area,	staff members belongings secured? (no purse or bags, in office area, and note location and unit) dows are not tampered with, not functioning, or damaged?

	Infection Control	S	core	Comme	ent
1	Gloves are readily available in	utility rooms		1	4
2	stored on the S drive, temperat		:	<b>*</b>	dotes more predicte
3	Food is not present in medication refrigerator other then what is used in giving medication.			é	, , , , , , , , , , , , , , , , , , ,
	Section Score: 2 /3	Percentage: U6 %			

Life Sa:	fety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	1	
2	Exit signs working and arrows pointed in correct direction?	,	
3	Does the fire extinguisher have a current inspection tag?	1	
4	Are safety pins in place?	3	
5	Are fire alarm pull stations accessible?	3	
6	Do fire doors open and security alarms sound?	ı	

			1	
8	Is fire/smoke doors free of being propped/he	eld wedged open?	i	
9	Sprinkler heads are clear of lin in storage areas.	t/debris and have 18" clearance especially	i	
10	Means of egress are free of fur 8' clearance and no items can be	niture, laundry carts, etc. Halls must have be hanging from coiling.	ı	
	Section Score: to /10	Percentage:%		
<u>F</u>	Jazardous Material Waste and	Communication Score	Comme	] ent
1	Chemicals stored in appropriate	e cabinets (i.e. metal)	1	
2	EVS closet is locked when not	in use.	ŧ	
3	Chemical containers have appr missing)	opriate labeling. (i.e. no labels faded or	ı	
4	Product labels are not altered o	r defaced.	1	
5	Personal Protective Equipment	is readily available (i.e. gloves)	1	
	Section Score: 5/5	Percentage: <u>/ 60</u> %		
Emergency	y Management/Utility Systems		Score	
1	Flash lights workextra batter	ies available	1	
2	Two way radios charged and w	orking properly?	1	more in chirgh
3	Weather radio plugged in and a	alerts when activated?	ı	
44	Code Green buttons easily acce	essible and not blocked.		
5	Emergency blankets easily accessible.			
6	Red Emergency Management Manual is readily available and up to date?			
7	Panel box is not block and is lo	ocked?	ı	
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	ł	
	Section Score: \$ /8	Percentage: 600 %		
Medical E	quipment Management Plan		Score	,
1	Medical Equipment have any f	rayed cords?	1	
2	Sharps container no more than	% full?	į	
3	Medication room is secure whe	n not in use?	ι	
4	Code Green buttons easily acce	essible and not blocked.	į	
5	No open medication containers	lying on top of medication cart.	ŧ	
	Section Score: 7/5	Percentage: <u>(00   </u> %		

2 E284

# 6 73 6 4 6 35 6

CRITERIA	RESPONSE		y	'ES		NO	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible		V	J"	~		
Who would receive a falling star logo?	Any patient that is at high risk for falls.		<b>V</b>	✓	V.		
Who is responsible for making fall reduction a priority?	All NRC staff.	V	<b>✓</b>	V	1		
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	$\checkmark$	``	V	V		
NRC has a tolerance for violence from staff and visitors.	ZERO	V	$\checkmark$	v,	/		
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.		1	V	V		
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	U.	✓.	V	V^		
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	V	J	V	1		
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	1	1	4	v s		
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,	V	V	V	v <sup>2</sup>		
Where is the hospital incident command center located?	Room 216	V	v.	1	1		
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.		$\sqrt{}$	V.	Ś		
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.		V	V	✓		
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor		J	√	1		

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

14

(A)

## Norfolk Regional Center

		Bi-Annual Environmental Tour Ins	pection Fo	orm	
Г	Cassing		<b>A</b>	2	
	Scoring		Arca:	12.28.7es _	
	0 = Non-Compliant			7 2 · 5 0 · CO	
L	1 = Compliant	Surveyors Signatures:	<i>/</i>		
		10 J	7		
		Safety/Security Management 5	Score	Comments Suc of Hearter	
1	Are walls in good condition? (i.e. no peeling paint, holes or	matala an	0	See a Herbert	
	Are ceiling tiles in place and in			5 clast 11-3 loos	
2	(i.e. no water stains, dirt or mo		()	4/Lc=	
3	working condition? (no loose s		7		
4	Storage areas are clean and use	ed appropriately? ored on floor, shelving secure)		Choken	
4	(i.e. free of clutter, no boxes si	ored on floor, sherving secure)	1,		
_ 5	All employees are wearing ID	badge in plain sight and carrying radios.	1		
6	Secure areas are locked and/or (i.c. utility rooms, offices, class	access controlled when not in use. s rooms, etc)	i		
7	Confidential papers are secure	and protected	1		
		-	'		
8	on floor, clothes not piled in co	er, debris and excess linens? (i.e. no boxes orner) List room # if non-compliant.	1		
9.	Patients have bed and dresser is alright.	for personal possessions? Mattress on floor	1		
10.	Units are free of excess staples	9	1.		
11.	Are staff members belongings	secured? (no purse or bags, in office area,	-		
12.	if found note location and unit	h, not functioning, or damaged?	i -		
12.	_				
	Section Score: 9 / 12	Percentage: 75 %			
	<b></b>				
_	Infection Control	Score	Сог	nment	
1	Gloves are readily available in	willier manua	0	100 attaca	
<u>, ,</u>		and up to date (refrigerator temps are	<u> </u>	IX2 Missing	
2	stored on the S drive, temperat	ure folder,		745	
3	Food is not present in medicat giving medication.	ion refrigerator other then what is used in	<u>i</u>		
	Section Score: 1/3	Percentage: 33 %			
Life S	Safety Management	Score			
	-		j		
1	Are means of egress/exit door	s clearly and correctly marked?	1		
2	Exit signs working and arrows	pointed in correct direction?	, ,		
_ 3	Does the fire extinguisher hav	e a current inspection tag?	'		

4

5

6

Are safety pins in place?

Are fire alarm pull stations accessible?

Do fire doors open and security alarms sound?

	1		,	<u>,</u>
8	Is fire/smoke doors free of being propped/he	eld wedged open?	l	
9	Sprinkler heads are clear of lin in storage areas.	t/debris and have 18" elearance especially	1	
10	Means of egress are free of fur 8' elearance and no items can be	niture, laundry carts, etc. Halls must have	İ	
	Section Score: 10 /10	Percentage: 600 %		
I	Hazardous Material Waste and	Communication Score	Commo	ent
1	Chemicals stored in appropriat	e cabinets (i.e. metal)	1	
2	EVS closet is locked when not	in use.	9	
3	Chemical containers have apprinissing)	opriate labeling. (i.e. no labels faded or		
4	Product labels are not altered of	r defaced.	1	
5	Personal Protective Equipment	is readily available (i.e. gloves)	)	
	Section Score: 5/5	Percentage: 100 %		
Emergency	y Management/Utility Systems		Score	T
1	Flash lights workextra batter	ries available	l	
2	Two way radios charged and w	orking properly?	1	
3	Weather radio plugged in and a	alerts when activated?	1	
4	Code Green buttons easily acco	essible and not blocked.	ť	
5	Emergency blankets easily acc	essible.	1	
6	Red Emergency Management I	Manual is readily available and up to date?	1	
7	Panel box is not block and is lo	ocked?	l	1 1 1 1 1 1 V V C
8	Toilets, faucets and drains wor	king properly? No apparent leaks.	ð	First rice hil to
	Section Score: 7 /8	Percentage: 57.5 %		This n
Medical E	quipment Management Plan		Score	T
1	Medical Equipment have any f	rayed cords?	1	
2	Sharps container no more than	¾ full?	ì	
3	Medication room is secure who	en not in use?	1	
4	Code Green buttons easily acco	essible and not blocked.	1	
5	No open medication containers	lying on top of medication cart.	i	
	Section Score: 5/5	Percentage: 100 %		

CRITERIA	RESPONSE	l <u>-</u>		ÆS			N	10	
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	1	V	V	V				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	V		$\checkmark$	✓ ·		V.		
Who is responsible for making fall reduction a priority?	All NRC staff.	1	1	1	1				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	1		1	<b>/</b>		/		
NRC has a tolerance for violence from staff and visitors.	ZERO	1	V	u ^	V				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	v"	V	U	V				,
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	1	J	$\checkmark$	1				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	V	✓	1	./				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	V					V.	VC	مري
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,	V	V	V	V				
Where is the hospital incident command center located?	Room 216			1	$\checkmark$	8.	1		
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	1	v	V	1				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	V		1	V		V		
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	V	V	j	1				

14

TOTAL NUMBER OF QUESTIONS

MINUS N/A

Subtotal

Subtract total number of NO answers

Divide (G) by (E) X 100

x \_\_\_\_\_ number of employees questioned (D) = \_\_\_\_\_ (E)

$$= 50 (E)$$

$$= \frac{\mathcal{G}}{\mathcal{G}}$$
 (G)

Scoring
0 = Non-Compliant 1 = Compliant

	Area:	3 50 ast
	Date/	12 28 20
	~ 27×1/	C
Surveyors Signatures:	471 Cl	
• •	7°47	

	Safety/Security Management Se	core	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	<u>ي</u>	See whohe
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	į	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	ì	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	ì	
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.	ı	
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.	6	5-15, 5-1
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	i	
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)	\ \	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 10/12 Percentage: 13 %		

]	Infection Control	Score	Comme	en <b>t</b>	
1	Gloves are readily available in		1		
2	Refrigerator longs maintained stored on the S drive, temperat	and up to date (refrigerator temps are trefolder, los in friends	c		
3	Food is not present in medicati giving medication.	on refrigerator other then what is used in	1		
	Section Score: 2/3	Percentage: 4 4 %			

Life S	afety Management	Score	
1	Are means of egress/exit doors clearly and correctly marked?	i	
2	Exit signs working and arrows pointed in correct direction?	1	<u> </u>
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	d wedged open?	t	
9	Sprinkler heads are clear of lint/d in storage areas.	debris and have 18" clearance especially	1	
10	Means of egress are free of furnit 8' clearance and no items can be	ture, laundry carts, etc. Halls must have hanging from ceiling.	i i	
	Section Score: 10 /10	Percentage: <u>60</u> %		
,	Ud Matawid No. 1 C	3		<u>.</u>
	Hazardous Material Waste and C		Comm	ent
1	Chemicals stored in appropriate of	cabinets (i.e. metal)	<del>                                     </del>	
2	EVS closet is locked when not in	n use.	1	
3	Chemical containers have appropmissing)	priate labeling. (i.e. no labels faded or	ı	
4_	Product labels are not altered or d	defaced.	t	
5	Personal Protective Equipment is	s readily available (i.e. gloves)	ı	
		Percentage: 100 %		
Emergenc	y Management/Utility Systems		Score	
1	Flash lights workextra batteries	s available	٠ .	
		· · ·	i	
2	Two way radios charged and wor	rking properly?		
3	Two way radios charged and wor  Weather radio plugged in and ale		0	phy in vnissisched
	Weather radio plugged in and ale	erts when activated?		phy in vnissed
3	Weather radio plugged in and ale Code Green buttons easily access	erts when activated?		phy in vnistiscled
3 4	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access	erts when activated? sible and not blocked. sible.		phy in vnissisched
3 4 5	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?		phy in vnissisched
3 4 5	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?	1 1	phy in vnissisched
3 4 5 6	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains working	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?	1 1	phy in vn stracked
3 4 5 6 7 8	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains working Section Score: 7 /8	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.	0 1 1	phy in vn stral
3 4 5 6 7 8	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains workin Section Score: 7 /8 P	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$7.5 %	1 1	phy in vnissiscled
3 4 5 6 7 8	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains working Section Score: 7 /8	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$7.5 %	0 1 1	phy in vnissisched
3 4 5 6 7 8	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains workin Section Score: 7 /8 P	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$7.5 %	C 1 1 1 1 1 Score	phy in vnissisched
3 4 5 6 7 8 Medical E	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains workin Section Score: 7 /8 P	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$\frac{27.5}{\pi}\%	0 1 1	phy in vnissisched
3 4 5 6 7 8 Medical E 1 2	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains workin Section Score: 7 /8 P  quipment Management Plan Medical Equipment have any fray Sharps container no more than 34	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$\frac{7}{3}\tag{6}\tag{6}\tag{7}  yed cords?  full?  not in use?	C 1 1 1 1 1 Score	phy in vnissisched
3 4 5 6 7 8 Medical E 1 2	Weather radio plugged in and ale Code Green buttons easily access Emergency blankets easily access Red Emergency Management Ma Panel box is not block and is lock Toilets, faucets and drains workin Section Score: 7 /8 P  quipment Management Plan Medical Equipment have any fray Sharps container no more than 3/4 Medication room is secure when a	erts when activated?  sible and not blocked.  sible.  anual is readily available and up to date?  ked?  ng properly? No apparent leaks.  Percentage: \$7.5 %  yed cords?  full?  not in use?	C 1 1 1 1 1 Score	phy in vnissisched

CRITERIA	RESPONSE	YES			Ņ	NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	x	x	1	7			_	
Who would receive a falling star logo?	Any patient that is at high risk for falls.	X	×	7	7				
Who is responsible for making fall reduction a priority?	All NRC staff.	٦.	×	>	7				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	Ą	X	¥	$\lambda$				
NRC has a tolerance for violence from staff and visitors.	ZERO	×	×	X	X				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	×	×	2	×				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	1	×	×	$\times$				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	7	×	×	*				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	7	×	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,	×	×	×	×				
Where is the hospital incident command center located?	Room 216	×	•				×	. <del>\</del>	7
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	×	$\lambda$	×	×				
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)

(B)

(C)

(C)

(E)

Subtract total number of NO answers

Divide (G) by (E) X 100

(A)

(B)

(B)

(C)

(C)

(C)

(E)

(E)

(D)

(E)

(E)

(E)

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

Nebraska Allitual 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

 $\bigcirc$  $\bigcirc$ 

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)

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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

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13 Must p	rovide current governor test tag/plate 1/5 year.
2.13.2.1	
(b)(6)	
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14 MCD 4	
	asks w/dates, tests, repairs, callbacks, oil usage. 2013+
2.40.1	
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CAR TO	
Crite 101	
15 Must n	nake car top stop switch operable.
3.1.1	and our top stop switch operation.
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16 Must n	nake car top inspection station operable.
3.3.1	
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17 Must n	nake car top light and GFCI outlet operable.
3.2.1	
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10 Marat	
18 Must n	nake hoist way venting clear and louvers operable.
3.11.1	
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19 Check	that a standard railing is provided where required.
3.4.3.1 (b)	in a sumum raming to provide a more required.
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20 Must k	eep all ropes free from rust/kinks/broken strands.
3.23.1	• •
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FIRE						
21 Must tes 6.5.2 & 6.5.		hase One & Two monthly	y.			
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22 Must ma	intain monthly	fire service testing log in	control room.			
6.1.1						
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HOISTWA	Y					
	intain door clos	ing foot pound pressure v	within limits.			
1.8.1						
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24 Maret mare			11 .1			
3.17.1	periy adjust doo	or equipment on car & ha	all doors.			
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	intain door gibs	and retainers if provided	l to code.			
1.7.1						
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26 Escutche	eons intact secu	re. Access switches & lin	nits work OK			
4.5.1	ons maci, seca	ic. recess switches & in	mis work ore.			
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PIT AREA						
27 Must pro	ovide pit ladder	on all pits over 30", on P.	.U. side of door.			
5.1.1 (b)	-	•				
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20 M	·	clean and paint pit equip				
ZX Willst ma	untain a dry bit.	clean and paint pit equip	iment.			

5.1.1 (e)

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29 Must make pit stop switch operable, locate adjacent to ladder.	
5.1.1 (c)	
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30 Must make pit light operable, switch adjacent to ladder, 18" high	
50 Must make pit light operable, switch adjacent to ladder, 16 migh	
5.1.1 (d)	
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31 Sump cover must be grated or 5-2" holes to allow water inside.	
5.1.1 (e)	
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32 Must keep pit equipment rust free, clean to bare metal, paint.	
5.10-14	
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ESCAL ATOPS	
ESCALATORS	
33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	
33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	
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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	
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	
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	
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 30 31 Must keep safety decals or signs in good shape for passengers to read.	
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	
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 30 31 Must keep safety decals or signs in good shape for passengers to read.	
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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.	
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	
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.	
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	naintain gap between moving step and stationary skirt panel 3/16-1/4.
7.17.1	
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38 Must ke	eep excessive play or rocking movement in steps to a minimum.
7.9.1 (b,1)	
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	rrent MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+
7.19.1	
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0	
Inspector 1	Name GREG VIRANT
Building F	Representative This field is required.
Inspection	Date 12/16/2019
	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				

 $\bigcirc$ 2 Must make car and floor sill's level. 1.3.1.1  $\bigcirc$  $\bigcirc$  $\bigcirc$ 3 Must make emergency light operable. 1.5.1 (b)  $\bigcirc$  $\bigcirc$  $\bigcirc$ 

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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

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10 ) (	
13 Must p	rovide current governor test tag/plate 1/5 year.
2.13.2.1	
(b)(6)	
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14 MCD +	asks w/dates, tests, repairs, callbacks, oil usage. 2013+
	asks w/dates, tests, repairs, candacks, on usage. 2015+
2.40.1	
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CAR TOP	
15 Must n	nake car top stop switch operable.
3.1.1	
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16 Must n	nake car top inspection station operable.
3.3.1	
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17 Must n	nake car top light and GFCI outlet operable.
3.2.1	lake car top light and Gr Cr outlet operatie.
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18 Must n	nake hoist way venting clear and louvers operable.
3.11.1	
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10.61 1	
19 Check	that a standard railing is provided where required.
3.4.3.1 (b)	
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20 Must k	eep all ropes free from rust/kinks/broken strands.
3.23.1	sep an repet nee from rate knike, ereken brande.
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FIRE	
21 Must test Fire Service 6.5.2 & 6.5.3	e Phase One & Two monthly.
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22 Must maintain mont	ally fire service testing log in control room.
6.1.1	
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HOISTWAY	
23 Must maintain door	closing foot pound pressure within limits.
1.8.1	
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24 March	
3.17.1	door equipment on car & hall doors.
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	gibs and retainers if provided to code.
1.7.1	
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26 Escutcheons intact, s	ecure. Access switches & limits work OK.
4.5.1	
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PIT AREA	
27 Must provide pit lad	der on all pits over 30", on P.U. side of door.
5.1.1 (b)	
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28 Must maintain a dry	pit, clean and paint pit equipment.

5.1.1 (e)

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20 M - 4 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
29 Must make pit stop switch operable, locate adjacent to ladder.	
5.1.1 (c)	
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30 Must make pit light operable, switch adjacent to ladder, 18" high	
5.1.1 (d)	
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31 Sump cover must be grated or 5-2" holes to allow water inside.	
5.1.1 (e)	
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O	
32 Must keep pit equipment rust free, clean to bare metal, paint.	
5.10-14	
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ESCALATORS	
ESCALATORS	
	hazards
33 Must keep handrails free from cuts, cracks, pinch points and other	hazards.
33 Must keep handrails free from cuts, cracks, pinch points and other 7.3	hazards.
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33 Must keep handrails free from cuts, cracks, pinch points and other 7.3  34 Must keep covers secure, no tripping hazards, maintain open area 7.4  35 Must keep safety decals or signs in good shape for passengers to r 7.6  36 Must keep stationary comb plates and escalator step edges which a second of the seco	for access.
33 Must keep handrails free from cuts, cracks, pinch points and other 7.3  34 Must keep covers secure, no tripping hazards, maintain open area 7.4  35 Must keep safety decals or signs in good shape for passengers to r 7.6	for access.

 $https://mail-attachment.googleusercontent.com/attachment/u/0/?ui=2\&ik=d1a636a06e\&attid=0.6.0.1\&permmsgid=msg-f:1694054996128\dots$ 

3/12/2021

3/12/2021	https://mail-attachment.googleusercontent.com/attachment/u/0/?ui=2&ik=d1a636a06e&attid=0.6.0.1&permmsgid=msg-f:1694054996128
37 Must m	naintain gap between moving step and stationary skirt panel 3/16-1/4.
7.17.1	minum gap between moving step and stationary skint panel 3/10 1/1.
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38 Must k	eep excessive play or rocking movement in steps to a minimum.
7.9.1 (b,1)	
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	rrent MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+
7.19.1	
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Inspector 1	Name GREG VIRANT
Building F	Representative This field is required.
	Date 12/16/2019
	Cancel

# STATE OF NEBRASKA\*STATE FIRE MARSHAL 246 SOUTH 14<sup>TH</sup> STREET LINCOLN, NE 68508-1804

#### Page 1 of 1

	Fee Sheet Number: 4626	3		
Facility Name	Occupant Street Address	<b>i</b>		
Norfolk Regional Center Hospital	1700 N Victory Rd			
Operator & Phone number	City / Town			
	Norfolk			
Owner / Address / Phone number/Email	County			
Tom Barr	Madison			
402-370-3400		How Occ	unied	
dhhs.nrclicensure@nebraska.gov		110W 000	аріоч	
1700 N Victory Rd		Existing He	althcare	
Norfolk, NE 68701-0000 Occupant load	OIK, INE 66701-0000			
150 beds	11-30-2020	□YES	⊠NO □N/A	
150 beds	11-30-2020			
	ORDER			
This is a Revisit of the inspection conducted corrected and upon payment of all required				
All items must be corrected to comply with the laws of the State of Nel mandated by section 81-502 to 81-541.01  It is the duty of the owner or person in charge of the above-named face regulations. ALL CORRECTIONS SHALL BE MADE AND ALL ITEM	ility to immediately take measure	es to bring the t		
mandated by section 81-502 to 81-541.01	ility to immediately take measure	es to bring the f	acility into compliance with state	

#### Subject: FW: Inspection Form - 12/17/2019 - 4095 - 233847



Whitmire, Don <Don.Whitmire@nebraska.gov>
to Devaraju, Usha, Bruegman, James

Thu, Mar 11, 3:00 PM (23 h

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 experiment with the attached as there were no checkmarks in the pass/fail boxes on the attached but you had verified that we had 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 conforms 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

<u>DHHS.ne.gov</u> | <u>Facebook</u> | <u>Twitter</u> | <u>LinkedIn</u>

From: Bruegman, James < <u>James.Bruegman@nebraska.gov</u>>

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 < <u>James.Bruegman@nebraska.gov</u>> **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



Garage of Contraction

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.

A SHOW NOY

# DHHS Public Health Licensure Unit Whitehall survey

Attachment W2



# S LV SU

Pete Ricketts, Covernor

#### **DEPT. OF HEALTH AND HUMAN SERVICES**

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 - Program Manager II

Mark Juger

DHHS Public Health - Licensure Unit

Office of DD and Behavioral Health

PO Box 94986, Lincoln, NE 68509-4986

Email:

ML/ti

Enclosure: CMS-2567

**Survey Evaluation** 

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

PRINTED: 09/22/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		28L032	B. WING			R	
NAME OF PI	ROVIDER OR SUPPLIER	202002		STREET ADDRESS, CITY, STATE, ZIP CODI	<u> </u>	09/21/2020	
LRC WHIT	EHALL PRTF			5845 HUNTINGTON AVENUE LINCOLN, NE 68507			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 000	Initial Comments		N 0	000			
	survey that was comp Representative. Durin found to be in complia Participation for Psyc	ted to the recertification bleted on 8/4/20 by a DHHS and the revisit, the facility was cance with the Conditions of hiatric Residential Treatment een cited at the time of the					
	NIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	= '	TITLE		(X6) DATE	

(X6) DATE TITLE

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.

PRINTED: 09/22/2020 FORM APPROVED

#### Nebraska DHHS Licensure Unit

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME			CONSTRUCTION		SURVEY PLETED
				A. BOILDING			R
		MHSU031		B. WING		09	/21/2020
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LRC WHI	TEHALL PSYCHIATRIC F	RESIDENTIAL TREAT	5845 HUNT LINCOLN, I	INGTON AVEN NE 68507	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
X 000	Initial Comments			X 000			
	Health conducted an Licensure Survey (en determine complianc Regulations Governir	iding 9/21/2020) to e with Title 175 Chapte ng Licensure of Mental e facility was found to he s cited and is now in	er 19,				

Licensure Uni

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE



# Pete Ricketts, Governor

#### **DEPT. OF HEALTH AND HUMAN SERVICES**

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 - Program Manager II

Mark Juger

DHHS Public Health - Licensure Unit

Office of DD and Behavioral Health

PO Box 94986, Lincoln, NE 68509-4986

Email:



#### Good Life. Great Mission.

#### **DEPT. OF HEALTH AND HUMAN SERVICES**



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:

- Action(s) that will be taken to correct the deficiency;
- 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;
- 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 - Program Manager II

DHHS Public Health - Licensure Unit Office of DD and Behavioral Health

DO D--- 04000 1:---|- NE 60500 4000

Mark Juger

PO Box 94986, Lincoln, NE 68509-4986

Email:

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

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		28L032	B. WING			08/	04/2020
NAME OF PROVIDER OR SUPPLIER  LRC WHITEHALL PRTF			5	TREET ADDRESS, CITY, STATE, ZIP CODE 845 HUNTINGTON AVENUE INCOLN, NE 68507			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 125	CFR(s): 483.356 (a) Restraint and seclusion residents.  This STANDARD is maked on record revifailed to ensure their maked on record revifailed to ensure their maked on record revifailed to ensure their maked on record revifailed to ensure their maked on the facility. The facility of the inspection.  Findings:  Record review of the maked on the procedure manual for revealed the policy, Concepts of the procedure manual for revealed a hold can be minutes in an emergence client in imminent data or others.  Interview with Youth Son 18/3/2020 at 1:00 P.M. timeframe which was crisis intervention train policy needed to be rewith Care guidelines.  Interview with the You (Handle with Care trains and section of the rewith Care trains and section of the policy needed to be rewith Care guidelines.	on policy for the protection of not met as evidenced by: ew and interview, the facility restraint and seclusion current system of ervention in a crisis situation. to effect all the clients in y census was 6 at the time	N	125	DEFICIENCY)		
	with Care stand up ho	emented the use of Handle olds for interventions the client has calmed.					

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

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF (	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	E SURVEY MPLETED
		28L032	B. WING _			8/04/2020
NAME OF PROVIDER OR SUPPLIER  LRC WHITEHALL PRTF				STREET ADDRESS, CITY, STATE, ZIP COL 5845 HUNTINGTON AVENUE LINCOLN, NE 68507		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE

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

PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		28L032	B. WING _		_	08/0	04/2020
NAME OF PROVIDER OR SUPPLIER  LRC WHITEHALL PRTF			STREET ADDRESS, CITY, STA 5845 HUNTINGTON AVENUE LINCOLN, NE 68507				
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E 000	review was conducted surveyor ending 8/4/2 was found to be in con Emergency Prepared Psychiatric Residentia	ness Requirements for a al Treatment Faciility e facility census was 6 at	E	000	EFICIENCY)		
LABORATORY	 	SUPPLIER REPRESENTATIVE'S SIGNATU	RF	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	ļ
STREET ADDRESS, CITY, ZIP:	5845 Huntington Avenue Lincoln, NE 68507		8/4/2020	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28 -	28L032	

PROVIDER'S PLAN OF CORRECTION

	(EACH CORRECTIVE ACTION SHOULD BE CROSS-	COMPLETI
CITED TAG #	REFERENCED TO THE APPROPRIATE DEFICIENCY)	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:	
	TO THE CITED DETICIENCY	
	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 MODIFICATION OF TRACKING PROCEDURE (C) TO ENGLIRE THE FACILITY IS EFFECTIVE IN	
	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



Jerall Moreland <imoreland@leg.ne.gov>

#### **Ombudsman's Contact**

Foster, Jesse < Jesse. Foster@nebraska.gov> To: "Moreland, Jerall" < jmoreland@leg.ne.gov> Thu, Feb 25, 2021 at 9:24 AM

- 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 - 12/3	1/2020
		We have had 10 positions turn over between 1/01/2020 and 12/31/2020.
1.	1 Youth Security Supervisor	
2.	2 Registered Nurses	
3.	3 Youth Security Specialist II positions	
4.	1 Clinical Director	
5.	2 Mental Health Providers	
6.	1 Social Worker	

- 6. The number of vacant positions as of December 31, 2020 1
- 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

Jesse Foster, Ph.D, M.Ed | Facility Administrator

BEHAVIORAL HEALTH

**Nebraska Department of Health and Human Services** 

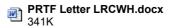
| CELL:

DHHS.ne.gov | Facebook | Twitter | LinkedIn

[Quoted text hidden]

#### 9 attachments

MHSU031 LRC Whitehall Psychiatric Residential Treatment Facility.pdf



## 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

8 Persons

Occupancy:
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

N/A

Occupancy:
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

8 Persons

Occupancy: 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

8 Persons

Occupancy:
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.



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. SATCO09 to STATE OF NEBRASKA HEALTH & HUMAN SERVICES to operate a SUBSTANCE ABUSE TREATMENT CENTER at P 0 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



Long of Buthoner mes

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



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, Director, Department of Health and Human Services Regulation and Licenseuse

# **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 <u>2017</u>: 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 <u>2019</u>: 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.

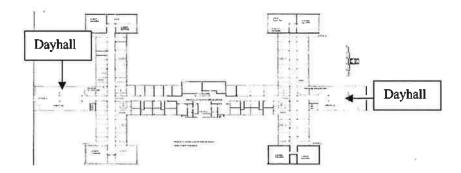
#### **Social Environment:**

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

# Building 3 Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
All of Building 3	Has conduit near walls with gap. 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.	Responsible	<ul> <li>Staff supervise clients.</li> <li>Suicidality Assessments performed</li> <li>The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.</li> <li>The staffing ratio is 1:4 for days and 1:6 for nights.</li> </ul>
Bathroom (in main corridor by PVC)	Exposed sink pipes		<ul> <li>Suicidality Assessments performed</li> <li>The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.</li> </ul>
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  Bathroom has sink pipes and toilet pipes exposed		<ul> <li>Staff supervise clients when room is in use.</li> <li>Suicidality Assessments performed</li> </ul>

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Second Floor	Windows/screens; large openings		Staff supervise clients when room is in use.
Offices	"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.
<b>⊢</b>	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		The Level System assesses the level of observation
	cords, jump ropes, elastic exercise equipment		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:

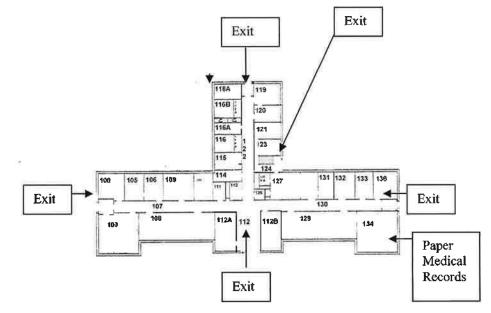
- EXITS-
  - 5 exits, one on each side of building, front and back, and one in center, east side.

#### 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.
	Exposed pipes up to 24" high		Staff supervise the area if clients are present.
Electrical/	No locks on		
Fixtures			
Basement	Handrails		
Ramp to	Handrails		
Building			
Windows	Openings are large		
Doors	No piano hinges		
	No suicide-proof knobs		
Mechanical	Not accessible - in tunnel		
Room/			
Equipment			

# **BUILDING 6**

# Chapel –

- **❖** Built in 1954
- ❖ 1 story plus upper level and basement
- ❖ No Sprinkler or Alarm System
- ❖ Used for youth recreation.

### Physical layout of building:

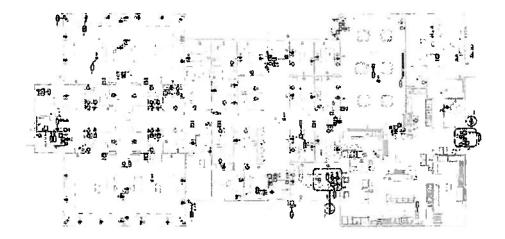
- EXITS-
  - 4 exits. 2 on the front side (North) of the building and 1 on each back side (East and West) side.
- Security
- Building has keyed locked doors on the front side and back side. The back side exits have STOP alarms that are used to prevent AWOA.
- The upper level is only accessible to authorized 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		<ul> <li>Staff supervise clients when room is in use.</li> <li>Suicidality Assessments performed</li> <li>The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.</li> </ul>
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

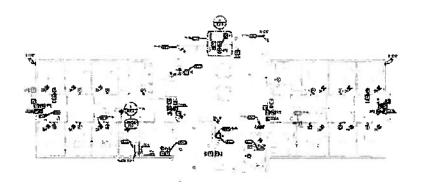
# **Building 27**

# Suicide Risk Assessment

Location	Findings	Person Responsible	Procedure/Control or Repair/Remove
Bathrooms	Automatic door closers     Door knobs		<ul> <li>Staff supervise clients.</li> <li>Suicidality Assessments performed</li> <li>The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.</li> <li>The staffing ratio is 1:4 for days and 1:6 for nights.</li> </ul>
Group/Meeting Rooms	<ul> <li>Automatic door closers</li> <li>Door hinges</li> <li>Door knobs</li> </ul>		
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		<ul> <li>Staff supervise clients.</li> <li>Suicidality Assessments performed</li> <li>The Level System assesses the level of observation necessary and whether the level needs to be increased or decreased.</li> <li>The staffing ratio is 1:4 for days and 1:6 for nights.</li> </ul>
Client Rooms	<ul> <li>Automatic door closers</li> <li>Door hinges</li> <li>Door knobs</li> </ul>		
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 înside 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 H	VA		2019 HVA		2018 HVA	
Event Rating		Event Rati		Event	Rating	
	Epidemic	8	1. Tornado	8	1. Tornado	8
	Tornado	8	2. Civil Disturbance	8	<ol> <li>Civil Disturbance</li> </ol>	8
3.	Civil Disturbance	8	3. Fire, Internal	8	2. Fire, Internal	8
	Blizzard or Ice	6	4. Water Failure	8	3. Water Failure	8
5.	Wildfire	6	5. HVAC Failure	8	4. HVAC Failure	8
	Fire, Internal	6	6. Blizzard or Ice Storm	6	<ol><li>Blizzard or Ice Storm</li></ol>	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

				ospital Emergency Response		
Emergency Type	Emergency Type Probability		Mitigation	Preparedne ss	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	Reptenish supplies. Internal and external notification. Documentation of disaster response and recovery costs. Review response procedures

Bldg. has little flammable material     & bldg. is concrete.		
	2	

### HAZARD VULNERABILITY ASSESSMENT

EVENT	PROBA	BILITY			RISK					PREPAR	REDNESS		TOTAL
	HIGH	MED	row	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPT ION	MOD DISRUPT ION	LOW DISRUPT ION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
NATURAL EVENTS										L			
Tomado	l	2				4						11	8
Severe Thunderstorm		2						2				1	4
Snow fall		2							1			1	2
Blizzard	1	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		1			4						1	4
Wild Fire		2					3					1	6
Epidemic		2				4						1	8

Gray areas are changes from previous year.

EVENT		PROBA	BILITY				RISK			PR	EPARED	NESS	TOTAL
	HIGH	MED	LOW	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPT ION	MOD DISRUPT ION	LOW DISRUPT ION	POOR	FAIR	GOOD	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	
TECHNOLOG ICAL EVENTS													
Electrical Failure			1					2			4	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		6/2	100	0					1			11.525	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						11	8
Flood, Internal		2					3					11	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	PROBAL	BILITY			RISK					PREPAR	REDNESS		TOTAL
	HIGH	MED	LOW	NONE	LIFE THREAT	HEALTH /SAFETY	HIGH DISRUPT ION	MOD DISRUPT ION	LOW DISRUPT ION	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)	isa .		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 Cotte	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%	20 //0
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%	- 77
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: Sent: To: Subject:	Johnson, Grant Monday, February 8, 2021 12:46 PM Jacobe, Camella RE: Ombudsman info needed
We had 0 assaults on staff in 202	20.
The reports Corinne should have can email you as soon as I get a r	e. I know we had a PRTF inspection and child care in 2020. Internal reports I have and minute.
Ted Buck should have the fire ma	arshal reports and inspections.
Grant Johnson   Safety Coordin	
Nebraska Department of Health office:   CELL:   CELL:   DHHS.ne.gov   Facebook   Tw	FAX: 402-460-3145
From: Jacobe, Camella Sent: Monday, February 8, 2021 To: Johnson, Grant Subject: Ombudsman into neede	/>
Grant,	
	sting the below information. Could you let me know who I could contact to get a response back to the Ombudsman by the end of the week?
B. The number of assaults on	staff for calendar year 2020
	ne most recent inspections or audit reports for calendar year 2020. To include, but Fire Marshal's office, DHHS inspections, internal safety, emergency inspections Licenses, etc.
Thanks,	
Camella Jacobe   State Comp CHILDREN & FAMILY SERVICES	oliance Coordinator
Nebraska Department of Health	h and Human Services

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

	HOTTINGS 1200 (W. Flustings	Youth In	1/10/	INSPECTION DATE  TYPE OCCUPANCY
FORMS INCLUDE	D WITH THIS CO	VER SHEET	TYPE OF INS	
UNDERGROUND TES	T CERTIFICATION	(FORM 85-AB)	INITIAL ACCEPTANCE OF SYS	TEM
ABOVEGROUND TES	T CERTIFICATION	(FORM 85-AC)		
REPORT OF INSPECT			PERIODIC ANNUAL INSPECTIO	
DRY PIPE VALVE TES			BACKFLOW PREVENTER TEST	
ITEM#	DIRECTORY		DEFICIENC	IES
1 – WET RISER	5 - BACKFLOW	PREVENTER		
2 – DRY RISER	6 - STANDPIPE		TEMIZE DEFICIENCIES NOTED ON	INSPECITON AND
3 - PREACTION RISER	7 - OTHER	A	MY OTHER PERTINENT COMENTS	ON SYSTEM
TAG#	ITEM#		MAJOR DEFICIENCIES / CO	DIVINENTS
48368	1			
48369				
78301			<b>化型对对型型设置</b>	
			Charles and the second second	
				THE RESIDENCE OF THE PARTY OF
	· (6) (2) (2) (2)			
				And the second second
	A CONTRACTOR OF THE PROPERTY OF			
	A FOREST LIPE A SON			
			Machine Construction of th	
		TATUS OF EVOT	EM CHECK ONE	
	S		EM - CHECK ONE	MAJOR DEFICIENCIES
IN COMPLIANCE		MINOF	DEFICIENCIES	MAJOR BEHOLENOIES
COMPANY PERFORMIN			////	
Meininger Fire Protection	Inc		Man Hoperston of	CNATURE
ADDRESS: 2521 West "L	" Street, Suite 5		INSPECTOR SI	GNATURE
CITY: Lincoln		STATE: NE	NE LICENSE #: 05046	MANUAL PROSESSION OF THE PROPERTY OF
ZIP CODE: 68522			TESTER BFP LICENSE #: 8	119
PHONE: 402-466-2616			<b>以主义,是《</b> 图》	<b>美国的国际</b>
		CA TOURS NO. NO.	<b>展展</b>	1 A 1 Carlo - 10 Was 1 2 W 1 1 1 1 0
			OWNER REPRESENTA	TIVE 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

White: AHJ



Yellow: MFP

Pink: Business



# Report of Inspection, Testing & Maintenance of Dry Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

lame c	of Inspected Property: +1455 MS Your	h		1160	17770/	TT LPFIKI	1000	1	22	
spect	or Name:	20		×	27	Date:	10/19/0	# 13	23	
nspect	ion Frequency: Monthly	QL	uarte	erly		Annually -	Other	MITE MANUAL MANUA MANUAL MANUAL MANUAL MANUAL MANUAL MANUAL MANUAL MANUAL MANUAL MANUA MA MANUA MANUA MANUA MANUA MANUA MANUA MANUA MANUA MANUA MANUA MA	E THE	
Serie.	Blauthly Inches	ođ:	OP)	of De	y Dine	Sprinkler Systems			S COL	3
	Mourn's make			N	yripe			Y	N/A	N
v.1.0	System in service on inspection	/			A.2.6	System control valve sig	n indicates area served	SOU	-	100
o do de	Supply (water) gauge pressure		55	psi	A.3.0	Backflow prevention ass	embly valves are locked			
1.1.1	System (air) gauge pressure	-	W/2014	> psi	404	or electrically supervise Reduced pressure back	d in open position	COLUM	100	重
	Quick opening device gauge pressure	0.0	59.47	- psi	A.3.1	assembly not in continu	ious discharge		-	
\.1.3	The second secon	19	and the same	C-psi	A.4.0	Dry pipe valve free of p	hysical damage			
1.1.4	Gauge near compressor Gauge pressures are normal	-	F	T	A.4.1	Dry pipe valve trim valv	es are in appropriate	-	316	
1.1.5	Control valves in normal open or closed position		45	1000		open or closed position		-	P. Lo	Die Control
1.2.0	Control valves properly locked or supervised	1			A.4.2	Dry pipe valve intermedi	The state of the s	1		
.2.2	Control valves accessible	100		a figure	A.5.0	ALARM PANEL CLEA		77 33	21115	400
.2.3	Control valves provided with appropriate wrenches		-		A.6.0	COMMENTS:				
1.2.4	Control valves free from external leaks	1	178							
1.2.5	Control valve identification signs in place	37	1					8834		10
1.2.,0	Quarterly Inspection of		MAYER		Qua	rterly Testing for I	Dry Pipe Sprinkle	r S	yste	m
	Dry Pipe Sprinkler Systems				C.1.0	System in service before	e testing	1		53
3.1.0	System in service on inspection	1	1		C.1.1	Pertinent parties notifie		1	Regi	
.2.0	Hydraulic nameplate attached and legible	-			C.1.2	Adequate drainage prov		1		188
1.2.1	Alarm device free from physical damage	-	100		C.2.0	Water flow alarm tested		/		图
3.3.0	FDC is visible		18		C.2.1	Test conducted with ins	pectors test connection	10		運
3.3.1	FDC is accessible	1		1 100	C.2.2	Test conducted with by	pass connection		ME	
3.3.2	FDC swivels/couplings undamaged/rotate smoothly	1	1		\$ 50x 400	(freezing weather)	f to the feet of the section of		155.24	100
3.3.3	FDC plugs/caps in place/undamaged	1			C.2.3	Test conducted per man		1	-	
3.3.4	FDC gaskets in place and in good condition	1	130		C.2.4 C.3.0	Alarm devices appear for Supervisory switch initial	ee of physical damage		1000	100
3.3.5	FDC identification sign in place	1	+		C,3.0	during first two hand wi	neel revolutions of		<b>展</b>	
3.3.6	FDC check valve not leaking	1	1			before valve stem mov	ed one-lifth from		95	屬
3.3.7	FDC automatic drain valve in place	1	100		C.3.1	normal position (semi-	nen valve returned	1.6	19,00	lie i
	and operating properly	1			0.3.1	to normal position (sen	ni-annual)	-		18
3.3.8	FDC clapper is in place and operating properly FDC interior inspected where caps missing	1			C:4.0	One main drain test co	nducted downstream			A RE
3.3.9	FDC obstructions removed as necessary				C.4.1	from backflow prevente One main drain test co	nducted downstream			
3.4.0	Pressure reducing control valves (PRV)		100		0.4.1	from pressure reducing			165	10
	indicate open				C.4.2	Supply water gauge re-	ading before flow (station	2)	60	2 0
3.4.1	PRV not leaking		-	4		Gauge reading during	stable flow (residual)	EYE	44	F
3.4.2	PRV maintaining downstream pressure per design		1		THE RESERVE OF THE PERSON	Time for supply pressu			-	S
3.4.3	PRV in good condition		1		C.5.0	Priming water level tes	The state of the s		-	
3.4.4	PRV handwheel installed and not broken				C.6.0	The second second second second second second			-	櫃
3.5.0	ALARM PANEL CLEAR		ď	1 1	C.7.0	Low pressure alarm tes	sted	_		
3.6.0	COMMENTS:	18/	53.18			Pertinent parties notifie		-		10
			103		C.9.0	ALARM PANEL CLEA	R	1		13
					C.10.0	SYSTEM RETURNED	TO SERVICE	1	100	18
NA.			silis			COMMENTS:				
			11.8	(A)	No.					
1					ESIZAR.			25	(V) 50	

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE |1) |19 |2

(AFSA Form 107A) Page 1 of 3



Panert of Inspection, Testin	ag & Maintenance of Dry Pi	pe Sprinkler Systemscontinued
Inspecting Firm:	ng & twantionance of 5.7	Inspection Contract#
Name of Inspected Property: 1/1/3	hous Youth Treat	ment center 10/19/20
Inspector Name: Inspection Frequency:  Monthly	Quarterly	Annually Other
Annual Inspection for Dry F	Pipe Sprinkler Systems	Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	-	23.56	
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	-	43.5	
D.3.2	Piping appears free of corrosion		4	
D.3.3	Piping appears properly aligned	-	-	
D.3.4	Piping appears free of external loading	-	200	2
D.4.0	Sprinklers appear free of leakage			W
D.4.1	Sprinklers appear free of corrosion	1	(b) (f)	1
D.4.2	Sprinklers appear free of foreign materials	1		W.
D.4.3	Sprinklers appear free of paint	-		能
D.4.4	Sprinklers appear free of physical damage	S. Jan		N.
D.4.5	Sprinklers appear properly oriented	-	51.5	200
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions			
D.4.7	Glass bulbs appear full of liquid	_		92
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	-		作版
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	1		
D.4.10	Wrench available for each type of sprinkler	-		M
D.5.0	Dry pipe valve in good condition internally (check at trip test)			1000
	PRIOR TO FREEZING WEATHER:			9
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			TANK DE
D.7.0	ALARM PANEL CLEAR	3 /	300	100

	Annual Maintenance for Dry Pipe Sprinkler Systems			
		Υ	N/A	N
E.1.0	System in service before conducting maintenance	_		15/1
E.2.0	Pertinent parties notified before conducting maintenance	1		
E.3.0	Adequate drainage provided before flow testing or draining	1		
E,4.0	Operating stems of OS&Y (including backflow) valves lubricated	2		9.95
E.4.1	Valve completely closed and reopened	-		S
E.5.0	Main drain test conducted	1	8+0	SAM
E.5.1	Supply water gauge reading before flow (statio	)	105	psi
E.5.2	Gauge reading during stable flow (residual)	de i	14 G	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		-	
Ē,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	1		120
E.11.0	SYSTEM RETURNED TO SERVICE	1	1	(20)

Justian 1819

E.12.0 COMMENTS:

**Trip Test Table** Year. Q.O.D. Dry Valve Size Year Serial No. Model Make Serial No. Model Make Alexand Time Water Dry Pipe Alarm Trip Point Reached Air Time to Trip Water Operating Operated Air Pressure **Test Outlet** Pressure Pressure Thru Test Pipe Test Yes No Sec PSI PSI Min Min Sec PSI Without Q.O.D With Q.O.D

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE

PINK - OWNER

(AFSA Form 107A) Page 2 of 3



Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...continued

lame of	Inspected Property: Hashins Vou	1		15	04-177	DAT LEVITE	1		Cultural Control	-
THE RESERVE	r Name:				200	Date:	10/19/20	5	DA .	
		Qu	arter	y		-Annually	Other O			
773						U CE V.	s or Greater Frequ	on.	-1/	na-
Ann	ual Testing for Dry Pipe Sprinkler S	ys	tem	8		items of a rear	S or Greater Frequ		1	1 1
		Y	N/A	N				Y	N/A	N
F,1.0	System in service before testing	~	35.54		G.1.0	System in service be		(1) (A)	1000	500
F.1.1	Pertinent parties notified before testing				G.2.0		ed before conducting tasks	1		
F.1,2	Adequate drainage provided before flow testing	-			G.3.0	Dry pipe valve interna	ally inspected ers, filters, and restriction	1		
	Dry pipe valve trip tested with control valve partially open (required at full flow every 3 years)	-			G.3.1	orifices internally inst	pected			100
	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in	/			G.3.2	cleaned/replaced as Dry pipe valve intern	necessary			
F.2.2	freezer Tag or card showing trip test date and name				G,3.3	inspection/maintenar	ice date:		12 (S)	
	of person and organization conducting test attached to DPV Separate records of initial air and water pressure,				G.4.0 G.4.1		ed by comparison with	318	151	No.
	tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	/			G.4.2		rate within 3% of full scale			
	Records of tripping time maintained for full	1	6		G.4.3		librated as necessary	1075	100	180
VACINE.	flow trip tests	1			G.4.4	System gauges test/	TO A STATE OF THE PARTY OF THE			-
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	100	200		G.5.0	Check valves interna		10,15		133
	Control valves (including backflow and PIVs)				G.5.1		omponents operate correctly	100 to		
	operated through full range & returned to normal position				G.5.2 G.5.3	Check valve internal	components move freely components in			
	PIVs opened until spring or torsion felt in rod	-	1000		001	good condition Check valve internal	nompopents	1000		羈
	PIVs and OS&Ys backed 1/4 turn from full open	1		S100	G.5.4	cleaned/repaired/rep	laced as necessary	200		18
-	Main drain test conducted		16		G.5.5		inspection/maintenance d			7
F.5.1	Supply water gauge reading before flow (static)		17.00	psi	G.6.0	Adequate drainage p	rovided before flow testing	HE		410
F.5.2	Gauge reading during stable flow (residual)	A I di S	195	psi	G.6.1	PRV control valves f sectional drain valve	ulliflow tested by opening			
F.5.3	Time for supply pressure to return to normal	200	1	sec	0.00			NO.	1940	p
F.6.0	Backflow prevention assembly forward flow test conducted	1			The second second	Supply side static pr	の対象を表示されておりまでは、12万円できずるとなる。		30,03	
	System demand flow was achieved through	100	533		The second second	System side static p	AND THE RESERVE THE PARTY OF TH		0 ( P)	p
1.0.1	the device				G.6.4	Supply side residual			0 16 V	04/2016
F.6.2	Forward flow test conducted at maximum rate	1			G.6.5	System side residua				P
	possible (only where connections do not permit full flow test)				G.6.6	The second secon	previous full flow test	10E-7		A 1265
F.6.3	Forward flow test conducted without measuring	刨			G.6.7	Adjustments made a Extra high temp sold	s necessary ler type sprinklers	002		
	flow (device =2" and outlet sized to flow system demand)</td <td></td> <td>/</td> <td></td> <td>G,7.1</td> <td>tested/replaced - da</td> <td>te:</td> <td>120</td> <td></td> <td></td>		/		G,7.1	tested/replaced - da	te:	120		
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last				G.7.2	tested/replaced + da	ite: I/replaced (10 years) -	100		
F.6.5	more than 1 year and rationing enforced by AHJ) Forward flow test satisfied by annual fire		1		G.7.2	date: Sprinklers with fast r		193		
F.6.6	pump flow test  Backflow preventer performance test conducted as required by the AHJ	1				tested/replaced (at 2 date:	0 years, 10 thereafter) -			
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		1			All sprinklers tested/ (at 50 years, 10 ther	reafter) – date:			
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve		1			thereafter) - date:	replaced (at 75 years, 5			
	enclosure)			200	G.7.6	All sprinklers manufa replaced - date:	actured before 1920	V	1	1
F.9.0 F.10.0	Pertinent parties notified of test conclusion ALARM PANEL CLEAR	1			G.8.0	Obstruction investigation (see AFSA Form 11	ation conducted	1		
	SYSTEM RETURNED TO SERVICE	1			G.9.0	Pertinent parties notif	ied after conclusion of tasks	1		86
-	COMMENTS					ALARM PANEL CL			3 3 3 3	5
						SYSTEM RETURNI		中程	MAS	
SE WE		1	0		The second second	COMMENTS:				

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

WHITE - AHJ

DATE 10 PINK - OWNER



# Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

Name of Inspected Property: Inspection Name: Inspection Frequency:	Inspecting Firm: Inspection Contract#	STEEDE BUILD
Inspection Name: Inspection Frequency: Monthly Quarterly Annually Other  Monthly Inspection for Wet Pipe Sprinkler System  A.1.0 System in service on inspection A.2.0 Supply pressure gauge A.2.1 System pressure gauge A.2.2 Gauges appear to be in good condition A.3.1 Control valves properly locked or supervised A.3.2 Control valves properly locked or supervised A.3.3 Control valves provided with appropriate wrenches A.3.4 Control valves free from external leaks A.3.5 Control valve indentification 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.5.1 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:		
Monthly Inspection for Wet Pipe Sprinkler System  A.1.0 System in service on inspection A.2.0 Supply pressure gauge A.2.1 System pressure gauge A.2.2 Squest 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 provided with appropriate wrenches A.3.3 Control valves fire from external leaks A.3.4 Control valves fire from external leaks A.3.5 Control valve didentification signs in place A.3.6 Reduced pressure backflow prevention assembly not in continuous discharge A.3.6 Alarm valve gauges indicates area betwed A.3.6 Alarm valve gauges indicates area served A.3.6 Alarm valves free from care the pressure A.3.6 Alarm valve free of physical damage A.3.7 Octor of the valve gauges indicates or man supply water pressure A.3.6 Alarm valve free of physical damage A.3.7 Alarm valve free or physical damage A.3.8 Alarm valve free valves are in appropriate open or closed position A.3.9 Alarm valve free valves are in appropriate open or closed position A.3.1 Alarm valve free valves are in appropriate open or closed position A.3.1 Alarm valve free valves are in appropriate open or closed position A.3.1 Alarm valve revarding chamber or alarm drain not leaking A.3.1 Control valves are in appropriate open or closed position A.3.1 Alarm valve revarding chamber or alarm drain not leaking A.3.1 Control valves are in appropriate open or closed position A.3.2 Alarm valve revarding chamber or alarm drain not leaking A.3.9 Control valves are in appropriate open or closed position A.3.1 Alarm valve free of physical damage A.3.2 Control valves are in appropriate open or closed position A.3.3 Alarm valve free of physical damage A.3.4 Control valves are in appropriate open or closed position A.3.9 Alarm valve free of physical damage A.3.1 Alarm valve free of physical damage A.3.1 Alarm valve free of physical damage A.3.2 Control valves are alarm drain not leaking A.3.3 Alarm valve free of physical damage A.3.4 Control valves are alarm dr		100
Monthly Inspection for Wet Pipe Sprinkler System  Y NA N A.1.0 System in service on inspection A.2.0 Supply pressure gauge A.2.1 System pressure gauge A.2.1 System pressure gauge 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 properly locked or supervised A.3.3 Control valves protein place A.3.4 Control valves in the form external leake A.3.5 Control valves in the same served A.3.6 System control valve sign indicates area served A.3.6 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.3.6 Alarm valve gauges indicate normal supply valer pressure A.3.6 Alarm valve gauges indicate normal supply valer pressure A.3.1 Alarm valve fire of physical diamage A.3.2 Alarm valve tim valves are in appropriate open or closed position A.3.3 Alarm valve refarding chamber or alarm drain not leaking A.3.0 ALARM PANEL CLEAR A.7.0 COMMENTS:		1 5 5 6 5
A 2.0 Supply pressure gauge A 2.1 System pressure gauge A 2.1 System pressure gauge A 2.2 Gauges appear to be in good condition A 3.0 Control valves in normal open or dosed position A 3.1 Control valves properly locked or supervised A 3.2 Control valves ground with appropriate wrenches A 3.3 Control valves free from external leaks A 3.5 Control valves provided with appropriate wrenches A 3.6 System control valve isign indicates area served A 3.0 Backflow prevention assembly not in continuous discharge A 5.0 Alarm valve gauges indicate normal supply waiter pressure A 5.1 Alarm valve gauges indicate normal supply waiter pressure A 5.2 Alarm valve time valves are in appropriate open or closed position A 5.3 Alarm valve retarding chamber or alarm drain not leaking A 5.0 COMMENTS:		
A.1.0 System in service on inspection  A.2.0 Supply pressure gauge  A.2.1 System pressure gauge  A.2.2 Gauges appear to be in good condition  A.3.1 Control valves in normal open or dissed position  A.3.2 Control valves properly locked or supervised  A.3.3 Control valves free from waternal leaks  A.3.4 Control valves free from waternal leaks  A.3.5 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.5.1 Alarm valve gauges indicate normal supply water pressure  A.5.1 Alarm valve free of physical damage  A.5.2 Alarm valve retarding obtamber or alarm drain not leaking  A.6.3 Alarm valve retarding obtamber or alarm drain not leaking  A.6.4 COMMENTS:	Monthly Inspection for Wet Pipe Sprinkler System	
A.2.1 System pressure gauge A.2.1 System pressure gauge 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 provided with appropriate wrenches A.3.3 Control valves free from external leaks A.3.4 Control valve identification signs in place A.3.5 Control valve identification signs in place A.3.6 Control valve identification signs in place A.3.6 Control valve identification signs in place A.3.6 Control valve identification signs in place A.3.7 Control valve identification signs in place A.3.8 A.3 Control valve identification signs in place A.3.9 Control valve identification signs in place A.3.1 Alarm valve prevention assembly valves are socked or electrically supervised in open position A.3.1 Alarm valve gauges indicate normal supply water pressure A.3.2 Alarm valve fee of physical damage A.3.3 Alarm valve fee of physical damage A.3.4 Alarm valve fee of physical damage A.3.5 Alarm valve trim valves are in appropriate open or closed position A.3.8 Alarm valve trim valves are in appropriate open or closed position A.3.8 Alarm Valve fee of physical damage A.3.9 Control Valves are in appropriate open or closed position A.3.1 Alarm Valve fee of physical damage A.3.0 ALARRA PANEL CLEAR A.7.0 COMMENTS:		Y N/A N
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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 accessible A.3.2 Control valves accessible A.3.3 Control valves provided with appropriate wrenches A.3.4 Control valves fer from external leaks A.3.5 Control valve signs in place A.3.6 System 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 gauges indicate normal supply water pressure A.5.2 Alarm valve free of physical damage A.5.3 Alarm valve trim valves are in appropriate open or closed position A.6.0 ALARM PANEL CLEAR A.7.0 COMMENTS:		(eO psi
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A 3.2 Control valves accessible  A 3.3 Control valves from external leaks  A 3.4 Control valve identification signs in place  A 3.6 System control valve sign indicates area served  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 7.0 COMMENTS:	A 3.0 Control valves in normal open or closed position	
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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:		
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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 COMMIENTS:		
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A.7.0 COMMENTS:		
	A.7.0 COMMENTS:	
		SPECIAL

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

PINK - OWNER

(AFSA Form 106A) Page 1 of 4



Section of the Party of the Par	ing Firm: of Inspected Property:	. 45		9	ulh	TREMTI	na Na 13/0	19	1	2
EASTERN C	or Name:			-0	n	Date	e: 10/19/	20	1	- 11
nspect	ion Frequency: Monthly	Q	iarte	rly		Annually	Other			
	Quarterly Inspection for	-			Quar	terly Testing	for Wet Pipe Sprinki	er S	yste	m
	Wet Pipe Sprinkler Systems							Y	N/A	I
		Y	NIA	IN	C.1.0	System in service	before testing	-	3.4	i
B.1.0	System in service on inspection	_		1	C.1.1	Pertinent parties r	notified before testing	-	Sys.III	
B.2.0	Hydraulic nameplate attached and legible	-					provided before flow testing	1	28	2
B.2.1	Alarm device free from physical damage		-80		C.2.0		(other than vane type)	-		
B.3.0	FDC is visible				004	tested and is oper	h inspector's test connection		-	
3.3.1	FDC is accessible	-		1911	C.2.1		th bypass connection			710
3.3.2	FDC swivels/couplings undamaged/rotate	1	-	98.	0.2.2	(freezing weather)	)		-	
	smoothly	504	*		C.2.3		r manufacturer's instruction	3		
3.3.3	FDC plugs/caps in place/undamaged	Mall Mall	4450		C.2,4	Alarm devices app	ear free of physical damage	4		3
3.3.4	FDC gaskets in place and in good condition		SOLD SOLD		C.3.0	Adequate drainage	provided before flow testing	1		W.
B.3.5	FDC identification sign in place		100		C.3.1	A main drain test	conducted downstream			
B.3.6	FDC check valve not leaking FDC automatic drain valve in place and		(15) (15)		C.3.2	from backflow pre	conducted downstream			100
B.3.7	operating properly				0.3.2	from pressure red	ucing valve			100
3.3.8	FDC clapper is in place and operating properly	-			C.3.3	the second second second second second second second	ge reading before flow (stat	ic)	40	р
3.3.9	FDC interior inspected where caps missing	950	1		C.3.4	The state of the s	ring stable flow (residual)		45	р
	FDC obstructions removed as necessary		1		C.3.5		ressure to return to normal		-	SE
3.4.0	Pressure reducing control valves (PRV)		-		C.4.0		notified of test conclusion			
	indicate open	10.15	-	1000	C.5.0	ALARM PANEL C	CONTROL DESCRIPTION OF THE PARTY OF THE PART	-	17	200
B.4.1	PRV not leaking PRV maintaining downstream pressure		100		C.6.0	SYSTEM RETUR	NED TO SERVICE	-	5317	
B.4.2	per design	W			THE RESERVE OF THE PERSON NAMED IN	COMMENTS:				
B.4.3	PRV in good condition	10		1				1 - Tayl	기택병	300
B.4.4	PRV handwheel installed and not broken		-				The state of the s	1321		M.
B.5.0	ALARM PANEL CLEAR	-	3000							
B.6.0	COMMENTS:	F.S	576						10 VI/	
								10.03		
		Alex Market						A SHE		I
	A CONTRACTOR OF STREET	11.5	19							
		10-31		98.6	26.4			MY-01	1000	
	Semi-Annual T	est	ing	for \	Vet Pipe	e Sprinkler Sy	stems			
		V.						Y	N/A	N
0.10	System in service before testing		ALL S					-	+	Vicinity (
D.1.1	Pertinent parties notified before testing	EW						-		370
D.2.0	Supervisory switch initiates distinct signal durin	g firs	t tw	o hand	wheel rev	volutions or before	valve stem moved	188		墨
	one-fifth from normal position		2318	16750				720		100
D.2.1	Signal restored only when valve returned to no		pos	ition						900 WA
D.3.0	Adequate drainage provided before flow testing	1		46				+	No. of Contract of	
D.3.1	Main drain test conducted	Next	2010					1		
D.3.2	Supply water gauge reading before flow (static							- 4	00	p
D.3.3	Gauge reading during stable flow (residual)	3 4				Expended to the service of the	Maria Art	4	15	р
D.3.4	Time for supply pressure to return to normal	100	Shi						20010	SE
D.4.0	Pertinent parties notified of test conclusion		<b>35</b>	34		120		1		
D.5.0	ALARM PANEL CLEAR	JI.		18/10					5 5	(C) P
D.6.0	SYSTEM RETURNED TO SERVICE	188	154					11		100
D.7.0	COMMENTS:	2000	1518					100		
		X137		WE SHAN			Control of the Contro	188(14	200	30
	CONTRACTOR OF THE PROPERTY OF	10.								

WHITE - AHJ

INSPECTOR'S INITIAL

YELLOW - MFP

PINK - OWNER



Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...continued

Inspec	sting Firm:			100		Inspection Contract#			-
Name	of Inspected Property:	45		40.	110	TREATMENT, 15/0	Page .	1	5
Inspec	etor Name:		- 4	1	m	Date: 10/19/20	-		
Inspec	tion Frequency: Monthly	Q	uarterl	у		☐ Annually ☐ Other			
					4 144	0.011.0	-	0110	69.1
	Annual Inspe	-		-	et Pipe	Sprinkler Systems		LAIFA	A L AL
		-	N/A	N	E 4.7	Glass bulbs appear full of liquid	1	N/A	N
E.1.0	System in service on inspection	Sant St	1	$\dashv$	E.4.7 E.4.8	Spare sprinklers are of proper number			
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	-				(at least 6), type and temperature rating	_	200	4
E.3.0	Piping appears free of mechanical damage	1000	-		E.4.9	Spare sprinklers stored where temperature	1000		
E.3.1	Piping appears free of leakage	1		S III	<u></u>	maximum is 100°F	1		
E.3.2	Piping appears free of corrosion	-			E.4.10		1		200
E.3.3	Piping appears properly aligned	-			E.5.0	PRIOR TO FREEZING WEATHER: Building is secure such as not to expose	Г		T
E.3.4	Piping appears free of external loading	10			⊏,5,0	piping to freezing conditions	_	-	
E.4.0	Sprinklers appear free of leakage	-			E.5.1	Adequate heat is provided maintaining	10.00		
E.4.1	Sprinklers appear free of corrosion	-	-			temperatures at 40°F or higher	Name of Street		1100
E.4.2	Sprinklers appear free of foreign materials	-		70	E.6.0	ALARM PANEL CLEAR	1		100
E.4.3 E.4.4	Sprinklers appear free of paint  Sprinklers appear free of physical damage	1			E.7.0	COMMENTS:		2001	
E.4.4 E.4.5	Sprinklers appear properly oriented	1						ATTACK!	
E.4.6	Sprinkler spray patterns appear free of	1			CALL ST			100	NOTE AND
	unacceptable obstructions								V.
ill an	Annual Tes	ting	for	Wet	Pipe S	prinkler Systems			
E40	System in service before testing		P		F.5.2	Forward flow test conducted at maximum			
F.1.0 F.1.1	Pertinent parties notified before testing			100		rate possible (only where connections do		100	
F.1.2	Adequate drainage provided before flow testing	1				not permit full flow test)		500	15,000
F.2.0	Main drain test conducted	1	1996		F.5.3	Forward flow test conducted without measuring flow (device =2" and outlet</td <td>553</td> <td></td> <td></td>	553		
				nci	the state of	sized to flow system demand)	357	استندا	
F.2.1	Supply water gauge reading before flow (static	1 4	40			Backflow prevention assembly internal		2	
F.2.2	Gauge reading during stable flow (residual)	CLESSES.	45	NOW PAGE		inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		-	
F.2.3	Time for supply pressure to return to normal  Antifreeze solution tested and freezing	1	5	ec		Forward flow test satisfied by annual fire		155	AUEST
F.3.0	point determined					pump flow test		2	1
F.3.1	Antifreeze solution freezing point		-	°F		Backflow preventer performance test conducted as required by the AHJ			
F.3.2	Antifreeze solution freezing point after adjustme	ent		°F		PRV control valves partial flow test			
F.4.0	Control valves (including backflow and PIVs)	200	W.S. B			conducted and adequate to unseat valve		-	199
	operated through full range and returned to	-			F.7.0	Pertinent parties notified of test conclusion	-		
	normal position	-	30 Mg 2	10 M	F.8.0	ALARM PANEL CLEAR	_		
F.4.1	PIVs opened until spring or torsion felt in rod PIVs and OS&Ys backed 1/4 turn from full open				F.9.0	SYSTEM RETURNED TO SERVICE	1	Top !	
F.4.2			NAME OF		F.10.0	COMMENTS:	(i) ko		
F.4.3 F.5.0	Main drain test conducted (see F.2.0)  Backflow prevention assembly forward				NEW ALE			600	SYN
1.0.0	flow test conducted		POY!					1 1	
F.5.1	System demand flow was achieved	1	170						
1000	through the device	(5085) V 1076	Mr. Is V	30 12				98 14	(V)
			e fo	r We	Programme and the second	Sprinkler Systems			
	System in service before conducting maintenance	_	COULD S			Time for supply pressure to return to normal		-	sec
G.2.0	Pertinent parties notified before conducting maintenance		200			Pertinent parties notified after conclusion of maintenance	-	275	
G.3.0					10000000	ALARM PANEL CLEAR	-	10.8	
0.0.0	valves lubricated	/	137		A local contract of	SYSTEM RETURNED TO SERVICE	-		NEW I
G.3.1	Valve completely closed and reopened	/			Street Section	COMMENTS:	3450	198	
G.4.0	Adequate drainage provided before flow testing	1	1811	# 5	Z.0.0		30	1,20	
G.4.1	Main drain test conducted	1	150	開於		A STATE OF THE PARTY OF THE PAR	K S	200	
G.4.2	Supply water gauge reading before flow (static)	1	11)	osi			E 1/2	N.	
-	Gauge reading during stable flow (residual)	1	16	osi					
		COMUS		7 24	72		180	No.	disk to
12.26	. MA (All "NO" ans	wers	to be	expla	ined.)	(AF	SAF	orm	106A

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 19 /2

(AFSA Form 106A) Page 3 of 4

# NEBRASKA STATE FIRE MARSHALL FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM:			NE 68901	INSPECTION DATE TYPE OCCUPANCY
FORMS INCLUDED UNDERGROUND TEST ABOVEGROUND TEST REPORT OF INSPECTI DRY PIPE VALVE TEST	CERTIFICATION CERTIFICATION	ON (FORM 85-AB)	TYPE OF IN:  INITIAL ACCEPTANCE OF SYSTEM OF THE PERIODIC ANNUAL INSPECTION DUE TO REMOVE THE PERIODIC ANNUAL INSPECTION DISPERSION PREVENTER TEST	ODEL, REPAIR, ETC ON
1 – WET RISER 2 – DRY RISER 3 – PREACTION RISER	IRECTORY 5 - BACKFLO 6 - STANDPII 7 - OTHER	W PREVENTER PE	DEFICIENCIES NOTED ON ANY OTHER PERTINENT COMENTS	INSPECITON AND
TAG#	ITEM#		MAJOR DEFICIENCIES / C	OMMENTS
46368 48369	2	Det Sys		
IN COMPLIANCE	INSPECTION	■ MIN	STEM - CHECK ONE OR DEFICIENCIES	MAJOR DEFICIENCIES
Meininger Fire Protection,	nc		8/7/	IONATURE
ADDRESS: 2521 West "L" CITY: Lincoln ZIP CODE: 68522 PHONE: 402-466-2616	Street, Suite	STATE: N	INSPECTOR S  NE LICENSE #: 05046 TESTER BFP LICENSE #:	7932
			OWNER REPRESENTA	ATIVE 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



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.

	C.L.		BEAUTH BALLIN	A TOTAL CONTRACTOR				1				
PROPERTY NAME	HARTIE	12 5 Vous	ru Te	CATMENT	- RED/-	, "	5	DATE				
PROPERTY ADDR	ESS 47	TO W	SUL	2 mg W	ACTINIAS	AI	6	6990	1			
	ACCEP	TED BY AF	PROVIN	G AUTHORITIES	(NAMES)	YES	4					
	ADDRE	ADDRESS / IAC COLA /										
PLANS	INSTAL	INSTALLATION CONFORMS TO ACCEPTED PLANS									0110	
		MENT USEI EXPLAIN D						Silber		O'YES	© NO	
	HAS PE CONTR	RSON IN C	CHARGE S AND C	OF FIRE EQUIP ARE AND MAINT	MENT BEEN INS ENANCE OF TH	STRUC IIS NEV	TED AS 1 W EQUIP	TO LOCA MENT? I	TION OF FNO, EXPL	AIN DYES	O NO	
	HAVE C	HAVE COPIES OF THE FOLLOWING BEEN LEFT ON THE PREMISES:										
INSTRUCTIONS		1. SYSTEM COMPONENTS INSTRUCTIONS									□ NO	
	2. CARE AND MAINTENANCE INSTRUCTIONS									□ YES	O NO	
	3. NFPA 25									YES	□ NO	
LOCATION OF SYSTEM	SUPPLI	ES BUILDI	NGS				25					
	MAKE		MODEL	YEAR OF MANUFACTURE		ORIFICE SIZE		UANTITY	A STREET AND DESCRIPTION OF THE PARTY OF THE	TEMPERATURE RATING		
	A)W	1246		02300	19		1/2		2	150	District	
SYSTEM  SPRINKLERS  PIPE AND FITTINGS	THE WAS THEE			W (XII)	19		99		R S	200		
SPRINKLENG	MIL	NW W/s 18			19		3/.			195		
	-TH	10		14 5261	19	N. London	1/3		多型。			
	H.	100		TY 2261	17 19		1/2		5	155	1	
1000 TO 1000 T	Type of Type of	Pipe Fittings	HEEL									
			AL	ARM DEVICE			IXAM	MUM TIN	E TO OPER CONNEC	ATE THROUG TION	SH TEST	
ALARM VALVE OR FLOW	TYPE			MAKE	MODEL		MINIMUM		SECONDS			
INDICATOR											ASTRONO .	
							Annie.					
			DRY VA	LVE					Q.O.0	).		
		MAKE		MODEL	SERIAL NO	D.	M	AKE	MOD	EL SER	IAL NO.	
	Victo	which		768N	13254	3						
DRY PIPE OPERATING		TIME TO THROUG CONNEC	HTEST	WATER PRESSURE	AIR PRESSURE		POINT AIR SSURE	REAC	WATER HED TEST ITLET*	ALARM OF		
TEST		MIN.	SEC.	PSI	PSI	ı	PSI	MIN.	SEC.	YES	NO	
	Without Q.O.D.		3	35	16		le		10			
	With Q.O.D											
	IF NO, E	IF NO, EXPLAIN										

MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

# NEBRASKA STATE FIRE MARSHAL'S OFFICE

	OPERATIO	N	D PNEUMA	ATIC DELECTR	c o	HYDR	AULIC				
	PIPING SUI	PERVISED	D YE	S ONO DETE	CTING ME	DIA SU	JPERVI <b>SE</b> C		ם	YES	□ NO
	DOES VALV	/E OPERATE	FROM THE MA	NUAL TRIP AND/O	REMOTE	CON	TROL STAT	IONS	0	YES	ON D
DELUGE & PREACTION	IS THERE A			NEACH CIRCUIT FO	R IF	NO, E	XPLAIN		ya 1) LS		
	MAKE	MODEL.									
			YES	NO	Y	ES	N	0	MIN.		SEC.
REDUCING	LOCATION & FLOOR	MAKE & MODEL	SETTING	STATIC PR	ESSURE		PRES	SURE	FL	.OW	RATE
			INLET (PSI)	OUTLET	TLET (PSI)   INLET (PSI)		OUTLET (PSI)			M)	
ACCUSED TO A STATE OF THE PARTY	static pressulto prevent de PNEUMATION Hours, Test	ire in excess of amage. All abo C: Establish 40 pressure tanks	of 150 psi (10.2 l oveground piping O psi (2.7 bars) a s at normal wate	bars) for two hours. It g leakage shall be st air pressure and mea er level and air pressu	Differential opped. Sure drop, ore and me	dry-pip which	e valve clap <sub>i</sub> shall not exc	oers shail t eed 1-1/2   drop, which	osi (0.1 ba shall no	en du ars) i t exc	iring test in 24 eed 1-
	DRY PIPING	PNEUMATIC	CALLY TESTED	D YES Q	NO T	7	_HRS.				
	DRAIN TEST SUPPLY TEST CONNECTION: PSI CONNECTION OPEN WIDE 30 PSI										
DESCRIPTION  TESTS  BLANK TESTING	FLUSHED B	EFORE CON Y COPY OF T	NECTION MAD THE U FORM N	E TO SPRINKLER P O. 85B	IPING.	O YES	S DNO	OTHER		EXPI	LAIN
	REPRESEN	THERE AN ACCESSIBLE FACILITY IN EACH CIRCUIT FOR IF NO, EXPLAIN  STING? O YES ONO  DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM  PERSTURAL  YES NO YES NO  CATION MAKE & SETTING STATIC PRESSURE  FLOOR MODEL  SETTING STATIC PRESSURE  PRESSURE  FLOWING)  DOUTLET (PSI) INLET (PSI) OUTLET (PSI) INLET (PSI) OUTLET (PS	IF NO, E	F NO, EXPLAIN							
	NUMBER US	SED	LOCATIONS					NUMBE	R REMO	/ED	
	WELDED PI	PING					7-11/201		□ YE	S	□ №
Constants are				IF YE	S						
WELDING	DO YOU CERTIFY AS THE SPRINKLER CONTRACTOR THAT WELDING PROCEDURES COMPLY UYES UNO WITH THE REQUIREMENTS OF AT LEAST AWS D10 9. LEVEL AR-3?									ME TO LEASE SEC.  RATE  w)  above ring test  1 24 sed 1-  N  TEST SI	
TESTING?  TESTING?  TESTING?  TESTING?  TESTING?  TESTING  TEST DESCRIPTION  ALL PPING PREQUESTION AND ADDES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE VALVE RELEASE OPERATE REDUCING VALVE TEST OF A PLOOR MODEL SETTING STATIC PRESSURE RESIDUAL PRESSURE (FLOWING)  TEST DESCRIPTION  HYDROSTATIC: Hydrostatic tests shall be made at not less than 200 psi (13.9 bars) for two hours of 50 psi static pressure in excess of 160 psi (10.2 bars) for two hours. Differential dry-pipe valve clappers shall be let opped. Pressure in excess of 160 psi (10.2 bars) for two hours. Differential dry-pipe valve clappers shall be let opped. Pressure tarks at normal water level and air pressure and measure drop, which shall not exceed 1-1/2 psi (6.1 bars) in 24 hours.  ALL PIPING PNEUMATIC: Establish 40 psi (2.7 bars) air pressure and measure drop, which shall not exceed 1-1/2 psi (6.1 bars) in 24 hours.  ALL PIPING PNEUMATICALLY TESTED AT PSI FOR HRS. IF NO, STATE DEVIL PRESSURE PROPERLY PSI ON OBJECT OF THE PROPERLY PEST ON OBJECT OF THE PSI ON OBJECT	O YE	S	□ NO								
	QUALITY CO	ONTROL PRO	CEDURE TO IN	SURE THAT ALL D HAT SLAG AND OTH	ISCS ARE	RETR ING R	IEVED, THA ESIDUE AR	T E	□ YE	S	U NO
				ONTROL FEATURE	TO ENSU	IRE TH	AT ALL CU	routs	O YI	5	□ NO

Page 2

### NEBRASKA STATE FIRE MARSHAL'S OFFICE

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED  D YES D NO	IF NO, EXPLAIN	
REMARKS	DATE LEFT IN SERVICE WITH ALL CONTROL VALVES C	PEN:	
	NAME OF SPRINKLER CONTRACTOR MEININGER FIRE PROTECTION, 2521 West L St.,		02-466-2616
SIGNATURES	FOR PROPERTY OWNER (SIGNED)	TITLE	DATE
	FOR SPRINKLER CONTRACTOR (SIGNED)	TITLE	DATE
	FOR AUTHORITY HAVING JURISDICTION (IF WITNESSE	D) TITLE	DATE
		+ DSFM)	15/1
ADDITIONAL EXPL	ANATION AND NOTES		

Page 3

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.



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°	
NK 684 200°	
VK 300 200°	
VK 630 1550	
Who are a supplied to the supp	
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OWNER:	
DATE:	
GENERAL:	The second secon
DATE:	
was said	
MFP: MFPian	

DATE: //-7-/9

### FIRE ALARM INSPECTION

GT Fire & Security

	Customer:	Hastings You 4200 W 2 St Hastings, NE	reet	ent Facility	7	Location: North Dorm
	Panel Type: No 100 % Smoke T Frequency: 4/1 Notes:	est: 10-31-19	100 % I	Heat Test:		Remote Connection: Calibration:
	<ol> <li>Heat De</li> <li>Smoke I</li> <li>Duct De</li> <li>Flow Sw</li> <li>Pressure</li> </ol>	Annunciators Annun	Actual 1	ZI	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.	Additional Questions Code the system installed under: NFPA 72 Is the ground Fault Functioning? Yes No N/A Signals received at receiving station? Yes No N/A Are system components functioning properly? Yes No Did Trouble Signal Operate Properly? Yes No Checked system in Emergency Power? Yes No Elevator Recall? Yes No N/A Main Power (AC) Test Value: Emergency Power (Gell Cell ) Test Value: FACP Battery Change Out Date: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out:
*	Comments:  Inspection Start Inspections Dat		Hem -	Teste	La	spection End Time: 10:05 am st Inspected: 10-31-19
	Inspector:	1 M	h l		Lic	zense #:_H79 Exp: 2023

### **DEVICE TEST RESULTS**

**Customer Name: Hastings Youth Treatment Facility North Dorm** 

Page: 1

Device Type	Address	Location	4	sual ection	1	Functional Test	
	A VENT		Pass	Fail	Pass	Fail	
NORTH DORM							
Smoke Detector	L1/D1	Front Desk by FACP			Þ		
Duct Detector	L1/D2	East Hall			Ø		
Smoke Detector	L1/D3	Room 313	D		1/2		
Smoke Detector	L1/D4	Room 312			Ŕ		
Smoke Detector	L1/D5	Room 311			Ø		
Smoke Detector	L1/D6	Room 308			ĴŽI		
Smoke Detector	L1/D7	Room 309					
Smoke Detector	L1/D8	Room 310			Q		
Duct Detector	L1/D9	West Hall			(A)		
Smoke Detector	L1/D10	Data Room 318			Ŕ		
Smoke Detector	L1/D11	Room 319			囟		
Smoke Detector	L1/D12	Room 320			É		
Smoke Detector	L1/D13	Room 321			囟		
Smoke Detector	L1/D14	Room 324			ŹJ		
Smoke Detector	L1/D15	Room 323			P		
Smoke Detector	L1/D16	Room 322			户		
Flow Monitor	L1/M1	Sprink Wet Fl, Me. Rm.			戶		
Tamper Monitor	L1/M2	Spri. Wet Tam, Me.Rm			P		
Pressure Monitor	L1/M3	Spri. Low Air, Me. Rm			(in		
Pressure Monitor	L1/M4	Spri,. Dry Flo, Me. Rm.				-/-	
Monitor	L1/M5	Sprink Spare, Me. Rm.			Ø		
Tamper Monitor	L1/M6	Spri Dry Tamp, Me. Rm			沪		
Wall Horn Strobe		Exercise 305			je .		
Wall Horn Strobe		Lounge 304			<u>P</u>		
Wall Strobe		Restroom 303			ÄD.		
Wall Strobe		Bedroom 331			P		
Wall Strobe		Bedroom 320					
Wall Strobe		Bedroom 319			P	3 🗆	
Wall Strobe		Bedroom 313			灾		
Wall Strobe		Bedroom 312			Ų C		
Wall Strobe	6:	Bedroom 311			P		
Wall Horn Strobe		West Corridor 316			Þ		
Wall Horn Strobe		West Corridor 316			<b>P</b>		
Wall Horn Strobe		Outside Bath 307			P		
Wall Horn Strobe		Outside Bedroom 310			QC OK		
Wall Strobe		Bedroom 322			ý <u> </u>		
Wall Strobe		Bedroom 323			ÚD.		
Wall Strobe		Bedroom 324			ŽI		
Wall Strobe	3	Laundry 326					
Wall Strobe		Bath 307			ýD		

### DEVICE TEST RESULTS

Customer Name: Hastings Youth Treatment Facility North Dorm

Page: 2

Device Type	Äddress	Location		sual ection Fail	Functional Test Pass Fail		
Wall Strobe		Bedroom 308			A		
Wall Strobe		Bedroom 309			Á		
Wall Strobe		Bedroom 310			Á		
Wall Strope		Dedi Obili 310					
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## South Dorm

## NEBRASKA STATE FIRE MARSHALL FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM	Hastings,	NE		INSPECTION DATE  TYPE OCCUPANCY
FORMS INCLUDE	D WITH THIS CO	OVER SHEET	TYPE OF	NSPECTION
I UNDERGROUND TE	ST CERTIFICATIO	N (FORM 85-AB)	INITIAL ACCEPTANCE OF S	YSTEM ,
ABOVEGROUND TES	ST CERTIFICATIO	N (FORM 85-AC)	REINSPECTION DUE TO RE	
REPORT OF INSPEC		The state of the s	PERIODIC ANNUAL INSPEC	
DRY PIPE VALVE TE			BACKFLOW PREVENTER TO	EST
1 - WET RISER 2 - DRY RISER 3 - PREACTION RISER	DIRECTORY 5 - BACKFLOV 6 - STANDPIP 7 - OTHER	W PREVENTER E	DEFICIE TEMIZE DEFICIENCIES NOTED ( ANY OTHER PERTINENT COMEN	ON INSPECITON AND
TAG#	ITEM#		MAJOR DEFICIENCIES /	COMMENTS
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48367	2			
7024				
	And the second			
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JAN 2014				
	M 5 10 10 10 10 10 10 10 10 10 10 10 10 10			THE OWNER WAS TO SHOW
			Stramphon Sylving Consults	
		Name of the Control o		
	TO BOOK DESIGNATION			
			TEM – CHECK ONE R DEFICIENCIES	MAJOR DEFICIENCIES
IN COMPLIANCE	VO INCRECTION	AND REAL PROPERTY AND ADDRESS OF THE PARTY AND	PEPIGENGIES	
COMPANY PERFORMI				
Meininger Fire Protection	I, INC		INSPECTOR	SIGNATURE
ADDRESS: 2521 West "	L Street, Suite 5	STATE: NE	NE LICENSE #: 05046	
CITY: Lincoln		STATE, NE	TESTER BFP LICENSE #:	3115
ZIP CODE: 68522			TEGRENOT. COLINGE IN 5	
PHONE: 402-466-2616				
			OWNER REPRESEN	TATIVE 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



White: AHJ

Yellow: MFP

Pink: Business



## Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

Name of Inspected Property:  Inspector Name:  Inspection Frequency:  Monthly Inspection for Wet Pipe Sprinkler System  White Pipe Sprinkler System  Y N/A N  A.1.0 System in service on inspection  A.2.0 Supply pressure gauge  A.2.1 System pressure gauge  A.2.2 Gauges appear to be in good condition  A.3.0 Control valves in normal open or closed position	Inspecting Firm:			Inspection Cont	ract#
Monthly Inspection Frequency: Monthly Quarterly Annually Other    Monthly Inspection for Wet Pipe Sprinkler System   Y N/A N   N   N   N   N   N   N   N   N   N	CONTROL OF THE PROPERTY OF THE	Michig	You dela	BldaA	1
Monthly Inspection Frequency: Monthly Quarterly Annually Other    Monthly Inspection for Wet Pipe Sprinkler System   Y N/A N		140 31.42	111	Date:	10/19/20
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  A.2.1 System pressure gauge  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 properly locked or supervised  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		□ Quarterly	ΓΟΓΔα		7 Other
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INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 /19 /20

(AFSA Form 106A) Page 1 of 4



Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...continued

Inspec	ting Firm:			-			ln:	spection Contract#	-		
Name	of Inspected Property:	1,	1 5	5	13	lode	th.	15/d on 11 1			
Inspec	tor Name:		1	_	-	211		ite: 10/19/2	0		STEEL BY
Inspec	tion Frequency: Monthly	Q	uarte	rly		7	Annually	Other			
		17/300	100		-1	Corre	deuls Tootine	for Wet Pipe Sprinkle	- S	vete	2000
	Quarterly Inspection for Wet Pipe Sprinkler Systems				78	Quar	neny resung	tot ater Libe abuner		1	
	thet Libe obtaining obstants		Live	LNI	٦				Y	N/A	N
		Y	N/A	N	+ 1	THE RESERVE OF THE PERSON NAMED IN	System in service	e before testing notified before testing	-		
B.1.0	System in service on Inspection		-		+1	C.1.1		ge provided before flow testing		inco	06.54
B,2.0	Hydraulic nameplate attached and legible	-		18	11			(other than vane type)		April	
B.2.1	Alarm device free from physical damage		100	1243		J.2.0	tested and is ope	erational		1 30	ES.
B.3.0	FDC is visible FDC is accessible		-		1	C.2.1		ith inspector's test connection	-	3 - 1	EN
B.3.1 B.3.2	FDC is accessible FDC swivels/couplings undamaged/rotate	100		100	1	0.2.2		vith bypass connection			
6,0,2	smoothly	1	Tig.	100		000	(freezing weathe	er manufacturer's instructions	سرا		
B.3.3	FDC plugs/caps in place/undamaged	part of the same	13			C.2.3		pear free of physical damage	_		
B.3.4	FDC gaskets in place and in good condition	1				TO THE REAL PROPERTY.		e provided before flow testing		200	
B.3.5	FDC identification sign in place	-	387			C.3.1	A main drain test	conducted downstream			
B.3.6	FDC check valve not leaking	1	2		3	0.0.1	from backflow pr	eventer	6		
B.3.7	FDC automatic drain valve in place and operating properly	/				C.3.2	A main drain test from pressure re	t conducted downstream ducing valve		v	
B.3.8	FDC clapper is in place and operating properly	-		7-60		C.3.3	Supply water gat	uge reading before flow (station	) /	100	) psi
B.3.9	FDC Interior inspected where caps missing		1	13.51	4	C.3.4	Gauge reading d	uring stable flow (residual)		75	psi
-	FDC obstructions removed as necessary		1		4	C.3.5	Time for supply p	pressure to return to normal			sec
B.4.0	Pressure reducing control valves (PRV) indicate open		-			C.4.0	Pertinent parties	notified of test conclusion		1/3	
B.4.1	PRV not leaking	Six	1			C.5.0	ALARM PANEL	CLEAR			
B.4.2	PRV maintaining downstream pressure	SALE.				C.6.0	SYSTEM RETUR	RNED TO SERVICE	230		
a de la composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della comp	per design	36	1			C.7.0	COMMENTS:		G. B	1118	
B.4.3	PRV in good condition		1							1 (10)	A SEC
B.4.4	PRV handwheel installed and not broken					RON DO				500	
B.5.0	ALARM PANEL CLEAR	1									
B.6.0	COMMENTS:	CE PER	E COL	17.71	-31					0.00	
									110	5 (TO 10)	6 E S 3
MOVE OF		PROPERTY.		100	- 0	Marie Marie			5 - S		2000
177ero (Ved		Man.									
				1000		Page to a			200	E 50 W	
	Semi-Annual T	esti	ng	for	W	et Pipe	e Sprinkler Sy				South
									Y	N/A	N
D.1.0	System in service before testing								-		. 30
D.1.1	Pertinent parties notified before testing				West of				-		
D.2.0	Supervisory switch initiates distinct signal during one-fifth from normal position	g firs	t two	) ha	nd v	wheel rev	volutions or before	valve stem moved	-		
D.2.1	Signal restored only when valve returned to nor	mal	posi	tion	Sille.					-0.4	14.7
D.3.0	Adequate drainage provided before flow testing			SV/RI					-	200	
D.3.1	Main drain test conducted								(BIR)		
D.3.2	Supply water gauge reading before flow (static)		SE.	YEN	8				1	00	psi
G0010000000000000000000000000000000000	Gauge reading during stable flow (residual)				ME				1	15	psi
(C+1)(S+1)(A)	Time for supply pressure to return to normal								5		sec
The second second	Pertinent parties notified of test conclusion	aŭ.		413					1	4	(4) E)
SALES AND DESCRIPTION OF THE PERSON NAMED IN	ALARM PANEL CLEAR	630							-		1 25
Charles Charles	SYSTEM RETURNED TO SERVICE		W.	84							
200 miles - 100 miles	COMMENTS:	14.80		10			<b>对表现的</b> 是是				
THE S		Settle:	E	31/8	300	ATT THE					
		1000	淵色		N.G				V 16	Ole- 2	
7	1011	SMESSION ASSESSED	42.772	AZIISA TOR				1 11 100	CAL	COTTO	1064

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10/19/20

(AFSA Form 106A) Page 2 of 4



## Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...continued

Vame	of Inspected Property: Hast	Na	5	borth	19/19/	7 / /		
nspec	tor Name:	-	de	27	Date:	10/19/0	25	
nspec	tion Frequency:  Monthly	Qua	arterly		Annually	Other	OILS)	
1.618					C Calley Carebon			
	Annual Inspe		-	et Pipe	Sprinkler Systen	15	V	N/A
		Y	N/A N	E.4.7	Glass bulbs appear f	uti of liquid	-	15.00
1.0	System in service on inspection			E.4.8	Spare sprinklers are	of proper number		11 3212
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	-	EW CO	- 3000	(at least 6), type and	temperature rating		6.26
3.0	Piping appears free of mechanical damage	- Santara	Ag Ja	E.4.9	Spare sprinklers store	ed where temperature		101111
3.1	Piping appears free of leakage	1	an an	F 440	maximum is 100°F	and two of carinklar		-
3.2	Piping appears free of corrosion	No.		E.4.10	PRIOR TO FREEZIN	each type of sprinkler		
E.3.3	Piping appears properly aligned	1	•	E,5.0	Building is secure su			
E.3.4	Piping appears free of external loading	1		E,0.0	piping to freezing cor		1	
E.4.0	Sprinklers appear free of leakage	1	80	E.5.1	Adequate heat is pro-	vided maintaining		98
₹.4.1	Sprinklers appear free of corrosion	1			temperatures at 40°F			
E.4.2	Sprinklers appear free of foreign materials	1		E.6.0	ALARM PANEL CLE	AR		
E.4.3	Sprinklers appear free of paint	1		E.7.0	COMMENTS:		100	
=.4.4	Sprinklers appear free of physical damage	1						
E.4.5	Sprinklers appear properly oriented  Sprinkler spray patterns appear free of						W.	723
4.0	unacceptable obstructions	1						11/2-11
馬加馬	Annual Tes	tina	for We	t Pipe S	prinkler Systems			
			- 1	F.5.2	Forward flow test cond		1	
.1.0	System in service before testing			5 A A B TO S	rate possible (only wh	ere connections do		
1.1	Pertinent parties notified before testing	-			not permit full flow tes	t)		period
.1.2	Adequate drainage provided before flow testing			F.5.3	Forward flow test cond measuring flow (device	ducted without		
2.0	Main drain test conducted				sized to flow system d	lemand)		
2.1	Supply water gauge reading before flow (station	) 6	o psi	F.5.4	Backflow prevention a	ssembly internal		
.2.2	Gauge reading during stable flow (residual)	7	psi		inspection conducted	(where shortages last ationing enforced by AHJ	V	
.2.3	Time for supply pressure to return to normal	· ·	-sec	F.5.5	Forward flow test satis			100 6 31
.3.0	Antifreeze solution tested and freezing point determined			1-3.0	pump flow test	siles by difficulty in a	85	-
2.4			·- °F	F,5.6	Backflow preventer pe	rformance test		The same
.3.1	Antifreeze solution freezing point	t	- °F		conducted as required		1000	
3.2	Antifreeze solution freezing point after adjustm Control valves (including backflow and PIVs)	T		F.6.0	PRV control valves pa conducted and adequa	ate to unseat valve		
.4.0	operated through full range and returned to			F.7.0	Pertinent parties notific			
	normal position		E 100		ALARM PANEL CLEA	STREET, STATE OF STATE OF STATE OF STREET, STATE OF	/	
.4.1	PIVs opened until spring or torsion felt in rod				SYSTEM RETURNED		1	
.4.2	PIVs and OS&Ys backed 1/4 turn from full open			N. Comments of the	COMMENTS:		EVS	
.4.3	Main drain test conducted (see F.2.0)	-		THE 100	The second second second			1884
.5.0	Backflow prevention assembly forward			N SERVICE	Walsan te de par		180	12.5
784	flow test conducted System demand flow was achieved							
.5.1	through the device							World.
	Annual Mainte	nanc	e for V	Vet Pipe	Sprinkler System	ms		
10	System in service before conducting maintenance	-			Time for supply pressu			
3.1.0	Pertinent parties notified before			G.5.0	Pertinent parties notific	ed after conclusion	1250	1000
3.2.0	conducting maintenance	1			of maintenance		_	-
3.3.0	Operating stems of OS&Y (including backflow)	1		CARLO CARLO	ALARM PANEL CLEA			
2476	valves lubricated	-		G.7.0	SYSTEM RETURNED	TO SERVICE	· Sand	
Control of the	Valve completely closed and reopened	1		G.8.0	COMMENTS:	A STATE OF THE OWNER, AS A		
3.4.0	Adequate drainage provided before flow testing	1		100			535	EX.
3.4.1	Main drain test conducted	1						
	Supply water gauge reading before flow (statio	) /	o psi					1477
5.4.3	Gauge reading during stable flow (residual)	1	psi					

INSPECTOR'S INITIAL

OWNER/DESIGNATED REP. INITIAL

PINK - OWNER



# Report of Inspection, Testing & Maintenance of Dry Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

specting Firm: / // / / / / / / / / / / / / / / / /	th	114	anne	Ada CHITCH	11.71.01	20		7.6
spector Name:	1		41	Date:	TV Othor	10	Die	100
	Qua	rterly		Annually	Other		715	
	otio	n of De	v Pine	Sprinkler Systems				
Montaly make		WAIN				Υ	N/A	N
a visit and an inconstian	1		A.2.6	System control valve sig	n indicates area served	-		
1.0 System in service on Inspection	-	opsi	A.3.0	Backflow prevention ass	embly valves are locked	-		
.1.1 Supply (water) gauge pressure		20 psi	4.04	or electrically supervise Reduced pressure back	d in open position			40
1.2 System (air) gauge pressure	1051	psi	A.3.1	assembly not in continu	ous discharge		4	
.1.3 Quick opening device gauge pressure	,	N. G. T. W.	A.4.0	Dry pipe valve free of p	hysical damage	~		
.1.4 Gauge near compressor		/ psi	A.4.1	Dry pipe valve trim valv	es are in appropriate	Laborator .		8
.1.5 Gauge pressures are normal	-		TO THE	open or closed position	t t bereitling	-		+
.2.0 Control valves in normal open or closed position	-		A.4.2	Dry pipe valve intermedi		-	A SILV	
.2.1 Control valves properly locked or supervised	-		A.5.0	ALARM PANEL CLEA	R	JAN.	2003	18
.2.2 Control valves accessible		100	A.6.0	COMMENTS:			200 M	
2.3 Control valves provided with appropriate wrenches		1000						
1.2.4 Control valves free from external leaks	-						mal.	
2.5 Control valve identification signs in place	1960	to the middle	Louis	rterly Testing for	Dry Pipe Sprinkle	r Sy	/ste	m
Quarterly Inspection of			THE PROPERTY OF THE			-		T
Dry Pipe Sprinkler Systems	-		M. District Control	System in service before Pertinent parties notified	d before testing		1891	
1.0 System in service on inspection	Jane 1		C.1.1	Adequate drainage pro	ided before flow testing	-	150	
2.0 Hydraulic nameplate attached and legible	1200		C.1.2	Water flow alarm tester	d and is operational		1015	
3.2.1 Alarm device free from physical damage	-		C.2.0	Vyater now alam teste	pectors test connection	1	(30)	
3.3.0 FDC is visible	0.03		C.2.1	Test conducted with by	pass connection		100	180
3.3.1 FDC is accessible			0.2.2	(freezing weather)		10		4
3.3.2 FDC swivels/couplings undamaged/rotate smoothl	4		C.2.3	Test conducted per ma	nufacturer's Instructions		(53)	1
3.3.3 FDC plugs/caps in place/undamaged			C.2.4	Alarm devices appear t	ree of physical damage	-	900	
3.3.4 FDC gaskets in place and in good condition			C.3.0	Supervisory switch init	iates distinct signal			
B.3.5 FDC identification sign in place				during first two hand w before valve stem mov	red one-fifth from	1		
B.3.6 FDC check valve not leaking				normal position (semi-	annual)			1
B.3.7 FDC automatic drain valve in place and operating properly	-		C.3.1	to normal position (ser	mi-annual)			
B.3.8 FDC clapper is in place and operating properly			C.4.0	One main drain test of	onducted downstream	1		
B.3.9 FDC interior inspected where caps missing			011	One main drain test co	inducted downstream			
B.3.10 FDC obstructions removed as necessary B.4.0 Pressure reducing control valves (PRV)	a sa			from pressure reducin		1	1000	
B.4.0 Pressure reducing control valves (PIXV) indicate open	3 33		C.4.2	Supply water gauge re	eading before flow (statio	2)	41	1
B.4.1 PRV not leaking	5 35		C.4.3	Commence of the Commence of th	stable flow (residual)		4	5
B.4.2 PRV maintaining downstream pressure per desig	n	05000	C.4.4	THE RESERVE OF THE PROPERTY OF THE PARTY OF			500	- 3
B.4.3 PRV in good condition		1	C.5.0				1	-
B.4.4 PRV handwheel installed and not broken		1	C.6.0	THE RESIDENCE OF THE PARTY OF T	(s) (QOD) tested	13	100	**
B.5.0 ALARM PANEL CLEAR	1		C.7.0	Donatic Control of the Control		-	4	
B.6.0 COMMENTS:			C.8.0	Pertinent parties notifi	ed of test conclusion	20	-	
			C.9.0	ALARM PANEL CLE	AR	1	1	0
	1016		C.10	0 SYSTEM RETURNED	TO SERVICE	1	1	
			NUMBER OF STREET	0 COMMENTS:				68
						5		
	-		1					

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 19 DU

(AFSA Form 107A) Page 1 of 3



Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...continued

Inspecting Firm:					Insp	ection Contract#	11		
Name of Inspecter	d Property: Hastings	Vouts	700	atmo	nt Center	Bldg 1	7		
Inspector Name:		P	4111		Date	e: 10/19/20	823		191
Inspection Freque	ncy: Monthly	Qu	arterly		Annually	Other			
		-Idor Cu	etome	landa R	Annua	al Maintenance for			
Annual Inspe	ection for Dry Pipe Spri	The second second	1		Dry Pip	e Sprinkler Systems			
		Y	N/A N	TEL SE			Y	N/A	N
D.1.0 System in	service on inspection	Server Comments		E.1.0	System in service	before conducting	-	an	
D.2.0 Hangers a	and seismic bracing appears ed and tightly attached			#10 XX	maintenance				
	pears free of mechanical damag	je /		E.2.0	maintenance	notified before conducting	-		
	pears free of leakage		85 5 5	E.3.0	Adequate drainag	e provided before	-	0 12	
	pears free of corrosion	200		5.10	flow testing or dra	ining of OS&Y (including backflow)			7,630
	pears properly aligned	1		E.4.0	valves lubricated	M CS&T (Including backnew)	-		1927
	pears free of external loading	1		E.4.1		closed and reopened	-		
	appear free of leakage			E.5.0	Main drain test co		-		
	appear free of corrosion	-		E.5.1		ge reading before flow (stati	c)	loi	) psi
	s appear free of foreign material	S		E.5.2		uring stable flow (residual)	1.0	45	psi
	s appear free of paint	-		E.5.3		ressure to return to normal			sec
And the second s	s appear free of physical damag			E.6.0	Looks resulting in	air pressure losses		11.5	
D.4.5 Sprinklers D.4.6 Sprinkler	s appear properly oriented spray patterns appear free of	HVA S S S	100 55 (	3 /	greater than 10 p	si/week located and repaired			1000
unaccepta	able obstructions			E.7.0	and parts replace	erior thoroughly cleaned d/repaired as necessary		-	18
D.4.7 Glass bul	bs appear full of liquid	1888100		E.7.1	Grease or other s	ealing materials not applied		1	1
D.4.8 Spare spi	rinklers are of proper number 5), type, and temperature rating	1	1.8		to seating surface	es of dry pipe valve ow points drained after			
D.4.9 Spare spi maximum	rinklers stored where temperatu	ге		E.8.0	operation and bel weather condition	fore onset of freezing	-	1	ď.
	vallable for each type of sprinkl	er 🤛		E.9.0	Pertinent parties	notified after conclusion	1		170
D.5.0 Dry pipe	valve in good condition internal	У		7000	of maintenance		1	-	1 0 00
(check at					ALARM PANEL		1		193
	O FREEZING WEATHER: s secure such as not to expose			The second second	THE RESIDENCE OF THE PARTY OF T	NED TO SERVICE	100 870		
D.6.0 Building to	freezing conditions			E.12.0	COMMENTS:				
D.6.1 Adequate	heat is provided maintaining ures at 40°F or higher			<b>发</b>					
D.7.0 ALARM	PANEL CLEAR							900 147	
D.B.O COMME	NTS:								7
				色数色					
					PARTIAL -	-41			
					0 1	16			
				Ray	7				
							37.7	100	
		TOTAL PROPERTY AND ADDRESS.	Trip Te	st Ta	bie	Ye	ar		
Dr	y Valve Size		Year	1.616	Q,O.D. Make		Serial	No.	1456
A MARKS STATE	Make	Model	Sena	al No.	ANIONG STATE	AND THE RESIDENCE.	18		
WAS THE PERSON NAMED IN COLUMN TWO OF THE PERSON.		-07 0 F 2 8 3	WHEN PERSON NAMED IN	THE PERSON NAMED IN COLUMN TWO IS NOT			Control of the last	CHEST STREET, SQUARE,	ALC: UNKNOWN

Dry Pipe Operating Test

Dry valve	Make	Mark	Model	Serial No.	Make	Model		Serial N	0.
N.	Motor	10	DIOPIN	THE REPORT OF		OK I STATE OF STATE OF			
		to Trip	Water Pressure	Air Pressure	Time Wat Trip Poir Air Pressu	nt Read	THE REAL PROPERTY.	WOLDS RESIDE	arm erated
	Min	Sec	PSI	PSI	PSI	Min	Sec	Yes	No
Without Q.O.D.	100/12/04/04	10	Tell	26	7			X	1 - 9
With Q.O.D							WE ST		

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 119 /

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Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...continued

nspecti	ng Firm: /?/)/	P						Value:	Ins	pection C	ontract#		120		- 111
		perty: HAST	inas You	11	(	7	reating	ent	Con	00	1	1		G K	
	or Name:		0		×	1	4/1		Da	ite:	0/1	9/2	C	19 (1)	
	on Frequency:	☐ Monthly		Qua	arter	ly		DA	nnually		Other				
2002	ZIESEWIKIESE	Charleman er							E V	02KE 01	Greater	Freque	enc	v	
Ann	ual Testing	for Dry Pipe	Sprinkler S	yst	tem	5		item	15 01 3 1	ears u	Greater		-	N/A	N
		Man (d)		Y	N/A	N					0.000004		1	NIA	14
F.1.0	System in servi	ce before testing		-			G.1.0				onducting to			1	4390
F.1.1	Pertinent partie	s notified before	testing	1	240		Fig. 2.5 and in page 2				ore conducti	ng tasks			
		age provided be				-24	G.3.0	Dry pi	ipe valve in	iternally in	spected	etriction	01.0M 01.0E		
26	open (required	l at full flow eve	trol valve partially ery 3 years)				G.3.4	orifice	s internally	inspecter	Iters, and re	Siricuon	1		
F2.1	Dry pipe valve	protecting freeze oducing moisture	ers trip tested in					clean	ipe valve in ed/replaced	as neces	ssary		10		
F22	freezer Tag or card sho	owing trip test da	te and name				G.3.3	inspe	ipe valve in ction/maint	enance da	ate:	/			
	of person and of attached to DP	organization con-	ducting test			1 80	HARL CARRY CO.	Syste	m gauges	replaced a	s necessar	y /			
F23	Separate record	ds of initial air and	d water pressure,				G.4.1	calibra	ated gauge	1-1-1-1	comparison	1			
EN YOR	conditions main	sure, and dry pip tained on premisi	e valve operating es for comparison	ME			G.4.2				ithin 3% of fo			27/10	
F.2.4	Records of trip	ping time mainta	ined for full				G.4.3				ed as neces				
To Common	flow trip tests			1			G.4.4				ement date	1	121.5		
F.3.0	Automatic air p	ressure mainten	ance devices				G.5.0	Chec	k valves int	ternally in:	spected				
E 4 0	Central values	dance with mfg. (including backfl	ow and PIVs)	100		100.0	G.5.1	Check	c valve inter	hal compor	ents operate	correctly	265		the d
F.4.0	operated throughout normal position	gh full range & n	eturned to				G.5.2 G.5.3	Check	k valve inte k valve inte	ernal comp ernal comp	onents mov	e freely			
F.4.1		ntil spring or tors	sion felt in rod	-				good	condition	0.00	1		250		93
F.4.2	PIVs and OS&	Ys backed 1/4 tu	ırn from full open	1	23		G.5.4	Check	k valve inte	ernal com	onents as necessa	arv			
F.5.0	Main drain test			1			0.55	The state of the state of			ection/mainte		ate:	3000	1999
F.5.1		auge reading be	fore flow (static)		1,0	psi	G.5.5				ed before flo		400		20
F.5.2	Contract the second second second second	during stable flo		U	45	psi	G.6.1	PRV	control val	ves full flo	w tested by	opening	100	TO SEL	
250000000000000000000000000000000000000		pressure to ret	CASH CANADA TO THE PROPERTY OF THE PARTY OF			sec	30.0.1	section	onal drain v	ralve	1		133		
F.5.3 F.6.0	Packflow preve	ention assembly	forward		1801		G.6.2	Supp	ly side stat	ic pressur	e\		No.		ps
1.0.0	flow test condu	icted		-	175	TYS.	THE RESERVE OF THE PERSON NAMED IN		m side sta		SECTION NAMED IN COLUMN		in t		ps
F.6.1	System deman	d flow was achie	eved through	-			G.6.4	Supp	ly side resi	dual pres	sure \		15.00		ps
F.6.2	Forward flow to	est conducted at	maximum rate	-	A RES		G.6.5		em side res				100	THE STATE OF	ps
		where connectio	ns do not permit				G.6.6				ious full flov	v test	E31	la de	
500	full flow test)	oot conducted w	thout measuring		FORE	100	G.6.7	Adjus	stments/ma	de as nec	essary \		Fish	1825	
F.6.3	flow (device -</td <td>2" and outlet siz</td> <td>ed to flow</td> <td></td> <td>1</td> <td></td> <td>G.7.0</td> <td>teste</td> <td>d/replaced</td> <td>- date:</td> <td>oe sprinklers</td> <td>\</td> <td></td> <td></td> <td></td>	2" and outlet siz	ed to flow		1		G.7.0	teste	d/replaced	- date:	oe sprinklers	\			
F.6.4	Backflow preve	ention assembly ducted (where s	internal hortages last				G.7.1	teste	klers in ha d/replaced	– date:			(0,0		
F.6.5	more than 1 ye	ar and rationing est satisfied by a	enforced by AHJ)				G.7.2	date:			aced (10 yea	SHOW W			100
<b>BENEZO</b>	pump flow test			55	1/15		G.7.3	Sprin	klers with t	fast respo	nse element ars, 10 there	ts eafter) –			
F.6.6	as required by	the AHJ	ce test conducted	1			The second	date:					100		100
F.7.0	PRV control va	alves partial flow to unseat valve	test conducted		-		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(at 5)	orinklers te: 0 years, 10	thereafte	r) – date:		1		
F.8.0	Low temperatu	ure alarm tested son (where prov	at beginning ided for valve			7000		there	eafter) - da	te:	ced (at 75 y			1	
E0.0	enclosure)	es notified of tes	SIM, MY TESE LIVING	1	A.			repla	iced - date		ed before 19	120	107	1	N.
F.9.0	ALARM PANE		CONTROL OF THE REAL PROPERTY OF	1	1		G.8.0	Obst	ruction inve	estigation	conducted				N S
		URNED TO SEL	RVICE	1	333	0000	000	Porti	nent narries	notified at	ter conclusio	n of tasks	39.5	100	Ma
A PROPERTY OF THE PARTY OF	COMMENTS	TANDON DE LA VALOR			A ST	3/38			RM PANEL				NE.	100	183
1.12.0	SOMMEN S	O CONTRACTOR		na s	Son.	27015					SERVICE	L. S. Walter	100	1 000	
									MENTS:			VASSIL	7 VS 1	ille.	de la
	<b>以表外性的</b> 是18			alt:	70.7		G.12.	U CON	INICIATO:	New york and a		POTO CALL	145.		1000

INSPECTOR'S INITIAL (All "NO" answers to be explained.)
OWNER/DESIGNATED REP, INITIAL

DATE 10 19 35

## NEBRASKA STATE FIRE MARSHALL FIRE SPRINKLER INSPECTION

TO THE OWNER OF THE PARTY OF TH				11-7-19
LOCATION OF SYSTEM	Toning	+ - BULDI	s6 A	INSPECTION DATE
HAMINGS YOUTH	- LEGATING		1000	TYPE OCCUPANCY
1200 W 3"	PARKET	DAKSUN (45)	NE 6890	
FORMS INCLUDE	D WITH THIS C	OVER SHEET	TYPE OF IN	STEM
UNDERGROUND TES	ST CERTIFICATION	ON (FORM 85-AB)	☐ REINSPECTION DUE TO REM	ODEL, REPAIR, ETC
ABOVEGROUND TES	TICK	JN (FURNI 65-AC)	PERIODIC ANNUAL INSPECTI	ON
REPORT OF INSPEC			BACKFLOW PREVENTER TES	STATE OF THE STATE
DRY PIPE VALVE TE			NA TOUR SERVICE STREET	
ITEM#	DIRECTORY		DEFICIEN	CIES
1 - WET RISER	5 - BACKFLO	W PREVENTER	NOTED NOTED ON	LINEDECITON AND
2 - DRY RISER	6 - STANDPI	PE	ITEMIZE DEFICIENCIES NOTED ON ANY OTHER PERTINENT COMENT	S ON SYSTEM
3 - PREACTION RISER	7 - OTHER			
TAG#	ITEM#		MAJOR DEFICIENCIES / C	OMMENTS
48366		4	JET SYLTEM	
48367	2	n.	y System	
Ew court Mag		STATUS OF SYS	STEM – CHECK ONE OR DEFICIENCIES	MAJOR DEFICIENCIES
IN COMPLIANCE	NG INSPECTIO	The state of the last of the l		
Meininger Fire Protection	n. Inc		8/7/	
ADDRESS: 2521 West	"L" Street, Suite	15	INSPECTOR S	SIGNATURE
CITY: Lincoln		STATE: NE	NE LICENSE #: 05046	7777
ZIP CODE: 68522	HS. E. To Leave to h		TESTER BFP LICENSE #:	7732
PHONE: 402-466-2616				
			OWNER REPRESENT	TATIVE 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



White: AHJ

Yellow: MFP

Pink: Business

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED  Q YES	□ NO	IF NO, EXPLAIN	
REMARKS	DATE LEFT IN SERVICE WITH ALL CONTROL	VALVES OP	EN:	
	NAME OF SPRINKLER CONTRACTOR MEININGER FIRE PROTECTION, 2521 V			2-466-2616
SIGNATURES		TESTS WIT	NESSED BY	775 111 111
	FOR PROPERTY OWNER (SIGNED)		TITLE	DATE
	FOR SPRINKLER CONTRACTOR (SIGNED)		TITLE	DATE
	777-24		Fiction	11-7-19
	FOR AUTHORITY HAVING JURISDICTION (IF	WITNESSED)	TITLE	DATE
	12/-19/14/9/0	Tion	A PART OF THE PART	117.19
ADDITIONAL EXPL	ANATION AND NOTES		07/6	

Page 3

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.

## 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 fallure to comply with approving authority's requirements or local ordinances.

PROPERTY NAME			1721 1	De LOUIS IN	T- BIN	- A	VELSION.	DATE			
PROPERTY ADDRE				A STATE OF THE STA	DESTINGS		16	1089	ol.		
			PROVING	AUTHORITIES		1	M				
	ADDRES	SS	14	Wron				ALALES			
PLANS	INSTALL	ATION CO	-	TO ACCEPTED	PLANS	1	heria.			☐ YES	O NO
		ENT USED XPLAIN DE								Q YES	ON O
	HAS PER	RSON IN CI DL VALVES	HARGE (	OF FIRE EQUIPA RE AND MAINT(	MENT BEEN INS ENANCE OF THI	TRUC S NEV	TED AS TO W EQUIPA	O LOCAT MENT? IF	TON OF NO, EXPLA	IN YES	□ NO
	HAVE CO	OPIES OF	THE FOL	LOWING BEEN	LEFT ON THE P	REMIS	SES:	W 2.5			
INSTRUCTIONS		AND DESCRIPTION OF	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ONENTS INSTR		200				O YES	□ NO
	Value of	A STATE OF THE PARTY OF THE PAR		NTENANCE INS		7.17.E				☐ YES	□ NO
		3. NFPA 2	5				Fals A. A			₫ YES	O NO
LOCATION OF SYSTEM	SUPPLIE	ES BUILDIN	GS								
		MAKE		MODEL	YEAR OF MANUFACTU	RE	ORIFIC SIZE		JANTITY	TEMPERA RATIN	THE RESERVE TO SERVE THE PARTY OF THE PARTY
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SPRINKLERS	OW	4. 167		W 630	19		9/4		2	155	
	TY	(1)	7	Y8281	19		1/3		13	155	
	74	10		Y 7301	19		5		120	155	
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FITTINGS	Type of F	ittings	427				ALAVIA	ALABA TIKA	TO OBER	ATE THROUGH	H TEST
			ALA	RM DEVICE			MAXIII		CONNECT	TION	
ALARM VALVE OR FLOW	TYPE			MAKE	MODEL		uni e	MINIMUI	V	SECON	IDS
INDICATOR	心預慮以							of vertical			
	Res III										
		966	DRY VA	LVE					Q.O.D		11 1/6
		MAKE		MODEL	SERIAL NO	).	M.	AKE	MODE	L SERI	AL NO.
	Victo	autic		768 N -	155221-3			Taraba sees			
DRY PIPE OPERATING		TIME TO THROUGH	H TEST	WATER PRESSURE	AIR PRESSURE		P POINT AIR SSURE	REACH	WATER IED TEST TLET*	ALARM OP	
TEST		MIN.	SEC.	PSI	PSI		PSI	MIN.	SEC.	YES	NO
	Without Q.O.D.		+/	35	16		6		14		
	With Q.O.D										
	IF NO, E	XPLAIN									

\*MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

	OPERATION	1	D PNEUMA	TIC DELECTRI	C Q HYDE	RAULIC			4.1
	PIPING SUF	ERVISED	□ YE	S TO NO DETE	CTING MEDIA S	SUPERVISED	YII MALE	O YES	ON C
	DOES VALV	E OPERATE	FROM THE MA	NUAL TRIP AND/O	REMOTE COM	TROL STATE	SNC	O YES	□ NO
DELUGE & PREACTION	IS THERE A		BLE FACILITY IN	EACH CIRCUIT FO	OR IF NO, E	EXPLAIN			
VALVES	MAKE	MODEL		IRCUIT OPERATE IN LOSS ALARM		DOES EACH CIRCUIT OPERATE VALVE RELEASE			IME TO ELEASE
			YES	NO	YES	NO	<b>)</b>	MIN.	SEC.
						RESI	21401	FLOW	PATE
PRESSURE REDUCING VALVE TEST	& FLOOR	MAKE & MODEL	SETTING	STATIC PR	ESSURE	PRES: (FLOV	SURE	T.O.V	IVIL
				INLET (PSI)	OUTLET (PSI)	INLET (PSI)	OUTLET (PSI)	FLOW (GI	PM)
TEST DESCRIPTION	static pressu to prevent da PNEUMATIO hours. Test	ire in excess of amage. All ab	of 150 psi (10.2 t oveground piping 0 psi (2.7 bars) a s at normal wate	e made at not less the bars) for two hours. I g leakage shall be st air pressure and mea ar level and air press	Offerential dry-pi opped. Sure drop, which	pe valve clapp shall not exc	eed 1-1/2 p	si (0.1 bars)	in 24
	ALL PIPING	HYDROSTA	TICALLY TESTE	DAT 200 F	SI FOR	_HRS.	IF NO, ST	ATE REASC	)N
	DRY PIPING	PNEUMATIO	CALLY TESTED PROPERLY	□ YES □	NO NO				
	DRAIN TEST	SUPPLY TE	ST CONNECTION		SI CO	SIDUAL PRE	SSURE WI PEN WIDI	TH VALVE I	N TEST PSI
TESTS	FLUSHED B	EFORE CON	INECTION MAD THE U FORM N	CONNECTIONS TO E TO SPRINKLER F O, 85B ROUND SPRINKLER	IPING.	s ono	OTHER	EXF	LAIN
	IF POWDER	DRIVEN FA	STENERS ARE PLE TESTING E	USED IN CONGRE	RILY		IF NO, E	XPLAIN	
	COMPLETE	D?			O YE	S D NO	NUMBER	REMOVED	
BLANK TESTING GASKETS	NUMBER U	SED	LOCATIONS				NOMILLE		
	WELDED P	PING						O YES	□NO
				IF YE	S				
WELDING	DO YOU CE WITH THE F	RTIFY AS TH	IE SPRINKLER NTS OF AT LEA	CONTRACTOR THA ST AWS D10 9. LE	AT WELDING PI VEL AR-3?	ROCEDURES	COMPLY	O YES	000
	DO YOU CE	RTIFY THAT	THE WELDING	WAS PERFORMED ITS OF AT LEAST A	BY WELDERS WS D10 9. LEV	QUALIFIED 1 EL AR-3?	N	DYES	□ NO
	QUALITY C	ONTROL PRO	DOEDURE TO IT	S CARRIED OUT IN NSURE THAT ALL E HAT SLAG AND OT DIAMETERS OF PIE	HER WELDING	RESIDUE AR	E	□ YES	<b>3</b> NO
CUTOUTS (DISCS)	DO YOU CE (DISCS) AR	RTIFY THAT	YOU HAVE A C	CONTROL FEATUR	E TO ENSURE 1	THAT ALL CU	TOUTS	☐ YES	□ NO

Page 2



P.O. BOX 85535, LINCOLN, NE 68501 VOICE: 402.466.2616 FAX: 402.466.2617

## ATTIC STOCK RECEIPT

JOB: FULLDING A **DESCRIPTION** QUANTITY 1650 Ty 3381 Ty 3281 1650 2000 VK684 2000 VK 300 VK 630 155 OWNER: DATE: GENERAL: DATE: MFP: 11-7-19

DATE:

### FIRE ALARM INSPECTION

GT Fire & Security

Custom		Hastings You 4200 W 2 Str Hastings, NE	reet	ent Facility		Location: South Dorm	L
Panel Ty 100 % Si Frequence Notes:	moke Tes	st: 10-31-19	100 %	Heat Test:		Remote Connection: Calibration:	
2. Pi 3. Ri 4. H 5 Si 6 D 7. Fi 8. Pi 9 Ti 10. A 11. V 12. D 13. Fi 14. Si 15 Fi	eat Dete moke De uct Dete low Swit	annunciators ect	Actual 1  2 1 2 3 6 21	7ested	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.	Additional Questions Code the system installed under: NF Is the ground Fault Functioning? Yes Signals received at receiving station? Are system components functioning Did Trouble Signal Operate Properly? Checked system in Emergency Power Elevator Recall? Yes No N/A Main Power (AC) Test Value: 12 Emergency Power (Gell Cell ) Test Va FACP Battery Change Out Date: 202 Voice Evac Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out: FCPS Battery Change Out:	No N/A Yes No N/A properly? Yes No Yes No Yes No OvAC alue: 27.Zv
	on Start T		am Tes	sted (	La	pection End Time: 9:40am st Inspected: 10-31-19 cense #: H79 Exp: 2023	

Witness:

#### **DEVICE TEST RESULTS**

**Customer Name: Hastings Youth Treatment Facility** 

Page: 1

Device Type	Address	Location		ual		tional est
	W. A. S. W. S.		Pass	Fail	Pass	Fail
SOUTH DORM						
Smoke Detector	L1/D1	Front Desk by FACP			□Žį*	
Duct Detector	L1/D2	East Hall			Ø	
Smoke Detector	L1/D3	Room 213			[3.	
Smoke Detector	L1/D4	Room 212			Ϋ́	
Smoke Detector	L1/D5	Room 211			Ŋ.	
Smoke Detector	L1/D6	Room 208			面	
Smoke Detector	L1/D7	Room 209			ŢŢ.	
Smoke Detector	L1/D8	Room 210			Q	
Duct Detector	L1/D9	West Hall			区	
Smoke Detector	L1/D10	Data Room 218, W Hall			Œ	
Smoke Detector	L1/D11	Room 219			Q	
Smoke Detector	L1/D12	Room 220			Ø.	
Smoke Detector	L1/D13	Room 221			<u> </u>	
Smoke Detector	L1/D14	Room 224			闰	
Smoke Detector	L1/D15	Room 223			团	
Smoke Detector	L1/D16	Room 222			M	
Monitor	L1/M1	Sprin Wet Tamp/Me Rm			囟	
Monitor	L1/M2	Waterflow, Mech Rm			ĮĮ.	
Monitor	L1/M3	Sprink Low Air, Mec Rm			贝	, 🗆
Monitor	L1/M4	Waterflow, Mech Rm	. 🗆		Ø	
Monitor	L1/M5	Sprin Dry Tamp, Me Rm			团	
Monitor	L1/M6	Sprink Spare, Mech Rm			図	
Wall Horn Strobe		Exercise 205			<b>[</b> X]	
Wall Horn Strobe		Lounge 204			团	
Wall Strobe		Restroom 203			风	
Wall Strobe		Bedroom 221			UPF	
Wall Strobe	8	Bedroom 220			1 12	
Wall Strobe		Bedroom 219			角	
Wall Strobe		Bedroom 213			12/	
Wall Strobe		Bedroom 212			过	
Wall Strobe		Bedroom 211			į.	
Wall Horn Strobe		West Corridor 216			Ø	
Wall Horn Strobe		West Corridor 216			区	
Wall Horn Strobe		Outside Bath 207			図	
Wali Horn Strobe		Outside Bedroom 210			(XI	
Wall Strobe		Bedroom 222			Ø	
Wall Strobe		Bedroom 223			团	
Wall Strobe		Bedroom 224			(A)	
Wall Strobe		Laundry 226				

### DEVICE TEST RESULTS

**Customer Name: Hastings Youth Treatment Facility** 

Page: 2

Device Type Addre		Address Location					Inspecti		ction	Funct	st
			Pass	Fail	Pass	Fail					
Wali Strobe		Bath 207			2						
Wall Strobe		Bedroom 208			ĮŽ.						
Wall Strobe		Bedroom 209			P						
Wall Strobe		Bedroom 210			P						
E											
2 -											
	_	_			6	1					
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		- V		붑							

## **Program Building**

Central, Inc	RANGE HOOD II Area: F	reducing: NGPEC:EDR		
Bill To:	-L.	Facility: Host: 75		Cenetr
System Model: Ansul (2)00 Link & Indicator Changeout Da Fuel Shut Off: (circle one) Facility Notes:	le 事分 1-21 Gas Electric	Mexi Hydrotesi Da	als (2021) one N/A	9
Addivonal Quaetions			¥! 	$\sim$
1. Pressure gauge indicator is 2. For Ansul Orly: Weight of 0 3. All lead and wire seals are it 4. Check positioning of all noz 5. Oheck action on all self-clos 6. Check fuse links, clean great 7. Did you replace the fuse links 8. Test system for proper oper 9. Test system for proper oper 10. Test microswitch and/or gauge 11. Check exhaust fan for prop 12. Clean system cylinder and 13. Check inspection and serving.	CO2 Cartridge ntact des ling caps or covers ling caps or covers ling caps or covers ling caps or covers ling caps or covers ling caps or covers ling caps or covers ling caps or covers ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps and links ling caps are covers ling caps a	ជុំ ម៉េយ <b>់ជុំមិ ៤</b> ១៥៤៣៨]	1. Yes No No No No No No No No No No No No No	N/A N/A N/A N/A N/A N/A N/A N/A
Comments: System Jesteh	€		\	222
Changed 4-5	60° Etype	K Frenk	アイト	رجد

<u> </u>						
	· · · · · · · · · · · · · · · · · · ·					
Inspector 1 DS	License #	KØ6				
Inspector 2	Elcenso #					
A.H.J.	_ Cleinner					
Insp. Date 2-1-21	Insp. Start Time	Inep. Fnd Time				
Start Drive Time	_ Start Mileage	Eud Wileage				

Last Inspected By:

Other - White, State - Yellow, City - Pirk, Customer - Gokt

Last Inspecied:

## Protey Central, Inc.

last Inspected By:

#### RANGE HOOD INSPECTION

Account # Area:	Frequency:		à5
BIN To:	Facility: Hazing	S Regional	Cart.
Contact:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		14,1,1
System Model: //s/ /// // // // // // // // Link & Indicator Changeout Date: 1/2/30 Fuel Shut Off. (circle one) Gas Electric Facility Notes:	Location: Kirul Next Hydrotest D ic Both N		
Additional Questions			
1. Pressure gauge indicator is in the operable ra	nge	1. Yes No	N/A)
2. For Ansul Only: Weight of CO2 Cartridge		2 35 62	Ŀ
3. All lead and wire seals are intact		3. Yes No	N/A
4. Check positioning of all nozzles		4. (@3) No	N/A
5. Check action on all self-closing caps or covers	3	5. YES No	
6. Check fuse links, clean grease from links.		6. (TES) No	N/A
7. Did you replace the fuse links?		7. Yes 🔞	N/A
8. Test system for proper operation from termina		8. (YES) No	N/A
9. Test system for proper operation from manual	and remete manual	9. Yes No	N/A
0. Test reicroswitch and/or gas valve		10. (Yes) No	¥
11. Check exhaust fan for proper operation		11. Yes No	
12. Clean system cylinder and component		12. YES No	N/A
13. Check inspection and service tag on system (	cylinder	13. XES No	
14. Are all cooking auriaces protected		14. 753 No	N/A
Comments			581
System Tested Of PU Station Differen	of so for	(	
Inspector 1 Lion	nse# <u>8</u> 2	3	
	nse #	e.'	
· · · · · · · · · · · · · · · · · · ·	tomer		
	. Start Time	Insp. End Time	<b>.</b>
	rt Mileage	End Mileage	

### RANGE HOOD FIRE SUPPRESSION SYSTEM REPORT

TCC	DATE OF SERVICE	
	ANNUAL SEMI-ANNUAL RI	ECHARGE INSTALLATION RENOVATION
	K3.1.	
INTEGRATED SECURITY SOLUTION	LOCATION OF SYSTEM CYLINDERS	
1710 West 2nd Street Hastings, NE 68901	Answ	P-101
2620 East Highway 30 Kearney, NE 68847	MANUFACTURER	MODEL NUMBER WET DRY CHEMICAL
Phone (402) 462-0348 Fax (308) 236-7323	CYLINDER SIZE MASTER	CYLINDER SIZE SLAVE
info@iss-ne.net www.iss-ne.com	3	OTENDER SIZE SERVE
IIIOCO In WWW.1557 IC.COIII	FUSE LINKS 360 F	FUSE LINKS 450°F FUSE LINKS 500°F
Name Hasting Youth Tocalment Facily		T T
	FUEL SHUT-OFF	ELECTRIC GAS
Address 4200 WEST 2nd Street	1/w 202	0
	LAST HYDRO TEST D	ATE LAST RECHARGE DATE
City Hashin, NE 68901 State	Zip Code	
The base		
Telephone Store No.	y	
NOTIFICATION OF DEFICIENCIES		
A mark made in the adjacent box indicates that deficiencies exist with the curren		
her signature and initials acknowledges these deficiencies represent an IMMEDIA responsible if the Fire Suppression System malfunctions or fails to function. It is		
	in Partic	CUSTOMER INITIALS:
		18 -
AUTHORITY HAVING JURISDICTION OR INSURANCE NOTES		
SIGNATURE AND WEEK	DATE /- 2-	2020
1 Company of the second of the second of	KIND SEASON SHIP TRANSPORT OF THE	TERRORE ELECTION
1. Duct and plenum property covered	N/A 15. Piping & conduit secur	ely bracketed YES NO N/A
2. Check positioning of all nozzles	16. Exhaust fan in operatio	
3. System installed in accordance with UL300	17. All tilters replaced	
4. Check if seals intact, evidence of tampering	18. Manual & remote set/s	
5. Pressure gauge in proper range (If gauged)	19. Replace systems cover	
6. Check cartridge weight (if applicable)	20. System operational & s	
7. Hydrostatic test date 2.32	21. Slave system operation	
8. Inspect cylinder and mount	22. Fan warning sign on ho	
9. Operate system from terminal link	The second of th	ucted in manual operation of system
10. Check operation of micro switch	24. Proper hand portable e 25. Service & Certification	
11. Check operation of gas valve  12. Proper nozzle covers in place		M H H
13. Replaced fuse links	27. Recommend Cleaning	Y D N
14. Check travel of cable nuts/S-hooks	28. Tamper Seals in place	
	TENEDE NEW YORK OF SEP	OW
NOTE DISCREI	PANCIES OR DEFICIENCIES BEI	-OW
COMMENTS:		
g glv před tog mod st voci	n still a	
2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m	7 - 7 - 7	V -0
On this date, the above system was tested and inspected in accordance with	h procedures of the presently adopted editi	ons of NFPA 17, 17A, 96 and the manufacturer's manual
and was operated according to these procedures with results indicated abo		The second secon
v of 1		
1/62	THE THE PERSON NAMED IN	AUGUSTALISM AND AND AND AND AND AND AND AND AND AND
SERVICE TECHNICIAN	DATE	CUSTOMERS AUTHORIZED AGENT

#### FIRE ALARM INSPECTION

GT Fire & Security

Location: Program Bldg Hastings Youth Treatment Facility Customer: 4200 W 2 Street Hastings, NE 68901 Remote Connection: Panel Type: Notifier 320 Calibration: 100 % Heat Test: 100 % Smoke Test: 10-31-19 Frequency: 4/10 Notes: Actual Tested **Additional Questions** 1. Code the system installed under: NFPA 72 1 1. Circuits 2. Is the ground Fault Functioning? Yes 'No N/A 2. **Pull stations** Signals received at receiving station? Yes No N/A 3. 3. Remote Annunciators 4. Are system components functioning properly? Yes? No 4. **Heat Detectors** Did Trouble Signal Operate Properly? Yes No 5 **Smoke Detectors** 5. Checked system in Emergency Power? Yes (No 6.. **Duct Detectors** 7. Elevator Recall? Yes No N/A Flow Switches 7. 2 Main Power (AC) Test Value: 120 v 8. Pressure Switches 8. Emergency Power (Gell Cell ) Test Value: 2 9. 9 **Tamper Switches** FACP Battery Change Out Date: 2023 14 10. **Audibles** 10. hi. Voice Evac Battery Chang e Out: 11. 11. Visuals 12. FCPS Battery Change Out: \_\_\_\_\_ **Door Holders** 12. 13. FCPS Battery Change Out: 13. Fan Relays FCPS Battery Change Out: 14. **Smoke Relays** 14. 15 **FCPS** Voice Evac 16 Comments: Inspection End Time: Inspection Start Time: Last Inspected: Inspections Date: License #: 479 Exp: 2023 Inspector:

Witness: \_

#### **DEVICE TEST RESULTS**

Customer Name: Hastings Youth Treatment Facility Program Bldg

Page: 1

Device Type	Device Type Address Location		1	Visual Inspection		tional est	
			Pass	Fail	Pass	Fail	
PROGRAM ADMIN BLDG							
Smoke Detector	L1/D1	W Entry Vestibule over FACP			N		
Pressure Monitor	L1/M1	Sprink. Low Air, Mech. Rm.			A		
Tamper Monitor	L1/M2	Dry Tamper/Bkflow, Mech Rm			区		
Pressure Monitor	L1/M3	Sprink. Dry Flow, Mech. Rm.			Ø		
Tamper Monitor	L1/M3	Sprink. Tamper, Mech. Rm.			Q		
Flow Monitor	L1/M4	Sprink. Wet Flow, Mech. Rm.			A		
Monitor	L1/M5	Kitchen Hood System			区		
Wall Strobe		Outside Storage 144			ĮĮ.		
Wall Horn Strobe		By Restroom 139			Į.		
Wall Strobe		Kitchen 138			囡		
Wall Horn Strobe		Kitchen 138			Ø		
Wall Horn Strobe		Kitchen 138			<b>1</b> 4		
Wall Strobe		Cafeteria 136			運		
Wall Horn Strobe		Cafeteria 136					
Wall Strobe		Small Meeting Room 118			Ň,		
Wall Strobe		PVX 115			Ø	, D	
Wall Strobe		Small Meeting 114			闽		
Wall Strobe		Medium Meeting 119			团		
Wall Strobe		Small Meeting 117			<b>A</b>		
Wall Horn Strobe		Outside Sm Meeting 117			网		
Wall Strobe		Visitor Meeting 116			Ď.		
Wall Strobe		Small Meeting 113			Þ		
Wall Horn Strobe		Outside Sleeping Un 104A			戶		
Wall Strobe		Outside Visitor Meeting 110			区		
Wall Strobe		Sleeping Unit 104A			jīZļ.		
Wall Strobe		Intake Health 103			风		
Wall Strobe		Restroom 112			ìă ≁	s 🔲	
Wall Strobe		Restroom 111			Ŋ		
Wall Strobe		Exam 104B			区	25	
Wall Strobe		Restroom 105			卤		
Wall Strobe		Restroom 106			凤		
Wall Horn Strobe		Outside Restroom 106			ĈĄ(		
Wall Strobe		Admin Work 109A			Ø		
Wall Strobe		Admin Break 109B			这		
Wall Strobe		Waiting 108A			ĮΔĺ,		
Wall Horn Strobe	-97	Outside Art 120			12		
Wall Strobe		Art 120			Ø		
Wall Strobe		Study 121			颅		
Wall Strobe		Classroom 132			Ø		

### DEVICE TEST RESULTS

**Customer Name: Hastings Youth Treatment Facility** 

Page: 2

sroom 131 side Restroom 122 room 122 side Restroom 123 room 123 ridor 134	Pass	Fail	Pass	Fail
side Restroom 122 room 122 side Restroom 123 room 123 ridor 134			,E	
room 122 side Restroom 123 room 123 ridor 134				
ride Restroom 123 room 123 ridor 134				
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room 124			四	
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troom 124			庾	
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	troom 124 sroom 130 troom 125 is 133B is 130B ary 126 side IT Data 128	troom 124 sroom 130 troom 125 is 133B is 130B ary 126 side IT Data 128	troom 124 sroom 130 troom 125 is 133B is 130B ary 126 side IT Data 128	troom 124 sroom 130 croom 125 is 133B is 130B ary 126 side IT Data 128



## Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

Inspect	ting Firm: MFP Inspection Contract#	2113						
AND ADDRESS.	of Inspected Property: +/astims Youth Treatment Center	1						
	tor Name: Date: 10 /19 /	20						
THE RESERVE OF THE PARTY OF THE	tion Frequency: Monthly Quarterly Annually Other							
		A.E.		107				
	Monthly Inspection for Wet Pipe Sprinkler System	July 1		2.8				
A.1,0	System in service on inspection	Y	N/A	N				
State Self-Self-Self-Self-Self-Self-Self-Self-			100	psi				
A.2.0	Supply pressure gauge		100	psi				
A.2.1	System pressure gauge Gauges appear to be in good condition							
A.2.2	Control valves in normal open or closed position	_		A'S				
A.3.0	Control valves in hormal open of closed position  Control valves properly locked or supervised	-						
A.3.1 A.3.2	Control valves properly locked of supervised	-	1600	Soli				
A.3.3	Control valves accessible  Control valves provided with appropriate wrenches	-	TO SERVICE					
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	-	Me.					
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	-	635					
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							
	Alarm valve trim valves are in appropriate open or closed position			CEL				
	Alarm valve retarding chamber or alarm drain not leaking		1					
200000000000000000000000000000000000000	ALARM PANEL CLEAR	2						
A.7.0	COMMENTS:							
32 ST (S			BKE N	E.EV				
TE ASSE		-	L. Je					
C.								
			100					
9.98		DEY.						
FR 55								
Sept.			4.1					
			25/100					
378.371			105					
Tax Si				IN LOSS				
			7115	- 0				
		100		VALE				
100			100	1000				
(BALLAN		7		100 S				
2000								
Pille W		2015						
Say the								
			183					

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 /19/20

## NEBRASKA STATE FIRE MARSHALL FIRE SPRINKLER INSPECTION

			7 1 1 1 1 1 1 1 1
LOCATION OF SYSTEM	Hastings Youth 7	rootment center	INSPECTION DATE
	4/200 QJ 2 nd 5	treet	Adulational
	Flashous NE		TYPE OCCUPANCY
FORMS INCLUDE	D WITH THIS COVER SHEET	TYPE OF I	
I UNDERGROUND TE	ST CERTIFICATION (FORM 85-AB	)       INITIAL ACCEPTANCE OF S'	
	ST CERTIFICATION (FORM 85-AC	REINSPECTION DUE TO RE	
REPORT OF INSPEC		PERIODIC ANNUAL INSPEC	
DRY PIPE VALVE TE	ST	BACKFLOW PREVENTER TE	:51
	DIDECTORY	DEFICIE	NCIES
1 – WET RISER	DIRECTORY  5 - BACKFLOW PREVENTER		
2 – DRY RISER	6 - STANDPIPE	ITEMIZE DEFICIENCIES NOTED O	N INSPECITON AND
3 - PREACTION RISER	7 - OTHER	ANY OTHER PERTINENT COMEN	TS ON SYSTEM
	ITEM#	MAJOR DEFICIENCIES /	COMMENTS
TAG#	ITEM#	MAJON DELIGIENSIES	
4836	17		
48362	+ 5		
48363	<del>-</del>		
48364	1 -		
48365			The state of the s
		atematic for the second second	
	STATUS OF	SYSTEM - CHECK ONE	
IN COMPLIANCE		NINOR DEFICIENCIES	MAJOR DEFICIENCIES
COMPANY PERFORMI			
Meininger Fire Protection		INSPECTOR	SIGNATURE
ADDRESS: 2521 West "	L" Street, Suite 5		GIGHATORE
CITY: Lincoln	STATE:	TESTER BFP LICENSE #:	3119
ZIP CODE: 68522		TEOTERION EIGENSE #. 2	
PHONE: 402-466-2616			
		OWNER REPRESEN	TATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL - 246 SOUTH 14TH ST - LINCOLN, NE 68608-1804 A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER



White: AHJ

Yellow: MFP

Pink: Business



	ling Firm: // // P	/	17		7 0 (0	The second secon	on Contract#	,	657.48	The state of
THE RESERVE OF THE PARTY OF THE	of Inspected Property: 112517/195	06	do		statt.	nent l'ente	11/19/	20	-	
CHARLES IN NO.	or Name:	-			111	Date:	To Other			
Inspect	ion Frequency: Monthly	1 Q	uarte	rly		☑-Annually	Other			
	Quarterly Inspection for				Quai	terly Testing for	Wet Pipe Sprinkle	er S	yste	ems
	Wet Pipe Sprinkler Systems							Y	1	N
		Y	N/A	N.	C.1.0	System in service bef	ore testing	1		130
B.1.0	System in service on inspection	-	5.31		C.1.1	Pertinent parties notifi				
B.2.0	Hydraulic nameplate attached and legible	_					vided before flow testing	-	100	100
B.2.1	Alarm device free from physical damage	_			C.2.0	Water flow alarm (oth-	er than vane type)	-		
B.3.0	FDC is visible			100		tested and is operatio		-		
B.3.1	FDC is accessible	-			C.2.1	Test conducted with b	spector's test connection			1 11 1
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	-				(freezing weather)			-	
B,3,3	FDC plugs/caps in place/undamaged	-			C.2.3		anufacturer's instructions			
ACCRECATE VALUE OF	FDC gaskets in place and in good condition		Est.				free of physical damage	-		
B.3.4	FDC Identification sign in place						vided before flow testing	-	7 200	900
B.3.5	FDC check valve not leaking				C.3.1	A main drain test cond from backflow prevent		0.0	1	
B.3.6 B.3.7	FDC automatic drain valve in place and operating properly	=			C.3.2	A main drain test cond from pressure reducin	ducted downstream		1	
B.3.8	FDC clapper is in place and operating properly		Cas.		C.3.3		eading before flow (station	2)	600	ps
B.3.9	FDC interior inspected where caps missing	(pn	-		0.00	Gauge reading during	THE RESIDENCE OF THE PARTY OF T		45	ps
_	FDC obstructions removed as necessary	100	_	2012	C.3.4	THE RESERVE OF THE PARTY OF THE			-	sec
B.4.0	Pressure reducing control valves (PRV)	1949			C.3.5	Time for supply press Pertinent parties notifi				300
	indicate open	1388			G.4.0	ALARM PANEL CLE		_		500
B.4.1	PRV not leaking	100			C.5.0	SYSTEM RETURNED				
B.4.2	PRV maintaining downstream pressure per design		-		C.6.0 C.7.0	COMMENTS:	TO SERVICE	11, 11		9316
B.4.3	PRV in good condition	200	_		G.1.0	COMMELIA EG.				1122
B.4.4	PRV handwheel installed and not broken		-							7
-	ALARM PANEL CLEAR	/	7 0		-			THE		
B.6.0	COMMENTS:		Toy o		12				110	E R
5.0.0	C De la la la la la la la la la la la la la	Say	0.70					in.		N
				Y						
N BY										
		3	BR							100
	Semi-Annual T	est	ing	for \	Net Pip	e Sprinkler Syste	ms		refig.	
			Ni Ci					Y	N/A	N
D.1.0	System in service before testing	6 28	15//5					-		1575
D.1.1	Pertinent parties notified before testing		W.							
D.2.0	Supervisory switch initiates distinct signal during one-fifth from normal position	g firs	t two	han	d wheel re	volutions or before valv	e stem moved			
D.2.1	Signal restored only when valve returned to no	rmal	posit	ion				-		13 (8)
D.3.0	Adequate drainage provided before flow testing							-	-785	7
D.3.1	Main drain test conducted							-	100	15.3
D.3.2	Supply water gauge reading before flow (static	)							600	psi psi
-	Gauge reading during stable flow (residual)	Tall.						6621	45	psi
D 3 3	Time for supply pressure to return to normal	1030	TO P	4100	The street				-	sec
D.3.3	THE TO SUPPLY STOUGHT TO LOCALITY TO HOTELD	275		W. W.	Service Control of	TO SHOW THE PARTY OF THE PARTY			-200	
D.3.4			W 125/13		Section 2		The same of the sa	100 C 100 C	Children and Control	
D.3.4 D.4.0	Pertinent parties notified of test conclusion							1		
D.3.4								1		

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

PINK-OWNER

(AFSA Form 106A) Page 2 of 4



Report of Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems...continued

Inspec	eting Firm: MFP					Inspection Contract#			
Name	of Inspected Property: Hastinas To	4+1	4	Th	Atmo	ent Center,			
NAME OF TAXABLE	ctor Name:			12	m	Date: 10/19/2	20		
Inspec	ction Frequency:  Monthly	Q	uarte	riy		Annually			
								1111	
	Annual Inspe	etic	9	-	et Pipe	Sprinkler Systems	132		L
= 4.0		Y	N/A	N	E.4.7	Class bulbs appear full of liquid	Y	N/A	N
E.1.0 E.2.0	System in service on inspection Hangers and seismic bracing appears	1000			E.4.8	Glass bulbs appear full of liquid  Spare sprinklers are of proper number			
2.2.0	undamaged and tightly attached	-	+		2.4.0	(at least 6), type and temperature rating			
E.3.0	Piping appears free of mechanical damage	-prior			E.4.9	Spare sprinklers stored where temperature			
E.3.1	Piping appears free of leakage	1			= 1.10	maximum is 100°F	_69		
E.3.2	Piping appears free of corrosion	-		N.B	E.4.10		1		L.,
E.3.3	Piping appears properly aligned		Thomas .	175G	==0	PRIOR TO FREEZING WEATHER:			
E.3.4	Piping appears free of external loading	1000		-35	E.5.0	Building is secure such as not to expose piping to freezing conditions		0.25	
E.4.0	Sprinklers appear free of leakage	1			E.5.1	Adequate heat is provided maintaining	-		402
E.4.1	Sprinklers appear free of corrosion					temperatures at 40°F or higher			
E.4.2	Sprinklers appear free of foreign materials	1			E.6.0	ALARM PANEL CLEAR	- Control		
E.4.3	Sprinklers appear free of paint		4		E.7.0	COMMENTS:		0.00	100
E.4.4	Sprinklers appear free of physical damage Sprinklers appear properly oriented	1		E 17 1			T. All		
E.4.5 E.4.6	Sprinkler spray patterns appear free of	10							
	unacceptable obstructions						6		
LOTTO .	Annual Tee	tino	for	Wal	Pine S	prinkler Systems	1		Syl
		enna					900		1200
F.1.0	System in service before testing	-			F.5,2	Forward flow test conducted at maximum rate possible (only where connections do		Ca.	
F.1.1	Pertinent parties notified before testing		2000			not permit full flow test)			
F.1.2	Adequate drainage provided before flow testing			JIEN -	F.5.3	Forward flow test conducted without			源
F.2.0	Main drain test conducted		3833			measuring flow (device =2" and outlet sized to flow system demand)</td <td></td> <td>-</td> <td></td>		-	
F.2.1	Supply water gauge reading before flow (static	0	10	psi	F.5.4	Backflow prevention assembly internal	100		
F.2.2	Gauge reading during stable flow (residual)	30/2	75	psi		inspection conducted (where shortages last	13	-	100
F.2.3	Time for supply pressure to return to normal			sec	-	more than 1 year and rationing enforced by AHJ)			
F.3.0	Antifreeze solution tested and freezing point determined		-		F.5.5	Forward flow test satisfied by annual fire pump flow test			
F.3.1	Antifreeze solution freezing point		-	°F	F.5.6	Backflow preventer performance test			100
F.3.2	Antifreeze solution freezing point after adjustme	tre	-	°F	F.6.0	conducted as required by the AHJ	550	(15 XI)	245
F.4.0	Control valves (including backflow and PIVs)		235			PRV control valves partial flow test conducted and adequate to unseat valve		-	
	operated through full range and returned to		ES		Marie Laborator	Pertinent parties notified of test conclusion	-	7	-AA
	normal position			200	and the second second	ALARM PANEL CLEAR		400	
F.4.1	PIVs opened until spring or torsion felt in rod		5015		A CONTRACTOR OF THE PARTY OF TH	SYSTEM RETURNED TO SERVICE	-	Ma	1/2
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open		080		THE RESIDENCE OF THE PARTY OF T	COMMENTS:	RA.	NO PTO	
F.4.3	Main drain test conducted (see F.2.0)	_					15	1350	die
F.5.0	Backflow prevention assembly forward flow test conducted	_			EN CONT			- 30	
F.5.1	System demand flow was achieved	_							STORY
	through the device	Sid					100		
	Annual Mainter	and	ce f	or W	et Pipe	Sprinkler Systems	Ver 1		
G.1.0	System in service before conducting maintenance	اسا				Time for supply pressure to return to normal		-	sec
G.2.0						Pertinent parties notified after conclusion		6.3	100
0.004	conducting maintenance	/	0			of maintenance	-		
G.3.0	Operating stems of OS&Y (including backflow)			1000	The State of the S	ALARM PANEL CLEAR	-	80	
C 2 4	Valves lubricated	13,835	200	100	G.7.0	SYSTEM RETURNED TO SERVICE	-	213	
G.3.1	Valve completely closed and reopened				G.8.0	COMMENTS:	AVA.	SURVI	914
G.4.0	Adequate drainage provided before flow testing				72 01 11		SI S	STATE OF	
G.4.1	Main drain test conducted	-	N					<b>B</b> 148	75.50
G.4.2	Supply water gauge reading before flow (static)	U	10	psi			11/2/2		
G.4.3	Gauge reading during stable flow (residual)	9	15	psi		, ,	Mel		
	//// //// //// /// /// /// /// /// ///				2. 2.		RA Fo	- T	0001

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 18/19/20

(AFSA Form 106A) Page 3 of 4



## Report of Inspection, Testing & Maintenance of Dry Pipe Fire Sprinkler Systems



ALL QUESTIONS ARE TO BE ANSWERED AND ALL BLANKS TO BE FILLED (Weekly inspection tasks are NOT included in this report)

	ng Firm: 977 P	. 11	a Land	iont	Conto	- 1	1	
ame of	Inspected Property: Hastings You	NTN 11	1 11	9	Date:	10/19/	20	,
specto	or Name:	0 1 1	-111	☑ Annu		Other	N. N. L.	8 8 4
spection	on Frequency: Monthly	Quarterly		E Addic	adily			188T
	Monthly Inspe	ction of D	ry Pipe	Sprinkl	er System	S		× IV
		Y N/A N					Y	N/A
v.1.0	System in service on inspection	1	A.2.6	System c	ontrol valve si	gn indicates area serve	3	
	Supply (water) gauge pressure	//O psi	A.3.0	Backflow	prevention as	sembly valves are locke ed in open position		-
	System (air) gauge pressure	2 4 psi	A.3.1	Reduced	nressure bac	ckflow prevention		
	Quick opening device gauge pressure	psi	H.07.1	assembly	y not in contin	uous discharge		
	Gauge near compressor	1/0 psi	A.4.0	Dry pipe	valve free of	physical damage	1	
	Gauge pressures are normal		A.4.1	Dry pipe	valve trim val	ves are in appropriate		
	Control valves in normal open or closed position	-		open or o	closed position	n diate chamber not leakin	0 -	- 3
	Control valves properly locked or supervised		A.4.2		PANEL CLEA		2	
	Control valves accessible	-	A.5.0 A.6.0	COMME				200
	Control valves provided with appropriate wrenches	-	A.6.0	COMME				
	Control valves free from external leaks							
	Control valve identification signs in place	1			Tisky as Ta		0000	0.57
	Quarterly Inspection of	STAN STAN	Qua	rterly T	esting for	Dry Pipe Sprinkl	er S	yster
	Dry Pipe Sprinkler Systems		C.1.0	System i	n service befo	ore testing	1	The said
1.0	System in service on inspection		C.1.1	Pertinen	t parties notifi	ed before testing	95	
3.2.0	Hydraulic nameplate attached and legible		C.1.2	Adequate	e drainage pro	ovided before flow testing	9	
3.2.1	Alarm device free from physical damage		C.2.0			ed and is operational		
3.3.0	FDC is visible		C.2.1	Test con	ducted with in	spectors test connection	1	
3.3.1	FDC is accessible		C.2.2	Test con	ducted with b	ypass connection	-	
3.3.2	FDC swivels/couplings undamaged/rotate smoothly		C.2.3		weather)	enufacturer's Instruction	S	
3.3.3	FDC plugs/caps in place/undamaged		Mary Street			free of physical damag		
3.3.4	FDC gaskets in place and in good condition		C.2.4 C.3.0	Supervis	sory switch ini	tiates distinct signal		
3.3.5	FDC identification sign in place			during fi	rst two hand v	wheel revolutions or		
3.3.6	FDC check valve not leaking			perore v	aive stem mo position (semi	ved one-fifth from i-annual)		
B.3.7	FDC automatic drain valve in place and operating properly		C.3.1	Signal re	estored only v	vhen valve returned		
B.3.8	FDC clapper is in place and operating properly		C.4.0	One ma	in drain test c	onducted downstream		
	FDC interior inspected where caps missing		1000	The second second second	ckflow preven	ter		
B.3.10	FDC obstructions removed as necessary		C.4.1	from ore	in drain test c essure reducir	onducted downstream ng valve	ST	1
B.4.U	Pressure reducing control valves (PRV) indicate open		C.4.2			reading before flow (sta	tic)	105
B.4.1	PRV not leaking		C.4.3	A PROPERTY OF THE PARTY OF THE		stable flow (residual)	TANK TO THE REAL PROPERTY.	45
B.4.2	PRV maintaining downstream pressure per design		C.4.4			sure to return to normal	Day't s	
B.4.3	PRV in good condition		C.5.0		water level te			
B.4.4	PRV handwheel installed and not broken		C.6.0			e(s) (QOD) tested		1
B.5.0	ALARM PANEL CLEAR		C.7.0		ssure alarm t			
B.6.0	COMMENTS:					fied of test conclusion		+
					PANEL CLE			
						D TO SERVICE	1	
			THE RESERVE OF THE PERSON NAMED IN COLUMN 1	O COMME	CAN THE RESIDENCE OF THE PARTY		W.O.	
STATE OF								
					Transfer to	ME PARES TO THE		

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 16 /19/20

(AFSA Form 107A) Page 1 of 3



Report of Inspection, Testing & Mainte	Hanc	, <del>C</del> 01	Diy i ip	Inspection Contract#	(CIII.)		
nspecting Firm: //// /	1	17	TARA	tmont Conter , ,	6,01		
Name of Inspected Property: 1/45+1045	TO W	1	-In	Date: 10/19/20		figet.	
nspector Name:	По	arterly	70	Annually Other			
nspection Frequency:  Monthly	ل لاي	arterry					140
Annual Inspection for Dry Pipe Sprink		stem N/A N		Annual Maintenance for Dry Pipe Sprinkler Systems			
a u l santa de farecelles					Y	N/A	И
D.2.0 System in service on inspection D.2.0 Hangers and selsmic bracing appears			E.f		100		
undamaged and tightly attached		000	-   E.2	maintenance .0 Pertinent parties notified before conducting			
D.3.0 Piping appears free of mechanical damage			_  2	maintenance			
D.3.1 Piping appears free of leakage	-		E.3	.0 Adequate drainage provided before		1	
0.3.2 Piping appears free of corrosion		-		flow testing or draining  Operating stems of OS&Y (including backflow)			
D.3.3 Piping appears properly aligned	100		E.4	valves lubricated			
D.3.4 Piping appears free of external loading			E.4		1	1865	
D.4.0 Sprinklers appear free of leakage	100		E.5		1	-X-10	
D.4.1 Sprinklers appear free of corrosion			E.5	I before flow (otati	c)	40	ps
D.4.2 Sprinklers appear free of foreign materials			- E.5	to status IV		45	, ps
D.4.3 Sprinklers appear free of paint			E.5				sec
D.4.4 Sprinklers appear free of physical damage			E.E	n I eaks resulting in air pressure losses			38
D.4.5 Sprinklers appear properly oriented				greater than 10 psi/week located and repaired			10
D.4.6 Sprinkler spray patterns appear free of unacceptable obstructions			- E.7	7.0 Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		-	
D.4.7 Glass bulbs appear full of liquid			- E.7	7.1 Grease or other sealing materials not applied to seating surfaces of dry pipe valve	0.10	-	
D.4.8 Spare sprinklers are of proper number (at least 6), type, and temperature rating			—   Ē.8	the state of the s			
D.4.9 Spare sprinklers stored where temperature maximum is 100°F				weather conditions	35%	200	38
D.4.10 Wrench available for each type of sprinkler			E.9	9.0 Pertinent parties notified after conclusion	10000		
D.5.0 Dry pipe valve in good condition internally		1		of maintenance	1		
(check at trip test)	152 X			10.0 ALARM PANEL CLEAR 11.0 SYSTEM RETURNED TO SERVICE	-		權
PRIOR TO FREEZING WEATHER:  D.6.0 Building is secure such as not to expose				12.0 COMMENTS:		100	100
D.6.0 Building is secure such as not to expose piping to freezing conditions	碧点			12.0 COMMENTS.			
D.6.1 Adequate heat is provided maintaining temperatures at 40°F or higher							
D.7.0 ALARM PANEL CLEAR							
D.8.0 COMMENTS:				~ · l			
				1 at			
<b>《李文·</b> · · · · · · · · · · · · · · · · · ·	20			V.011P			SEX
				Var 1			
				105			
				ROTIAL TAIL			
	CENTER OF	Trin	Test 7	Table			
Dry Valve Size	411	Ye		Q.O.D. Ye		TI.	5.5
UIV VAIVE	THE RESERVE OF THE PERSON NAMED IN	******	The second second	10000	Carial	No	

Serial No. Model Make Serial No. Model Make Time Water Dry Pipe Alarm Trip Point Reached Air Water Time to Trip Test Outlet Operated Operating Air Pressure Pressure Pressure Thru Test Pipe Test No Min Sec Yes PSI PSI PSI Min Sec 24 Without Q.O.D With Q.O.D

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10

(AFSA Form 107A) Page 2 of 3



	t of Inspection, Testing & Maintena						_In	spection (	Contract#		N. E.	1.9	
		1-	14		Monte	mai	it (0	nter	1	/	100		
Witness Tolkinson	Inspected Property: 110,5110,55 Pol			_	2/2		D	ate: /	0/19	120		32	
THE COURSE OF THE	or Name: on Frequency:  Monthly	Qu	arter	iy		D	Annually	Special	/ Othe	r			
		vsl	terr	ıs		Ites	ms of 5 \	ears o	r Greater	Freque	enc	,	
Ann	ual Testing for Dry Pipe Sprinkler S		N/A									N/A	N
		1	13,7	7.0	G.1.0	Syst	tem in servi	ce before	conducting t	asks		725	
	System in service before testing	100	6		G.2.0	Pert	inent parties	notified be	fore conduct	ing tasks		85	
	Pertinent parties notified before testing					Dry	pipe valve i	nternally i	nspected			.30	
	Adequate drainage provided before flow testing Dry pipe valve trip tested with control valve partially	-	177.0	78	G.3.1	Dry	pipe valve s	strainers, t	ilters, and re	estriction			15
	open (required at full flow every 3 years)				G.3,2	Dry	ces internal pipe valve i	internal co	mponents				
.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in	1			G.3.3	Clea	plpe valve	ed as nece internal co	mponents	/			
2.2	freezer Tag or card showing trip test date and name	188	128	188	4 6 0 5	insp	ection/mair	itenance c	late:	015000000	934b		-
	of person and organization conducting test attached to DPV		1		C PARTIES	Sys	tem gauges	replaced	as necessar comparisor	ry n with			
223	Separate records of initial air and water pressure,				G.4.1	calil	brated gaug	10	1				
	tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	1	511	100	G.4.2	Sys	tem gauges	accurate	within 3% of	full scale	SIL		-
-2.4	Records of tripping time maintained for full		100		G.4.3	Sys	tem gauges	recalibra	ted as neces	ssary		d (25)	1
	flow trip tests	1	9.0	1001	G.4.4				cement date	<del>)</del> :	1000	200	E
.3.0	Automatic air pressure maintenance devices				G.5.0	Che	eck valves ii	nternally in	spected		18,00		牆
	tested in accordance with mfg. inst.  Control valves (including backflow and PIVs)		3/01/		G.5.1	Che	ck valve inte	mal compo	ments operate	e correctly			13
.4.0	operated through full range & returned to	1	150		G.5.2	Che	eck valve in	ternal con	ponents mo	ve freely		100	H
	normal position				G.5.3	Che	eck valve in od condition	ternal con	iponents in		J.S.		100
-4.1	PtVs opened until spring or torsion felt in rod	4	-		G.5.4	Chi	eck valve in	temal con	ponents			9 03	
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open				0,0.4	cle	aned/repaire	ed/replace	d as necess			201	1.
F.5.0	Main drain test conducted			1	G.5.5				ection/main				
F.5.1	Supply water gauge reading before flow (static)	18	1,0	psi	G.6.0	) Ade	equate drain	age provid	led before flo	ow testing	300	2	
F.5.2	Gauge reading during stable flow (residual)		43	psi	G.6.1	I PR	V control va	dves full fl	ow tested by	y opening	3.6		10
F.5.3	Time for supply pressure to return to normal			sec			tional drain		1				F
F.6.0	Backflow prevention assembly forward	1	+		THE RESIDENCE TO SHARE		oply side st		THE RESERVE AND ADDRESS OF THE PARTY OF THE		N SA	× 30	
5 4	flow test conducted	30	1000		201		stem side si	COMPANY TO SERVICE STREET	CONTRACTOR OF THE PARTY OF THE				resy.
F,6.1	System demand flow was achieved through the device	1			THE RESERVE OF THE PERSON NAMED IN COLUMN 1		oply side re			Special Control		0.40	No.
F.6.2	Forward flow test conducted at maximum rate				G.6.5	5 Sy	stem side re	esidual pre	ssure		1	100	7
10.2	possible (only where connections do not permit	1	1	4	G.6.6	6 Re	sults compa	ared to pre	vious full flo	w test			
	full flow test)  Forward flow test conducted without measuring	160		A TORK	G.6.7	7 Ad	justments n	nade as no	ecessary				
F.6.3	flow (device =2" and outlet sized to flow system demand)</td <td>100</td> <td></td> <td></td> <td>THE STATE OF</td> <td>tes</td> <td>ted/replace</td> <td>d - date:</td> <td>ype sprinkle</td> <td>rs</td> <td></td> <td></td> <td></td>	100			THE STATE OF	tes	ted/replace	d - date:	ype sprinkle	rs			
F.6.4	Backflow prevention assembly internal				G.7.1	1 Sp	rinklers in h	arsh envir d – date:	oument	1			
	inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)			1	G.7.2	2 Dr	y sprinklers	tested/rep	laced (10 ye	ears) –			N. Carlotte
F.6.5	Forward flow test satisfied by annual fire pump flow test		1	1	G.7.3	3 50	rinklers with	fast resp	onse elemer ears, 10 the	nts reafter) -			
F.6.6	Backflow preventer performance test conducted as required by the AHJ	1	1		-	da							
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve			1	1000000	(al	50 years,	10 thereaf	ter) - date: aced (at 75	vears, 5			
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve			1	G.7.	the	ereafter) - c	late:	red before 1		1		
SV 1	enclosure)		1		1   3.7.1	те	placed - da	te:				1	
F.9.0	Pertinent parties notified of test conclusion  ALARM PANEL CLEAR	10	1	W. Carl	G.8.	0 0	ee AFSA F	vestigatio	n conducted				
E 44 C	SYSTEM RETURNED TO SERVICE	E STATE	1		G 9	0 P	ertinent partie	es notified	after conclusi	on of tasks	5	8 30	8
-	COMMENTS	4	3407				ARM PAN						
C. 12.C	THE PROPERTY OF THE PARTY OF TH			7	G 11	1.0 S	YSTEM RE	TURNED	TO SERVICE	E			
		100					OMMENTS		3393		200	125	
	And the state of t	200	2/1/3		G.12	2.0 0	DIVINENTS			No. of the last of		GE!	

INSPECTOR'S INITIAL

(All "NO" answers to be explained.)
OWNER/DESIGNATED REP. INITIAL

DATE 10 PINK - OWNER (AFSA Form 107A) Page 3 of 3

WHITE - AHJ



## MEININGER FIRE PROTECTION

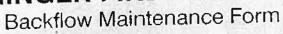
**Backflow Maintenance Form** 



ontact Person	Phon	e Number			
<ul><li>☑ Annual Test</li><li>☑ DC</li></ul>	□ RPP _	4" Size	Co1+ Manufacturer	Model No.	Serial #
☐ New Installation☐ DC	☐ Replacement	Size	Manufacturer	Model No.	Serial #
Domestic Containment Swimming Pool	Irrigation  Fire Servi		r 🔲 Carbona er Cooled Ice M	(Desc.)	10
Device Location	Check Valve #2	N/Side Press	sure Relief Valve	PVB/	SVB
INITIAL TEST	SID Held at  No Closed Tight   Yes  Leaked   Yes  Cleaned  #2 Shut Off  Closed Tight   Yes	No Cleaned Replaced	ppen	SID Air Inlet Opened at Did not open Check Valve Held at Leaked Cleaned	PSID PSID
FINAL TEST	Closed Tight  Yes			Check Valve	PSID PSID
I hereby certify the above ba	eSID ackflow preventer has been testine State of Nebraska Health and Licensure, Title 179, and the sare true and accurate to the b	Lincoln Water Sy	s with	Questions Call MEININGER FIRI 2521 West LS Lincoln, N	402-466-2616 E PROTECTION Street, Suite 5
State Certified Technician (p	w MAFF		743 Grad	de 6 Certificate No.	02-953- Cell/Phone No
State Certified Technician (s	signature) 1105019 Test Gauge Se		nature	12/15 Date o	Date of Test



## MEININGER FIRE PROTECTION





				68901	
ontact Person	Phone Nu	imber			
Annual Test	) DDD				
DC C	) RPP	Size	Manufacturer	Model No.	Serial #
New Installation	Replacement	"		2001	re 11217
□ DC 〔		Size	Manufacturer	Model No.	Serial #
Domestic In	rigation	☐ Boile		(Desc.)	
☐ Swimming Pool	☐ Cooling Tower	☐ Wate	er Cooled Ice Ma	aker	
evice Location		Droc	sure Relief Valve	] PV	B/SVB
Check Valve #1	Check Valve #2	Pres	sule Relief Valve		
INITIAL TEST	Held at 2.2. PSID	Opened	at PS	SID Air Inlet	
	Tield at	The state of the s	THE RESERVE THE PROPERTY OF TH	Opened at	PSID
Leaked Yes No	Closed Tight Yes No	Cleaned		Did not oper	1
Cleaned		Replace		Check Valve	AND THE PERSON NAMED IN COLUMN
Replaced	Cleaned	Періасс		Held at	PSID
	#2 Shut Off			Leaked	
	Closed Tight Yes No			Cleaned	
				Replaced	
EINAL TEST					
FINAL TEST	Closed Tight Yes No	0		Check Valve	The second secon
PSIC	501	Replace	d P	SID Air Inlet	PSIE
all rules and regulations of the S	ow preventer has been tested in tate of Nebraska Health and Hur icensure, Title 179, and the Linco e true and accurate to the best of	oln Water Sy		MEININGER FI 2521 West I	all 402-466-2616 IRE PROTECTION L Street, Suite 5 , NE 68522
	MEN		79	32 40	21853-157
State Certified Technician (pleas	se print) Company		Grad	e 6 Certificate No.	Cell/Phone N
State Certified Technician (signa	atoro,	ustomer Sig	nature		Date of Test
Anallo	7/050/96 Test Gauge Serial No			the same of the sa	of Calibration
Test Gauge Manufacturer	lesi Gauge Genai No				

## NEBRASKA STATE FIRE MARSHALL FIRE SPRINKLER INSPECTION

DUTY TRE	MREET, HAR	ENTER STINGS NE	68901	INSPECTION DATE TYPE OCCUPANCY
D WITH THIS OF CERTIFICA OF CERTIFICA TION ST  DIRECTOR 5 - BACKF 6 - STAND	TION (FORM 85-AB) TION (FORM 85-AC)  LOW PREVENTER PIPE	INITIAL ACCEL REINSPECTIO PERIODIC AN BACKFLOW P	TYPE OF INSPECTION  PTANCE OF SYS  IN DUE TO REMONITED TO	DDEL, REPAIR, ETC DN T CIES INSPECITON AND
ITEM#   5	CONTROL  CON	SYSTEM SYSTEM WANKE BU  A SYSTEM SYSTEM SYSTEM SYSTEM	NOW4 A	OMMENTS
n, Inc	STATUS OF S MII  ION:	YSTEM CHECK ON NOR DEFICIENCIES NE NE LICENSE # TESTER BFP I	INSPECTOR S : 05046 LICENSE #:	MAJOR DEFICIENCIES SIGNATURE ATIVE SIGNATURE
	D WITH THIS ST CERTIFICA TION ST  DIRECTORY 5 - BACKE 6 - STAND 7 - OTHER  ITEM #	DWITH THIS COVER SHEET OF CERTIFICATION (FORM 85-AB) OF CERTIFICATION (FORM 85-AC) THON ST  DIRECTORY 5 - BACKFLOW PREVENTER 6 - STANDPIPE 7 - OTHER  ITEM #  ITEM #  IDEA  INC.  STATUS OF STANDS  MIN.  ING. INSPECTION:  In, Inc.  ITEM STATUS OF STANDS  ING. INSPECTION:  ING. INSPECTION:  ING. INSPECTION:  ING. INSPECTION:  ING. INSPECTION:  ING. INSPECTION:  ING. INSPECTION:  INC.	D WITH THIS GOVER SHEET ST CERTIFICATION (FORM 85-AB) ST CERTIFICATION (FORM 85-AC) TION ST  DIRECTORY 5 - BACKFLOW PREVENTER 6 - STANDPIPE 7 - OTHER  MAJOR DEFI  TEM#  MAJOR DEFI  TONTROL JANE BUILDING A  DEFI  STATUS OF SYSTEM - CHECK ON MINOR DEFICIENCIES  NG INSPECTION: In, Inc  L'' Street, Suite 5  STATE: NE NE LICENSE # TESTER BFP I	DWITH THIS COVER SHEET  ST CERTIFICATION (FORM 85-AB)  ST CERTIFICATION (FORM 85-AB)  ST CERTIFICATION (FORM 85-AC)  TION  ST  DIRECTORY  5 - BACKFLOW PREVENTER 6 - STANDPIPE 7 - OTHER  MAJOR DEFICIENCIES NOTED ON ANY OTHER PERTINENT COMENTS  ITEM#  MAJOR DEFICIENCIES / C  MAJOR DEFICIENCIES / C  STATUS OF SYSTEM - CHECK ONE  MINOR DEFICIENCIES  NG INSPECTION:  ONLY OF SYSTEM - CHECK ONE  MINOR DEFICIENCIES  NG INSPECTION:  ONLY OF SYSTEM - CHECK ONE  MINOR DEFICIENCIES  INSPECTORS  INSPECTORS  STATE: NE NE LICENSE #: 05046  TESTER BFP LICENSE #:

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



White: AHJ

Yellow: MFP

Pink: Business

HYDRAULIC DATA NAMEPLATE	NAMEPLATE PROVIDED		YES DNO		), EXPLAIN		
REMARKS	DATE LEFT IN SERVICE W	ITH ALL CON	NTROL VALVE	S OPEN: /	0/31/19		
	NAME OF SPRINKLER COL MEININGER FIRE PRO	NTRACTOR TECTION, 2				522 • 402-466-2	616
SIGNATURES	FOR PROPERTY OWNER	(SIGNED)	IESI	SWITNESSE	TITLE		DATE
	FOR SPRINKLER CONTRA	256		4	TITLE	,	DATE / 7-/9
	FOR AUTHORITY HAVING	JURISDICTIO	ON (IF WITNE	SSED)	TITLE DI	en all	DATE
ADDITIONAL EXPL	ANATION AND NOTES	137447				1	
TYCO TYCO		14' 14' 16'	74 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2	8 31 26	155°		

Page 3

SEND TO: Nebraska State Fire Marshal - 246 South 14<sup>th</sup> 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.

## 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	44	265	1	A TECAM	MENT			DATE	10/311	19	
PROPERTY ADDRE	War and the Park	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN	1001	200 SIRE	THE RESIDENCE OF THE PARTY OF T	TIA	369	NE	459	rol	
	THE RESERVE TO SERVE		PROVIN	IG AUTHORITIES	The second secon	) T	M				10 10 1
	ADDRES	s i	NC	OLN							
PLANS	INSTALL			S TO ACCEPTED	PLANS					(☐ YES	□ NO
	EQUIPM	ENT USED	IS APP	ROVED						□ YES	O NO
	IF NO, E	XPLAIN DE	VIATIO	NS							
	HAS PE	RSON IN C	HARGE	OF FIRE EQUIPM	ENT BEEN INS	TRUC	TED AS T	O LOCAT	ION OF	Ď YES	O NO
	CONTRO	DL VALVES	AND C	ARE AND MAINTE	ENANCE OF TH	15 NEV	V EQUIPA	MEINT ( IF	NO, EAFLA		
				<b>的</b> 第二十二章		Kasa					1
12.71	HAVE C			LLOWING BEEN I		REMIS	iES:			III YES	□ NO
INSTRUCTIONS			752,410,710	PONENTS INSTRI				BRESCH		LAYES	□ NO
				AINTENANCE INST	IRUCTIONS		4			@YES	□ NO
Contract Contract		3. NFPA 2	25			2000		And the		12,120	
LOCATION OF SYSTEM	SUPPLIE	S BUILDIN	igs					100 July 22			
				MODEL	YEAR OF MANUFACTU	A PROPERTY AND ADDRESS.	ORIFIC		JANTITY	TEMPERA RATIN	ACCOUNT OF THE PARTY OF THE PAR
	. 1	MAKE		MODEL	WANDFACTORE		1/0		710	165	
A STATE OF	711	105		NEW COL	361		71.		2	126	
SPRINKLERS	1111	- INC		111200	40	100	1/2		MINES S	100/11	20
	MINING.			11/194	14		115		41-12	200	
	11	U LA G		VIV Local	101	Torus 2	311		27	200	
PIPE AND	Type of I	Pipe	TEX					THE N			
FITTINGS	Type of I		47	rect		7.48				THE TUDOUS	LTCOT
			AL	ARM DEVICE			MAXIN	AUM TIMI	CONNECT	TE THROUGH	H IESI
OR FLOW	TYPE			MAKE	MODEL			MINIMU	SECON	IDS	
INDICATOR	No. OF STREET			HUNKO						No. Marie	
		。平性。建				(250)					
			DRY V	ALVE					Q.O.D		
		MAKE		MODEL	SERIAL NO		M	AKE	MODE	L SERI	AL NO.
	Victo	natic		768N	12259	A STATE OF THE PARTY.		-0.45	WATER I		
DRY PIPE OPERATING		TIME TO THROUG CONNEC	H TEST	WATER PRESSURE	AIR PRESSURE		POINT AIR SSURE	REACH	WATER IED TEST TLET*	ALARM OP	
TEST		MIN.	SEC.	PSI	PSI	1	PSI	MIN.	SEC.	YES	NO
	Without Q.O.D.		14	35	15		7		37	~	
	With Q.O.D										
	IF NO, E	XPLAIN						10000			
PERSONAL PROPERTY AND INC.			The second second		the same of the sa	Contract of the last	THE RESERVE AND PERSONS NAMED IN	COLUMN TO SERVICE STREET	WATER CONTRACTOR	CONTROL STATE OF STREET	THE RESERVE AND ADDRESS OF THE PARTY OF THE

\*MEASURED FROM TIME INSPECTOR'S TEST CONNECTION IS OPENED.

ATTACHMENT "B-1 FOR Aboveground Piping" (Page 1)

PRESSURE REDUCING MAKE AND ACTION MAKE A STRING PRESSURE RECOUNT OF A THE CONTROL STATIONS OF A STRING PRESSURE RECOUNT OF A STATIC PRESSURE WITH VALVE IN THE STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RESTOR RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT OF A STATIC PRESSURE RECOUNT		OPERATION	1	. □ PNEUMA	TIC DELECT	RIC	O HYDR	RAULI	С	100			MAN.	
DELUGE & PREACTION VALVES  TESTING?  DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM  MODEL  DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM  PRESSURE PRESSURE PRESSURE PREDUCING VALVE TEST  LOCATION  MAKE & SETTING  STATIC PRESSURE PR		Contaction in		O YE	S NO DE	TECTIN	IG MEDIA S	UPER	RVISED		(lwi	□ YES	ON D	
DELIGIE & PREACTION PRESSURE PREACTION VALVES    MAKE		DOES VALV	E OPERATE	FROM THE MA	NUAL TRIP AND	OR RE	MOTE CON	ITRO	LSTATIO	SMC		□ YE\$	□ N0	
DOES EACH CIRCUIT OPERATE  DOES EACH CIRCUIT OPERATE  SUPERVISION LOSS ALARM  YES  NO  YES  NO  MIN.  SEC.  RESIDUAL PRESSURE (FLOWING)  ALET (PB)  UN	The Control of Section 19 Control of the Control of				EACH CIRCUIT	FOR	IF NO, E	XPLA	AIN					
PRESSURE REDUCING VALVE TEST  LOCATION MAKE & FLOOR MODEL SETTING STATIC PRESSURE RESIDUAL PRESSURE (FLOWING)  INLET (PS) OUTLET (PS) MILET (PS) OUTLE		MAKE	MODEL	DOES EACH C SUPERVISIO	IRCUIT OPERAT N LOSS ALARM	E (								
PRESSURE REDUCING VALVE TEST  LOCATION MODEL  SETTING  STATIC PRESSURE  (FLOWING)  INLET (PSI)  OUTLET (PSI)  INLET (PSI)				YES	NO	11	YES		NO		MIN.		SEC.	
PRESSURE REDUCING VALVE TEST  LOCATION MODEL  SETTING  STATIC PRESSURE  (FLOWING)  INLET (PSI)  OUTLET (PSI)  INLET (PSI)														
HYDROSTATIC: Hydrosfatic 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 depoyers 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 adrop, which shall not exceed 1-1/2 psi (0.1 bars) in 24 hours.  ALL PIPING HYDROSTATICALLY TESTED AT PSI FOR HRS. IF NO, STATE REASON DRY PIPING HYDROSTATICALLY TESTED AT PSI FOR PRIVATE REASON DRY PIPING PNEUMATICALLY TESTED AT PSI FOR PRIVATE REASON DRY PIPING PNEUMATICALLY TESTED AT PSI FOR	REDUCING				STATIC	STATIC PRESSURE			PRESS	SURE		FLOW	N RAIE	
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Page 2

## Fire Drill Reports

### FIRE DRILL REPORTS for 2020 Building 3

### 2020

1 <sup>st</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
<b>Days</b> 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
<b>Evenings</b> 2:30pm – <b>11</b> :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
<b>Nights</b> 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
2 <sup>nd</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
<b>Days</b> 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.
<b>Nights</b> 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
3 <sup>rd</sup> 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						
3 <sup>rd</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2 <sup>nd</sup> Shift						
3rd Shift						

4 <sup>th</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2 <sup>nd</sup> Shift						
3 <sup>rd</sup> Shift						
Building 29						
3 <sup>rd</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2 <sup>nd</sup> Shift						
3rd Shift						
4 <sup>th</sup> Quarter	Date/Time Announced/ Unannounced	Problem/Issue	Initial response	Action taken/Incident Commander	# Staff, Client, Visitors	Evacuation Time
1st Shift						
2 <sup>nd</sup> Shift						
3rd Shift						

## 2019/2020 Safety/Security Report

2019-2020 Safety / Security Incident Report

Description/Type				27
Fire Safety	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1st quarter 2020	4th quarter 2019
Smoking Contraband Found	Blue lighter found in the lawn in front of B4	•	<ul> <li>Vape pen found in youth's room</li> <li>2 youth had lighters in their pockets when returning from pass.</li> <li>Cigarette butt found near B3 elevator.</li> <li>Youth had a lighter in pocket after pass.</li> <li>Vape pen found outside in fire exit</li> <li>Vape pen found outside on building wall.</li> <li>Vape pen found in visitor locker room.</li> </ul>	<ul> <li>Juul pod and charger found in youth's room</li> <li>Juul found plugged into computer.</li> <li>Staff found matches and cigarettes outside building</li> <li>Juul and charger found in youth's room.</li> <li>Youth had vape pen after pass, turned into staff.</li> <li>Juul pod found in school bathroom.</li> <li>Juul and charger turned in by youth.</li> <li>A lighter was found on the front pillars of building 3.</li> </ul>
Smoking		30		
Other				
Fire Equipment	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1st quarter 2020	4 <sup>th</sup> quarter 2019
Tampering	•	•	•	Youth pulled the fire alarm in an attempt to escape     Youth punched exit sign and broke it.
Injuries	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1st quarter 2020	4th quarter 2019
Other	Injury Severity 1  O youth behavioral  I youth misc. Staff pulled muscle on back refilling sanitizer solution.  Injury Severity 2  Staff fell in the women's restroom and had 2 seizures, taken by ambulance to ER.	Injury Severity 1      3 youth behavioral     3 youth misc.     Staff member had 5 bug bites on his leg. Saw the bug while at work.	<ul> <li>Injury Severity 1</li> <li>6 youth behavioral</li> <li>3 youth misc.</li> <li>2 youth hitting ping pong balls at each other. Left red marks.</li> <li>Staff had knee pain after kneeling during annual physical assessment.</li> <li>Staff had keys taken from her at YRTC-K, injured her hand.</li> <li>Staff punched in the face 3x while at YRTC-K.</li> </ul>	Injury Severity 1  7 youth behavioral  18 youth misc.  Staff hit in face during basketball.  Staff bent finger playing football.  Injury Severity 2  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  •	<ul> <li>Injury Severity 0</li> <li>Youth sat on chair and tipped it over.</li> <li>Injury Severity 1</li> <li>Youth fell playing basketball and bruised his arm.</li> <li>Youth tripped on sidewalk and fell to his knees scraping them, also twisted ankle.</li> </ul>	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	<ul> <li>Youth slipped on wet spot in the chapel playing basketball.</li> <li>Youth leaned back in chair and fell over backwards</li> <li>Injury Severity 1</li> <li>Youth fell on knee playing basketball. Ice and IB.</li> <li>Youth fell and hit his knee playing basketball.</li> <li>Youth fell playing volleyball and caught himself with hand. Reports pain in hand.</li> <li>Youth fell on knee playing basketball. Abrasion on knee</li> <li>Youth slipped playing basketball, abrasion on knee.</li> <li>Youth fell playing basketball, abrasion on top of his hand.</li> </ul>
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.

32			<ul> <li>Staff received a small cut on his wrist while separating 2 youth.</li> <li>2 youth slapping each other, left red marks.</li> </ul>	<ul> <li>Youth slapped by peer. Had red mark on face. Hotline notified.</li> <li>Youth was hit in face by peer and caused bleeding from the mouth. Hotline notified.</li> </ul>
Abuse/Neglect Hotline		2 youth reported a staff member was making sexually inappropriate comments to them. Investigation complete, employee terminated.	<ul> <li>2 youth injured each other during physical hold.</li> <li>2 youth wrote sexual messages to youth.</li> <li>Youth made comment staff grabbed his genitals.</li> <li>2 youth slapping each other, left red marks.</li> <li>2 youth hitting ping pong balls at each other. Left red marks.</li> </ul>	•
Miscellaneous	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1st quarter 2020	4th quarter 2019
Contraband	<ul> <li>A razor blade knife was found on the street outside the chapel.</li> <li>Youth's room had a school book and green tea in it.</li> </ul>	<ul> <li>Self-tattooing material found in 2 youth's room.</li> <li>Homemade alcohol found in youth's room.</li> <li>Dab scrapper found in youth's belongings before discharge</li> <li>Staff found coffee creamer and a small screw in youth's room.</li> <li>Staff found coffee maker and can of disinfectant in 81 bathroom.</li> <li>Staff found a saw blade with duct tape. Determined to belong to maintenance.</li> </ul>	Nicotine Lozenge found in foyer Youth had broken glass in his room Tobacco pouch found outside. Can of chewing tobacco found outside.	<ul> <li>Youth had cellphone and tried to charge it on TV.</li> <li>Youth had prescribed pills in room. Determined youth was cheeking his meds.</li> <li>Youth had window crank, melted plastic and crushed white substance in room.</li> </ul>
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	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1st quarter 2020	4 <sup>th</sup> quarter 2019
Theft			Auxiliary cord may have been purchased by past employee using state charge card.	<ul> <li>Maintenance shop as broken into and \$2000 of tools and keys were stolen. Locks replaced.</li> <li>Multiple items were stolen from the kitchen area by a dietary staff member. Staff member resigned.</li> </ul>
Damage to state property			<ul> <li>Wardrobe in youth's room had a lot of tagging, was removed.</li> <li>Glass in southeast door cracked. Unknown how it happened.</li> <li>Staff broke windshield wiper off van. Replaced.</li> </ul>	<ul> <li>MP3 player thrown in toilet and ruined.</li> <li>Youth broke broom and then slammed door to his room breaking the door.</li> <li>Multiple computer wires were cut and split in the privacy room at school.</li> </ul>
Internet use/ computer misuse/ HIPAA			•	<ul> <li>Youth got on to unapproved website on his school computer.</li> <li>Youth got on teacher's computer and played music videos.</li> </ul>
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.)	3 <sup>rd</sup> Quarter 2020	2 <sup>nd</sup> Quarter 2020	1 <sup>st</sup> quarter 2020	4th quarter 2019
Elopement			•	Youth kicked out his window and eloped. Was returned by HPD the following day.

Other		2 physical holds     3 physical holds
3 11102		• 2 incidents of youth being • 2 incidents of youth being
		left unsupervised. left unsupervised.
		1 incident of attempted
	(ē	suicide. Youth transported to
		MLH.

# 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

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 **GOOD RETAIL PRACTICES** Supervision Safe Food and Water PIC present, demonstrates knowledge, and IN COMPLIANCE 1 28 IN COMPLIANCE Pasterurized eggs used where required performs duties IN COMPLIANCE 29 Employee Health/Responding to Contamination Events Water and ice from approved source IN COMPLIANCE 2 Management and food employee knowledge, 30 IN COMPLIANCE Variance obtained or specialized processing methods IN COMPLIANCE 3 Proper use of restriction and exclusion Food Temperature Control Good Hyglenic Practices Proper cooling methods used; adequate 31 IN COMPLIANCE Proper eating, tasting, drinking, or tobacco IN COMPLIANCE equipment for temperature control 4 use IN COMPLIANCE 32 Plant food properly cooked for hot holding IN COMPLIANCE 5 No discharge from eyes, nose, and mouth IN COMPLIANCE Approved thawing methods used 33 Control of Hands as a Vehicle of Contamination IN COMPLIANCE A IN COMPLIANCE Hands clean properly washed 34 Thermometers provided and accurate 7 IN COMPLIANCE No bare hand contact with RTE foods or a Food Identification pre-approved alternate properly followed IN COMPLIANCE 35 Food properly labeled; original container Adequate handwashing sinks, properly 8 IN COMPLIANCE Prevention of Food Contamination supplied and accessible IN COMPLIANCE Insects, rodents and animals not present Approved Source 36 9 IN COMPLIANCE Food obtained from approved source IN COMPLIANCE Contamination prevented during food 37 10 NOT OBSERVED Food received at proper temperature preparation, storage and display Food in good condition, safe, and 11 IN COMPLIANCE IN COMPLIANCE Personal cleanliness: hair restrained 38 unadulterated Required records available: shellstock tags, 12 NOT APPLICABLE 39 OUT OF COMPLIANCE Wiping cloths; properly used and stored parasite destruction IN COMPLIANCE Washing fruits and vegetables Protection from Contamination 40 13 IN COMPLIANCE Food separated and protected Proper Use of Utensils IN COMPLIANCE 41 In-use utensils; properly stored 14 IN COMPLIANCE Food-contact surfaces: cleaned sanitized Utensils, equipment and linens; properly IN COMPLIANCE IN COMPLIANCE Proper disposition of returned, previously 42 15 served, reconditioned, and unsafe food stored, dried, handled IN COMPLIANCE Single-use/single-service articles; properly 43 Time Temperature Control for Safety Food (TCS Food stored, used 16 NOT OBSERVED Proper cooking time and temperatures IN COMPLIANCE 44 Gloves used properly 17 NOT OBSERVED Proper reheating procedures for hot holding Utensils, Equipment, and Vending 45 OUT OF COMPLIANCE Food and non-food contact surfaces NOT OBSERVED 18 Proper cooling time and temperatures cleanable, properly designed, constructed, 19 NOT OBSERVED Proper hot holding temperatures and used IN COMPLIANCE IN COMPLIANCE Warewashing facilities, installed, maintained, 20 Proper cold holding temperatures 46 used, test strips IN COMPLIANCE 21 Proper date marking and disposition 47 IN COMPLIANCE Non-food-contact surfaces clean NOT APPLICABLE Time as a Public Health Control: procedures 22 and records Physical Facilities onsumer Advisory 48 Hot and cold water available: adequate IN COMPLIANCE Consumer advisory provided for raw or pressure 23 NOT APPLICABLE undercooked food 49 IN COMPLIANCE Plumbing installed; proper backflow devices Highly Susceptible Population 50 IN COMPLIANCE Sewage and waste water properly disposed Pasteurized foods used; prohibited foods not 24 NOT APPLICABLE offered Toilet facilities: properly constructed, IN COMPLIANCE 51 Food/Color Additives and Toxic Substances supplied, clean NOT APPLICABLE 25 Food additives: approved and properly used 52 IN COMPLIANCE Garbage and refuse properly disposed; facilities maintained Toxic substances properly identified, stored, 26 IN COMPLIANCE and used; held for retail sale, properly stored 53 IN COMPLIANCE Physical facilities installed, maintained, and

Compliance with variance, specialized

process, ROP criteria or HACCP plan

Conformance with Approved Procedures

**NOT APPLICABLE** 

IN COMPLIANCE

54

clean

areas used

Adequate ventilation and lighting; designated

TEMPERA	ATURE OBS	SERVATIONS	STAFFING/RECORDS REQUIREMENTS
FOOD PRODUCT	° F	LOCATION	Food Handler Permits IN COMPLIANCE
Milk	39	Cooler (reach-in)	Permit Records IN COMPLIANCE

		7	VIOLAT	ION DETAIL		
Code Priority Lev Location	Critical el Ris	Repeat k Factor	Violation Description Remarks Food Code Citation		Correct	ted Correct By
3-304.14			Wiping cloth bucket of sanitizer chlorine between 50-100PPM.	solution measured too strong. Apply	✓	CORRECTED
		RF 39	Cloths in-use for wiping counters a in a chemical sanitizer solution at a daily as specified under 4-802.11	nd other equipment surfaces shall be: (1) a concentration specified under § 4-501.11 (D).	Held betwe 4; and(2) L	en uses aundered
4-501.11			Dishmachine with thick lime de dispenser with corrosion as wel	posits on doors and top. Water/ ice		11/28/2019
		RF 45	Equipment shall be maintained in specified under Parts 4-1 and 4-2.	a state of repair and condition that meets	the requirer	ments
Remarks	:					
33846933 Printed 10/2			ם كفترة الأراز فارزر مصنات وروو وروو وروو روو وروو وروو وروو ورو	M 4(1) (1) (1) (4) (4) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	☐ Foll	ow-up
<i>C</i>		) //		Glow		
Environmental Health Specialist		Received by Person-In Ch	arge			
DAVE VOBORIL, REHS, CP-FS 65 dvoboril@lincoln.ne.gov (402) 441-8633			•	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

LINCOLN NEBRASKA

**BUILDING & SAFETY DEPARTMENT Bureau of Fire Prevention** 

555 S. 10th St., Suite 203, Lincoln, NE 68508



lincoln.ne.gov P: 402-441-7521						
Occupancy Class Instituted	License Number 1900171					
Occupancy Class INSTITUTE CO	License Number					
Address DCC Radici H ST						
Name of Business You W Sevuces C	enter					
Date of Inspection 8 27 2020 App	proved Occupant Load 45 beds					
FACILITY EVA	ACUATION CAPABILITY —— LOCATION ———					
□ Small	☐ Prompt ☐ Above Grade					
☐ Large ☐ New ☐ Remodeling	☑ Slow ☐ Below Grade ☐ Impractical ☑ Grade					
☐ Hemodeling ☐ Licensing Change	# of Storles					
All Code Numbers from	n 2012 101 Life Safety Codes					
Yes No N/A EXITS	Yes No N/A ALARM SYSTEMS					
☐ ☐ Unobstructed 33.3.2.1 ☐ ☐ Properly Identified 33.3.2.1 ☐ ☐ Proper door swing 33.3.2.1	Required alarm system 33.3.3.4.1 Properly maintained 33.3.3.4.1 Properly maintained 33.3.3.4.1 Sprinkler system (if required) 33.2.3.5.2 Approved range hood system 9.7.3					
Proper door swing 33.3.2.1	Sprinkler system (if required) 33.2.3.5.2					
☐ ☐ Emergency tighting (If required) 33.3.2.9 ☐ ☐ Generator 2012 IFC 604	☐ ☐ Ø Approved range hood system 9.7.3 Ø ☐ ☐ Carbon monoxide alarms 9.8					
MISCELLANEOUS	FLOOR SEPARATION					
🔟 🗓 Mechanical rooms in compliance 33.2.3.2	☐ ☐ ☑ Primary means escape 33.2.2.2.1					
☑ □ Storage areas in compliance 33.2.3.2 ☑ □ Housekeeping 33.3.2.5	Bedroom egress windows 33,2,2,3 Smoke detectors 33,3,3,4,7					
☐ ☐ Room Doors closes/latches 33.2.3.6.3	Rating between floors 33.2.3.1.1					
Blegal cords, splices, makeshift 605.5 2012 IFC 605						
GAS APPLIANCES  Approved venting 33,2,5,2,1	LARGE FACILITIES ONLY					
Approved venting 33.2.5.2.1  Approved installation 33.2.5.2.1	FIRE EXTINGUISHERS					
HAZARDOUS AREAS	Approved size 9.7.4.1  Approved type 9.7.4.1					
☑ □ □ Meets rating requirements 33.2.3.2	Properly maintained 9.7.4.1					
☑ ☐ Door closes/latches 33.2.3.2 ☑ ☐ ☐ Corridor penetrations 33.2.3.6.2	TRAVEL DISTANCE TO EXITS					
·	🗀 🗀 Under 75 feet 33,3,2.6.1					
EMERGENCY PLANNING  Safety & Evacuation Plan 33.7.1	Under 125 feet (sprinkled) 33.2.6.1	000				
☑ □ Fire drills 33.7.3	Approved	22 2000				
_Z □ □ Training 33.7.2	Approved 9	(AA)				
1.1	La contract (acc continents)	(XIII)				
COMMENTS: PI.V tamper still not	working					
	2					
A <del>-11 - 12 - 12 - 12 - 12 - 12 - 12 - 12 </del>						
You are ordered to comply with all 'No' items by the following date: 10 37 30 30 in accordance with						
provisions of the Regulations Promulgated by the Neb and Like Emergencies.	oraska State Fire Marshal, governing Safety to Life from Fire	9				
,) //:/	2/2/22					
FIRE INSPECTOR: Lin Helger	Date: 8/37 (303C)	}				
1						

## **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	11	100%	100%
179510	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

Sent: Monday, February 8, 2021 12:39 PM

To: Jacobe, Camella <

Subject: RE: Ombudsman's Contact

B is 0 (we didn't have any assaults during 2020)

C -I don't have anything.

### JoDeen Swartz

CHILDREN & FAMILY SERVICES

Nebraska Department of Health and Human Services

DHHS.ne.gov | Facebook | Twitter | Linkedin

From: Jacobe, Camella

Sent: Monday, February 8, 2021 12:34 PM

To: Swartz, Jodeen

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

Sent: Friday, February 5, 2021 12:26 PM

To: Jacobe, Camella

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

## **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:

DHHS.ne.gov | Facebook | Twitter | Linkedin

From: Jacobe, Camella

Sent: Wednesday, February 17, 2021 3:07 PM

To: Jacobe, Camella <

Subject: RE: Ombudsman information

Camella Jacobe | State Compliance Coordinator

**CHILDREN & FAMILY SERVICES** 

Nebraska Department of Health and Human Services

OFFICE:

DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Zoeller, Kenny

Sent: Friday, February 12, 2021 2:32 PM

To: Jacobe, Camella <

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**

LaFlesche

### 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	8		8
DESIGNATED TIME: 1217		, E	
EXIT: 12/8		10	
NUMBER OF STUDENTS: 3			
NUMBER OF STAFF:		3	
CONDUCTED BY: SO Boo			
COMMENTS:		3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	
V V			

# Standards Compliance Reaccreditation <u>Audit</u>

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 30<sup>th</sup> 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, upto-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, 1<sup>st</sup> shift; Steven Marten, Youth Program Specialist II, 3<sup>rd</sup> shift; Jamar Love, Youth

Security Supervisor, 3<sup>rd</sup> 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**

Juvenile Correctional Facilities, 4 <sup>th</sup> Edition
2016 Standards Supplement
Youth Rehabilitation and Treatment Center – Kearney
July 8 – 10, 2020
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
	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	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
Assaults	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

<sup>\*</sup>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.  Data Collection		100%

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		
(11)	Outcome Measures  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.  HIV	0	
	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)	the past 12 months.  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		

	AT 1 01 11 11 11 1		
(19)	Number of juveniles testing positive for Hepatitis A,B, and C in the past 12 months divided by the number of tests		0%
	administered in the past 12 months.		
(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		
	* * * * * * * * * * * * * * * * * * * *		

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		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	
В		Quality Review		
		Outcome Measures		
	(1)	Number of health care issues/problems identified by internal review that were corrected in the past 12 months divided		0%
		by the number of problems identified by internal review in the past 12 months.  Data Collection		

		37 1 C 1 / 11 11 11 10 1		
		Number of issues/problems identified by internal review in the past 12	0	
		months.		
		Number of issues/problems identified		
		by the internal review in the past 12	0	
		months that were corrected.		
		Grievances Related to Health Care		
		Outcome Measures		
		Number of juvenile health related		
		grievances found in favor of the		
	(2)	juvenile in the past 12 months divided		14%
		by the number of health related		
		grievances filed in the past 12 months.		
		Data Collection		
		Number of juvenile health related	01	
		grievances filed in the past 12 months.	21	
		Number of juvenile health related		
		grievances found in favor of the	3	
		juvenile in the past 12 months.		
		Health Related Lawsuits		
		Outcome Measures		
		Number of health related lawsuits filed		
		by or on behalf of juveniles found in		
	(3)	favor of the juvenile in the past 12		0%
		months divided by the number of		070
		lawsuits filed in the past 12 months.		
		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	0	
		in the past 12 months.	J	
С		Death in Custody		
		Outcome Measures		
		Number of juvenile deaths in custody in		
		the past 12 months divided by the		0.5
	(1)	average daily population in the past 12		0%
		months.		
		Data Collection		
		Number of juvenile deaths that were		
		medically expected in the past 12	0	
		months.	Ü	
		III VII VIII VIII VIII VIII VIII VIII		

Number of juvenile deaths that were medically unexpected other than injury, suicide and /or homicide in the past 12 months.  Number of juvenile deaths due to injury in the past 12 months.  Number of juvenile deaths due to suicide in the past 12 months.  Sexual Assaults  Outcome Measures  Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.  Data Collection  Number of juvenile(s) alleging sexual assault in the past 12 months.  Data Collection  Number of juvenile(s) alleging sexual assault in the past 12 months.  D Health Care Staffing  Outcome Measures  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.  Data Collection  Number of physician full-time equivalent position(s).
in the past 12 months.  Number of juvenile deaths due to suicide in the past 12 months.  Sexual Assaults  Outcome Measures  Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.  Data Collection  Number of juvenile(s) alleging sexual assault in the past 12 months.  Description of juvenile(s) alleging sexual assault in the past 12 months.  Description outcome Measures  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.  Data Collection  Number of physician full-time
suicide in the past 12 months.  Sexual Assaults  Outcome Measures  Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.  Data Collection  Number of juvenile(s) alleging sexual assault in the past 12 months.  Description of juvenile(s) alleging sexual assault in the past 12 months.  Description of juvenile(s) alleging sexual assault in the past 12 months.  Description 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.  Data Collection  Number of physician full-time
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Outcome Measures  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 (1) 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.  Data Collection  Number of physician full-time
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.  Data Collection  Number of physician full-time
Number of physician full-time
Number of physician vacancies in the past 12 months .
Number of full-time equivalent practitioner position(s).
Number of practitioner vacancies in the past 12 months.
Number of full-time equivalent dentist position(s).
Number of dentist vacancies in the past 12 months.
Number of full-time equivalent nursing (RN) positions(s).
Number of nursing (RN) vacancies in the past 12months.

	Number of full-time equivalent nursing (LPN, LVN) position(s).	1	
	Number of nursing (LPN, LVN)	0	
	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	14	
	needed to provide adequate health care		
	in the past 12 months.		
	Qualified Staff		
	Outcome Measures		
	Number of staff with lapsed licensure		
	and/or certification in the past 12		
(2)	months divided by the number of		0%
	licensed and/or certified staff in the past		
	12 months.		
	Number of specified health care		
	positions with a written job description		
(3)	divided by the number of specified		100%
	health care positions in the past 12		
	months.		
	Data Collection		
	Number of staff requiring a license		
	and/or certification (include physician,		
	psychiatrist, physician assistant, nurse	13	
	practitioner, R.N., L.P.N., psychologist,	15	
	et. al. therapists requiring licensure in		
	the past 12 months.		
	Number of lapsed licensure and/or		
	certification (include physician,		
	psychiatrist, physician assistant, nurse	0	
	practitioner, R.N., dentist, psychologist,	Ü	
	et al. therapist requiring licensure) in		
	the past 12 months.		
	Number of specified health care	14	
	positions in the past 12 months.		
	Number of specified health care	1 4	
	position with a written job description	14	
	in the past month.		
	Fair Treatment of Staff		
	Outcome Measures		
	Number of health care staff grievances		
(4)	decided in favor of staff in the past 12		00/
(4)	months divided by the total number of		0%
	health care staff grievances filed in the		
	past 12 months.		

	(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	
Е		Mental Health		
		Outcome Measures		

		Number of intake mental health		
		screenings (intersystem or intrasystem)		
	(1)	completed at admission in the past 12		98%
	(-)	months divided by the number of		, , , ,
		admissions in the past 12 months.		
		Number of juveniles receiving a mental		
		health appraisal in the past 12 months		
	(2)	divided by the number of admissions in		98%
		the past 12 months.		
		Number of juveniles with a Mental		
	(2)	Health Treatment Plan in the past 12		1000/
	(3)	months divided by the number of youth		100%
		requiring ongoing mental health		
		intervention in the past 12 months.		
	(4)	Number of suicide attempts divided by		00/
	(4)	the average daily population in the past		0%
		12 months.		
	( - C	Number of completed suicides divided		0.5.
	(5)	by the average daily population in the		0%
		past 12 months.		
		Data Collection		
		Number of juveniles receiving a mental		
		health screening at admission	103	
		(intrasystem and intersystem) in the	103	
		past 12 months.		
		Number of juveniles receiving mental		
		health appraisals within the past 12	103	
		months.		
		Number of intrasystem transfers within	0	
		the past 12 months.	U	
		Number of intersystem transfers within	0	
		the past 12 months.	<u> </u>	
		Number of juveniles requiring ongoing		
		mental health intervention in the past 12	53	
		months.		
		Number of juveniles with a mental		
		health treatment plan in the past 12	53	
		months.		
		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		
		O GOODING THOUSUION		

(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**

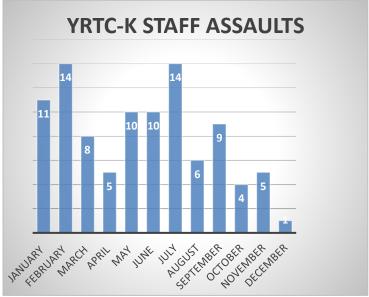
Staffing Levels
Staff Assaults

Attachment K2

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

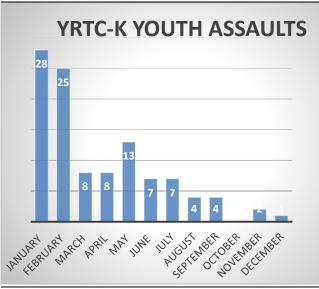
Job Code	Position	Filled	Vacant	Total	Vacancy %	2020 TO %
A19211	ACCOUNTANT I	1	0	1	0%	0%
S19112	ACCOUNTING CLERK II	1	0	1	0%	0%
V09121	ADMINISTRATIVE ASSISTANT I	1	0	1	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	0%	0%
V09212	BUSINESS MANAGER II	1	0	1	0%	0%
V72460	CLINICAL PROGRAM MANAGER	1	0	1	0%	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%
175013	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%	
177042	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	SECRETARYI	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

# Division of Public Health FOOD ESTABLISHMENT INSPECTION REPORT

Good	Life.	Great	Mission.
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DEPT, OF HEALTH AND HUMAN SERVICES

Firm: West Kennney High (YATE)	
Address: 2 70 2 30 H AVE	
City: Learney, NE	

Firm ID: 10 - 15	Inspector Code:			
Facility Codes:	Inspection Date:			
	9-17-20			

#### **Good Retall Practices**

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

	Good Relain Facilities are preventative modellies to se	R		Proper Use of Utensils	С	R			
Safe Food and Water C			K			-	- 1		
28	Pasteurized eggs used where required			41	In-use utensits; properly stored				
29	Water & ice from approved source			42	Utensils, equipment, & linens; properly stored, dried & handled				
30	Variance obtained for specialized proessing methods			43	Single-use & single-service articles; properly stored & used				
Food Temperature Control			44	Gloves used properly					
Proper cooling methods used; adequate equipment for temperature control				Utensils, Equipment, and Vending					
32	Plant food properly cooked for hot holding			45	Food & non-food contact surfaces cleanable, properly designed, constructed & used				
33	Approved thawing methods used			46	Warewashing facilities; installed, maintained, & used; test strips				
34	Thermometers provided & accurate			47	Non-food contact surfaces clean				
	Food Identification			Physical Facilities					
35	Food properly labeled; original container			48	Hot & cold water available; adequate pressure				
	Prevention of Food Contamination			49	Plumbing installed, proper backflow devices				
36	Insects, rodents, & animals not present; no unauthorized persons			50	Sewage & waste water properly disposed				
37	Contamination prevented during food preparation, storage, & display			51	Toilet facilities; properly constructed, supplied & cleaned				
38	Personal cleanliness; hair restraints			52	Garbage & refuse properly disposed, facilities maintained				
39	Wiping cloths; stored in sanitizing solution and properly used			53	Physical facilities installed, maintained, & clean				
40	Washing fruits & vegetables washed prior to use			54	Adequate ventilation & lighting; designated areas used				

Critical X	Item #	Code Reference	Violation Description/Remarks/Corrections
			perforgention logs - current on Cliphond - prior
			in folder file
			Dishwasher temp log- current on clipbond. prior
			in tolder / file
1			
			Food teaps Rucumbed on Daily Production Records
			For Brickfust / Lines / Dinner. Found some dr
			stant keeping throwologically. New mant will
			Short Kuping Chronologically.
			Cooling logs. Not Savergray TCS toods at this to
		1/4	CURRENTLY Not MAINTAINING A RECEIVing log Thrance
		X	Currently Not Mountaining a Receiving log Threads Calibration log or Danged Discarded log New
			pagent will stant using/mintaining these
		**	1.5

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

## Division of Public Health SEND IN MISSING forms for Murch FOOD ESTABLISHMENT INSPECTION REPORT

Good Life. Great Mission. DEPT. OF HEALTH AND HUMAN SERVICES

Address: 7832 30th A	
	V K
City: Legame / NE	

Firm ID: 15	Inspector Code:
Facility Codes:	Inspection Date:

City: 3-12-20									.0						
Unl	Unless otherwise stated, violations cited in this report shall be corrected within a period not to exceed 10 calendar														
day	s for critical items (§	8-405.11) or 90 days for	noncritical items (§8-	406.	11).				Regular		stigati	on: 4			
VIO	LATIONS: CRITIC	AL:	NON	CRI	TICA	L:			Follow-up Complain		er: 5				
				-		<u>.                                    </u>	.4**					=			
Temperature Observations															
	Food Product	Food Broduct-	Location				Food Product	Product Te	Product Temp.		Location				
Bext/1003les 188,2			Shean tab	سا	-										
		÷													
	Foodborne Illness Risk Factors and Public Health Interventions														
Circ IN=	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		Compliance Status					С	R		
		Demonstration of Knowle	dge				Potenti	ally Hazardous F	ood Time	Temperature					
1	DV OUT					16	IN OUT N/A N/O	Proper cooking t	ime & tem	perature					
Employee Health						17	IN OUT N/A N/O	Proper reheating	procedure	es for hot holding					
2	Foodborne Illness Risk Factors and Public Health Interventions  Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item N=in compliance OUT=not in compliance N/O=not observed N/A=not applicable  Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Compliance Status  C R Potentially Hazardous Food Time/Temperature  IN OUT N/A N/O Proper cooking time & temperature  Employee Health  IN OUT N/A N/O Proper reheating procedures for hot holding  Employee Health  IN OUT N/A N/O Proper cooling time and temperatures  B IN OUT Proper use of reporting, restriction & exclusion  Good Hygienic Practices  20 (IN)OUT N/A N/O Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures  Proper cold holding temperatures														
3	IN OUT	Proper use of reporting, res	striction & exclusion			19	INDOUT N/A N/O	Proper hot holdis	ng tempera	itures					
	7%	Good Hygienic Practice	8			20	(IN)OUT N/A	Proper cold hold	ing temper	ratures					
4 IN OUT N/O Proper eating, tasting, drinking, or tobacco use						21	IN OUT N/A N/O	Proper date man	king and d	isposition					

		Demonstration of Knowledge			Potenti	ally Hazardous Food Time/Temperature			
1	<b>№</b> оит	Certification by accredited program, compliance with code, or correct responses		16	IN OUT N/A N/O	Proper cooking time & temperature			
	~ * *	Employee Health		17	IN OUT N/A N/O	Proper reheating procedures for hot holding			
2	IN OUT	Management awareness; policy present		18	IN OUT N/A N/Q	Proper cooling time and temperatures			
3	IN OUT	Proper use of reporting, restriction & exclusion		19	INDOUT N/A N/O	Proper hot holding temperatures			
	The state of the s	Good Hygienic Practices		20	(IN)OUT N/A	Proper cold holding temperatures			
4	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		21	IN OUT N/A N/O	Proper date marking and disposition			
5	NO TUO	No discharge from eyes, nose & mouth		22	IN OUT NANO	Time as a public health control; procedures & record			
	Pi	reventing Contamination by Hands				Consumer Advisory			
6	M OUT NO	Hands clean & properly washed		23	IN OUT NA	Consumer advisory provided for raw or under cooked foods			
7	(IN) OUT N/A N/O	No bare hand contact with RTE foods				Highly Susceptible Populations			
8	IN OUT	Adequate handwashing facilities supplied & accessible		24 (	IN OUT N/A	Pasteurized foods used; prohibited foods not offered			
		Approved Source				Chemical			
9	INPOUT	Food obtained from approved source		25	IN OUT N/A	Food additives; approved & properly used			
10	IN OUT N/A NO	Food received at proper temperature		26	IN OUT	Toxic substances properly identified, stored & used			
11	IN OUT	Food in good condition, safe & unadulterated			Con	formance with Approved Procedures			
12	IN OUT N/A /O	Required records available; shellstock tags, parasite destruction	4	27	A/N TUO NIC	Compliance with variance, specialized process, & HACCP plan		X	
		Protection from Contamination			IN OUT N/A	Ventilation adequate in dry storage to maintain ideal temperatures			
13	A'M TUO (AP	Food separated & protected			IN OUT N/A	Thermometer in dry storage areas			
14	INDOUT N/A	Food-contact surfaces; cleaned & sanitized			IN DUT N/A	Locks on all storage areas to prevent pilferage			
15	IN OUT	Proper disposition of returned, previously served,							

	Tecondia	Cit, bilisale tood	
Critical X	Item #	Code Reference	Violation Description/Remarks/Corrections
			Y HACEP RECORDS CHECK &
×	27	7-201.14	nissing parts of Hacepaquials Papanwork
			MACCP Binden with Food Sulety Program.
			Program / Facility Overview + 5.0. P.'s
796			Food Safety checklist - management requires weekly
			WAS done for JAN, FOB 2020 - hand to tell PAIDR MON
llow-up			HACCP REGIONES AT WASH UNCE PER MANTE.

Yes 1 No 2

Received 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

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.

James Orme, Food Service Director

3/12/2020

Date