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ANNUAL REPORT

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

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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 December 15 each year beginning in 2021, for the period beginning with December 1 of the prior year through November 30 of the then-current year[1] on the condition of such DHHS state institutions. This report provides for the summary of the Ombudsman's Office efforts 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 reporting requirement is one of the statutory responses to the crisis that unfolded at the YRTC-Geneva in August of 2019. This crisis necessitated the sudden relocation of the female youth being served there to YRTC-Kearney, a facility that served male youth up until that point, due to the seriously poor conditions of YRTC-Geneva. [2] In the year leading up to the crisis, the Ombudsman's Office received a total of three complaints regarding youth residing at YRTC-Geneva: two complaints in October 2018 about the school and one complaint in February 2019 about a youth's desire for a 60-day notice. No complaints were received about the conditions of the institution.

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

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

For the Nebraska Legislature to continue its role in guiding and facilitating the goal of improving not only the YRTC-system, but all state institutions under DHHS, the legislature expressed its mandate for the Ombudsman's Office to assist with changes that strengthen agency effectiveness and highlight the quality of care to those Nebraskans residing in our state facilities through this report.

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 ongoing COVID pandemic, multiple visits continued to be 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 this time, there were periods in which the office delayed visits to state institutions that reported positive cases of COVID. When it was necessary to visit facilities, Ombudsman personnel wore personal protective masks. The COVID-19 public health pandemic posed significant challenges for DHHS program operations. Like other facilities throughout the country, these challenges, while unprecedented, created management issues with organizing facility resources and maintaining many provided services, treatments, and programs to the youth, individuals, and patients under their care. All 24-hour facilities should be recognized for their tremendous efforts.

Given the COVID-19 pandemic, oversight responsibilities are paramount, as the need to change facility operations because of the unprecedented times have a serious impact on public health and the safety of facilities. Consequently, during this reporting period, COVID-19 related issues were at the forefront. The Ombudsman's Office focused on data and site reviews examining the effectiveness of facilities' public health response through an independent and objective lens. The Ombudsman's Office has observed and learned a great deal related to COVID and changes in operations for the DHHS 24- hour facilities. There were facilities that transparently identified deficiencies in operations due to the pandemic. Discussions should continue within the leadership of DHHS to help with identifying and implementing policy options that can strengthen the DHHS Institution system for the next crisis and beyond.

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

Included in this report is documentation related to how each DHHS facility has managed during these COVID-19 times.

Here are the highlights of each of the DHHS facility operations over the past year:

The YRTC-Geneva facility was closed during this reporting period. It went through the Vacant Buildings and Excess Land Process (VBEL), which involves the sale and disposition of buildings and land declared in excess. The Department of Administrative Services on behalf of the Department of Health and Human Services requested to declare the following land and structures vacant and surplus to the needs of the agency. The Ombudsman's Office attended the open meeting for the process implemented by the Department of Administrative Services (DAS) on July 21, 2021 (See attachment M1). The recommendation by the VBEL committee was that the campus be transferred through selling the property from the state to another entity that agrees to work with DHHS in allowing it to continue utilizing the Administration building.

The Hastings Regional Center was repurposed and begin operating as Youth Rehabilitation and Treatment Center-Hastings. The female youth being housed at YRTC-Kearney, a facility meant for male juveniles, were transferred to the Hastings campus as it began its YRTC programming for females in a new building.

The DHHS, Division of Behavioral Health entered into a contract with Myers and Stauffer LC on December 8, 2020 (See attachment M2). The contract was scheduled to end on December 7, 2021. The purpose of the contract was to have Myers and Stauffer provide a comprehensive resource evaluation for the Beatrice State Development Center, the Lincoln Regional Center, and the Norfolk Regional Center. The scope of the contract included conducting stakeholder engagement, the development of actionable redesign recommendations, the performance of a comprehensive system assessment, and the production of a detailed plan for the redesign of three Nebraska state-owned and operated facilities. The Ombudsman's Office is waiting for its requested copy of the report.

DHHS submitted their Youth Rehabilitation and Treatment Center Kearney, Facility-Wide Site Evaluation & Cost Analysis Report to the Legislature on November 22, 2021.[4] The Ombudsman's Office continues to review this report for issues that may need to be addressed by the office.

The following report is organized by institutions under "Behavioral Health" which are hospitals or other licensed facilities, and institutions under the "Office of Juvenile Services" which includes all of the Youth Rehabilitation and Treatment Centers (YRTCs). Those listed under

[4] "The Youth Rehabilitation and Treatment Center Kearney Facility-Wide Site Evaluation & Cost Analysis Report" submitted to the Legislature by the Nebraska Department of Health and Human Services, November 22, 2021. https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/768_20211122-085100.pdf

"Behavioral Health" are those that statutorily[5] fall within the Division of Developmental Disabilities (Beatrice State Developmental Center) and within the Division of Behavioral Health (Public Psychiatric Hospitals) which include the Lincoln and Norfolk Regional Centers. Within the Lincoln Regional Center's organization is the adolescent sex offender program (psychiatric residential treatment facility or PRTF) at 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 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.

[5] Neb. Rev. Stat. §81-3116.

BEHAVIORAL HEALTH FACILITIES

HOSPITAL OR LICENSED STATE INSTITUTIONS

BEATRICE STATE DEVELOPMENT CENTER (BSDC)

The Beatrice State Development Center (BSDC) is a state institution licensed as an intermediate care facility 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.

While most buildings on the campus are being utilized, a few appear to no longer be in use or limited to storage and sit vacant. As should be expected, a campus as old as BSDC (over 130 years) has many buildings or structures on it that are dated. As a result, there are noticeable construction projects throughout the campus. 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, and a common area for individuals, and a laundry room. The crisis stabilization unit provides an important program for individuals and other stakeholders on campus. 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 four different wings and generally houses one to three individuals per wing, depending on the individual's needs.

Site Visit:

Several site visits were made to this facility in 2021. 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 individuals' housing needs, dining, medical services, administrative services, religious functions, and recreation. General cleanliness of all the homes was observed and individual rooms were fairly organized and clean.

During the July site visit, the grounds were accessed through the main public entrance to the campus, where there was noticeable construction going on throughout the campus. Observation of remodeling in the living cottages occurred and concrete work around campus continued during this reporting period. The campus appeared to be operational in terms of individuals being allowed off-campus. Individuals were in the community for activities and being escorted throughout campus. There were no COVID cases at this time and COVID precautions had been relaxed.

Based on observation, it appears that sidewalk project to the living cottages are completed. Observation of several patios in front of the cottages appeared to be recently completed as well. Current work was being done on campus. The work was being performed by the City of

Beatrice. The scope of the water entailed putting in a new water line as part of BSDC's campus annexation to the city.

Cottage 411 has been converted to a transition unit for the crisis stabilization program side. There was some painting being done on the exterior building and the pouring of cement for a patio. Generally, individuals who are most likely not to transition back to the community in 180 days are housed in 411. Typically, staffing levels are higher in this area.

The Lake Street building is housing for individuals going off-campus for work. There are 4 units that accommodate four individuals-for a total of 16 individuals. It is a Co-ed building. DHHS made the decision to close Lake Street, as it has recently been noted that the building is not in the best of shape and not ADA compliant. Additionally, the move helps to have people in places to ensure all resources are close by to provide a high level of quality care. The plan was to disperse individuals who were currently living at Lake Street to other buildings throughout the campus.

Major Projects:

There are major projects currently in progress. One such project is the ADA improvement project. This project entails improving sidewalks leading up to living cottages. DAS has indicated that the ADA project is still in progress (See Attachment B1).

The Nebraska State Building Division is working to implement a new work order system. The new system will be able to track preventative maintenance orders. The new system should be introduced by the end of 2021.

Health Surveys:

Based on the documentation provided, health 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 B2 through B4).

Staffing:

Like many facilities throughout Nebraska, BSDC continues to struggle with staffing levels. Various recruitment efforts are being pursued. Efforts range from job fairs, agency staff being used for nursing and direct support, to booths being staffed at community events. While creative approaches to recruit and retain staff are ongoing, the facility still experiences staffing shortages.

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment B5). There were 26 reported staff injuries due to Individual Aggression/Behavioral of Individuals this reporting period. No assaults on staff were result of a use of force event.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*****.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments B6).
2. ***There is a defined work order system utilized by DAS and DHHS to assure minor construction projects are identified, tracked, and completed. With regard 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*****.** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

For this reporting period, the Ombudsman's Office received contact from staff and individuals. Complaints reported about BSDC pertained to staff shortages, working conditions, safety, and other reported issues concerned management**.** Staffing is a challenge at BSDC and is an ongoing issue that the Ombudsman's Office is following closely.

Issues identified for possible review in the next reporting period*:*

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. Issues identified in reports received by the Office of Public Counsel (See attachments B7 and B8, Inspection and License report respectfully), including staffing levels, retention rates, and turnover.

LINCOLN REGIONAL CENTER (LRC)

The Lincoln Regional Center (LRC) is a 250-bed hospital licensed as a Mental Health Substance Use (MHSU) Treatment Center and Psychiatric Hospital. The psychiatric hospital license expires 12/31/2021. The MHSU License expires 9/30/2022 (See Licenses, Attachment L1). License renewals are expected.

LRC serves individuals in need of general and forensic psychiatric services and provides services to people who, because of mental illness, require a highly structured treatment setting. The primary mission of the psychiatric services program is to help individuals stabilize and transition back to the community. It also serves individuals in need of sex offender services who have a history of sexually deviant behaviors.

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. 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.

Site Visit:

Several visits were made to this facility in 2021. 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. Building 10 is not occupied at this time, due to what is known as the "ligature project" — a remodeling project to remove places where something could be tied or bound (detailed below). Therefore, only three buildings are being used for patient care.

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 most other state institutions in that most services can be provided to a patient without transportation out of their assigned building at the regional center. The campus has structures for individuals' housing needs, dining, medical services, administrative services, religious functions, and recreation.

Due to the ligature mitigation project and the addition of the COVID-19 pandemic, available space became an issue at LRC. Repurposing of areas such as the gymnasium for newly admitted patients while waiting for COVID testing was incorporated for care space. This challenge also impacted those waiting for services at the hospital. The waiting list increased during this reporting period. The changes in operations were noticeable and drove patients' complaints to our office.

Major project/s:

As referenced in last year's annual report, in September of 2019, the Joint Commission (J-Co), the accreditation body for the 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 housing units for a diverse range

of patients. 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.

As of this reporting period, LRC continues to operate under its mitigation plan to improve overall patient cares spaces. The construction project, generally referenced as the Ligature Project, was launched on January 11, 2021, and is scheduled to be completed in March 2022.

As noted in the site visit section above, Building 10 is unoccupied due to the litigation project. It is expected that building 10 will be completed by January 2022. The facility administrator hopes to move patients from Building 3 into Building 10 around the 1st week of January. It is reported by State Building Division that the Ligature Project is nearly completed and expected to be substantially completed by the end of 2021. See the attached list (Attachment L2), of other major projects that are all nearly completed and expected to be substantially completed by the end of 2021.

Health Surveys:

Health surveys conducted at BSDC by The Joint Commission and DHHS Public Health-Licensure Unit were documented. 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 LRC based on these findings are attached. (See Attachments L3).

LRC was granted by The Joint Commission, the accrediting body, an accreditation decision of Accredited for all services surveyed under the manual for Hospital and Behavioral Health Care. This accreditation cycle was effective September 19, 2019, and is customarily valid for up to 36 months (See Attachment L4).

Staffing:

Like all 24-hour state facilities throughout Nebraska, LRC continues to struggle with staffing levels. Various recruitment efforts are being pursued. These efforts range from job fairs, agency staff use, and other creative ideas. While creative approaches to recruit and retain staff have been used, the facility is still experiencing staffing shortages.

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment L5). There were 51 patient-to-staff assaults this reporting period. Staff injury incidents occurring during the application of patient seclusion or restraints are not considered assaults and are referred to as seclusion or restraint-related injury incidents by LRC.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments L6).

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.*** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

The Ombudsman's Office received over 50 reports of complaints about LRC, mostly from the patients themselves, but some from staff and families as well, for this reporting period. These complaints ranged from COVID concerns to operational-change complaints due to the ligature mitigation plan to reasons of placement at LRC. Staffing remained a challenge at LRC and is an ongoing issue that the Ombudsman's Office is following closely.

Issues identified for possible review in the next reporting period:

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. DHHS and DAS uses a web-based work order tracking system called Corrigo to track minor maintenance projects. It is reported that the maintenance department at LRC also has in-depth documentation kept on its shared drive on any non-projects that are completed at LRC (See e-mail, Attachment L7)
4. Ligature point project.
5. Issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment L8 and State Fire Marshall Occupancy Permits, Attachment L9).

NORFOLK REGIONAL CENTER (NRC)

The Norfolk Regional Center (NRC) is a 120-bed, Joint Commission-accredited state psychiatric hospital located on the northeast side of Victory Road and Benjamin Avenue in Norfolk, Nebraska. It is operated by the Department of Health and Human Services (DHHS). The hospital provides Inpatient Mental Health and Sex Offender Services

The NRC campus is enclosed within a wire gate. 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.

The main building on the NRC campus, which houses all patient services, is dated over 50 years. The building is a three-story brick structure with several walk-out basements and egress points. There are internal fences on both ends of the building to control independent yard access. 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 individuals' housing needs, a cafeteria area, medical services, administrative services, religious functions, recreation, and other essential programming areas. Patient Living areas are Unit 1-West, Unit 2-West and East, Unit 3-West and East.

Site Visit:

Several site visits were made to this facility in 2021. Generally, the outside grounds of the campus are well kept. The campus is comprised of several buildings. During the June site visit, the grounds were accessed through the main public entrance to the campus. We were met at the front doors by staff and continued a walk-through of the main building. General cleanliness of the rooms was observed and individual rooms were fairly organized and clean in some of the units. Patient restroom facilities are generally clean but should be reviewed for possible updates or renovation to include tiles, etc. No observable major projects were being performed at this time. The cafeteria area located on the lower level of the facility is where meals were provided to the patients. This was a congregate area where patients housed in different units came across each other for interaction for many years. Due to COVID, the patients have been served in their living unit.

During the October site visit, the grounds were accessed through the service entrance to the campus. The facility was just getting over a COVID outbreak. It was reported by the facility administrator, that due to the impact the outbreak had on staffing levels, Unit 2-East patients

were moved to other units and Unit 2-East was not being used for housing at this time. In addition, a review of NRC's COVID-19 Emergency Planning Meeting on October 12, 2021, 2-East will remain closed due to planned construction (cameras/monitoring station) beginning on October 18, 2021, to be completed on October 25, 2021. (See Attachment N4) As of the writing of this report, the unit was not yet open.

The cafeteria area located on the lower level of the facility is where meals were provided to the patients. For several decades, this area was considered a congregate area where patients housed in different units came across each other for interaction. Due to COVID, the patients have continued to be served on their living units. This office is told that meals may continue to be served on the units post COVID, with the dining area used by staff only.

Major Projects:

Major projects are not currently tracked at this facility (See Attachment N1). Plans are in place to begin the process of tracking major projects. Work orders for minor projects or day-to-day projects come through by e-mails. NRC is working on obtaining Corrigo, the same tracking system utilized at LRC for similar projects.

The Nebraska State Building Division is working to implement a new work order system. The new system will be able to track preventative maintenance orders. The Ombudsman's Office is told the new system should be introduced by the end of 2021.

Health Surveys:

Based on the documentation provided to the Ombudsman's Office, surveys conducted at NRC 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 NRC based on these findings are attached. (See Attachments N2).

Staffing:

Like many facilities throughout Nebraska, NRC continues to struggle with staffing levels. Various recruitment efforts are being pursued. These efforts range from job fairs, agency staff being used for nursing and direct support professional's use, to booths being staffed at community events. While creative approaches to recruit and retain staff have been used, the facility is still experiencing staffing shortages.

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment N3). There were 11 reported staff assaults during this reporting period. There were 8 assaults that occurred during the implementation of restraint or seclusion.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachment N4).
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*.** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

For this reporting period, the Ombudsman's Office received over 40 reports of complaints related to NRC, mostly from the patients themselves, but some from friends and family members of the patients. 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 resources and information, referred to Fast Case. Staffing and Fast Case access is a challenge at NRC and are ongoing issues that the Ombudsman's Office is following closely.

Issues identified for possible review in the next reporting period*:*

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked, and completed.
3. Issues identified in reports received by the Office of Public Counsel (See attachments Inspections N5, and State Fire Marshall Inspection/Occupancy Permit N6), including staffing levels, retention rates, and turnover.

WHITEHALL PRTF

The Whitehall Campus is located in the northeast quadrant of Lincoln, Nebraska. It is licensed and accredited as part of the Lincoln Regional Center and is 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. In addition, Whitehall is a Residential child-caring agency that has been licensed by The Division of Public Health. (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.

The campus is comprised of several buildings. The administrative offices are located in what is known as the TAB building, The Knight House is used for dining and staff training purposes. 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.

Site Visit:

Several visits were made to this facility in 2021. Generally, the outside grounds of the campus are well kept. The grounds on campus are surrounded by the community and provide space for social skill activities and educational opportunities.

The campus is comprised of several different buildings. There are two main living quarters currently being used for youth housing. Youth living quarters are determined by what programs the youth are participating in. Each youth has his bedroom in the living quarters. The youth rooms were generally clean and mostly neat. The recent carpet installation and lighting changes earlier this year continue to stand out and are a noticeable improvement in the youth cottages (Warner House and Community Life cottages).

Whitehall should be a place that male youth can develop physical, social, emotional, and cognitive abilities. This is in addition to the specific treatment youth receives at Whitehall. An important aspect to ensure the success of the facility is the space the youth reside in. While apparently meeting the requirements for an operational environment, the interior furnishings may not represent the best DHHS can provide to its youth. In addition, the interiors of the youth cottages are dated. DHHS should plan for upgrading these living quarter spaces, to include interior furniture make-overs. Investing in this uplift could create value for the program and youth under the care of both programs.

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 apparent.

The campus has structures for individuals' housing needs, dining, and administrative services. Medical services are provided by the Lincoln Regional Center and Whitehall contracts for recreational areas.

Major project/s:

As referenced in last year's annual report, there was a noticeable phone line connected to the Warner House living quarter building. This presented not only a security risk but also presented aesthetic concerns due to the placement of the campus being located in the community. This was discussed with facility administration. They relayed that the phone line is Windstream's and was to be taken down during the CAT 6 voice/VOIP line project, but that project is complete, but the line remains. As of December 7, 2021, the phone line is still hanging on the Warner House building. The line was supposed to be buried several years ago. The state has since changed to Allo for its services, therefore DHHS has submitted work orders to OCIO to address this issue. The Ombudsman's Office will continue to follow this matter.

As of this reporting period, no new construction projects have been identified. (See Attachment W2)

Health Surveys:

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 W3)

Staffing:

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment W4). There were 0 total youth on staff assaults and 0 youth on staff assaults during physical intervention.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments W5).
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*.** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

Historically, reports of complaints from Whitehall are low in number. Generally, we see an issue or two brought to our attention. During this reporting period, we had concerns from youth about the conditions of the facility and staff communication.

Issues identified for possible review in the next reporting period:

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. Whitehall uses a web-based work order tracking system called Corrigo. It is reported that the maintenance department has in-depth documentation kept on its share drive on any non-projects that are done at LRC(See Attachment W6)
4. Issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment W7 and State Fire Marshall Occupancy Permits, Attachment W8).

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, and Hastings with no YRTC in Geneva.

Over the last two years, DHHS has implemented many new 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 continue to unfold in 2022.

In 2021, the Ombudsman's Office continued to address concerns related to the YRTC system. The complaints were received from staff, youth and family members of youth. The issues were varied, including areas such as youth placement, safety, communication concerns, 60-day notices, facility damage, and critical incident reports.

Based on the many changes to the system, issues that were identified in the complaints were ongoing, in part due to the functional and fundamental changes of the use of state facilities under the Office of Juvenile Services. The Ombudsman's Office conducted several announced and unannounced visits to facilities across the YRTC system. During 2022, the Ombudsman's Office will continue to monitor and examine the 24-hour facilities operated by the Office of Juvenile Services as the system continues to stabilize and improve.

The following observations will provide brief point-in-time views of each facility's operations under the Office of Juvenile Services during this reporting period: 1) YRTC-Hastings, 2) YRTC-Lincoln, and 3) YRTC-Kearney.

YRTC-HASTINGS

On August 19, 2019, female youth from YRTC-Geneva were relocated to YRTC-Kearney after conditions on the Geneva campus were deemed insufficient and the girls could not be cared for on the Geneva campus. As mentioned in the introduction, the Geneva campus is no longer being used for YRTC purposes.

While the use of the YRTC-Kearney campus for the female youth presented many challenges to the system and was utilized for the safety and well-being of the youth, the Kearney facility was never meant to be considered home for the girls' YRTC program. Instead, the Hastings Regional Center campus located on the west edge of Hastings was to become the next home for those female youth in need of rehabilitation and treatment services.

On April 19, 2021, the first group of female adolescent youth was moved from YRTC-Kearney to YRTC-Hastings campus, (formerly known as the Hastings Regional Center campus). Several weeks later, the rest of the girls on the Kearney campus were transferred to the Hastings campus. The Ombudsman's Office with the Office of Inspector General of Nebraska Child Welfare conducted a site visit on April 27, 2021. There were several buildings on the Hastings campus slated for demolition. Several buildings had been demolished since the previous visit. The outside portions of the campus were generally clean. However, ongoing construction work was recognized.

In preparation for the use of the new campus, the two brand new cottages on campus were converted to house an all-female Youth Rehabilitation and Treatment Center (YRTC) program location. The new cottages went through renovations which include hardening of the walls, raising ceilings, and filming of windows. The campus is comprised of several additional buildings. The administrative offices are located in a new administration building. There is a new school and cafeteria building, an old chapel building used as an indoor recreation area, and other buildings on campus used by for maintenance work and storage.

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

Site Visit:

Several visits were made to this facility in 2021. This appears to be a busy campus. Generally, the immediate outside grounds of the living cottages are well kept. The grounds on campus are surrounded by other buildings that are not in use.

YRTC-Hastings should be a place that youth can develop physical, social, emotional, and cognitive abilities. This is in addition to the specific treatment a youth has been determined to need. An important aspect to ensure the success of the facility is the space the youth reside in. As mentioned earlier, the living cottages are new. The common area and sleeping quarters are updated and present a modern feel. The interior furnishing is sufficient as well. We believe the investment in the cottages could create value for the program and the youth under their care. The youth rooms were generally clean and mostly neat.

During a July visit, the campus was accessed through the north gates that are also used by the community to reach the cemetery. There are two entries to the campus (northeast and southeast sides of the facility). There are still several buildings erected that are slated for demolition. The outside portions of the campus were generally clean. No construction work was observed. Upon pulling up to the administration building, six youth were observed being escorted across campus by four staff escorts in blue shirts and a supervisor following behind in a Gator utility vehicle. It was noted that the assistant administrator was conducting a nature tour with the youth.

Major project/s:

As of this reporting period, there were five major projects identified and completed. (See Attachment H1)

Accreditations or Standards:

ACA standards focus on health, safety, and risk management practices. Accreditation provides a framework to manage resources, offer best practices in policies and procedures, and strive for continuous improvement. This facility did not go through an accreditation process during this reporting period.

Staffing:

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment H2). There were eight total youth-on-staff assaults and two of those were youth-on-staff assaults during physical interventions.
General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments H3).
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*.** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

In the last annual report, it was noted that with more stability to the system, the hope was that a better understanding of the facility conditions and changes necessary to right the ship will become apparent in 2021. Based on the changes to the living locality of the population, many of the issues identified at this facility are ongoing, in part, due to the operational grounding. In regards to the Hastings facility, progress is seen but there is still many improvements to be made. Generally, family members and youth reach out to the Ombudsman's Office concerning a varied list of items that generally includes staffing issues and treatment of the girls.

Issues identified for possible review in the next reporting period:

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. DAS uses a web-based work order tracking system called Corrigo. It is reported that the maintenance department has in-depth documentation kept on its share drive on any non-projects that are done at YRTC-Hastings (See Attachment H4)
4. Issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment H5 and State Fire Marshall Occupancy Permits, Attachment H6).

YRTC-LINCOLN

A newer facility, the YRTC-Lincoln was established in 2020. It was formed in 2019, from discussions between DHHS and Lancaster County about utilizing a portion of the Lancaster County Youth Services Center as an additional YRTC. DHHS then 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 (adult) to serve a specified timeframe.

YRTC–Lincoln facility is for high-acuity youth (male or female) who need more intensive and individualized interventions such as targeted behavioral and trauma-based programming, different from they would get at the YRTC's Intake facilities. It also provides for a different physical structure that is more secure. Upon more stable behaviors the youth at this facility should transition back to one of the main campuses, but many transition out of the YRTC system.

The housing unit where 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. The Lincoln facility will undergo initial American Correctional Association (ACA) Accreditation in 2022.

It is also understood that the facility will participate in the Performance-Based Standards (PbS) Project sponsored by the Council for Juvenile Correctional Administrators. The PbS improvement model identifies, monitors and improves conditions of confinement and treatment services in residential facilities programs using national standards and performance outcome measures.

Site Visit:

Several visits were made to this facility in 2021. The youth have access to outdoor spaces, the library, and a gym, but the times overlap with the detention center youth. The immediate outside grounds of the living units are well kept. The youth rooms were generally clean and mostly neat.

YRTC-Lincoln should be a place that youth can develop physical, social, emotional, and cognitive abilities. This is in addition to the specific treatment a youth has been determined to need. An important aspect to ensure the success of the facility is the space the youth reside in.

The facility has a correctional design and layout. The interior furnishings are correctional style as well.

During a November site visit, there were 2 boys and 3 girls at the facility. The Ombudsman's Office continues to collect data and gain a better understanding of how this facility will operate within the YRTC-System. The populations between the two facilities (YRTC and Lancaster County Youth Services) continue to share facility space of services such as school, cafeteria, and other essential service needs.

Major project/s:

No major projects provided this reporting period (See Attachment YLF1)

Accreditations or Standards:

ACA standards focus on health, safety, and risk management practices. Accreditation provides a framework to manage resource, offer best practices in policies and procedures, and strive for continuous improvement. This facility did not go through an accreditation process this reporting period.

Staffing:

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment YLF2). There were 22 total youth-on-staff assaults and 19 youth-on-staff assaults during physical interventions.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments YLF3).
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*.** DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

In the last annual report, it was mentioned that with more stability to the system, the hope was that a better understanding of the facility conditions and changes necessary to "right the ship" of the YRTC system will become apparent in 2021. Based on the changes to the living locality of the population, many of the issues identified at this facility were ongoing. In regards to the Lincoln facility, progress is seen but there is still a ways to go. Generally, we continue to hear

from family members and youth concerning a varied list of items including staffing and treatment of youth.

Issues identified for possible review in the next reporting period:

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. All ongoing building maintenance and major construction projects for YRTC-Lincoln is contracted through Lancaster County. However, YRTC-Lincoln keeps track of all routine repair work completed for the facility by the maintenance department. (See Attachment YLF4)
4. Issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment YLF5 and State Fire Marshall Occupancy Permits, Attachment YLF6).

YRTC-KEARNEY

YRTC-Kearney is located in Kearney, NE. During this reporting period, it had been serving both male and female youth since August of 2019 until spring of 2021. As mentioned previously, while the use of the Kearney campus for the female youth presented many challenges to the system and was made due to the safety and well-being of the youth, the Kearney facility was never meant to be home for the female focused YRTC program. Instead, the Hastings Regional Center campus was to become the next home for those female youth in need of rehabilitation and treatment services.

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 allowed for individual rooms. The facility also purchased two portable trailers for classroom use by the girls. In part due to the function changes of the facility, the Ombudsman's Office and Inspector General for Child Welfare conducted several announced and unannounced visits on this campus during the reporting period.

The Kearney facility saw the first group of female adolescent youth moved from its campus on April 21, 2021. Several weeks later, the rest of the girls on the Kearney campus were transferred to the Hastings campus. The Kearney campus is no longer co-ed.

As mentioned in the introduction section of this report, the Kearney campus recently went through a facility-wide Site Evaluation & Cost Analysis study that was submitted to the Legislature on November 22, 2021. As part of this study, an evaluation of existing infrastructure on the YRTC campus and a list of deficiencies were provided for future upgrade considerations. However, a complete ADA analysis was not completed during this time period.

The mission of the YRTC-Kearney is to help youth live better lives through effective services, giving youth the chance to become law-abiding citizens. The facility is the main YRTC for youth placed in their care. The YRTC-Kearney facility is accredited under the American Correctional Association (ACA). It also participates in the Performance-Based Standards (PbS) Project sponsored by the Council for Juvenile Correctional Administrators.

Site Visit:

Several visits were made to this facility in 2021. 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.

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 are a game/rec area, a bathroom area with showers, and a TV multi-purpose area. General cleanliness of the dorm areas was observed.

An August site visit indicated that the facility is taking steps to get back to normal operations-after female youth no longer reside there. The youth have access to outdoor spaces, and the outside grounds of the living units are well kept. The youth area rooms were generally clean and mostly neat. The school administration was planning for back-to-school—meeting with teachers, assigning classrooms, etc.

YRTC-Kearney should be a place that youth can develop physical, social, emotional, and cognitive abilities. This is in addition to the specific treatment a youth has been determined to need. An important aspect to ensure the success of the facility is the space the youth reside in. Constant monitoring of this point should remain an important part of any review of this facility.

The facility continues to be under contract with the Missouri Youth Services Institute (MYSI) for assistance with implementing basic principles of the MYSI therapeutic and rehabilitative model approach.

Major project/s:

The HVAC replacement on the Dickson Living Unit (309) is the most recent construction project this reporting period (See Attachment K1 for other projects this period).

Accreditations or Standards:

ACA standards focus on health, safety, and risk management practices. Accreditation provides a framework to manage resources, offer best practices in policies and procedures, and strive for continuous improvement. This facility did not go through an accreditation process during this reporting period.

Staffing:

Attached you will find facility staffing levels (See Facility Staffing Information, Attachment K2). There were 57 total youth-on-staff assaults and of those, 28 youth-on-staff assaults during physical interventions.

General:

Issues reviewed during this reporting period*:*

1. ***COVID plan, response, and impact to staff and individuals*.** The Ombudsman's Office was interested in how the COVID-19 Public Health crisis has posed challenges to DHHS 24 hour facilities during these unprecedented times. (See Attachments K3).
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. DAS is making changes to the work order system. This change is supposed to improve tracking capabilities and will be completed by the end of the year.

In the last annual report, it was mentioned that with more stability to the system, the hope was that a better understanding of the facility conditions and changes necessary to right the ship will become apparent in 2021. Based on the changes to the living locality of the population, many of the issues identified at this facility were ongoing. In regards to the Kearney facility, progress is seen but there are issues remain. Generally, to the Ombudsman's office hears from family members and youth concerning a varied list of items including staffing, conditions, and treatment of youth.

Issues identified for possible review in the next reporting period:

1. COVID plan, response, and impact to staff and individuals.
2. Updates and changes to the new work order system utilized by DAS and DHHS to assure minor projects are identified, tracked and completed.
3. YRTC-Kearny uses a web-based work order tracking system called Corrigo and an internal fillable pdf form to track non-major repair projects (See Attachment K4)
4. Issues identified in reports received by the Office of Public Counsel (See Inspection Forms, Attachment K5 and a PREA Facility Audit Report, Attachment K6).

Vacant Building and Excess Land Committee Meeting

Attachment M1

NEBRASKA

Good Life. Great Service.

DEPT. OF ADMINISTRATIVE SERVICES

VACANT BUILDING AND EXCESS LAND COMMITTEE
MEETING AGENDA
4:30 PM Monday July 21, 2021
1526 Building Conference Room 4D Hearing Room

I. Call to Order

II. Open Meeting Requirement

III. Attendees Sign-In and Member Roll Call

IV. Approval of Minutes June 21, 2021 Meeting

V. Public Comments

VI. Agency Requests

A. Department of Administrative Services on behalf of Department of Health and Human Services requests to declare the following land and structures vacant and surplus to the needs of the agency.

1.	Geneva YRTC Campus Land	65ZZ00056L
2.	Strom Cave	65A0426300B
3.	Picnic Shelter	65A0426200B
4.	Gazebo	65A0426000B
5.	LaFlesche Building	65A0409000B
6.	Swimming Pool	65A0271400B
7.	Calf Shed (Barn)	65A0248700B
8.	Loafing Shed (Barn)	65A0222000B
9.	Paint Shed	65A0201500B
10.	Granary	65A0201300B
11.	Chapel	65A0169300B
12.	Maintenance Shop	65A0137200B
13.	Boiler House #1	65A0137100B
14.	Sandoz Cottage	65A0137000B
15.	Burroughs Cottage	65A0136900B
16.	Dunbar Cottage	65A0136700B
17.	Food Service Building	65A0136600B

Michelle Potts, Director
Department of Administrative Services | STATE BUILDING DIVISION
P.O. Box 98940, Lincoln, Nebraska 68509-8940
1526 K Street, Ste. 160, Lincoln, Nebraska 68508
OFFICE 402-471-3191
FAX 402-471-0403
das.nebraska.gov

18. School/Admin Building	65A0136500B
19. Sacajawea Cottage	65A0136400B
20. Building 'A'	65A0136100B
21. Building 'B'	65A0136200B
22. Building 'C'	65A0136300B
23. Garage	65A0136000B
24. Warehouse	65A0136900B
25. Pump House	65A0135800B

VII. Future Meeting

- Monday September 20, 2021

VIII. Adjourn

Service Contract

Between

The Nebraska Department of Health and Human Services

And

Myers and Stauffer LC

Attachment M2

SERVICES CONTRACT

BETWEEN

THE NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

MYERS AND STAUFFER LC

This services contract, including any addenda and attachments (collectively, "Contract") is entered into by and between the Nebraska Department of Health and Human Services, Division of Behavioral Health [Programs] (hereinafter "DHHS"), and Myers and Stauffer LC (hereinafter "Contractor").

DHHS CONTRACT MANAGER:

Larry Kahl
301 Centennial Mall S
Lincoln, NE 68508
402.471.9185
larry.kahl@nebraska.gov

PURPOSE: The purpose of this Contract is to provide a comprehensive resource evaluation for the Beatrice State Developmental Center, the Lincoln Regional Center and the Norfolk Regional Center

FUNDING: This Contract involves state funds.

HIPAA: This Contract involves the sharing of or access to Protected Health Information and includes a Business Associate Agreement for compliance with the Health Insurance Portability and Accountability Act (HIPAA).

1. DURATION

1.1. TERM. This Contract begins on the later of December 8, 2020 or the date the Contract is executed. This Contract ends on December 7, 2021.

1.2. TERMINATION.

1.2.1. This Contract may be terminated by DHHS for any reason upon submission of written notice to the Contractor at least thirty (30) days prior to the effective date of termination. DHHS may also terminate the Contract to the extent otherwise provided herein.

1.2.2. This Contract may be terminated at any time upon mutual written consent.

1.2.3. This Contract may be terminated by the Contractor for any reason upon submission of written notice to DHHS at least at least thirty (30) days prior to the effective date of termination.

2. PAYMENT TERMS AND STRUCTURE

2.1. TOTAL PAYMENT. DHHS shall pay the Contractor a total amount not to exceed $346,810 (three hundred forty-six thousand eight hundred ten dollars) for the services specified herein.

2.2. PAYMENT STRUCTURE. Payment shall be structured as follows.

2.2.1. DHHS shall pay the Contractor in accordance with the rates and deliverable fixed fee amounts listed in the "Cost Proposal and Assumptions" section of Attachment 1.

2.2.2. Payment shall be made upon receipt, and approval, of an invoice from Contractor following completion of deliverables described in Attachment 1.

3. SCOPE OF WORK

3.1. THE CONTRACTOR shall perform all services, and provide all deliverables, as described in Attachment 1.

4. CONTRACT MANAGEMENT

4.1. DELIVERABLES. The Contractor shall provide the deliverables described on page 21 of Attachment 1.

4.2. DEADLINES. The Contractor shall meet the following deadlines:

4.2.1. Completion of Deliverables will be in accordance with the following schedule, which supercedes the schedule included on page 21 of Attachment 1:

Deliverable	Due Date
Final project work plan	30 business days after
Stakeholder engagement plan including presentation materials	30 calendar days after contract start date
Comprehensive System Assessment Redesign Recommendations Report	60 calendar days after contract start date
Completion of stakeholder meetings as required	90 calendar days after contract start date
Summary report of stakeholder engagement	120 calendar days after contract start date
Draft redesign plan	6 months after contract start date
Final redesign plan	8 months after contract start date
Training to DHHS staff on the plan	9 months after contract start date
Monthly status reports	15 calendar days after end of month

4.3. DELIVERABLE APPROVAL PROCESS.

4.3.1. DHHS must review all deliverables submitted by Contractor. DHHS must approve a deliverable submitted by Contractor if it is of sufficient quality and meets the requirements in section 4.1. Approval of a deliverable must be communicated by DHHS to Contractor in writing within a reasonable time period. DHHS will not disburse payment for a deliverable until the deliverable is approved.

4.3.2. DHHS must reject the deliverable submitted by Contractor if it is not of sufficient quality or does not meet the requirements in section 4.1. Rejection of a deliverable must be communicated by DHHS to Contractor in writing within a reasonable time period, and DHHS's written communication must include its reasons for rejection.

4.3.3. Within a reasonable time period established by DHHS, Contractor may correct the defects identified by DHHS and re-submit the rejected deliverable. Any corrections or improvements requested by DHHS are not changes in scope of this Contract. If a rejected deliverable requires more than two corrections, DHHS may permanently reject the deliverable and deny payment for the deliverable. Nothing in this section limits any other remedies available to DHHS under this Contract or at law.

5. DHHS RESPONSIBILITIES

5.1. DHHS shall do the following:

5.1.1. Provide payment as per terms of this Agreement.

6. ADDENDA

A. DHHS General Terms – Services Contracts
B. DHHS Insurance Requirements – Services Contracts
C. DHHS HIPAA Business Associate Agreement Provisions – Services Contracts

7. ATTACHMENTS

1. Myers and Stauffer Proposal

8. NOTICES

Notices shall be in writing and shall be effective upon mailing. All deliverables and required reports under this Contract shall be sent to the DHHS Contract Manager. Written notices, such as notices of termination or notice of breach, shall be sent to the DHHS Contract Manager identified above, and to the following addresses:

FOR DHHS:

Contracts Administrator
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509-5026

FOR CONTRACTOR:

Jerry Dubberly
Myers and Stauffer LC
Address
City, State, Zip
Phone
jdubberly@mslc.com

DHHS may change the DHHS Contract Manager to be notified under this section via letter to the Contractor sent by U.S. Mail, postage prepaid, or via email.

9. ACKNOWLEDGEMENTS

By signing below, Contractor certifies, acknowledges and agrees with the following statements:

Contractor acknowledges and represents that, under the Nebraska Political Accountability and Disclosure Act, no individual representing, and associated with, Contractor is a public official or public employee, or an immediate family member of a public official or public employee.

IN WITNESS THEREOF, the parties have duly executed this Contract hereto, and that the individual signing below has authority to legally bind the party to this contract.

FOR DHHS:

DocuSigned by:
Larry Kahl
[illegible]415

Larry Kahl

DHHS Chief Operating Officer

Department of Health and Human Services
Division of Behavioral Health

DATE: 1/4/2021 | 09:31:53 CST

FOR CONTRACTOR:

DocuSigned by:
Jerry Dubberly
5AC14148F2E2404...

Jerry Dubberly, Principal
Myers and Stauffer LC

DATE: 12/31/2020 | 08:38:37 PST

Major Projects

Attachment B1

Russell,

Here is the last information you were waiting on for BSDC.

Question 1:

1. Water Line Replacement Project (In Progress): $2,080,000.00
2. ADA Improvement Project (In Progress): $490,000.00
3. West Wing Roof (In Progress): $340,000

Question 2:

All recent major project are currently in progress.

Question 3:

SBD is working to implement a new work order system and will soon be working with the Beatrice Campus and DHHS to implement.

Question 4:

13002

Question 5:

The new system will be able to track preventative maintenance orders.

Let me know if you have questions.

Michelle Potts
Director | 309 Task Force
Director | State Building Division

Nebraska Department of Administrative Services
1526 K Street, Suite 170, Lincoln, NE 68508
CELL 531-207-9029
michelle.potts@nebraska.gov

DHHS Public Health-Licensure Unit

Lake Building Surveys

Attachment B2

Lake Street ICF

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Staff Assistant II

COMPANY:

DATE: June 25, 2021

FAX NUMBER: 402.742.2326

TOTAL PAGES INCLUDING COVER: 3

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached is the signed front page(s) for the Public Health -2567 received for Dawn Urbaschek and the Lake Street ICF at the Beatrice State Developmental Center.

The plan of correction is being emailed per the instructions on the email received.

Please advise if further information is needed.

Thank you

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: . Based on record review and interviews, the facility failed to ensure, for 1 of 1 client (Client 5) observed to engage in self injurious behaviors (SIB), the clients' behavior support guidelines (BSG) included a method or strategy for intervening with the client's SIB. This failure had the potential to affect all clients who engaged in SIB. The facility census was 15 at the time of the survey. Findings: Observations on 6/15/2021 in the Connections home room from 1:50pm 1:52pm identified Client 5 to hit themselves nine times on the left side of the chin and mouth area with a closed (left handed) fist. The force of the hits were such the impact made a "popping" sound when Client 5's fist made contact with their chin/mouth area. Staff A (the only staff in the room) was verbally interacting with Client 5, asking Client 5 what was wrong and to stop the behavior. At no time did Staff A intervene to block or physical disrupt Client 5's SIB. Review of Client 5's BSG (last updated on 1/08/2021) identified Client 5 engaged in the SIBs of hitting their head and body, head banging, face slapping, pinching and biting self. Review of BSG revealed no direction to staff on how to intervervene with Client 5's SIB. The BSG	W 234		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulbschel | TITLE: ICFA | (X6) DATE: 6-25-2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 1 directed staff to "use response blocking with the least amount of attentions possible" but did not specify what response blocking looked like or the circumstances under which response blocking should be implemented. When interviewed on 6/16/2021 at 2:00 pm, Staff A reported that when Client 5 engaged in SIB, they were to ask Client 5 what was wrong, what Client 5 needed or to get Client 5 to walk around. Staff A stated they had never physically intervened with Client 5's SIB and had never seen anyone else do so. Qualified Intellectual Disability Professional (QIDP) A, interviewed on 6/17/2021 at 11:00am, confirmed it was not acceptable for staff to allow Client 5 to repeatedly hit themselves with their fist and staff were expected to physically intervene by blocking the SIB.	W 234		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Representatives of the DHHS, Division of Public Health conducted a Recertification survey on 6/14-17/2021 and 6/21/2021 in order to determine compliance with federal regulations at Appendix Z, Emergency Preparedness. The facility was found to be in compliance with these regulations. Facility census was 15 at the time of the survey.	E 000		

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

Dawn Uldrschell | ICFA | 6-25-2021

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

PLAN OF CORRECTION

Provider/Supplier Name:	LAKE STREET ICF/ID	Survey Date
STREET ADDRESS, CITY, ZIP:	667 31ST ST, APT 103, 104, 205, 206, Beatrice, NE 68310	6/17/2021
	SURVEY EVENT ID#	TDRX11
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD16

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W-Tags		
W234	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	The Behavior Support Team (BST) will complete a review of Client 5's Behavior Support Guidelines (BSG) to revise and clarify "use response blocking with the least amount of attentions possible"; response blocking; what response blocking looks like, and circumstances when response blocking should be utilized to ensure staff are provided directions/instructions to intervene and block and/or physically disrupt Client 5's self-injurious behaviors (SIB).	7/23/2021
	Staff A and all other staff at the Lake Street ICF will be in-serviced, following clarification and revision of Client 5's BSG on utilizing response blocking with the least amount of attention possible for Client 5, with direction of what response blocking looks like and the circumstances when response blocking should be implemented to intervene with Client 5 when displaying SIB.	7/23/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 5 and all other individual's residing in the Lake Street ICF, the BST will review and revise BSPs/BSGs as needed, to ensure BSPs/BSGs have specific directions with clear instructions for intervention of SIB.	7/23/2021
	In-services will be provided to support staff regarding revisions to Client 5 and any other individual whose BSP/BSG has a revision and clarification.	7/23/2021
	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:	
	A monitoring system will be implemented to ensure staff understanding of BSP/BSG directions and instructions for intervention through treatment integrity reviews.	7/23/2021
	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 position for monitoring and to ensure compliance.	7/23/2021

	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 23, 2021

Dawn Urbaschek
Lake Street Icf/id
667 31st St, Apt 103, 104, 205, 206
Beatrice, NE 68310

Dear Ms. Urbaschek:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On June 14- 21, 2021, 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 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.DDBHFacilities@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 **August 5, 2021**.

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 402-742-2326.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING **01 - LAKE STREET ICF/ID** B. WING _____	R **07/23/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS 42 CFR 483.470 A revisit survey was conducted at Lake Street ICF/ID on 7/23/21 for all previous deficiencies cited on 6/15/21. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies" of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code.	{K 000}		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING _____ B. WING _____	R 07/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments This facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	{E 000}		

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

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

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Staff Assistant II

COMPANY:

DATE: June 29, 2021

FAX NUMBER: 402.742.2326

TOTAL PAGES INCLUDING COVER: 3

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front page(s) for the Life Safety Code -2567 received for Dawn Urbaschek and the Lake Street ICF at the Beatrice State Developmental Center.

The plan of correction is being emailed per the instructions on the email received.

Please advise if further information is needed.

Thank you

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	LAKE STREET ICF/ID	Survey Date
STREET ADDRESS, CITY, ZIP:	667 31ST ST, APT 103, 104, 205, 206, Beatrice, NE 68310	6/17/2021
	SURVEY EVENT ID#	TDRX21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD16

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-Tags		
K0211	**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:**	
	Observation on 6/15/2021 revealed the upper stair landing between Apartments 205 and 206 were obstructed with 3 bags of trash.	6/15/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator confirmed the 3 bags of trash/combustibles stored inside the stair enclosure between Apartments 205 and 206 and removed them from obstruction.	6/15/2021
	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.	6/15/2021
	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.	6/15/2021
K0225	**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:**	
	Observation on 6/15/2021 revealed the upper level north fire rated stair door in Apartment 206 failed to securely latch into the frame.	7/23/2021

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department requesting the upper level north fire rated stair door in Apartment 206 be adjusted so that it will securely latch within the frame.	7/23/2021
	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.	7/23/2021
	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.	7/23/2021
K0353	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed on 6/15/2021 an approximate 3' tall by 5' wide wooden curio cabinet with glass doors was permanently mounted to the wall located 4" below the sidewall sprinkler head on the north wall of Apartment 104, resident room 113.	7/23/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order was submitted to the Maintenance Department requesting the 3' tall by 5' wide wooden curio cabinet with glass doors be unmounted and removed from the north wall of Apartment 104, resident room 113 so to not obstruct the fire sprinkler.	7/23/2021
	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.	7/23/2021
	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.	7/23/2021

K0363	**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. Observation revealed on 6/15/21 that in Apartment 103, resident room 104, the door failed to securely latch into the frame.	7/23/2021
	2. Observation revealed on 6/15/2021 that in Apartment 205, resident room 203, the door failed to securely latch into the frame.	7/23/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. A work order was submitted to the Maintenance Department to ensure in Apartment 103, resident room 104, the door securely latches into the frame.	7/23/2021
	2. A work order was submitted to the Maintenance Department to ensure in Apartment 205, resident room 203, the door securely latches into the frame.	7/23/2021
	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.	7/23/2021
	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.	7/23/2021

Vogel, Rick

To: Fralin, Russell
Cc: Balderson, Mike
Subject: Fire Marshal Plan of Correction/311 Lake Street

Good morning Russell, here are the work orders for 311 Lake street.
KO211
1-Mike Balderson removed the trash on the stair landing
KO225
1-Work order was made to insure upper level fire door in apartment 206 would close and latch
KO353
1-Work order was made to remove wooden curio by sprinkler head in room 113 apartment 104
KO363
1-Work order was made to insure door latched in apartment 103 room 104
2- Work order was made to insure door latched in apartment 205 room 203

Fralin, Russell

From: Fralin, Russell
Sent: Tuesday, June 29, 2021 2:14 PM
To: Fralin, Russell
Subject: FW: WORK ORDER

Russell Fralin | *Staff Assistant II*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-223-6600 x2236827
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Balderson, Mike <Mike.Balderson@nebraska.gov>
Sent: Thursday, June 24, 2021 12:57 PM
To: Fralin, Russell <Russell.Fralin@nebraska.gov>
Subject: FW: WORK ORDER

FYI: The following was submitted to Maintenance to correct the deficiencies that were documented by the State Fire Marshal for their survey of 311 Lake East Apartments.

Mike Balderson | *Safety Coordinator*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-806-3759
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Balderson, Mike
Sent: Thursday, June 17, 2021 12:46 PM
To: DHHS BSDC Maintenance Work Order <DHHS.BSDCMaintenanceWorkOrder@nebraska.gov>
Subject: WORK ORDER

LOCATION: 667 31ST STREET / 311 LAKE EAST APARTMENTS

1. **APARTMENT #103**
   Bedroom #104
   Entrance door to the bedroom will not secure when closed. No positive latch (*the latch is stuck in the door*).
2. **APARTMENT #104**
   Bedroom #113 - North wall.
   The large display case attached to the wall of the bedroom is approximately 4 inches below a sprinkler head mounted on the wall above the cabinet.
   Code states that there can be nothing placed within 18 inches of a sprinkler head that could obstruct the flow of water.
   The display cabinet needs to be either relocated or removed to allow adequate clearance of the sprinkler head.
3. **APARTMENT #205**
   Bedroom #203

Entrance door to the bedroom will not secure when closed. No positive latch (*the latch is stuck in the door*).

4. **APARTMENT #206**
   North stairwell door
   The stairwell door will not close completely to obtain positive latch (*the closer needs to be adjusted*).

Mike Balderson | *Safety Coordinator*
DEVELOPMENTAL DISABILITIES

Nebraska Department of Health and Human Services
OFFICE: 402-806-3759

DHHS.ne.gov | Facebook | Twitter | LinkedIn

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.90(a) (b) 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 19, Existing Health Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Lake Street ICF ID is two story Type II (000) construction that was approved in 2013 and is fully sprinkled with a fire alarm system. Facility has 24 skilled certified beds, at the time of survey the census was 15. Lake Street ICF ID Apartments 103, 104, 205, 206 were found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a)(b), Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that stairs were maintained free of combustible storage. This deficient practice could slow egress in the stair	K0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Wroschek
TITLE: ICFA
(X6) DATE: 6/29/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0211	Continued From page 1 and increase the fire load inside of an exit enclosure. Facility census was 15 and licensed for 24 at the time of the survey. Finding are: Observation and staff interview on 6-15-2021 at 10:15 AM revealed the following: Upper stair landing located between Apartments 205 and 206 was obstructed with 3 bags of trash. During interview on 6-15-2021 at 10:15 AM, Administrative Staff A confirmed the combustibles stored inside the stair enclosure.	K0211		
K0225	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures 2012 EXISTING (Prompt) Interior stairs used as a primary means of escape shall be enclosed with fire barriers in accordance with Section 8.3 having a minimum 1/2-hour fire resistance rating. Stairs shall comply with 7.2.2.5.3. The entire primary means of escape shall be arranged so that it is not necessary for the occupants to pass through a portion of a lower story unless that route is separated from all spaces on that story by construction having not less than a 1/2-hour fire resistance rating. In buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction shall be protected to afford the required fire resistance rating of the supported wall. 1. Stairs that connect a story at street level to only one other story shall be permitted to be open to the story that is not at street level. 2. In Prompt Evacuation Capability facilities,	K0225		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0225	Continued From page 2 stair enclosures shall not be required in buildings of three or fewer stories protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception shall be permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is separated from all spaces on that floor by construction having a 1/2-hour fire resistance rating. 3. In Prompt Evacuation Capability facilities, stair enclosures shall not be required in buildings of two or fewer stories with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. The requirement found at section 33.2.2.3.3, 33.2.3.4.6 or 33.2.3.4.3.7 are not permitted to be used in this instance. 4. In Prompt Evacuation Capability facilities, of three or fewer stories protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs shall be permitted to be open at the topmost story only. The entire primary means of escape of which the stairs are a part shall be separated from all portions of lower stories. Stairs shall comply with 7.2.2 unless otherwise specified in Chapter 33. Winders complying with 7.2.2.2.4 shall be permitted. Exterior stairs shall be protected against blockage caused by fire within the building. 33.2.2.4, 33.2.2.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire rated stair enclosure doors would resist the passage of fire and smoke from one compartment to another. This deficient practice would not prevent the spread of fire and	K0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0225	Continued From page 3 smoke from one floor to another. Facility census was 15 and licensed for 24 at the time of the survey. Findings are: Observation and staff interview on 6-15-2021 at 10:25 AM revealed the following; The upper level north fire rated stair door in Apartment 206 failed to securely latch into the frame. During an interview on 6-15-2021 at 10:25 AM Administrative Staff A confirmed the findings.	K0225		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2).	K0353		

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	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353	Continued From page 4 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____	K0353		

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	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353	Continued From page 5 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 staff interview, the facility failed to ensure that there were no obstructions to the fire sprinkler discharge. This deficient practice would obstruct the water spray pattern from the sprinkler system causing water to not reach the point of fire origin allowing fire, smoke and gases to spread. Facility census was 15 and licensed for 24 at the time of the survey. Finding are: Observation and staff interview on 6-15-2021 at 10:00 AM revealed the following: An approximate 3' tall by 5' wide wooden curio cabinet with glass doors was permanently mounted to the wall located 4" below the sidewall sprinkler head on the north wall of Apartment 104 resident room 113. During interview on 6-15-2021 at 10:00 AM, Administrative Staff A confirmed the fire sprinkler obstruction.	K0353		
K0363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other	K0363		

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	28G116	A. BUILDING 01 - LAKE STREET ICF/ID B. WING _____	06/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0363	Continued From page 6 mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sleeping room doors securely latched. This deficient practice would allow fire, smoke and gases to migrate into the exit corridors. Facility census was 15 and licensed for 24 at the time of the survey. Finding are: Observation and staff interview on 6-15-2021 at 9:55 and 10:10 AM revealed the following: 1. Apartment 103 resident room 104 the door failed to securely latch into the frame. 2. Apartment 205 resident room 203 the door failed to securely latch into the frame. During interview on6-15-2021 at 10:10 AM Administration Staff A confirmed the doors failed to latch.	K0363		

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	28G116	A. BUILDING _____ B. WING _____	06/15/2021

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

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E 000	Initial Comments E0000 (emergency preparedness) this facility is in compliance with Emergency Preparedness regulations at E41 [483.73(e)].	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrscheln | TITLE: TCFA | (X6) DATE: 6/29/2021

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DHHS Public Health-Licensure Unit

Solar Building Surveys

Attachment B3

Solar Cottages ICF

PLAN OF CORRECTION

Provider/Supplier Name:	SOLAR COTTAGES	Survey Date
STREET ADDRESS, CITY, ZIP:	3052,3054, 3056, 3060 PET BLV 753, 743, 723, 715 SOL DR Z Beatrice, NE 68310	2/16/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W 260		
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	For Client 1, the IDT will meet to review the Individual Support Plan (ISP) to make revisions and update the ISP with documentation to include the Client's fracture and the team's plan to address the provision of services.	3/28/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 1, the IDT will meet on 2/24/21 to place the programs on hold that would involve the use of the Client's fractured right arm at this time. Client 1 is not able to participate in the program plans as designed. The QDDP will write an in-service for the direct support staff at the home to ensure they are made aware of the changes to Client 1's ISP and current provision of habilitative services.	3/28/2021
	The IDT team will meet on 3/11/21 and continue to meet to discuss progress in order to determine when the habilitative programs would be able to be re-implemented.	3/28/2021
	The facility QDDPs were provided an in-service by the QDDP Coordinator on 2/22/21 regarding identifying significant changes due to injury or a medical condition and ensuring the ISP team meeting documentation reflects discussion and changes to programming if necessary. The facility QDDPs will review current ISPs for all other individuals in the Solar Cottage ICF to identify needs to respond to significant functional changes which have occurred since the last ISP.	3/28/2021
	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:	
	A monitoring system will be implemented to ensure that all Client functional changes are discussed and reflected in the ISP team meeting documentation.	3/28/2021
	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 position for ensuring compliance.	3/28/2021

	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.	

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	28G114	A. BUILDING _____ B. WING _____	02/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Representatives of the DHHS, Division of Public Health conducted a Recertification Survey from 2/8/2021 through 2/16/2021, to determine compliance with the Appendix Z, Emergency Preparedness Regulations. The facility census was 62 at the time of the survey. The facility was found to be in compliance with the Emergency Preparedness requirements pertaining to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID).	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 2/24/21

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	28G114	A. BUILDING _____ B. WING _____	02/12/2021

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

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W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: . Based on record review, observation, and interview the facility failed to update the Individual Support Plan (ISP) for 1 of 1 clients in the sample (Client 1) who had a significant change in services due to an injury. This had the potential to affect all clients residing at the facility. The facility census was 62 at the time of the survey. Findings: Observations on 2/8/2021 at 4:15pm, 2/9/2021 at 11:20am and 5:20pm revealed Client 1's right arm was in a white hard plastic cast which extended from the upper arm to the fingers. The client's arm was propped up on two black soft pads that rested on the client's lap tray. Client 1 was unable to move their right arm or hand to grasp objects. Record review of Client 1's 1/14/2021 Individual Support Plan (ISP) meeting notes identified the facility had conducted an investigation into an incident of alleged abuse and neglect regarding the fracture to Client 1's arm. These meeting notes identified the investigation revealed no known or identified cause of the fracture. The meeting notes did not include a plan regarding Client 1's provision of services and supports.	W 260		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 2/24/21

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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	28G114	A. BUILDING _____ B. WING _____	02/12/2021

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

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W 260	Continued From page 1 Further review identified Client 1's ISP failed to be revised to include an active treatment support plan which provided guidance to staff about how and what programs and supports were to be implemented regarding the client's fractured arm. There was no ISP team meeting documentation between the 12/17/2020 Quarterly meeting (day before the incident) to the 1/14/2020 meeting notes (identified above) regarding what the client's plan would be during and after the client's right arm healed. Interview on 2/8/2021 with Staff A (at 4:27pm) and Staff B (at 5:05pm) revealed Client 1 fractured their right arm 5-6 weeks prior, the client could not move their arm, the incident was investigated, and there was no known cause. Staff A and B reported they were not aware of changes or revisions to the client's ISP after the fracture incident. Interviews on 2/9/2021 at 5:00pm and on 2/10/2021 at 12:18pm and 1:08pm, QIDP-A (Qualified Intellectual Disabilities Professional) verified Client 1's team had not met and the ISP had not been updated to include the client's fracture and the team's plan to address the provision of services. QIDP-A confirmed Client 1's arm was their dominant arm/hand used to perform grasping and holding as identified in the ISP and program plans. QIDP-A verified due to the fracture Client 1 was not able to participate in their program plans as designed. Interview on 2/11/2021 at 1:30pm, the Administrator verified that Client 1's ISP should have been updated to include the team's discussions and plan regarding what to do about Client 1's change in condition due to the client's	W 260		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	28G114	A. BUILDING _____ B. WING _____	02/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 2 fractured arm. According to the Administrator, the ISP should have included that the team had decided to put the clients programs on hold and the other adjustments which were made to the ISP and points of service that were impacted by the client's injury.	W 260		

PLAN OF CORRECTION

Provider/Supplier Name:	SOLAR COTTAGES	Survey Date
STREET ADDRESS, CITY, ZIP:	3052,3054, 3056, 3060 PET BLV 753, 743, 723, 715 SOL DR Z Beatrice, NE 68310	2/12/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K0500	**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:**	
	Observation on 2-9-21 revealed three oxygen cylinders stored in the nurse office at 723 Solar (422) and no warning signage was posted.	2/9/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator contacted the Respiratory Therapist and the three oxygen cylinders and the storage rack were immediately removed from 723 Solar (422) and are now being stored appropriately in the Administration Building oxygen storage room.	2/9/2021
	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.	2/9/2021
	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.	2/9/2021
K0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2-9-21 revealed a six-plex electrical adaptor plugged into an outlet near the television at 723 Solar (422).	2/9/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Safety Coordinator removed the six-plex electrical adaptor from 723 Solar (422) at approximately 1500.	2/9/2021

	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.	2/9/2021
	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.	2/9/2021
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2-9-21 revealed the Mechanical Room door equipped with a self-closing device failed to close and latch within the doorframe.	2/11/2021
	A work order request was submitted by the Safety Coordinator requesting the Mechanical Room door on 3060 Peterson (413) be adjusted so that it will close completely with positive latch.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A work order request was submitted by the Safety Coordinator requesting the Mechanical Room door on 3060 Peterson (413) be adjusted so that it will close completely with positive latch.	2/11/2021
	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.	2/11/2021
	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.	2/11/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

NEBRASKA
State Building Division

BS413- STATE COTTAGE 3 (#413)
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 3/3/2021 11:00 AM
NOT TO EXCEED $0.00

REGULAR

WO# BS4131866
STATUS OPEN

AGENCY

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

DATE CREATED 2/10/2021 7:50 AM

BASIC

Interior Repair (1) Mechanical Room Door: Please adjust the mechanical room door so that it will close completely with positive latch. (2) Repair hole in sheetrock wall behind laundry room door.

ASSIGNMENT

Assigned To	Wieden, Dan	Skill	General Maintenance
Mobile		Appointment	N/A
Email	daniel.wieden@nebraska.gov	Start Time	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)
Signature
Signed

~~2/10/21 2½ hrs measured door, got new door ready to hang~~

2/11/21 2½ hrs fixed latch fixed wall
2/18/21 ½ hr wall repair

D. Wieden

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 01 - 753 SOLAR DRIVE B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 753 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 9.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 2/24/21

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **02 - 743 SOLAR DRIVE** B. WING _____	**02/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLAR COTTAGES	**3052,3054,3056,3060 PET BLV 763,743,723,715 SOL DR BEATRICE, NE 68310**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	**INITIAL COMMENTS** 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 743 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 9.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ICFA | (X6) DATE: 2/24/21

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 03 - 723 SOLAR DRIVE B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Based on observation and interview, the facility failed to post "Oxygen in Use" signs on rooms where oxygen was stored. The deficient practice would not alert persons entering the room to use extra caution with potential sources of ignition. The facility has the capacity for 10 beds with a census of 10 on the day of survey. Findings are: Observation on 2-9-21 at 11:44 am revealed, three oxygen cylinders stored in the Nurse Office no warning signage was posted. During an interview on 2-9-21 at 11:44 am, Maintenance Staff A confirmed the oxygen cylinders stored in the office. Based on observation and interview, the facility failed to prohibit the use of electrical adaptors. This deficient practice would create electrical injury and increase a fire hazard. The facility has the capacity for 10 beds with a census of 10 on the day of survey. Findings are: Observation on 2-9-21 at 12:25 pm revealed, a six-plex electrical adaptor plugged into an outlet near the television. During an interview on 2-9-21 12:25 pm, Maintenance Staff A confirmed the use of the electrical adaptor.	K 000		

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

[signature] ICFA 2/24/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 03 - 723 SOLAR DRIVE B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 723 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 11.	K 000		
K0500	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 32.2.5 and 33.2.5 Building Services 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 failed to post "Caution - Oxygen in Use" signs on rooms where oxygen was stored. The deficient practice would not alert persons entering the room to use extra caution with potential sources of ignition. The facility has the capacity for 10 beds with a census of 10 on the day of survey. Findings are: Observation on 2-9-21 at 11:44 am revealed,	K0500		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 03 - 723 SOLAR DRIVE B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0500	Continued From page 2 three oxygen cylinders stored in the Nurse Office no warning signage was posted. During an interview on 2-9-21 at 11:44 am, Maintenance Staff A confirmed the oxygen cylinders stored in the office.	K0500		
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 prohibit the use of electrical adaptors. This deficient practice would create electrical injury and increase a fire hazard. The facility has the capacity for 10 beds with a census of 10 on the day of survey. Findings are: Observation on 2-9-21 at 12:25 pm revealed, a six-plex electrical adaptor plugged into an outlet near the television. During an interview on 2-9-21 12:25 pm, Maintenance Staff A confirmed the use of the electrical adaptor.	K0511		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 04 - 715 SOLAR DRIVE B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 715 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 16 skilled certified beds. At the time of the survey the census was 10.	K 000		

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

TITLE: LCFA

(X6) DATE: 2/24/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 10 - SOLAR 3052 B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3052 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 12 skilled certified beds. At the time of the survey the census was 9.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LCFA | (X6) DATE: 2/24/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **11 - SOLAR 3058** B. WING _____	**02/09/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	**INITIAL COMMENTS** 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3056 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 10 skilled certified beds. At the time of the survey the census was 9. 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LCFA | (X6) DATE: 2/24/21

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING 12 - SOLAR 3060 B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. Solar Cottage, 3060 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 10 skilled certified beds. At the time of the survey the census was 8.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CFA — (X5) DATE: 2/24/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **12 - SOLAR 3060** B. WING _____	02/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the door to a hazard area closed and latched within the doorframe. This deficient practice would allow smoke, fire and gasses to escape the hazard room and enter the exit corridor, which would delay egress. The facility has the capacity for 10 beds with a census of 8 on the day of survey. Findings are: Observations on 1-9-21 at 10:20 am revealed the Mechanical Room door equipped with a self-closing device failed to close and latch within the doorframe. During an interview on 2-9-21 at 10:20 am, Maintenance Staff confirmed the door to the Mechanical Room failed to close and latch.	K0321		

DHHS Public Health-Licensure Unit

State Building Surveys

Attachment B4

State Building ICF

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

TRANSMISSION OK

JOB NO.	1571
DESTINATION ADDRESS	914027422326
SUBADDRESS	
DESTINATION ID	
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NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS.DDBHFacilities@nebraska.gov FROM: Russell Fralin, Staff Assistant II

COMPANY: DATE: March 12, 2021

FAX NUMBER: 402.742.2326 TOTAL PAGES INCLUDING COVER: 4

PHONE NUMBER: PHONE NUMBER: 402.223.6827

☐ URGENT ✓ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

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

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

Please advise if further information is needed.

Thank You

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

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Please advise if further information is needed.

Thank You

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 4, 2021

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

Dear Ms. Urbaschek:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On February 22-26, 2021, 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 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.DDBHFacilities@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 **April 12, 2021**.

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 402-742-2326.

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

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

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE. BEATRICE, NE 68310	2/26/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E 200	**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:**	
	Record review revealed the documents titled "Beatrice State Developmental Center (BSDC) Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" and "Crisis Stabilization Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" dated 1/22/2021 revealed no evidence of a comprehensive Quality Assurance (QA) Plan developed and implemented specifically for the licensed ICF/IID know as 400 State Building located at 3104, 3070 and 3071 State Street. The BSDC plan was a compilation of combined data and recommendations for the ICF/IIDs know as Solar Cottages, Lake Street and 400 State Building (including living units 3070 and 3071). The Crisis Stabilization QA/QI plan was a separate QA plan specific to the four living units located at 3104 State.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Record review revealed the documents titled "Beatrice State Developmental Center (BSDC) Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" and "Crisis Stabilization Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" dated 1/22/2021 revealed no evidence of a comprehensive Quality Assurance (QA) Plan developed and implemented specifically for the licensed ICF/IID know as 400 State Building located at 3104, 3070 and 3071 State Street. The BSDC plan was a compilation of combined data and recommendations for the ICF/IIDs know as Solar Cottages, Lake Street and 400 State Building (including living units 3070 and 3071). The Crisis Stabilization QA/QI plan was a separate QA plan specific to the four living units located at 3104 State.	4/12/2021
	Beginning with the 1st quarter of 2021, the Quality Improvement (QI) Report will be separated, developed and specific for the licensed three ICF/IIDs known as Solar Cottages, Lake Street and 400 State Building (including living units 3070 and 3071).	4/12/2021

	Each of the Quality Improvement (QI) Reports will maintain documentation of activities and include the following: (1) identification of a responsible party; (2) identification of problems, recommendations, and actions; (3) identification of resolution; and (4) recommendations for improvement. Each report will develop and implement a quality assurance/performance improvement program that is ongoing, comprehensive and proactive in an internal review of the facility to ensure and improve quality, appropriateness, efficiency, and effectiveness of services and supports to individuals in the three specific ICF/IIDs know as Solar Cottages, Lake Street and State Building (including living units 3070 and 3071).	4/12/2021
	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:	
	Beginning with the 1st quarter of 2021, the Quality Improvement (QI) Report will be separated, developed and specific for the licensed three ICF/IIDs known as Solar Cottages, Lake Street and 400 State Building (including living units 3070 and 3071).	4/12/2021
	Each of the Quality Improvement (QI) Reports will maintain documentation of activities and include the following: (1) identification of a responsible party; (2) identification of problems, recommendations, and actions; (3) identification of resolution; and (4) recommendations for improvement. Each report will develop and implement a quality assurance/performance improvement program that is ongoing, comprehensive and proactive in an internal review of the facility to ensure and improve quality, appropriateness, efficiency, and effectiveness of services and supports to individuals in the three specific ICF/IIDs know as Solar Cottages, Lake Street and State Building (including living units 3070 and 3071).	4/12/2021
	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 DD QDDP Quality Control Supervisor will be the responsible position to monitor and ensure compliance.	4/12/2021
E 240	**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:**	
	Based on observation and interview, the facility failed to ensure all living units at State Building ICF/IID (3104 State – living units 402, 404, 406 and 408), 3070 and 3071 State Avenue were maintained in a manner that is safe, clean and functional.	4/12/2021
	The two remaining individuals residing at State Building ICF/IID (3104 State - living unit 408) will be moved from this home to 3071 State Avenue and the 3104 building will be vacated.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Based on observation and interview, the facility failed to ensure all living units at State Building ICF/IID (3104 State – living units 402, 404, 406 and 408), 3070 and 3071 State Avenue were maintained in a manner that is safe, clean and functional.	4/12/2021

	The two remaining individuals residing at State Building ICF/IID (3104 State - living unit 408) will be moved from this home to 3071 State Avenue and the 3104 building will be vacated.	4/12/2021
	Work Orders have been submitted to the Beatrice State Developmental Center (BSDC) Maintenance Department to evaluate the structural and the physical environment at all of the designated living units at State Building ICF/IID (3104 State - living units 402, 404, 406 and 408), and 3070 and 3071 State Avenue, to make the needed repairs and/or replacements identified during the recent survey and specified in the Work Orders submitted to ensure the building and living units are maintained in a manner that is safe, clean, functional to receive clients.	4/12/2021
	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:	
	Through consultation and observation, the ICF Administrator and Home Manager will meet with the Facility Maintenance Manager weekly to ensure the needed repairs and/or replacements identified are completed and that the building/living units are maintained in a manner that is safe, clean and functional to receive clients.	4/12/2021
	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 position to monitor and ensure completion for compliance.	4/12/2021
W 240	**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:**	
	Client 3's 12/8/20 Speech Evaluation and 1/6/21 Individual Support Plan (ISP) referenced the need to alter consistency of food based on symptoms of mental illness (mania) and direct support staff may need to "downgrade" diet when Client 3 displayed unsafe eating behavior.	4/12/2021
	For Client 3, the IDT will meet to review and revise the ISP to include directions for direct support staff on when to modify Client 3's food consistency and the extent of modification based on Client 3's behavioral changes.	4/12/2021
	The IDT will meet to ensure the evaluations to include Speech Evaluation, ISP and Dining Card all provide clear, concise, and consistent directions to direct support staff as to what behaviors constitute the need to modify Client 3's food consistency and/or to the extent of the modification, based on Client 3's behaviors	4/12/2021
	The QDDP will in-service all direct support staff at the home and in the ICF to ensure they are made aware and understand the directions of what behaviors constitute the need to modify Client 3's food consistency and/or to the extent of the modification, based on Client 3's behaviors.	4/12/2021

	For all other individuals residing within the State Building ICF, the IDT will review mealtime strategies to ensure they contain clear and concise directions to direct support staff.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 3, the IDT will meet to review and revise the ISP to include directions for direct support staff on when to modify Client 3's food consistency and the extent of modification based on Client 3's behavioral changes.	4/12/2021
	The IDT will meet to ensure the evaluations to include Speech Evaluation, ISP and Dining Card all provide clear, concise, and consistent directions to direct support staff as to what behaviors constitute the need to modify Client 3's food consistency and/or to the extent of the modification, based on Client 3's behaviors	4/12/2021
	The QDDP will in-service all direct support staff at the home and in the ICF to ensure they are made aware and understand the directions of what behaviors constitute the need to modify Client 3's food consistency and/or to the extent of the modification, based on Client 3's behaviors.	4/12/2021
	For all other individuals residing within the State Building ICF, the IDT will review mealtime strategies to ensure they contain clear and concise directions to direct support staff.	4/12/2021
	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:	
	Monitoring will be completed through observation and audits by the Compliance Specialists, QDDPs, Home Manages and DTSS.	4/12/2021
	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 position for monitoring and to ensure compliance.	4/12/2021
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:**	
	a. For Client 3; Staff Member A will be provided an in-service regarding the need for ensuring that Client 3's Individual Support Plan (ISP) is implemented and that Client 3 participates in their Administration of Medication Program at every given opportunity.	4/12/2021
	For all other individuals residing within the State Building ICF, all staff will be re-in-serviced on medication administration programs as outlined in the Individual Support Plan (ISP).	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	a. For Client 3; Staff Member A will be provided an in-service regarding the need for ensuring that Client 3's Individual Support Plan (ISP) is implemented and that Client 3 participates in their Administration of Medication Program at every given opportunity.	4/12/2021
	For all other individuals residing within the State Building ICF, all staff will be re-in-serviced on medication administration programs as outlined in the Individual Support Plan (ISP).	4/12/2021
	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:	
	A monitoring system will be developed to ensure implementation of the ISP and the medication administration programs to be completed by Compliance Specialists, QDDPs, Home Managers and DTSS.	4/12/2021
	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 position for monitoring and to ensure compliance.	4/12/2021
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:**	
	b. For Client 3; Staff Member B will be re-in-serviced on the appropriate training techniques and implementation of the Individual Support Plan (ISP) program "Set Spoon Down" to ensure staff are encouraging Client 3 to set their spoon down between bites to learn to eat at a slower pace and allow time to swallow after each bite at every meal or at every given opportunity as appropriate.	4/12/2021
	For Client 1: Staff Members E, F and G will be re-in-serviced on the appropriate training techniques and implementation of the Individual Support Plan (ISP) dated 1/13/21 and Dining Card updated 1/13/21 identifying Client 1's current diet as regular calorie servings with "bite-size texture" to be cut before presentation to Client 1 at mealtime.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	b. For Client 3; Staff Member B will be re-in-serviced on the appropriate training techniques and implementation of the Individual Support Plan (ISP) program "Set Spoon Down" to ensure staff are encouraging Client 3 to set their spoon down between bites to learn to eat at a slower pace and allow time to swallow after each bite at every meal or at every given opportunity as appropriate.	4/12/2021
	For Client 1: Staff Members E, F and G will be re-in-serviced on the appropriate training techniques and implementation of the Individual Support Plan (ISP) dated 1/13/21 and Dining Card updated 1/13/21 identifying Client 1's current diet as regular calorie servings with "bite-size texture" to be cut before presentation to Client 1 at mealtime.	4/12/2021
	For all other individuals residing within the State Building ICF, all staff will be re-in-serviced on mealtime programs as outlined in the Individual Support Plan (ISP).	4/12/2021

	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:	
	A monitoring system will be developed to ensure implementation of the ISP and the mealtime programs to be completed by Compliance Specialists, QDDPs, Home Managers and DTSS.	4/12/2021
	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 position for monitoring and to ensure compliance.	4/12/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 200	17-006.06 Quality Assurance/Performance Improvement The facility must develop and implement a quality assurance/performance improvement program that is an ongoing, comprehensive, and proactive internal review of the facility to ensure and improve quality, appropriateness, efficiency, and effectiveness of services and supports to individuals. The program must maintain documentation of activities and include the following, but is not limited to: 1. Identification of responsible party; 2. Identification of problems, recommendations, and actions; 3. Identification of resolution; and 4. Recommendations for improvement. This Standard is not met as evidenced by: . Based on record review and interview, the facility failed develop and implement a comprehensive quality assurance (QA) plan which identified facility specific problems, resolutions, improvement recommendations and the party responsible for oversight of the QA plan. This had the potential to affect all clients residing at the facility. The facility census was 12 at the time of the survey. Findings: Record review of the documents titled, "Beatrice State Developmental Center (BSDC) Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" and "Crisis Stabilization Fourth Quarter 2020 (4Q20) Quality Improvement (QI) Report" revealed no evidence of a comprehensive Quality Assurance (QA) Plan developed and implemented specifically for the licensed ICF/IID	E 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 200	Continued From page 1 known as 400 State Building located at 3104, 3070, and 3071 State Street. The BSDC plan was a compilation of combined data and recommendations for the ICFIIDs known as Solar Cottages, Lake Street, and 400 State Building (living units 411 and 412). The Crisis Stabilization QA/QI plan was a separate QA plan specific to the four living units located at 3104 State. In an interview on 2/25/2021 at 1:30pm, the Quality Assurance (QA) Specialist confirmed there was not a QA plan developed or implemented specifically for the ICFIID licensed as 400 State Building. The QA Specialist verified the data collected for the BSDC QA plan was an overall arching plan for the three ICFIIDs located on the BSDC campus and did not separate or identify the data, resolutions, and recommendations specific for the licensed ICFIID known as 400 State Building. The QA Specialist further verified that the QA plan for Crisis Stabilization Unit was separated as there were different quality improvement measures due to the specialized behavioral services provided in those four living units. The QA Specialist confirmed the facility was not in compliance with the regulation which required a specific comprehensive and proactive QA plan for the licensed 400 State Building ICFIID. Review of the facility policy titled, "Quality Improvement Program Plan" (dated 1/22/2021) identified that the purpose of the plan was to monitor and ensure the delivery and support of quality services to the independent ICFIID facilities located on the Beatrice State Developmental Center (BSDC) campus. The QA plan was to be an ongoing, comprehensive, and proactive internal review of the facility to ensure and improve quality of the provision of services.	E 200		

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

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

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E 200	Continued From page 2	E 200		
E 240	17-007 Physical Plant Standards The facility must be designed, constructed and maintained in a manner that is safe, clean, and functional for the type of services to be provided. The physical plant standards, which include support services, construction standards, building systems, and waivers, are set forth below. 17-007.01 Support Areas: The facility may share the following support service areas among detached structures, and with other licensed facilities. This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure all living units were maintained in a manner that is safe, clean, and functional. This failure had the potential to affect all clients residing at the facility. Facility census was 12 at the time of the survey. FINDINGS: Observations on 2/24/2021 at 10:30AM-1:00PM and 2:00PM-3:30PM revealed the following: A. Living units: 402, 404, 406 1) Bathrooms: a) Sealant in and around showers, tubs, and toilets was discolored, peeling away, and missing in some areas b) There was a large hole in the ceiling of one bathroom from maintenance fixing water damage	E 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 240	Continued From page 3 (402) c) Multiple toilets were not in working order d) Missing mirror (402) e) One bathroom without running water (406) 2) Bedrooms: a) Bubbles under paint on walls stemming from water damage b) Holes in the walls in multiple bedrooms c) Areas in walls and window wells with drywall exposed due to water damage. d) One bedroom with floor-to-ceiling hole in wall due to maintenance fixing water damage (402) 3) Living Rooms: a) Carpet in the living rooms was worn and had multiple large, dark brown stains in higher traffic areas (402, 404) b) One home had missing ceiling tiles (406) Interview with the House Manager on 2/24/2021 during the physical environment walkthrough confirmed the preceding issues needed to be fixed or replaced and the living units were not maintained in a way that was ready to receive clients. B. Living unit 408 1) Bathrooms: a) Sealant in and around showers, tubs, sinks, and toilets was discolored, peeling away, and missing in some areas b) Grout in the showers was a dark brown color, when the original color was a light gray c) The floor in the toilet stall area in Client 1's bathroom had a dark yellow, crusted substance along the wall and in corners d) The interior of Client 1's toilet contained brown and dark yellow colored streaks inside and outside of the water 2) Bedrooms: a) Bubbles under paint on walls stemming from	E 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 240	Continued From page 4 water damage in an unoccupied bedroom b) Dents/holes in bedroom walls revealing inner drywall in unoccupied bedrooms 3) Living Room: a) One chair in the living room was discolored brown color with tears in the seating revealing the inner cushion 4) Kitchen a) The door to the locked cabinet where drinking glasses are kept was stained with brown prints and smears from opening and closing. The cabinet also had multiple shelves covered in sawdust. C. Living unit 3071 1) In two bathrooms, sealant in and around showers, tubs, and toilets was discolored, peeling away, and missing in some areas 2) In one bathroom, the grout where the shower and floor met was chipped and discolored black color. 3) In one bathroom, a wall storage cabinet was missing one of the doors and the other door did not open D. Living unit 3070 1) Bathrooms: a) Sealant and grout in and around showers and toilets was discolored, peeling away, and missing in some areas b) Two toilets were found to have yellow and brown matter both inside and outside the toilet and toilet seat 2) Bedrooms: a) Two client bedrooms had large holes in the wall; One hole above client bed and one hole near base board next to bedroom door 3) Living Room: a) Tile in living room area was chipped and missing	E 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	02/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 240	Continued From page 5 Interview with the House Manager on 2/24/2021 during the physical environment walkthrough confirmed the preceding issues in all units needed to be fixed or replaced. Interview with the Administrator on 2/25/2021 at 2:00PM confirmed living units 402, 404, and 406 were not maintained in a way that was ready to receive clients. The Administrator confirmed the findings of the preceding issues in all units needed to be fixed or replaced.	E 240		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Representatives of the DHHS Division of Public Health conducted a Survey from 2/22/2021 through 2/26/2021 to determine compliance with the Appendix Z, Emergency Preparedness regulations. The facility census was 12 at the time of the Survey. The facility was found to be in compliance with the Federal Emergency Preparedness requirements pertaining to Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFIID).	E 000		

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

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

Dawn C. Ulrichek ICFA 3/12/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the Individual Support Plan (ISP) for 1 of 3 clients reviewed (Client 3) included directions to staff on when to modify Client 3's food consistency and the extent of that modification based on Client 3's behavioral changes. This failure had the potential to affect all clients who required a diet where modification in food consistency was necessary. Facility census was 12 at the time of the survey. Findings: A review of Client 3's 1/2/2021 dining card identified Client 3's regular food texture was bite-size." Further review of the dining card found it included the following eating strategies: "1. If I am exhibiting unsafe/impulsive behaviors of increased rate of eating or not chewing my food, staff may alter my food to chopped, found or pureed consistency. Review of Client 3's 12/8/20 Speech Evaluation and their 1/6/2021 ISP both reference the need to alter the consistency of Client 3's food based on symptoms of mental illness (mania) and staff may need to "downgrade" Client 3's diet when Client 3 displayed unsafe eating behavior. Neither the ISP, Speech Evaluation or dining card provided direction to staff as to what behaviors	W 240		

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.

Dawn C. Ubaschek ICFA 3/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	Continued From page 1 constituted the need to modify Client 3's food consistency or to the extent of the modification (from bite-size to puree) based on Client 3's behaviors. Staff C, interviewed 2/24/2021 at 10:45am, confirmed they routinely worked with Client 3 and staff were to modify Client 3's diet based on Client 3's behavior during manic episodes. Staff C reported they were not aware of any directions for staff to follow when modifying Client 3's diet from a bite-size consistency. Staff C reported staff were to "use their own judgement" as to when and how to modify Client 3's food consistency. Interview with QIDP B on 2/25/21 at 1:30pm confirmed Client 3's records (dining card, ISP or other evaluations) did not include direction to staff on when to modify Client 3's diet or what food consistency Client 3 should have based on Client 3's changing behaviors.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 2 This STANDARD is not met as evidenced by: . Based on record review, observation and interview, the facility failed to ensure training programs and dining protocols were implemented in accordance with Individual Support Plans (ISPs) for 2 of 3 clients in the sample (Client 1 and Client 3). This failure had the potential to affect all clients residing at the facility. Facility census was 12 at the time of the survey. Findings: Client 3: Review Client 3's 1/6/2021 ISP identified two training program which were not implemented as written. Specifically: a) Medication Administration Program Client 3 had an Administration of Medication Program to "complete 45% of the steps to administer my medications". According to the program, Client 3 was to locate the medication administration area, state their name and identify were their medication was located. The program also documented training of the skills "should occur at every given opportunity." Observation of the 4:00 pm medication administration pass on 2/23/2021 identified Staff A failed to implement the program, giving Client 3 their medications without asking the questions listed in the program. Interview with QIDP B on 2/25/21 at 1:30pm confirmed Client 3's medication administration program should have been implemented during	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

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

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W 249	Continued From page 3 the 4:00pm medication pass. b) Meal Time Program Client 3 had a "Set Spoon Down" program to be implement as needed and at every given opportunity. According to the program, staff were to provide a verbal prompt following each bite should Client 3 fail to set their spoon down between bites. The program stipulated the purpose of getting Client 3 to set their spoon down between bites was to have Client 3 "learn to eat at a slow pace and allow time to swallow" after each bite. Observations of the evening meal on 2/22/2021 at 5:07pm - 5:30pm identified Client 3 to take multiple bites of their evening meal without putting their spoon down between each bite. Staff B, who was assigned to be 1 to 1 with Client 3 during the meal, failed to provide Client 3 with cues to put the spoon down, as directed in the training program. When asked on 2/22/21 at 5:33pm, if Client 3 had a program to be implement at meals, Staff B reported they "did not know and would have to check". When informed of the "setting the spoon down" program, Staff B confirmed they did not implement the program as they did not cue Client 3 to put the spoon down between each bite. Interview with QIDP B on 2/25/21 at 1:30pm confirmed Client 3's "set the spoon down" program should be implemented anytime Client 3 was eating and failed to set down their spoon between bites. Client 1	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 4 Review of Client 1's Individual Support Plan (ISP) (dated 1/13/2021) and the Dining Card (updated 1/13/2021) identified the client's current diet was regular calorie servings with "Bite-sized texture." The Dining Card identified that staff were to cut Client 1's before presentation of food. Observations on 2/22/2021 at 5:35pm revealed that Client 1 was provided penne pasta noodles, sliced kielbasa, asparagus spears, and a bowl of diced apple. After 6 minutes, Staff F looked at Client 1's dining card, then asked Client 1 to stop eating and cut up the noodles into bite sized pieces but not the kielbasa and asparagus. At 5:53pm, Client 1 requested and served themselves second helpings of noodles, kielbasa, and asparagus. Staff E was sitting at the table and did not assist or prompt Client 1 to cut up their food into bite sized pieces. Observations on 2/23/2021 at 11:30am revealed Client 1's lunch of canned carrots, penne noodles, and tater tots were not cut into bite sized pieces. Staff G was present during the lunch meal and did not offer or prompt Client 1 to cut their food into bite sized pieces. Interview on 2/24/2021 at 2:10pm, QIDP-A (Qualified Intellectual Disabilities Professional) verified that Client 1's diet was to be presented in bite-sized pieces according to the Nutrition and Speech Therapy assessments and Client 1's ISP. QIDP-A confirmed that Client 1's meals (as described above) should have been cut into bite sized pieces as ordered and identified in the ISP.	W 249		

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 28, 2021

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 **unlicense** the ten beds at 3070 State Avenue in the 400 State ICF. The unlicensed beds at 3070 State Avenue will remain vacant and with the 400 State ICF until such time as the rennovations of this home are completed and the home is ready for occupancy. This will decrease the number of licensed beds in the 400 State ICF from 58 to 48 during this time period.

We would like this request to become official on September 28, 2021.

If you have any questions, please do not hestitate to contact me at dawn.urbaschek@nebraska.gov or 402.239.0993.

Dawn Urbaschek

Dawn Urbaschek, ICF/DD Manager
400 State ICF
402.239.0993

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE, BEATRICE, NE 68310	9/22/2021
	SURVEY EVENT ID#	KE0812
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E-240		
	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:	
	Based on observation and interview, the facility failed to ensure all living units were maintained in a manner that is safe, clean, and functional. Observations on 9/21/2021 revealed none of the physical environment issues cited at 3070 State Avenue during the 2/26/2021 recertification survey have been repaired.	Indefinite
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Based on observation and interview, the facility failed to ensure all living units were maintained in a manner that is safe, clean, and functional. Observations on 9/21/2021 revealed none of the physical environment issues cited at 3070 State Avenue during the 2/26/2021 recertification survey have been repaired.	Indefinite
	Interview with the Administrator on 9/21/2021 confirmed that 3070 State Avenue remained in disrepair and was not in a way that was ready to receive clients.	Indefinite
	A letter is being sent to Public Health requesting to **unlicense** the ten beds at 3070 State Avenue in the 400 State ICF. The beds will remain vacant and with the 400 State ICF until such time as the rennovations of this home are complete and the home is ready to receive clients. (Attached request letter)	Indefinite
	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 ICF Administrator will continue to meet with the Facility Maintenance Manager to ensure the needed repairs and/or replacement identifed are completed and that 3070 State Avenue is maintained in a manner that is safe, clean and functional to receive clients.	Indefinite
	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 position to monitor and ensure completion for compliance.	Indefinite

	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	C. THE MONITORING OR TRACKING PROCEDURE(S) TO ENSURE THE FACILITY IS EFFECTIVE IN CORRECTING THE DEFICIENCY AND TO ENSURE THE FACILITY REMAINS IN COMPLIANCE WITH THIS DEFICIENCY:	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	R 09/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 240	17-007 Physical Plant Standards The facility must be designed, constructed and maintained in a manner that is safe, clean, and functional for the type of services to be provided. The physical plant standards, which include support services, construction standards, building systems, and waivers, are set forth below. 17-007.01 Support Areas: The facility may share the following support service areas among detached structures, and with other licensed facilities. This Standard is not met as evidenced by: . Based on observation and interview, the facility failed to ensure all living units were maintained in a manner that is safe, clean, and unctional. This failure had the potential to affect all clients residing at the facility. Facility census was 5 at the time of the survey. FINDINGS: Observations on 9/21/2021 at 10:45AM revealed none of the physical environment issues cited at 3070 during the 2/26/2021 recertification survey had been repaired. Specifically 1) Bathrooms: a) Sealant and grout in and around showers and toilets was discolored, peeling away, and missing in some areas b) Two toilets were found to have yellow and brown matter both inside and outside the toilet and toilet seat 2) Bedrooms: a) Two client bedrooms had large holes in the wall; one hole above client bed and one hole near base board next to bedroom door	E 240		

Licensure Unit
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbanchek — TITLE: ICFA — (X6) DATE: 9/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ICFDD07	A. BUILDING: _____ B. WING _____	R 09/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 240	Continued From page 1 3) Living Room: a) Tile in living room area was chipped and missing Interview with the House Manager on 9/21/2021 during the physical environment walkthrough confirmed the concerns cited at the recertification survey had not been fixed. Interview with the Administrator on 9/21/2021 at 1:00pm confirmed 3070 remained in disrepair and not in a way that was ready to receive clients.	E 240		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING _____ B. WING _____	R 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 000	INITIAL COMMENTS Representative of the DHHS, Division of Public Health conducted a revisit on 9/20-22/21 to the 2/26/2021 recertification survey. This revisit was 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. Facility census was 5 at the time of this revisit. The facility was in compliance with the regulations previously cited.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Urbaschek | TITLE: ICFA | (X6) DATE: 9-28-2021

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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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 27, 2021

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

Dear Ms. Urbaschek:

The enclosed report documents a finding of noncompliance with the licensure regulations for 400 State Building Intermediate Care Facility For Intellectually Disabled following the revisit survey at your facility completed on September 22, 2021 by representatives of the Nebraska Department of Health and Human Services Division of Public Health.

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

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

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

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

Sincerely,

Mark Luger

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

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER
FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Staff Assistant II

COMPANY:

DATE: March 26, 2021

FAX NUMBER: 402.742-2326

TOTAL PAGES INCLUDING COVER: 9

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ☐ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567's received from the Fire Marshal for Dawn Urbaschek and the State Building ICF at the Beatrice State Developmental Center.

The plan of correction is being emailed per the instructions on the email received.

Please advise if further information is needed.

Thank you

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE. BEATRICE, NE 68310	2/26/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
400 State		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. At State Building-406, the west north-west door equipped with a self-closing device was held open with a wet floor sign. The Safety Coordinator immediately removed the wet floor sign so that the door would close with the self-closing device.	3/9/2021
	2. Observation revealed that several ceiling tiles were out of the grid in the laundry linen closet. A work order was submitted to the Maintenance Department to install ceiling tiles into the grid in the laundry linen closet at State Building-406.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. At State Building-406, the west north-west door equipped with a self-closing device was held open with a wet floor sign. The Safety Coordinator immediately removed the wet floor sign so that the door would close with the self-closing device.	3/9/2021
	2. Observation revealed that several ceiling tiles were out of the grid in the laundry linen closet. A work order was submitted to the Maintenance Department to install ceiling tiles into the grid in the laundry linen closet at State Building-406.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
K0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	

	Observation revealed circuit breaker #27 in Electrical Panel Box G located in the basement had been removed and a cover had not been installed in the opening. A work order was submitted to the Maintenance Department to install a cover in the opening.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed circuit breaker #27 in Electrical Panel Box G located in the basement had been removed and a cover had not been installed in the opening. A work order was submitted to the Maintenance Department to install a cover in the opening.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
K0700	**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. Observation revealed the valves for Type 1 natural gas generator were not locked or restricted/removed. A work order was submitted to the Maintenance Department to remove the handle on the gas valve and locate the handle in the generator doors.	4/12/2021
	2. Observation revealed the remote annunciator failed to be located in an attended area. A work order was submitted to the Maintenance Department to move the annunciator panel to an "attended location".	4/12/2021
	3. Observation revealed the facility failed to provide documentation for testing emergency generators on a monthly basis to assure the water temperature and oil pressure have stabilized.	4/12/2021
	4. Observation revealed the facility failed to document testing of the maintenance free batteries for the emergency generator.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Observation revealed the valves for Type 1 natural gas generator were not locked or restricted/removed. A work order was submitted to the Maintenance Department to remove the handle on the gas valve and locate the handle in the generator doors.	4/12/2021

	2. Observation revealed the remote annunciator failed to be located in an attended area. A work order was submitted to the Maintenance Department to move the annunciator panel to an "attended location". ****See attached email response from State Building Division, Lincoln, Nebraska.**	4/12/2021
	3. Observation revealed the facility failed to provide documentation for testing emergency generators on a monthly basis to assure the water temperature and oil pressure have stabilized. **This was forwarded to NMC CAT, Lincoln.**	4/12/2021
	4. Observation revealed the facility failed to document testing of the maintenance free batteries for the emergency generator. ****Documentation of testing is located in the Facility Maintenance Manager's office.**	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE. BEATRICE, NE 68310	2/26/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
D Building		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. Observation revealed the 1 - 1/2 hour fire rated tunnel door had an undercut greater than 3/4". A work order was submitted to the Maintenance Department to install a door sweep on the tunnel door.	4/12/2021
	2. Observation revealed two wheelchairs holding open the double 3-hour fire rated doors to the east mechanical room. The Safety Coordinator removed the two wheelchairs immediately so the doors would close.	3/9/2021
	3. Observation revealed several unsealed penetrations on the west wall of the east mechanical room. A work order was submitted to the Maintenance Department to seal all penetrations in west wall of the east mechanical room.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Observation revealed the 1 1/2 hour fire rated tunnel door had an undercut greater than 3/4". A work order was submitted to the Maintenance Department to install a door sweep on the tunnel door.	4/12/2021
	2. Observation revealed two wheelchairs holding open the double 3 hour fire rated doors to the east mechanical room. The Safety Coordinator removed the two wheelchairs immediately so the doors would close.	3/9/2021
	3. Observation revealed several unsealed penetrations on the west wall of the east mechanical room. A work order was submitted to the Maintenance Department to seal all penetrations in west wall of the east mechanical room.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021

	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.	

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Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE. BEATRICE, NE 68310	2/26/2021
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD07

CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
Chapel		
K0211	**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:**	
	Observation revealed a large portion of sidewalk from the exit door in the Chapel classroom had been removed due to a landscaping drainage project. A work order was submitted to the Maintenance Department to have the concrete sidewalk replaced by a Contractor with the start up of the ADA project.	Beginning 6/1/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed a large portion of sidewalk from the exit door in the Chapel classroom had been removed due to a landscaping drainage project. A work order was submitted to the Maintenance Department to have the concrete sidewalk replaced by a Contractor with the start up of the ADA project.	Beginning 6/1/2021
	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.	6/1/2021
	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.	6/1/2021
	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.	

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CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
Carstens Center		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. Observation revealed ceiling tiles out of the grid in the Café dish room. A work order was submitted to the Maintenance Department to install ceiling tiles back into the grid in the Café dish room.	4/12/2021
	2. Observation revealed the Gym Equipment Storage Room door failed to be equipped with a self-closing device. A work order was submitted to the Maintenance Department to install a self-closing door closer on the Gym Equipment Storage Room.	4/12/2021
	3. Observation revealed the room next to the Pool Manager's office was used as a storage room and the door failed to provide a self-closing device. A work order was submitted to the Maintenance Department to install a self-closing door closer on the door for the room next to the Pool Manager's office used as a storage room.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Observation revealed ceiling tiles out of the grid in the Café dish room. A work order was submitted to the Maintenance Department to install ceiling tiles back into the grid in the Café dish room.	4/12/2021
	2. Observation revealed the Gym Equipment Storage Room door failed to be equipped with a self-closing device. A work order was submitted to the Maintenance Department to install a self-closing door closer on the Gym Equipment Storage Room.	4/12/2021
	3. Observation revealed the room next to the Pool Manager's office was used as a storage room and the door failed to provide a self-closing device. A work order was submitted to the Maintenance Department to install a self-closing door closer on the door for the room next to the Pool Manager's office used as a storage room.	4/12/2021
	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.	4/12/2021

	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.	4/12/2021
K0353	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. Observation revealed items on the top shelf of the closet next to the fitness room were within 18 inches of the sprinkler head. Items were removed immediately by the Safety Coordinator.	3/9/2021
	2. Observation revealed the top shelf in the storage closet in the gym equipment room obstructed the sprinkler head. The Safety Coordinator immediately lowered the shelf and removed the brackets.	3/9/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Observation revealed items on the top shelf of the closet next to the fitness room were within 18 inches of the sprinkler head. Items were removed immediately by the Safety Coordinator.	3/9/2021
	2. Observation revealed the top shelf in the storage closet in the gym equipment room obstructed the sprinkler head. The Safety Coordinator immediately lowered the shelf and removed the brackets.	3/9/2021
	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.	3/9/2021
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	3/9/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

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Provider/Supplier Name:	400 STATE BUILDING	Survey Date
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CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
Admin Building		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed the fire rated door equipped with a self-closing device to the 1st floor laundry room failed to close when the exterior door in the room was open. A work order was submitted to the Maintenance Department to repair door closers on both doors (interior and exterior) of the 1st floor laundry room to ensure they both close and latch.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed the fire rated door equipped with a self-closing device to the 1st floor laundry room failed to close when the exterior door in the room was open. A work order was submitted to the Maintenance Department to repair door closers on both doors (interior and exterior) of the 1st floor laundry room to ensure they both close and latch.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
	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.	

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Provider/Supplier Name:	400 STATE BUILDING	Survey Date
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CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
3071 State		
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed a wooden chock holding open the office door equipped with a self-closing device. The Safety Coordinator removed the wooden chock holding open the door immediately.	3/9/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed a wooden chock holding open the office door equipped with a self-closing device. The Safety Coordinator removed the wooden chock holding open the door immediately.	3/9/2021
	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.	3/9/2021
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	3/9/2021
K0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed a ladder stored in front of the electrical panel boxes in the Mechanical Room. The Safety Coordinator removed the ladder immediately from in front of the electrical panel boxes in the Mechanical Room.	3/9/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Observation revealed a ladder stored in front of the electrical panel boxes in the Mechanical Room. The Safety Coordinator removed the ladder immediately from in front of the electrical panel boxes in the Mechanical Room.	3/9/2021
	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.	3/9/2021
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The Facility Maintenance Manager will monitor and ensure compliance.	3/9/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

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CITED TAGS #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
200 Sheridan		
K0200	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed that the basement exit door was locked. A work order was submitted to the Maintenance Department to install a new door handle on the basement mechanical room south exit door, so as not to impede egress in an emergency.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed that the basement exit door was locked. A work order was submitted to the Maintenance Department to install a new door handle on the basement mechanical room south exit door, so as not to impede egress in an emergency.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
K0225	**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:**	
	Observation revealed the basement stair door failed to close and latch within the doorframe, it appeared to be due to air pressure. A work order was submitted to the Maintenance Department to adjust the door to ensure the door closes and latches within the doorframe.	4/12/2021

	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed the basement stair door failed to close and latch within the doorframe, it appeared to be due to air pressure. A work order was submitted to the Maintenance Department to adjust the door to ensure the door closes and latches within the doorframe.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
K0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	1. Observation revealed the door equipped with a self-closing device in the Bear Creek kitchen storage room failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	2. Observation revealed the south storage room door across from the Women's restroom in Bear Creek equipped with a self-closing device failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	3. Observation revealed the Phone Room door equipped with a self-closing device failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	4. Observation revealed the fire rated door in the basement leading to the crawl space failed to latch as the spring was removed. A work order was submitted to the Maintenance Department to re-install the spring on the crawl space door to ensure it will latch.	4/12/2021
	5. Observation revealed the south 1 - 1/2 hour fire rated tunnel door had an undercut greater than 3/4 of an inch. A work order was submitted to the Maintenance Department to install a door sweep to the tunnel door by the generator room.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	1. Observation revealed the door equipped with a self-closing device in the Bear Creek kitchen storage room failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	2. Observation revealed the south storage room door across from the Women's restroom in Bear Creek equipped with a self-closing device failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	3. Observation revealed the Phone Room door equipped with a self-closing device failed to close and latch within the doorframe. A work order was submitted to the Maintenance Department to adjust the door to ensure it will close and latch within the doorframe.	4/12/2021
	4. Observation revealed the fire rated door in the basement leading to the crawl space failed to latch as the spring was removed. A work order was submitted to the Maintenance Department to re-install the spring on the crawl space door to ensure it will latch.	4/12/2021
	5. Observation revealed the south 1 - 1/2 hour fire rated tunnel door had an undercut greater than 3/4 of an inch. A work order was submitted to the Maintenance Department to install a door sweep to the tunnel door by the generator room.	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
K0345	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation revealed a plastic bag covering a smoke detector in the north-east corner of the Physical Therapy area. A work order was submitted to the Maintenance Department to remove the plastic bag over the smoke detector in the Physical Therapy area.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Observation revealed a plastic bag covering a smoke detector in the north-east corner of the Physical Therapy area. A work order was submitted to the Maintenance Department to remove the plastic bag over the smoke detector in the Physical Therapy area.	4/12/2021

	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.	4/12/2021
	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.	4/12/2021
K0700	**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. Observation revealed the valves for Type 1 natural gas generator were not locked or restricted/removed. A work order was submitted to the Maintenance Department to remove the handle on the gas valve and locate the handle in the generator doors.	4/12/2021
	2. Observation revealed the remote annunciator failed to be located in an attended area. A work order was submitted to the Maintenance Department to move the annunciator panel to an "attended location".	4/12/2021
	3. Observation revealed the facility failed to test emergency generators on a monthly basis to assure the water temperature and oil pressure have stabilized.	4/12/2021
	4. Observation revealed the facility failed to document testing of the maintenance free batteries for the emergency generator	4/12/2021
	5. Observation revealed the facility failed to provide documentation that a 3-year 4-hour load test must operate using the load from the ATS. For spark-ignited generators, the load is permitted to be the available load.	4/12/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Observation revealed the valves for Type 1 natural gas generator were not locked or restricted/removed. A work order was submitted to the Maintenance Department to remove the handle on the gas valve and locate the handle in the generator doors.	4/12/2021
	2. Observation revealed the remote annunciator failed to be located in an attended area. A work order was submitted to the Maintenance Department to move the annunciator panel to an "attended location". ****See attached email response from State Building Division, Lincoln, Nebraska.**	4/12/2021
	3. Observation revealed the facility failed to provide documentation for testing emergency generators on a monthly basis to assure the water temperature and oil pressure have stabilized. **This was forwarded to NMC CAT, Lincoln.**	4/12/2021
	4. Observation revealed the facility failed to document testing of the maintenance free batteries for the emergency generator. ****Documentation of testing is located in the Facility Maintenance Manager's office.**	4/12/2021

	5. Observation revealed the facility failed to provide documentation that a 3-year 4-hour load test must operate using the load form the ATS. For spark-ignited generators, the load is permitted to be the available load. ****Documentation of testing is located in the Facility Maintenance Manager's office.**	4/12/2021
	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.	4/12/2021
	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.	4/12/2021
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.	

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 4, 2021

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

Dear Ms. Urbaschek:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On February 22-26, 2021, 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 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.DDBHFacilities@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 **April 12, 2021**.

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 402-742-2326.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - F Building/Main is a two story building of Type III (200) 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 2 residents. 400 State Building - Main was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt and Slow) Rooms containing high-pressure boilers, refrigerating machinery, transformers, or other service equipment subject to possible explosion shall not be located under or adjacent to exits. All such rooms shall be effectively separated from other parts of the building as specified in section 8.7. Hazardous areas shall be separated with construction of a minimum of 1-hour fire resistance with openings protected with	K0321		

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

Dawn Unverzagt | ICFA | 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 self-closing fire doors or have an automatic extinguishment system and smoke partition in accordance with 8.4. Hazardous areas shall include but not be limited to the following: boiler or heating rooms, laundries, repair shop, spaces storing combustibles in quantities deemed hazardous. 33.3.3.2.2 33.3.3.2.1, 33.3.3.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosure for hazardous areas to separate them from the rest of the facility. This deficient practice would allow fire and smoke to migrate out of the hazard areas into the exit corridor which could delay egress. The facility census was 0. Findings are: Observation on 3-9-21 between 12:06 pm and 12:16 pm revealed: Unit 406 1. The west north-west door equipped with a self-closing device, was held open with a wet floor sign. 2. Several ceiling tiles out of the grid in the Laundry Linen closet. During an interview on 2-10-20 between 12:06 pm and 12:16 pm, Facility Staff A confirmed the findings.	K0321		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric 2012 EXISTING Utilities shall comply with the provisions of 9.1. 33.3.6.1	K0511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0511	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide dead fronts for all circuits in the electrical panels. This deficient practice could cause a delay and injury when turning off the power during an electrical emergency due to accidental contact with live electrical components. Findings are: Observations on 3-9-21 at 11:40 am revealed circuit breaker #27 in Electrical Panel Box G located in the basement had been removed and a cover had not been installed in the opening. During an interview on 3-9-21 at 11:40 am, Maintenance Staff A confirmed the missing dead front in the Kitchen panel box. NFPA Standard: 2011 NFPA 70, 408.38 Panel boards shall be mounted in cabinets, cutout boxes, or enclosures designed for the purpose and shall be dead front.	K0511		
K0700	Operating Features - Other CFR(s): NFPA 101 Operating Features - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.7 Operating Features 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, documentation review and interview, the facility failed to secure the shut-off for the gas supply to the newly installed	K0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 02 - 400 STATE BUILDING B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0700	Continued From page 3 generator which was located outdoors, failed to provide a remote stop button and failed to assure that the emergency generator was tested prior COVID Emergency Declaration. These deficient practices would allow the generator's fuel source to be inadvertently or intentionally be turned off and would not assure the generator would operate. Findings are: Observation on 3-9-21 at 11:13 am revealed: 1. The valves for the Type 1 natural gas generator were not locked or restricted/removed. 2. Remote annunciator failed to be located in an attended location. During an interview on 3-9-21 at 11:13 am, Facility Staff A confirmed the valves on the natural gas pipe were not locked/restricted or removed. During documentation review on 3-9-21 at 3:38 pm revealed: 1. Facility failed to provide documentation for test emergency generator on a monthly basis to assure the water temperature and oil pressure have stabilized. 2. Facility failed to document testing of the maintenance free batteries for the emergency generator. During an interview on 3-9-21 at 3:38 pm, Facility Staff B confirmed the lack of documented testing for the emergency generator. NFPA Standard: NFPA 110-2010, 8.4.9.5.3 The fuel supply to gas-fueled generators shall be connected ahead of the building's main shutoff valve and marked as supply the generator. The	K0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **02 - 400 STATE BUILDING** B. WING _____	**03/03/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0700	Continued From page 4 buildings main gas shutoff valve shall be marked to indicate the existence of the separate generator shutoff valve. Valving for natural gas-fired generators shall be configured so that the gas supply cannot be inadvertently or intentionally shut off by anyone other than qualified personnel such as the gas supplier. Placing valves in an isolated, secured area or locking the valves open can accomplish this. NFPA 110-2010, 8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized.	K0700		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 13, Assembly Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Carstens is a single story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 400 State Building - Carstens was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ubrochek — TITLE: ICFA — (X6) DATE: 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **04 - CARSTENS CENTER- NON-RES** B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous area would close and latch. These deficient practices would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 3-9-21 between 12:50 pm to 1:09 pm revealed: 1. Celling tiles out of the grid in the Café dish room. 2. The Gym Equipment Storage Room measured 22 feet by 20 feet, door failed to be equipped with self-closing device. 3. Room next to the Pool Manager office was used as a storage room, the door failed to provide a self-closing device.	K0321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 2 During an interview on 3-9-21 between 12:50 pm to 1:09 pm, Facility Staff A confirmed the door failed to latch within the doorframe.	K0321		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).	K0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353	Continued From page 3 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that a fire sprinkler was not	K0353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 04 - CARSTENS CENTER- NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353	Continued From page 4 obstructed. This deficient practice would not allow the sprinkler to efficiently extinguish a fire and possibly allow the fire to spread outside of the closet, which would affect all occupants. Findings are: Observation on 3-9-21 at 1:04 pm and 1:10 pm revealed: 1. Items on the top shelf of the closet next to the Fitness Room, obstructed the sprinkler. 2. The top shelf in the storage closet in the Gym Equipment room, obstructed the sprinkler. During an interview on 3-9-21 at 1:04 pm and 1:10 pm, Facility Staff A confirmed the obstruction to the sprinklers.	K0353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 05 - CHAPEL NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 13, Assembly Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Chapel is a single story building of Type V (000) construction that was approved in 2002 and is not sprinkled. 400 State Building - Chapel was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012	K 000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the a side walk was provided, so that egress from the exit would not impede it to full instant use in the case of fire or other emergency. Findings are: Observations on 3-9-21 at 1:28 pm revealed, a	K0211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulrochek | TITLE: ICFA | (X6) DATE: 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **05 - CHAPEL NON-RES** B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0211	Continued From page 1 large portion sidewalk from the exit door in the Chapel Classroom had been removed. During an interview on 3-9-21 1:28 pm, Facility Staff A confirmed the sidewalk was removed for a landscape drainage project and had not been replaced. NFPA Standard: 2012 NFPA 101, 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K0211		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 3071 State is a single story building of Type V (000) construction that was built in 1970 and is fully sprinkled. The facility has 12 certified beds. At the time of the survey the census was 2 residents. 400 State Building - 3071 State was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler	K0321		

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

Daren Ubbesen | ICFA | 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure doors with self-closing devices were not blocked open. This deficient practice could allow smoke, fire and gasses to spread throughout the facility. Findings are: Observations on 3-9-21 at 11:28 am revealed a wooden chock holding open the office door equipped with a self-closing device. During an interview on 3-9-21 at 11:28 am, Facility Staff A confirmed the door held open with	K0321		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0511	Continued From page 3 equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (6?2 ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 65.34(A). In all cases, the work space shall permit at least a 90 degree opening of doors or hinged panels.	K0511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 11 - 3071 STATE AVENUE B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 2 a wooden chock.	K0321		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility allowed storage to obstruct access to the electrical disconnect boxes. This deficient practice could cause a delay and injury when turning off the power during an electrical emergency. Findings are: Observations on 3-9-21 at 11:22 am revealed a ladder stored in front of the electrical panel boxes in the Mechanical Room. During an interview on 3-9-21 at 11:22 am, Facility Staff Staff A confirmed the ladder stored in front of the electrical panel boxes. NFPA Standard: 2011 NFPA 70, 65.26 Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. 2011 NFPA 70,65.32 Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such	K0511		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **12 - 3070 STATE AVENUE** B. WING _____	**03/03/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	**INITIAL COMMENTS** 42 CFR 483.470 The facility is in compliance with the applicable provisions of Chapter 33, Existing Residential Board and Care Occupancies of the 2012 Edition of the National Fire Protection. Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 3070 State is a single story building of Type V (000) construction that was built in 1970 and is fully sprinkled. The facility has 12 certified beds. At the time of the survey the census was 8 residents.	K 000		

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

Dawn Uebrecht | ICFA | 3/26/2021

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - D Building is a three story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 400 State Building - D Building was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Uebrecht | TITLE: ICFA | (X6) DATE: 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosure for hazardous areas to separate them from the rest of the facility. This deficient practice would allow fire and smoke to migrate out of the hazard areas, which could delay egress. Findings are: Observation on 3-9-21 between 12:03 pm and 12:24 pm revealed: 1. The 1 ½-hour fire rated tunnel door had an undercut greater than ¾". 2. Two wheel chair holding open double 3-hour fire rated doors to the east mechanical room. 3. Several unsealed penetrations on the west wall of the east mechanical room	K0321		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 06 - D BLDG NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 2 During an interview on 3-9-21 between 12:03 pm and 12:24 pm, Facility Staff A confirmed the findings.	K0321		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - Administration is a two story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 400 State Building - Administration was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such	K0321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ulbrecht | TITLE: ICFFA | (X6) DATE: 3/26/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 10 - ADMINISTRATION BLDG NON-RES B. WING	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 1 separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous area would close and latch within the door frame. This deficient practice would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 3-9-21 at 1:50 pm revealed, the fire rated door equipped with a self-closing device to the 1st floor "laundry" room failed to close when the exterior door in the room was open During an interview on 3-9-21 at 1:50 pm, Facility Staff A confirmed the door failed to close and latch when the exterior door was open.	K0321		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.470 The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This facility is governed by Chapter 39, Existing Business Occupancies of the 2012 Edition of the National Fire Protection Association [NFPA], Chapter 101: Life Safety Code. 400 State Building - 200 Sheridan is a two story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 400 State Building - 200 Sheridan was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.470 Life Safety from Fire, and the related National Fire Protection Association (NFPA) Standard 101 - 2012 edition.	K 000		
K0200	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Escape Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.2 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 failed to assure that exit doors were not locked. This deficient practice would delay egress during an emergency. Findings are: Observations on 3-9-21 at 2:00 pm revealed that	K0200		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Uebrscher | TITLE: TCF A | (X6) DATE: 3/26/2021

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0200	Continued From page 1 the Basement exit door was locked. During an interview on 3-9-21 at 2:00 pm, Facility Staff A confirmed the exit door was locked.	K0200		
K0225	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures 2012 EXISTING (Prompt) Interior stairs used as a primary means of escape shall be enclosed with fire barriers in accordance with Section 8.3 having a minimum 1/2-hour fire resistance rating. Stairs shall comply with 7.2.2.5.3. The entire primary means of escape shall be arranged so that it is not necessary for the occupants to pass through a portion of a lower story unless that route is separated from all spaces on that story by construction having not less than a 1/2-hour fire resistance rating. In buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction shall be protected to afford the required fire resistance rating of the supported wall. 1. Stairs that connect a story at street level to only one other story shall be permitted to be open to the story that is not at street level. 2. In Prompt Evacuation Capability facilities, stair enclosures shall not be required in buildings of three or fewer stories protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception shall be permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is separated from all spaces on that floor by construction having a 1/2-hour fire	K0225		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0225	Continued From page 2 resistance rating. 3. In Prompt Evacuation Capability facilities, stair enclosures shall not be required in buildings of two or fewer stories with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. The requirement found at section 33.2.2.3.3, 33.2.3.4.6 or 33.2.3.4.3.7 are not permitted to be used in this instance. 4. In Prompt Evacuation Capability facilities, of three or fewer stories protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs shall be permitted to be open at the topmost story only. The entire primary means of escape of which the stairs are a part shall be separated from all portions of lower stories. Stairs shall comply with 7.2.2 unless otherwise specified in Chapter 33. Winders complying with 7.2.2.2.4 shall be permitted. Exterior stairs shall be protected against blockage caused by fire within the building. 33.2.2.4, 33.2.2.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that the Basement stair doors would close and latch within the doorframe. This deficient practice would allow smoke, fire and gasses to spread. Findings are: Observations on 3-09-21 at 1:46 pm revealed, the Basement stair door failed to close and latch within the doorframe, it appeared to be air pressure. During an interview on 3-09-21 at 1:46 pm Facility Staff A confirmed the stair door failed to close and latch within the doorframe.	K0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt) Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means: 1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. 2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8. Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following: 1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction. 2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure. Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment. Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2. 33.2.2.2.4, 33.2.3.2, 33.2.3.2.5	K0321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure doors to hazardous areas were operational. These deficient practices would allow fire, smoke and gasses to migrate into the exit corridor. Findings are: Observation on 3-9-21 between 1:37 am and 3:27 pm revealed: 1. The door equipped with a self-closing device in the Bear Creek Kitchen Storage room failed to close and latch within the doorframe. 2. The south storage room door across from the Women's restroom in Bear Creek equipped with a self-closing device failed to close and latch within the doorframe. 3. The Phone room door equipped with a self-closing device failed to close and latch within the doorframe. 4. The fire rated door in the Basement, leading to the crawl space failed to latch as the spring was removed. 5. The south 1 ½ hour fire rated tunnel door had an undercut greater than ¾ of an inch. During an interview on 3-9-21 between 1:37 pm and 3:27 pm, Facility Staff A confirmed the findings	K0321		
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0345	Continued From page 5 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoke detectors were not covered to make them nonoperational. This deficient practice would delay the activation of the fire alarm and would allow smoke to spread throughout the area. Findings are: Observations on 3-9-21 at 2:10 pm revealed, a plastic bag covering a smoke detector in the north-east corner of Physical Therapy. During an interview on 3-9-21 at 2:10 pm, Facility Staff confirmed the plastic bag covering the smoke detector.	K0345		
K0700	Operating Features - Other CFR(s): NFPA 101 Operating Features - Other List in the REMARKS section any LSC Section 32.7 and 33.7 Operating Features 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, documentation review and interview, the facility failed to secure the shut-off for the gas supply to the Type 1 generator which was located outdoors, failed to provide a remote stop button and failed to assure that the emergency generator was tested prior COVID. These deficient practices would allow the	K0700		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0700	Continued From page 6 generator's fuel source to be inadvertently or intentionally be turned off and would not assure the generator would operate. Findings are: Observation on 3-9-21 at 3:13 pm revealed: 1. The valves for the Type 1 natural gas generator were not locked or restricted/removed. 2. Remote annunciator failed to be located in an attended location. During an interview on 3-9-21 at 3:13 am, Facility Staff A confirmed the valves on the natural gas pipe were not locked/restricted or removed. During documentation review on 3-9-21 at 3:38 pm revealed: 1. Facility failed to test emergency generator on a monthly basis to assure the water temperature and oil pressure have stabilized. 2. Facility failed to document testing of the maintenance free batteries for the emergency generator. 3. Facility failed to provide documentation, that a 3-year 4-hour load test must operate using the load from the ATS. For spark-ignited generators, the load is permitted to be the available load. During an interview on 3-9-21 at 3:38 pm, Facility Staff B confirmed the lack of testing for the emergency generator. NFPA Standard: NFPA 110-2010, 8.4.9.5.3 The fuel supply to gas-fueled generators shall be connected ahead of the building's main shutoff valve and marked as supply the generator. The buildings main gas shutoff valve shall be marked to indicate the existence of the separate	K0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 03 - 200 SHERIDAN NON-RES B. WING _____	03/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0700	Continued From page 7 generator shutoff valve. Valving for natural gas-fired generators shall be configured so that the gas supply cannot be inadvertently or intentionally shut off by anyone other than qualified personnel such as the gas supplier. Placing valves in an isolated, secured area or locking the valves open can accomplish this. NFPA 110-2010, 8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized.	K0700		

200 Sheridan K0200

NEBRASKA
DEPT. OF ADMINISTRATIVE SERVICES
State Building Division

BSIW17- HOSP. INFIRMARY #17/ WEST WING
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 2:00 PM

REGULAR

WO# BSIW176067

STATUS NEW

NOT TO EXCEED $0.00

AGENCY

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

BASIC

DATE CREATED 3/23/2021 10:36 AM

Basement Repair Basement – South exit door leading outside – Door was closed and locked – No key available to unlock the door – Install a box containing #4 key.

ASSIGNMENT

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

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

200 Sheridan K0225

NEBRASKA
State Building Division

BSIW17- HOSP. INFIRMARY #17/ WEST WING
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 2:00 PM | **REGULAR** | **WO# BSIW176065**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 10:33 AM**

Stairwell Other: Center stairwell door leading to basement – Adjust door closer to ensure door will close completely.

ASSIGNMENT

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

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

200 Sheridan K-0321

NEBRASKA
State Building Division

BSIW17- HOSP. INFIRMARY #17/ WEST WING
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 2:00 PM

REGULAR

WO# BSIW176066

STATUS NEW

NOT TO EXCEED $0.00

AGENCY

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

BASIC

DATE CREATED 3/23/2021 10:34 AM

Basement Repair Basement – North crawl space fire door – Door was open and springs were removed from door. (Fire Marshal replaced the spring and closed the door.)

ASSIGNMENT

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

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

200 Sheridan K0321

NEBRASKA

State Building Division

BSA151- NEW ADMINISTRATION
BLDG. #15
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 12:30 PM | **REGULAR** | **WO# BSA1510484**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 9:23 AM**

Interior Repair Basement – South Tunnel door (by old generator room) – gap on the bottom of the door exceeds ¾" .

ASSIGNMENT

Assigned To	Wieden, Dan	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email	daniel.wieden@nebraska.gov	**Start Time**	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

400 State #2 K0321

NEBRASKA
DEPT. OF ADMINISTRATIVE SERVICES
State Building Division

BSF5- STATE BUILDING (F) #5
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 3/30/2021 9:00 AM | **REGULAR** | **WO# BSF56738**

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

AGENCY

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

BASIC | **DATE CREATED 3/23/2021 9:00 AM**

Interior Repair 406 St. - North side of hallway - Linen closet – Ceiling needs panels installed

ASSIGNMENT

Assigned To	Buss, Nate	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email		**Start Time**	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

400 State K0511

NEBRASKA
State Building Division

BSF5- STATE BUILDING (F) #5
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 3/30/2021 8:58 AM | **REGULAR** | **WO# BSF58737**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 8:58 AM**

Basement Other: Basement – North Wall – left electrical panel – Open space in panel needs a blank cover.

ASSIGNMENT

Assigned To	Lux, Bill	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email	william.lux@nebraska.gov	**Start Time**	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

D Building - K 0321

NEBRASKA
State Building Division

BSD4- D BUILDING #4
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 12:30 PM | **REGULAR** | **WO# BSD48466**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 9:11 AM**

Interior Repair Basement – Tunnel door – gap on the bottom of the door exceeds ¾" – Threshold can be installed to eliminate excess gap.

ASSIGNMENT

Assigned To	Wieden, Dan	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email	daniel.wieden@nebraska.gov	**Start Time**	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

Carstens Center #1 K0321

NEBRASKA
State Building Division

BSCC12- CARSTEN'S CENTER #12
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 12:30 PM | **REGULAR** | **WO# BSCC124962**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 9:04 AM**

Interior Repair Café – Dish washing room – Replace ceiling tile.

ASSIGNMENT

Assigned To	Bartels Shawn	**Skill**	General Maintenance
Mobile		**Appointment**	N/A
Email	shawn.bartels@nebraska.gov	**Start Time**	
		PO#	

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

Carstens Center #2 K0321

NEBRASKA
DEPT. OF ADMINISTRATIVE SERVICES
State Building Division

BSCC12- CARSTEN'S CENTER #12
3000 LINCOLN BLVD.
BEATRICE, NE
68310

DUE BY 4/13/2021 12:30 PM | **REGULAR** | **WO# BSCC124963**

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

AGENCY

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

BASIC **DATE CREATED 3/23/2021 9:06 AM**

Office Other: Store room (Roger Girch old office) – Clean out room or install door closer if the room continues to be used for storage.

ASSIGNMENT

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

COMPLETION

Work Completed

REQUIRED SIGNATURE

Name (print)

Signature

Signed

Fralin, Russell

From: Vogel, Rick
Sent: Wednesday, March 24, 2021 10:52 AM
To: Fralin, Russell
Subject: FW: IMPORTANT results from your life safety code survey ending 3/3/2021

From: Hunt, Mac <Mac.Hunt@nebraska.gov>
Sent: Wednesday, March 24, 2021 10:33 AM
To: Vogel, Rick <Rick.Vogel@nebraska.gov>
Subject: FW: IMPORTANT results from your life safety code survey ending 3/3/2021

Thanks,

McLain (Mac) Hunt, C.L.S.S.Y.B.
Operations Manager | BUILDING DIVISION
Nebraska Department of Administrative Services
Mobile (402) 580-0589
Mac.Hunt@nebraska.gov
das.nebraska.gov | **Facebook** | **Twitter**

From: Kris Burnham <KBurnham@specializedeng.com>
Sent: Tuesday, March 23, 2021 2:47 PM
To: Hunt, Mac <Mac.Hunt@nebraska.gov>
Subject: RE: IMPORTANT results from your life safety code survey ending 3/3/2021

Mac –

I spoke with Rick to get confirmation on the comments, because the buildings listed (Buildings 2 and 3) did not appear to be the buildings in question. Rick confirmed for me that generator comments listed for "Building 2 – 400 State Building (F Building/Main)" and "Building 3 – 200 Sheridan Non-Res" are intended to actually apply to the following buildings:

- Building 15 – Admin – 201 Kennedy Blvd
- Building 5 – F Building – 400 State Ave
- Buildings 21a,b,c – North East Cottages – 411,412,413 State Ave
- Buildings 21d,e,f – North East Cottages – 414, 415, 416 Sheridan Ave
- Buildings 24g,h,j,k – South Cottages – 418, 420, 422, 424 Solar Drive
- Buildings 27/28 – Employee Quarters – 311 Lake St

The primary concern from the original design appears to be the application of generator remote annunciators. In each case, the original design included mounting of the annunciator in a nearby utility space with integration into the campus-wide Johnson Control System for central notification to operating personnel of four different generator conditions on each generator: generator running, generator transfer, generator trouble, generator alarm.

Building 15: The generator at this building is code required - life safety components within the building are served from the generator as a Level 1 EPSS (emergency power supply system). This generator was replaced under a 2014 construction project. Monitoring by operating personnel, as configured through the Johnson Controls System (as described above), would appear to satisfy the codes applicable at the time of installation (NFPA 110-1999, and NFPA 99-1999 as applicable to any patient care) – with the annunciator reporting to "a work site observable by personnel" at that time. The more recently adopted version of NFPA 99-2012 for patient care (adopted in 2016) includes a restriction that "a centralized computer system (e.g., building automation system) shall not be permitted to be substituted for the alarm annunciator but shall be permitted to be used to supplement the alarm annunciator." If patient care is provided in the building, and is provided at a high enough acuity/risk to require NFPA 99 compliance, an additional annunciator under the newer codes could potentially be enforced by CMS. If no significant patient care is performed, it appears that the centrally monitored configuration currently in place would satisfy the applicable requirements of NFPA 110.

Buildings 5,21, 24, 27,28: The generators at these buildings are optional - life safety components within the buildings are served from local batteries. These generators were added to the existing buildings under a 2014 construction project as optional support to the existing building-wide electrical services.

As a side note, here was a description of the scope for those generators at the time...

"Standby power has also been identified as a practical need for staff and client residence spaces and is included with the scope of this project. Five (5) natural gas standby generators will be strategically located near these buildings to serve as a standby source of electric power upon the loss of utility power or interruption of campus utilities. In order to provide a cost effective solution for that need, these generators will serve the entire building electrical load as a standby source and will not be configured with separate emergency life-safety distribution. Any existing battery lighting or battery fire alarm system devices will need to remain in service."

When you have a moment, just give me a call. I can help to carry the conversation further with the Fire Marshall if that would be valuable.

Thanks Mac!
- Kris

Kristopher Burnham, PE, FPE, CHC, LEED AP
Associate Principal
Specialized Engineering Solutions
https://specializedeng.com/
402-991-5520 (office)
402-699-8534 (cell)

From: Hunt, Mac <Mac.Hunt@nebraska.gov>
Sent: Monday, March 22, 2021 8:33 AM
To: Kris Burnham <KBurnham@specializedeng.com>
Subject: FW: IMPORTANT results from your life safety code survey ending 3/3/2021

Kris,

I'm at a loss with all that the Fire Marshal wrote us up on for the newly installed generators in Beatrice. Please review and let me know your thoughts. I would like some help with this one and not sure how to proceed. I would have thought the Fire Marshal reviewed drawings prior to construction. There are some major items listed. Let me know when you are free, and I will call.

Thanks,

Mac Hunt, CLSSYB
Operations Manager | State Building Division

Department of Administrative Services
1526 K Street, Suite 250 I Lincoln, NE 68508
Phone 402.580.0589
mac.hunt@nebraska.gov

From: Vogel, Rick <Rick.Vogel@nebraska.gov>
Sent: Thursday, March 18, 2021 7:45 AM
To: Hunt, Mac <Mac.Hunt@nebraska.gov>
Subject: FW: IMPORTANT results from your life safety code survey ending 3/3/2021

Mac, Duty state fire marshal Susen Linder. Office number-402-471-2027, Cell number-402-326-1666

From: Urbaschek, Dawn <Dawn.Urbaschek@nebraska.gov>
Sent: Wednesday, March 17, 2021 2:15 PM
To: Fralin, Russell <Russell.Fralin@nebraska.gov>
Cc: Harrison, Corina <Corina.Harrison@nebraska.gov>; Vogel, Rick <Rick.Vogel@nebraska.gov>; Balderson, Mike <Mike.Balderson@nebraska.gov>; Schmidt, Joan <Joan.Schmidt@nebraska.gov>
Subject: Fwd: IMPORTANT results from your life safety code survey ending 3/3/2021

Hello,

I am forwarding these to everyone, I just saw they were received, so have not got to review them yet, have been in meetings.

Thanks,

Dawn Urbaschek | ICF/DD Manager

DEVELOPMENTAL DISABILITIES

Nebraska Department of Health and Human Services

OFFICE: 402-239-0993

DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: DHHS DDBH Facilities <DHHS.DDBHFacilities@nebraska.gov>
Sent: Wednesday, March 17, 2021 2:08:08 PM
To: Urbaschek, Dawn <Dawn.Urbaschek@nebraska.gov>
Subject: IMPORTANT results from your life safety code survey ending 3/3/2021

Good Afternoon:

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

Attached is a copy of the results from the Life safety code survey recently completed at your facility.

FEDERAL DEFICIENCIES: PLEASE RESPOND TO THE ATTACHED CMS-2567s:

1. Open the attached PDF form of the CMS-2567; print the first page, sign and date and fax to (402)742-2326. There is no need to mail any documents.
2. Use the attached "E-2567 " for providing a response to the deficiencies. Please do not change the formatting of the document including the margins and column sizes.
3. Type each deficiency number cited in the column labeled "ID Prefix Tag". Type your plan of correction in the column labeled "Providers Plan of Correction". The required elements for an acceptable plan of correction are outlined in the attached letter.
4. Save the Health poc as an Excel document.
5. Attach the poc document in an email and send to DHHS.DDBHfacilities@nebraska.gov. Please complete this form and **submit within 10 calendar days of receipt** of this email.

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:

https://www.surveymonkey.com/r/CK38LWZ?sm=gm7Zn4csC71zAxfP6OgMyQ%3d%3d.

If you have any further questions, please feel free to contact Mark Luger DDBH Program Manger II at mark.luger@nebraska.gov

Sincerely,

Fe Esquivel-Olivares | *Staff Assistant*
PUBLIC HEALTH
Nebraska Department of Health and Human Services
OFFICE: 402-471-9607
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Facility Staff Information

Attachment B5

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data

12/1/2020 - 11/30/2021

Facility: BSDC Beatrice State Developmental Center

			11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
			205	215	420	308	37	109	3%	32%
Job Code	Position		Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
A19211	ACCOUNTANT I		0	0	0	1	0	0	0%	0%
A19011	ACCOUNTANT I (NEW)		3	0	3	0	0	0		
S19112	ACCOUNTING CLERK II		0	0	0	1	0	0	0%	0%
I76461	ACTIVE TREATMENT PROGRAM AIDE		2	2	4	2	0	0	0%	0%
I76462	ACTIVE TREATMENT PROGRAM ASSISTANT		15	6	21	21	0	2	1%	10%
V76465	ACTIVE TREATMENT PROGRAM MANAGER		1	0	1	1	0	0	0%	0%
H76463	ACTIVE TREATMENT PROGRAM SPECIALIST		5	9	14	12	0	5	3%	42%
V76464	ACTIVE TREATMENT PROGRAM SUPERVISOR		1	2	3	2	0	1	4%	50%
H77023	ACTIVITY SPECIALIST		3	0	3	3	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)		2	0	2	2	0	0	0%	0%
V09012	ADMINISTRATIVE PROGRAMS OFFICER II (NEW)		1	0	1	0	0	0		
A01014	ADMINISTRATIVE SPECIALIST (NEW)		1	0	1	0	0	0		
S01013	ADMINISTRATIVE TECHNICIAN (NEW)		1	2	3	0	0	0		
M84623	AUTOMOTIVE MECHANIC II		1	0	1	1	0	0	0%	0%
H76300	BEHAVIOR SUPPORT SPECIALIST		2	0	2	4	0	0	0%	0%
H72442	BOARD CERTIFIED BEHAVIOR ANALYST		0	3	3	2	0	3	13%	150%
V09212	BUSINESS MANAGER II		0	0	0	1	0	0	0%	0%
A04311	BUYER I		0	0	0	1	0	0	0%	0%
S72110	CASE AIDE		0	0	0	2	0	0	0%	0%
V72314	CHILD AND FAMILY SERVICES SPECIALIST SUPERVISOR		0	0	0	2	0	0	0%	0%
C72312	CHILD/FAMILY SERVICES SPECIALIST		0	0	0	7	0	2	2%	29%
C72311	CHILD/FAMILY SERVICES SPECIALIST TRAINEE		0	0	0	1	1	1	4%	50%
H75321	CLINICAL NURSE TRAINER (NEW)		1	0	1	1	0	0	0%	0%
A76410	COMPLIANCE SPECIALIST		1	2	3	2	0	1	4%	50%
N91110	CONSULTANT		1	0	1	0	0	0		
M82121	CUSTODIAN/HOUSEKEEPER		0	0	0	9	0	1	1%	11%
C72841	DD COMMUNITY COORDINATOR SPECIALIST		0	0	0	1	0	0	0%	0%
V76230	DD QDDP QUALITY CONTROL SUPERVISOR		1	0	1	1	0	0	0%	0%
C72831	DD SERVICE COORDINATOR		0	0	0	2	0	0	0%	0%
G78601	DD SERVICE DISTRICT ADMINISTRATOR		0	0	0	1	0	0	0%	0%
D74150	DENTIST		0	0	0	1	0	1	8%	100%
P76251	DEVELOPMENTAL DISABILITIES SAFETY & HABILITATION SPECIALIST		18	24	42	21	6	11	3%	41%
R76251	DEVELOPMENTAL DISABILITIES SAFETY & HABILITATION SPECIALIST		2	5	7	1	1	0	0%	0%
V76252	DEVELOPMENTAL DISABILITIES SAFETY AND HABILITATION SUPERVISOR		4	5	9	5	1	3	4%	50%
I76211	DEVELOPMENTAL TECHNICIAN I		2	5	7	1	0	0	0%	0%
R76211	DEVELOPMENTAL TECHNICIAN I		5	12	17	4	5	5	5%	56%
I76212	DEVELOPMENTAL TECHNICIAN II		38	83	121	73	15	44	4%	50%
V76215	DEVELOPMENTAL TECHNICIAN SHIFT SUPERVISOR		12	16	28	17	1	5	2%	28%
G78801	DHHS ADMINISTRATOR I		0	1	1	1	0	1	8%	100%
C73210	DHHS PROGRAM SPECIALIST		1	0	1	1	0	0	0%	0%
C73231	DHHS RESOURCE DEVELOPER		1	0	1	1	0	0	0%	0%
G78701	DHHS SERVICE DELIVERY ADMINISTRATOR I		0	0	0	1	0	0	0%	0%
H80410	DIETITIAN		2	1	3	2	0	0	0%	0%
G75017	DIRECTOR OF NURSING (NEW)		1	0	1	1	0	0	0%	0%

M84142	FACILITY MAINTENANCE TECHNICIAN II	0	0	0	1	0	0%	0%
N00750	FACILITY OPERATING OFFICER	1	0	1	1	0	0%	0%
S02201	HEALTH INFORMATION TECHNICIAN	0	0	0	2	0	0%	0%
V82124	HOUSEKEEPING SUPERVISOR	1	0	1	1	0	0%	0%
V76231	ICF/DD HOME MANAGER	1	5	6	5	1	2	3%	33%
V76232	ICF/DD MANAGER	1	1	2	2	0	0	0%	0%
H76220	INTERDISCIPLINARY TEAM LEADER/ODDP	9	5	14	10	0	2	2%	20%
I75013	LICENSED PRACTICAL NURSE (NEW)	13	14	27	22	1	10	4%	43%
R75013	LICENSED PRACTICAL NURSE (NEW)	0	3	3	0	0	0		
M84011	MAINTENANCE TECHNICIAN (NEW)	9	1	10	0	0	1		
D75350	NURSE PRACTITIONER	1	3	4	3	0	1	3%	33%
H77312	OCCUPATIONAL THERAPIST	1	0	1	1	0	0	0%	0%
S01012	OFFICE SPECIALIST (NEW)	6	0	6	0	0	0		
S01011	OFFICE TECHNICIAN (NEW)	2	0	2	0	0	0		
K17122	PERSONNEL MANAGER I	1	0	1	1	0	0	0%	0%
V17122	PERSONNEL MANAGER I	1	0	1	1	0	0	0%	0%
V17123	PERSONNEL MANAGER II	1	0	1	1	0	0	0%	0%
K17121	PERSONNEL OFFICER	1	0	1	1	0	0	0%	0%
H77114	PHYSICAL THERAPIST II	2	0	2	2	0	0	0%	0%
I77111	PHYSICAL THERAPY AIDE	3	0	3	3	0	1	3%	33%
G77115	PHYSICAL THERAPY DIRECTOR	1	0	1	1	0	0	0%	0%
N75420	PHYSICIAN	1	0	1	0	1	0	0%	0%
A04011	PROCUREMENT SPECIALIST (NEW)	1	0	1	0	0	0		
G15400	PROJECT MANAGER	0	0	0	2	0	0	0%	0%
N74823	PSYCHOLOGIST/LICENSED	0	0	0	1	0	0	0%	0%
N74822	PSYCHOLOGIST/PROV LICENSED	1	1	2	0	1	0	0%	0%
I77042	RECREATION ASSISTANT	1	0	1	1	0	0	0%	0%
H75014	REGISTERED NURSE (NEW)	5	3	8	4	1	0	0%	0%
R75014	REGISTERED NURSE (NEW)	0	1	1	0	0	0		
C79920	RELIGIOUS COORDINATOR	1	0	1	1	0	0	0%	0%
H77420	RESPIRATORY THERAPIST	1	0	1	1	0	0	0%	0%
V82330	SAFETY COORDINATOR	1	0	1	1	0	0	0%	0%
P61851	SECURITY COMMUNICATIONS SPECIALIST	1	0	1	1	0	0	0%	0%
C72173	SOCIAL SERVICES LEAD WORKER	0	0	0	2	0	0	0%	0%
V72174	SOCIAL SERVICES SUPERVISOR	0	0	0	1	0	0	0%	0%
C72171	SOCIAL SERVICES TRAINEE	1	0	1	1	2	1	3%	33%
C72172	SOCIAL SERVICES WORKER	0	0	0	7	0	3	4%	43%
S01841	STAFF ASSISTANT I	0	0	0	5	0	0	0%	0%
S01842	STAFF ASSISTANT II	0	0	0	1	0	0	0%	0%
S05012	SUPPLY TECHNICIAN II (NEW)	1	0	1	0	0	0		
S05212	SUPPLY WORKER II	0	0	0	1	0	1	8%	100%
A11012	TRAINING COORDINATOR (NEW)	1	0	1	0	0	0		
A11011	TRAINING SPECIALIST (NEW)	1	0	1	0	0	1		
A11122	TRAINING SPECIALIST I	0	0	0	1	0	0	0%	0%
A11123	TRAINING SPECIALIST II	0	0	0	1	0	0	0%	0%
V79360	TRANSPORTATION MANAGER	1	0	1	1	0	0	0%	0%
M79311	VEHICLE OPERATOR I	2	0	2	2	0	0	0%	0%
M79312	VEHICLE OPERATOR II	2	0	2	2	0	0	0%	0%
		205	**215**	**420**	**308**	**37**	**109**	**3%**	**32%**

B. Staff Assaults: *The number of assaults on staff for the period of 12/2020 – 11/30/2021. Please provide a separate number of assaults borne out of a use of force event.*

BSDC has documentation of 26 reported staff injuries due to Individual Aggression / Behavioral of Individuals.

12/20/2020 - 12/31/2020 = 0
01/01/2021 – 03/31/2021 = 9
04/01/2021 - 06/30/2021 = 7
07/01/2021 – 09/30/2021 = 5
10/01/2021 – 11/30/2021 = 5

*No assaults on staff were result of a use of force event.

Mike Balderson | *Safety Coordinator*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-806-3759
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Responses:

#3: ***The number of positions needed in your HR Staffing Plan for FY22***

Please see the DHHS Business Plan for 2021-2022. Human Resources section; pages 40 and 41.

https://dhhs.ne.gov/Documents/DHHS-Business-Plan-2021-2022.pdf

#4: ***The number of positions filled in your HR Staffing Plan for FY22 as of November 30, 2021.***

Please see attachment #4 and the DHHS Business Plan for 2021-2022. Human Resources section; page 40 and 41.

https://dhhs.ne.gov/Documents/DHHS-Business-Plan-2021-2022.pdf

Human Resources

Recruitment and Retention of an Engaged Workforce

NEW INITIATIVE

Goals

1. Develop recruitment and retention strategies for positions with highest turnover rates.
2. Build a culture focused on opportunity, teamwork, and respect.

Background

Competition for talented teammates is fierce and teammate turnover is expensive and can negatively impact the services DHHS provides. In order to provide consistent service in all operational areas of DHHS, we must maintain knowledgeable, talented staff who are capable of providing exceptional customer service throughout the state of Nebraska. By recruiting and retaining an engaged workforce, DHHS will be able to reduce the cost of hiring, improve the quality of services we provide, create financial efficiencies for the taxpayers of Nebraska, and lead to improved services overall.

With increasing turnover in our core direct care and clinical groups, we need to be proactive and identify the talent and skills needed to perform the job functions and retain teammates with those skills. Our inability to recruit and retain staff significantly impacts the quality of care we can provide for the most vulnerable Nebraskans.

Workplace opportunity is a continual challenge in multiple ways for employers. Within all the ethnic and cultural differences, there are many factors that make workplace opportunity a continual challenge for all businesses. DHHS must continue to create a culture of teamwork and respect that will keep the work environment positive and productive while also ensuring we understand the needs of all Nebraskans. By creating a sense of pride and involvement within the DHHS team, we will be able to build a stronger foundation for fulfilling the Department's mission of helping people live better lives.

With five generations in the workforce - Traditionalists, Baby Boomers, Generation X, Millennials, and Generation Z - we must continue evaluating our internal strategies to recruit and retain this diverse group. With the growing number of a younger workforce whose values and career priorities are different from those of the previous generations, we must further assess our processes to grow our workforce, include our teammates, and ensure opportunity for all Nebraskans.

Leadership and workforce development are critical in keeping our team effective and motivated. The impact is increased turnover at all levels. As an agency, we need to make sure leadership and workforce development is part of our culture by creating opportunities for them to use their strengths every day.

These goals are important to DHHS as they will have a positive impact on helping our teammates live better lives at work, which in turn will help us better serve the people of Nebraska.

We will retain teammates, which in turn will save money and time. We will also create more opportunity, teamwork, and a sense of belonging for DHHS employees and prospective future employees to provide a more effective, efficient, and customer-focused experience for all Nebraskans.

Strategy

Recruitment and Retention
The Human Resources team has identified several causes of high turnover and is working closely to develop specific action plans with division leadership to recruit and retain teammates in these areas. The goal is to reduce open positions by 3% by end of fiscal year for these roles. Plans will include active recruitment and sourcing of external candidates as well as a review of current practices related to recruitment and retention.

In order to improve retention, the Human Resources team has identified gaps in training and development for the DHHS leadership team. Working in collaboration with the Department of Administrative Services (DAS), the DHHS Human Resources team will develop innovative professional development programs to increase morale, retention and productivity. Leadership development programs will be implemented for all stages of leader life cycle. The programs will be reflective of the needs of a diverse workforce.

Opportunity
The Human Resources team will work with DHHS leadership to review current practices to ensure engagement, teamwork, and respect. This will include developing training for leadership and teammates on all three areas.

Deliverables

Deliverable	Target Completion
Implement 12-month DHHS leadership development certification program, aligned with State Personnel Training & Development, for current people leaders ready for the next step in leadership; goal 100% complete and published.	Complete
DHHS top five positions with highest turnover account for 53% of the Agency's total turnover. Work with Division leadership HR will develop action plans to reduce loss by 3%; goal 100% complete.	November 2021
Develop innovative professional development programs to increase morale, retention and productivity; goal 100% complete and published.	November 2021
Implement best practices by division/position related to recruitment and retention; goal 100% complete.	January 2022
Develop recruitment plan to identify talent needs, target markets, and recruitment sources to attract the best talent inclusive of underrepresented groups; goal 100% complete and published.	January 2022
Working with DAS, DHHS will review compensation strategy and submit recommendations to attract and retain talent; goal 100% complete.	January 2022
In collaboration with State Personnel Training & Development, DHHS will implement ongoing training program on teamwork and respect; goal 100% complete and implemented.	May 2022

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

November 24, 2021

Dear Teammates:

As we prepare to enjoy the long weekend and reflect on the things that we are grateful for, I encourage you to take time to rest and recharge for the next month. For those of you in our 24-hour facilities, please know that you are appreciated not only by your teammates, but also by the residents and the families of those you serve. Whether you spend your holiday with loved ones, home alone streaming your favorite shows, or serving our clients, please know I am grateful for you, my DHHS family. I am blessed to serve with you, and I am thankful for such an amazing team of dedicated, caring professionals.

On Monday we celebrated "Thank You to Public Health Day" and I want to personally say to all of our staff that work directly in our Division of Public Health and those in other areas within DHHS that support public health efforts. I am sincerely grateful for all that you do.

This fall, Governor Ricketts announced agreements with the Nebraska Association of Public Employees (NAPE) and the Fraternal Order of Police (FOP), which resulted in significant pay adjustments for a number of staff. DAS continues to finalize various contracts/agreements and their impacts. In addition, just this week, the Governor announced that teammates on the State insurance plan would not be subject to any deductions for December 2021 premiums. He also announced insurance premiums will remain the same and not increase next year!

I am thankful for all DHHS has accomplished over the past year despite still navigating the pandemic. Many of these accomplishments are highlighted in the DHHS Business Plan for 2021-2022. It recaps the agency's recent accomplishments and also outlines 17 priority initiatives for the Department for the current state fiscal year. I encourage every teammate to review this plan and familiarize yourself with these priorities.

As we enter the holiday season, remember that through the many good deeds of each of you, we are helping Nebraskans live better lives daily!

Thank you for all that you do for teammates and Nebraskans. Happy Thanksgiving!

Sincerely,

Dannette R. Smith, MSW
Chief Executive Officer

COVID-19 Impact Challenges

Impact

Pandemic plan

Operational guidelines

Teammate letter

Testing

Recent protocols

Family/Guardian/Individual letter

Attachment B6

Impact

Department of Health and Human Services

COVID-19 Summary Sheet

Beatrice State Developmental Center

NEBRASKA
Good Life. Great Mission.

January 7, 2021

Impact

Long-term-care facilities have been hit hard by COVID-19. The Beatrice State Developmental Center (BSDC) has been diligent in implementing practices to protect the health and safety for those persons that live and work at BSDC.

Beginning in March BSDC implemented its Emergency Preparedness/Pandemic Plan and is routinely in contact with the local Public Health Solutions and Nebraska Medicine ICAP.

As the COVID-19 pandemic began to impact Nebraska and Gage County, the Beatrice State Developmental Center (BSDC) recognized that it was crucial for our team to take extra precautions within our campus. As a long-term care facility, our individuals are at a heightened risk, and every effort has been being implemented to mitigate those risks. This includes regular temperature checks of staff and residents, enhanced sanitization processes, hygiene reminders and mask wearing.

At this time, BSDC is balancing individuals' social and emotional needs, including visits from family and loved ones. BSDC has developed many strategies to meet individuals' support needs during this pandemic. We did not have our first COVID-19 positive case until end of October 2020.

Precautions currently in place:

- All off campus activities are suspended.
- All off campus employment for individuals is suspended.
- Off campus medical appointments have been reviewed for essential and non-essential. Only "essential" appointments are being scheduled, and this can change dependent upon the medical provider and their acceptance of patients on-site. Telemedicine is being considered for off-campus essential medical visits.
- Bear Creek has closed. Including the studio where individuals were employed.
- Chapel services (large group) have been cancelled. If a home would like to attend the Chapel, they should schedule time for their cohort group (group living together at same home that is not in isolation or quarantine)
- Carstens Center Social Center and Gym – homes may schedule a time to attend separately as cohort group (group living together at same home that is not in isolation or quarantine)
- Screening of employees was implemented on Friday, March 20, 2020. Direct care employees all have their temperatures taken, answer COVID-19 specific questions, and are sent home if they have signs or symptoms.
- BSDC on November 9, 2020 ceased in-person visitation of individuals until further notice. Parents, guardians, other potential friends and family visitors are offered virtual visit opportunities.

Individuals

Current Census 90 Long-term-care ICF Solars and Lake...85

Short-term-care ICF State Building..... 5

COVID-19 testing

BSDC Individuals will continue to be closely monitored and cared for to include temps daily by 24-hour Nursing and Direct Support Staff in order to ensure that they remain healthy. We will continue to be alerted to the earliest signs of altered homeostasis in order to maintain wellness and provide a quality of life that allows for each Individual to obtain and maintain a maximum level of independence and well-being in keeping with our philosophy of normalization.

To ensure the health and safety of the individuals in our care at the Beatrice State Developmental Center (BSDC), we recognize that it has been critical for the BSDC team to take extra precautions for our individuals who are at the highest risk and to protect those we support.

Number of tests done at BSDC.....97

Testing dates;

6/17/2020	11/6/2020	12/2/2020
9/24/2020	11/9/2020	12/4/2020
10/1/2020	11/10/2020	12/8/2020
10/15/2020	11/12/2020	12/10/2020
10/21/2020	11/13/2020	12/11/2020
10/23/2020	11/17/2020	12/15/2020
11/4/2020	11/24/2020	
11/5/2020	11/30/2020	

Communication

It has been very important that BSDC individuals are provided information about COVID-19. Methods of communication used have included;

- Picture Guide with narrative
- COVID-19 information programmed for on individual in their Dynavox/12 plus
- Explanation as events/situations occur – individualized based on abilities of individual
    - Visuals
    - Use of gestures
    - Sign language (i.e. sick)
    - Demonstrations
- On-going discussion as situation/events changed
    - Discussion with group – home

- 1-1 with QDDP (in person and/or phone)
- Nursing
- Opportunity for guardian assistance with explanation

Over the period of time in which there has been changes in schedules, activities available, and contact with others, communication methods have been;

- Picture Guide that provides a picture along with narrative regarding COVID-19 and what one might see or expect to happen.
- Use of gestures paired with the items and actions.
- QDDPs, home staff, vocational staff, and nursing have provided on-going communication as situations occur (i.e. isolation, quarantine, visitation restrictions, testing, etc.)
  - Mask usage by staff, completed mask assessments for individuals with explanation of why masks are important, paired activities such as handwashing/use of hand sanitizer with verbalization of how it relates to the pandemic.
  - Based on level of abilities, QDDPs and staff have provided opportunities to discuss questions and concerns. As applicable, nursing has contributed to explanation.
- Behavior Support has been available to provide emotional support
- Prior to COVID-19 testing, nursing has provided visuals paired with verbal explanation as to what would happen when given the test.

BSDC speech language pathologist (SLPs) worked with Crisis Stabilization Unit individuals. SLPs touched on emotions and concerns of individuals who were part of the PEERS program that was implemented with Crisis individuals as well as version of that program focusing on coping strategies In dealing with COVID-19.

Notifications

BSDC is communicating to families and guardians on COVID-19 status, testing, and current health of their loved ones. We try to communicate as much as we can in a fluid situation with new information emerging daily.

When an individual is experiencing a medical concern that may be related to COVID-19 BSDC Primary Care Provider and/or primary nurse contacts the guardian and explains the individual's health status.

When an individual has been exposed to COVID-19 and are symptom free, the Qualified Developmental Disability Professional (QDDP) is provided that information by nursing and completes contact with the guardian(s) through phone call and/or email depending on guardian(s) preference for communication. The QDDP logs that contact and any concerns in their guardian contact log. Should the guardian(s) have any medical related questions, the QDDP coordinates the opportunity for the guardian(s) to speak with the medical provider.

BSDC conducted baseline testing for COVID-19 in June, 2020. Guardians were contacted and provided information about the testing, and BSDC obtained consent. Guardian agreement for the individual to be tested was given to the QDDP who then logged this in a spreadsheet for administration and medical staff's reference. There were individuals who declined to take this baseline COVID-19 test, either verbally or through body language. These individuals' wishes to decline were acknowledged and they were not tested.

Additional testing has been completed within a home in those events where a staff assigned to the individuals' home or a housemate have been diagnosed as COVID-19 positive. Guardians are notified of the status and plans for testing of the individual. These contacts have been made and logged by the QDDP.

Guardian concerns regarding an individual being tested was limited, and when there has been a concern it has been that the individual is not able to tolerate the test. Guardians have been supportive and are wanting individuals to be tested.

When an individual requires isolation due to COVID-19 the following takes place;

- Depending on the specific situation, either medical provider, nursing or the QDDP contacts the guardian through phone call and/or email.
    - If an individual is isolated due to a medical concern related to symptoms of COVID-19, a medical or nursing staff would provide notification through phone call, to allow for prompt answers to any medical related questions.
    - If isolation is not due to a medical concerns specific to the individual, and isolation is due to precautions, the QDDP provides notification via phone call and/or email based on guardian's preference for contact.
    - These contacts are logged in the guardian log or in medical/nursing notes as applicable.

When an individual has been placed in quarantine due to COVID-19 the following takes place;

- Depending on the specific situation, either medical provider, nursing or the QDDP contacts the guardian through phone call and/or email.
    - If an individual is placed in quarantine due to a medical concern related to symptoms of COVID-19, a medical or nursing staff would provide notification through phone call, to allow for prompt answers to any medical related questions.
    - If quarantine is not due to a medical concerns specific to the individual, and quarantine is due to precautions, the QDDP provides notification via phone call and/or email based on guardian's preference for contact.
    - These contacts are logged in the guardian log or in medical/nursing notes as applicable.

Restrictions

Individuals participate in group activities such as vocational programs, day services and family dining. To mitigate COVID-19 risks there are times that restrictions must be put in place for health and safety. BSDC restrictions related to COVID-19 have been;

- Individuals who live together, do dine together. Exceptions to this have been when an individual within the home is displaying symptoms, precautions to not expose others would be followed such as supporting the individual to dine in a different location.
- Individuals participate in group activities together at the home, such as watching movies, arts and game activities. Exceptions to this have been when an individual within the home is displaying symptoms, precautions to not expose others would be followed such as supporting the individual with activities in their room.
- Day Service Program and Vocational activities have been modified to ensure that participation is in cohort groups, which are groups of individuals from the same home that live together. There has been restrictions to attendance at the day services and work activities throughout this pandemic based on an assessment of risk. These restrictions have been continuously monitored and adjusted based on situational risk. The goal has always been to find an

appropriate balance between mitigating risk of exposure and supporting individuals to have meaningful days.

- Community jobs were placed on hold, then resumes with strict criteria to ensure safety, and then placed on hold. They are currently on hold due to the elevated community risk.
- Campus jobs were placed on hold, and then those which could be modified and completed by individuals who were able to follow infection control resumed. These were then placed on hold again due to changes within the risk assessments and are currently on hold.
- Day Services were placed on hold, no attendance to the Day Service program areas such as the home rooms, social center, gym/pool, Bear Creek, and Chapel.
    - Modifications to the schedules for attendance at the home rooms, social center and gym occurred. These modifications included limiting the number of individuals in the building and location of activities within the building, along with enhanced infection control between groups attending.

As mentioned, medical and administration continuously assessed for risks based on outcomes within the facility and community, such as community increase in spread and staff/individual diagnosis of COVID-19. With this, these programs and activities were again placed on hold and are currently on hold.

Decisions to put precautions in place, which resulted in restrictions for attendance to specific areas at BSDC, have been based on assessment of risk by medical and administration teams. This has been a continuous assessment, and based on situational status of COVID-19 within the community and diagnosis of positive COVID-19 cases within staff and individuals.

Decisions have been made to limit or suspend activities to these areas at some point during the pandemic. When possible, decisions to mitigate risk yet continue services needed in areas such but not limited to therapy and day services were made by ensuring groups attending did so as a cohort group, with enhanced infection control between groups. There have been times in which individuals have not been able to visit any of the areas listed, and times in which they have been able to with additional precautions or revisions.

When unable to visit areas that are important to individuals such as Financial Responsibility for money, Chapel for religious preference, or therapies, BSDC has identified and communicated with the individuals how this will be accommodated. For example, the religious coordinator has met individually or provided opportunities for cohort groups; processes were identified for how to obtain money and reinforcement money for individuals; as needed therapy was provided at the home. Vocational jobs at Bear Creek, the Administration building and other places on the campus at BSDC were placed on hold for a period of time and then resumed with strict guidance and safeguards. As positive cases rose, and the risk dial moved to higher risk, these jobs were suspended again.

At some point during the pandemic, all areas listed; OT/PT, Chapel, Activity Center, Carsten's Center, Bear Creek Gift shop, and the Administrative Building been closed for attendance by the individuals.

Areas such as OT/PT, Activity Center, Gym, Bear Creek Gift shop have been opened based on risk assessment and if needed closed again. This has been closely monitored and assessed to provide a balance for individuals in regards to meaningful life and activities and risk for exposure.

There is a COVID-19 protocol for individuals leaving BSDC campus for vocational programs, medical appointment, leisure activities, and family visits. Medical and Administrative staff are continuously assessing risks in relation to individual activities.

Medical Appointments are reviewed to determine which appointments are medically necessary to attend at this time. Others, which are not have or will be rescheduled. As appropriate, telehealth appointments were established for specific individuals to be seen by their off-site medical speclallst. Individuals remained at BSDC with support staff and PCP present as the moderator for these telehealth appointments.

Family Visitation is discussed by administrative leadership group and decisions are made based on situational risk, such as community spread risk dial and the status of facility cases.
When a decision is made to restrict visitation, QDDPs notify the guardians of the change and an informational letter is sent by the Facility Administrator to all guardians. There has been opportunity for visitation at the facility in identified locations. Protocols for those visitations were developed to reduce risks.

Since the pandemic began, other than medical appointments, and a brief period when individuals were involved in community job, there has not been activities away from BSDC. There has been opportunities to get away through what are called "day cruises", where individuals are able to go in the van in small cohort groups and remain in the vehicle. Changes to these restrictions will be discussed by leadership and may be implemented as soon as mid-January. More information will be sent when those decisions are made.

Employees

BSDC is currently working with the local public health authority to move to the next phase of expanded testing. BSDC has been provided with COVID-19 testing kits. The test kits are available for testing residents and employees and were first made available on June 17 - 19, 2020. In an effort to ensure we continue to provide the safest environment for both employees and our residents, employees are strongly encouraged to take advantage of all testing opportunities.

Number of tests done at BSDC.....259

Number of BSDC employees.....257

Testing Dates:

6/18/2020	10/21/2020	11/9/2020
6/19/2020	10/22/2020	11/10/2020
8/12/2020	10/23/2020	11/12/2020
8/19/2020	11/4/2020	11/13/2020
10/1/2020	11/5/2020	11/18/2020
10/15/2020	11/6/2020	11/19/2020

Strategies

Timeline March 2020 to January 2021	

Visitation	• All visits went virtual on 11/9/2020 due to COVID-19 positive cases at BSDC. In January we will go back to allowing limited in-person visits more information will be sent soon.
	• Until 11/9/2020 all individuals did have the ability to have limited visitation.
	• For guardians/parents/family who do not wish to visit their loved one in person, BSDC continues to have available alternative methods of communication such as virtual visits.
	• Prior to 11/9/2020 BSDC had developed a visitation protocol that included:
	  ○ Visitation schedule, hours and locations outside of the homes
	  ○ Number of visitors
	  ○ Infection control practices including proper hand hygiene, facility supervision of safe practices related to visitors, social distancing and use of PPE.
	• Visitors provided a disposable face mask for use while at the facility. Personal cloth masks are acceptable.
	• Visitors were required to have a disposable face mask or cloth face mask on the entire duration of their visit.
	• Before and after visits, visitors were required to wash their hands with soap and water or use alcohol-based hand sanitizer.
	• Visitors were encouraged to make all efforts to limit touching their loved one during a visit.
	  ○ This includes hugging, shaking hands and holding hands.
	  ○ Any physical contact with other individuals will be discouraged.

Communal Dining	• Individuals from the same home (cohort group) will continue to eat in the same home/dining room with appropriate social distancing. Individuals that are in room isolation will dine in their room with assistance from staff. This includes:
	  ○ A limited number of individuals in the dining room at one time
	  ○ Limited number of individuals at a table
	  ○ Spaced at least 6 feet apart
	• If staff assistance is required, appropriate hand hygiene will occur between individuals, as well as use of appropriate PPE.

Group Activities	• BSDC continues to follow guidelines for cohort groups and to maintain social distancing. In January cohort groups will be able to start going to Chapel, Social Center, and Gym. Individuals that had jobs on campus will once again be able to work following risk assessment that will be completed by vocational team. Off-campus jobs will continue to be on hold but will be reassessed in January for possible return to work in February. • Cohort groups prior to 11/9/2020 continued to attend appointments based on home schedules keeping cohort groups separated to avoid cross infection between homes. • Chapel, Social Center and Gymnasium – cohort group homes schedule a time to attend separately. • Mandatory disinfection will occur between groups.
Screening	• Individuals and employees will continue to be screened on a daily basis. • Prior to entering the facility, visitors and employees are asked to complete a self-assessment. If they do not feel well or are running a temperature, they are encouraged to stay home and contact their facility contact or supervisor for further instructions. • A designated screening room is where COVID-19 screening questions are asked and a temperature check is completed. • Employees having confirmation on the screening questions, signs/symptoms or a temperature will be directed to contact their supervisor and local Public Health for further instruction. • Visitors having confirmation on the screening questions, signs/symptoms or a temperature will not be allowed entrance to the facility. • Employees/Visitors/Contractors/Vendors will be provided a disposable face mask for use while at the facility. Personal face masks are acceptable. • **All** BSDC employees who work with or have sustained contact with individuals supported are required to wear a disposable face mask throughout their assigned work hours – no exceptions. • All Visitors/Contractors/Vendors must have a disposable or cloth face mask on the entire duration of their visit.
Universal Source Control and PPE	• All BSDC employees who work with or have sustained contact with individuals supported are required to wear a disposable face mask throughout their assigned work hours – no exceptions. • All other BSDC employees and DHHS employees occupying office space at this facility who do not work with or have direct

	contact with individuals throughout their assigned shift are required to wear a disposable/cloth face masks. Face masks are required in any common area of the buildings (i.e., hallways, when entering/exiting, restrooms, conference rooms). Face masks may only be safely removed when alone in an office or breakroom.
Cohorting	• If an individual tests positive, the BSDC Emergency Preparedness Pandemic Plan will be enacted and the individual will be isolated in a separate room and/or a designated home identified for managing care for individuals who are symptomatic or who test positive for COVID-19.
Essential and Non-Essential Healthcare Personnel	• All BSDC employees who work with or have sustained contact with individuals supported are required to wear a disposable face mask throughout their assigned work hours – no exceptions. • All Visitors/Contractors/Vendors must have a disposable or cloth face mask on the entire duration of their visit.
Medical Trips outside the Facility	• Off facility medical appointments are being reviewed for essential and non-essential. Only "essential" appointments are being scheduled and this can change based upon the medical provider and their acceptance of patients on site. • BSDC employees transporting an individual will wear a disposable face mask throughout their assigned work hours. • Individuals' are encouraged to wear a disposable face mask as tolerated.
Testing	• All staff (including administrative) in the facility have been offered testing for COVID-19. o Staff and residents declining testing are monitored daily for signs/symptoms and daily temperature screening. • If a staff member refused testing: o And is symptomatic, the staff member should be isolated in accordance with the following guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html o Does not have symptoms and was exposed to COVID-19, the staff member should be quarantined in accordance with the following guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html o Does not have symptoms and was not exposed to COVID-19, the staff member should use PPE in

	accordance with the following guidance without reuse or extended use strategies: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html • If an individual refuses testing: o And is symptomatic (without alternative diagnosis), the facility will assume the individual to be infected and respond accordingly (to include isolation of the individual) o Does not have symptoms and is a close contact case, the individual should be quarantined for 14 days after their last exposure to the case (regardless whether testing is needed) o Does not have symptoms and is not a close contact case, no additional measures are required.
Vaccinations	Organization must administer COVID-19 Vaccine in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices (ACIP). BSDC is enrolled and shot clinics for employees will begin January 11, 2021. • BSDC has received **100 doses** of COVID-19 Moderna vaccine. We will be following CDC guidelines for prioritizing employees groups to be vaccinated first. Direct support professionals, nursing staff, medical staff, and vocational staff will be in the first group. • Our goal is to start vaccinating first 100 employees in staggered groups starting week of January 11, 2021. Second dose will be given to this first group within 28-days. We will continue with shot clinic schedule roll-out until all 257 employees have been offered vaccination. • Once we have employees vaccinated we will begin vaccinating BSDC individuals. Before vaccinating individuals we will be contacting guardians to provide vaccine fact sheet and to get consent forms signed. Our communication plan for guardians will be similar to the one used for COVID-19 testing. • QDDPs will be calling and emailing guardians first, letting them know we are getting ready to vaccinate individuals. Nursing and Primary Care Practitioners will be available to answer any medical questions guardians may have about vaccine and side effects. • Attached are Moderna vaccine fact sheet and patient consent form for your review. Below is the CDC guidance BSDC is following to prioritize employee groups for vaccination. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/hcp.html ***Vaccinating healthcare personnel protects healthcare capacity*** *When healthcare personnel get sick with COVID-19, they are not able to work and provide key services for patients or clients. Given the evidence of ongoing COVID-19 infections among healthcare personnel*

	and the critical role they play in caring for others, continued protection of them at work, at home, and in the community remains a national priority. Early vaccine access is critical to ensuring the health and safety of this essential workforce of approximately 21 million people, protecting not only them but also their patients, families, communities, and the broader health of our country. ***Vaccinating healthcare personnel helps prevent patients from getting COVID-19*** *Healthcare personnel who get COVID-19 can also spread the virus to those they are caring for—including hospitalized patients and residents of long-term care facilities. Many of these individuals may have underlying health conditions that put them at risk for severe COVID-19 illness. Healthcare personnel can also spread the virus to other healthcare personnel. Learn more about the importance of COVID-19 vaccination for residents of long-term care facilities.* ***Risks and benefits will be explained to everyone offered a COVID-19 vaccination*** *Before anyone can receive a COVID-19 vaccine, they must be given an EUA fact sheet with detailed information about the COVID-19 vaccine they will be receiving.*

In addition, DHHS encourages that at a minimum, BSDC should encourage contact with local health care providers and Public Health for COVID-19 testing to all who:

- Are currently symptomatic
- Have had close contact with an individual, either at work or in the community that has tested positive for COVID-19
- Staff or individuals that meet either of the above two bullets and decline testing should be treated as having a positive or unknown COVID-19 status.

BSDC will be partnering with local public health for administration of COVID-19 vaccine following all rules as outlined in the CDC COVID-19 Vaccination Program Provider Agreement.

Observations

BSDC has a robust emergency preparedness plan that includes dealing with viral outbreaks. This plan have been reviewed on multiple occasions by public health surveyors that have been trained by Centers for Medicare & Medicaid Services (CMS) to ensure Intermediate Care Facilities, like BSDC, are in compliance with all CMS conditions of participation.

BSDC has done well in containing the spread of the virus. A minimal number of homes were impacted. We currently only have one home that remain in quarantine and will be cleared by Monday January 11, 2021. All individuals that were treated at area hospitals have returned to BSDC as of 12/18/2020 and continue to improve. With our numbers of COVID-19 positive cases trending downward we are now in a position to discuss relaxing restrictions that were put in place October 2020 to stop the spread.

All departments have had their teammates working on the homes to provide needed supports to BSDC individuals. These teams, as well as direct support professionals, not impacted by COVID-19, have been outstanding in their dedication to the care of individuals living at BSDC. Employees that were impacted by COVID-19 and quarantined are returning to work. BSDC currently has 257 employees and as of today less that fifteen are out due to COVID-19.

BSDC has partnered with Public Health Solutions and Nebraska Medicine ICAP to make sure that we are following best practices for dealing with COVID-19. We have implemented many infection control protocols as outlined in BSDC pandemic plan.

This is a lot of information but it is important that it be shared with all of you who have people living at BSDC. If there are questions, concerns, or you just want to talk please feel free to contact me at 402.806.6191.

Warmest Regards,

Corina Harrison

BSDC Facility Administrator.

Pandemic plan

COVID-19 PANDEMIC PLAN
Guidance for Prevention and Control of Transmission of Novel Coronavirus-19 at Beatrice State Developmental Center (BSDC)

3/10/2020
Reviewed October 2020

PURPOSE: Recognizing the potential impact the Novel COVID-19 can have on the BSDC community, BSDC has developed a pandemic safety plan to provide guidance and information to ensure a sustainable healthcare response and reduce the spread of Pandemic COVID-19. Our plan is based on the Nebraska Department of Health and Human Services (DHHS) and the latest Center for Disease Control (CDC) recommendations for health facilities and will be updated as necessary as the CDC monitors the National and State situation. BSDC will work closely with Southeast Nebraska Health Department officials to monitor conditions in the area and make decisions about the best way to provide early detection and containment to protect our individual residents and employees while maintaining the overall operation of BSDC and meeting the basic needs of our facility.

SCOPE: Applies to all individuals supported at the ICFs, all employees, contractors, consultants, interns and volunteers. This policy/plan also applies to any agency or person(s) providing services or supports to individuals supported through funding, contract, or provider agreement with the State of Nebraska.

POLICY: BSDC will ensure a sustainable healthcare response to Pandemic COVID-19 in accordance with the BSDC Infection Control Policy and Operational Guidelines (OGs). BSDC will follow the standard CDC and Nebraska Public Health Department guidelines.

EQUIPMENT/RESOURCES:

- Personal Protective Equipment (PPE):
  - N-95 disposable particulate respirator masks
  - Surgical masks
  - Disposable isolation gowns
  - Eye protection – shields and goggles
  - Hand sanitizer
  - Gloves
- Resources:
  - BSDC Emergency Preparedness Planning and Continuity of Operations Plan (COOP) Resource Manual
  - BSDC Policy Manual – Infection Control Policies
  - Operational Guidelines (OGs) Manual – Infection Control OG

PROCEDURE:

Stage I – Initial Implementation

- BSDC will work with State, Lancaster County Health Department, and other local Health Departments.
- Contingency Staffing Plan will go into effect.
- Identify infection detection process at BSDC to promptly detect and isolate residents.
- Designation of BSDC Leadership (as per Emergency Management Plan) who will meet daily and/or as needed to address essential needs and emergent situations as they arise.
- Identification of essential personnel will be reassessed daily by the Leadership Team and are as follows:
  - All employees are considered essential for anti-viral therapy when available.
  - Ancillary staff will be rotated to areas of need.
- When an individual is suspected of having COVID-19, the Primary Care Provider (PCP) determines if testing is indicated.
- Director of Nursing/designee will inform local and state department officials within 24 hours of outbreak recognition.

Stage II – Containment

A. Signs and symptoms associated with an infectious agent ranges in severity from little to no symptoms to being severely ill and dying.
   - Fever
   - Cough
   - Shortness of breath
   - Sore throat
   - Fatigue

B. If the above signs and symptoms are identified in an individual, we will implement Airborne/Droplet Precautions immediately until lab test can confirm a diagnosis.
   - Follow directions within Infection Control OG related to Airborne/Droplet Precautions.
   - Confine first symptomatic individual and exposed roommate to their room, restrict them from common activities, and serve meals in their rooms.
   - If others become symptomatic, cancel common activities and serve all meals in their rooms.
   - Signs will be placed at each entrance notifying visitors that if they have symptoms of respiratory illness, they will need to reschedule their visit and/or, as applicable, "No Visitors".
   - Restrict personnel movement from areas of facility having outbreaks to areas without symptomatic individuals.
   - Implement daily active surveillance for respiratory illness among all individuals and employees in contact with confirmed or probable COVID-19 until two weeks after last confirmed case occurs.

C. If **signs and symptoms** indicate infectious agent:
   - Isolate individual pending lab results.
   - Confirmed positive test results require quarantine.
   - PCP will see individual at the home and provide medical orders as necessary.
   - Employees entering the room of an individual in isolation should be limited to those performing direct care.
   - Encourage individuals in isolation and quarantine to wear a surgical mask since no Airborne Infection Isolation Rooms (AIIR) are available on campus (single rooms at negative pressure relative to the surrounding areas and with a minimum of six air changes per hour).

D. **Appropriate lab procedures** will be used to perform diagnostic testing.
   - Testing is available through the Nebraska Public Health Lab (NPHL).
   - NPHL will send test to CDC who will confirm positive test results.
   - Results will be obtained in 24 hours.
   - At some point, commercial testing will also be available.

E. The **Facility Administrator, Medical Director/PCPs, Director of Nursing (DON), and other applicable Senior Leadership Members** will be involved in the decision to confine individuals with confirmed illness from those who are not ill. Due to medical limitations of BSDC and level of severity of symptoms, the PCP will determine who may need immediate emergency medical attention and will need to be transferred to an acute care hospital for treatment. Isolation areas outside of the residence will be determined as needed.

F. Personal Protective Equipment (PPE)

1. Caring for Individual with Pandemic Infections

Direct support/health care staff should be particularly vigilant to AVOID:

- Touching eyes, nose, or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before individual contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important (donning and doffing procedure).
- Touching environmental surfaces that are not directly related to individual's care (e.g., door knobs, light switches) to prevent further contamination.

2. Masks (refer to attached supply inventory):

- Wear a mask when entering an individual's room. A mask should be worn once and then discarded. If pandemic COVID-19 individuals are cohorted in a common area or in several rooms in a home, and multiple individuals must be visited over a short time, it may be practical to wear one mask and eye protection, if needed, for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between individuals and disposed of in an adjacent waste receptacle, and hand hygiene performed.
- Change masks when they become moist.
- Do not leave masks dangling around the neck.
- Upon touching or discarding a used mask, perform hand hygiene.

3. Gloves (refer to attached supply inventory):

- A single pair of healthcare gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.
- Gloves should fit comfortably on the wearer's hands.
- Remove and dispose of gloves after use on an individual ; do not wash gloves for subsequent reuse.
- Perform hand hygiene after glove removal.
- If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive individual or environmental contact with blood or body fluids.
- Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with an individual's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. Gowns (refer to attached supply inventory):

- Wear an isolation gown if soiling of personal clothes with an individual's blood or body fluids, including respiratory secretions, is anticipated. Most resident interactions do not necessitate the use of gowns.
- Ensure that gowns are of the appropriate size to fully cover the area to be protected.
- Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
- If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used.

5. **Goggles or Face Shield (refer to attached supply inventory):**
   - If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet Precautions.

PPE for Special Circumstances

PPE for aerosol - generating procedures

- During procedures that may generate increased small-particle aerosols of respiratory secretions, healthcare personnel should wear a mask, gloves, gown, and face/eye protection.

G. Hand Hygiene

- Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of Standard Precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based products containing an emollient that do not require the use of water.
- If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
- In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based products for hand disinfection are used.
- Always perform hand hygiene between individual contacts and after removing PPE.
- Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based products) are readily accessible in areas where care is provided.

H. Disposal of Solid Waste

- Standard Precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus.
- Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps and non-medical waste. Directions for disposing of medical waste are found in the Infection Control OG (Biohazardous Waste).
- Discard as routine waste used healthcare supplies that are not likely to be contaminated (e.g., paper wrappers).
- Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

I. Linen and Laundry

- Standard Precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from individuals with pandemic COVID-19.
- Place soiled linen directly into a laundry bag in the individual's room. No red bags are needed.
- Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per Standard Precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
- Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
- Wash and dry linen according to routine standards and procedures.

J. **Dishes and Eating Utensils**

- Standard Precautions are recommended for handling dishes and eating utensils used by an individual with known or possible pandemic COVID-19:
  - Wash reusable dishes and utensils in a dishwasher with recommended water temperature per BSDC policy.
  - Disposable dishes and utensils should be discarded with other general waste per Emergency Management Plan.
  - Wear gloves when handling individuals' dishes and utensils.

K. **Equipment Used by Residents**

- Follow standard practices for handling and reprocessing used healthcare equipment, including medical devices, if substitute disposable item is not available.
  - Wipe heavily soiled equipment with a BSDC approved surface disinfectant before removing it from the individual's room. Follow current recommendations for cleaning and disinfection of reusable care equipment. When possible, allocate the equipment that is not disposable (i.e. stethoscope) to remain in room for use only with one individual.

L. Environmental cleaning and disinfection

- Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Prime Sani-Cloths and other EPA approved cleaning supplies will be used.

M. Cleaning and Disinfection of Individuals' Bedrooms

- Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with Droplet Precautions. Gowns are necessary for routine cleaning of an infection positive room when individual is present.
- Keep areas around the room free of unnecessary supplies and equipment to facilitate daily cleaning.
- Use only BSDC approved detergent-disinfectant with special attention to doorknobs, bathrooms, and bedside tables, in addition to floors and other horizontal surfaces.

N. **Postmortem care**

- Follow standard facility practices for care of the deceased. Practices should include Standard Precautions for contact with blood and body fluids.

O. **Laboratory specimens and practices**

- BSDC will follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

Stage III - OUTBREAK NOTIFICATION

- Visual alerts will be at entrances advising visitors that visitation is restricted.
- Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:
  - Cover the nose/mouth when coughing or sneezing.
  - Use tissues to contain respiratory secretions.
  - Dispose of tissues in the nearest waste receptacle after use.
  - Perform hand hygiene after contact with respiratory secretions.
- Facility group activities will be cancelled until the outbreak is over. Individual activities and home activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the individuals.

- Department Heads/Supervisors may contact the DON, RN Supervisors, or PCPs for any clarification of memos/orders/notifications/questions.
- DON or designee, in collaboration with the Medical Director/PCP, will contact the State Health and Human Services division of Infectious Disease and the Lancaster Health Department.

MONITORING OF HEALTH CARE PERSONNEL

- Employees who report to work may be asked to be screened for signs and symptoms of the COVID-19 before reporting for duty.
- All symptomatic staff will be sent home for self-isolation and asked to contact their health care provider before returning to work.
- Restrict staff personnel movement from area of the facility having outbreaks to areas without outbreak.

TREATMENT

- No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of clinical signs and symptoms.

Please Note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies, and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

COVID-19 PANDEMIC PLAN

Return to Work Clearance/Protocol

Suspected/Confirmed COVID-19 Illness

If you are suspected of having COVID-19 symptoms or were tested and confirmed positive for COVID-19 and are out ill, you must meet two (2) criteria before returning to work:

1. It needs to be ten (10) days since your first symptom and all your symptoms have improved.
2. You need to be fever-free for twenty-four (24) hours without the use of fever reducing medication.

If both criteria are met, you are cleared to return to work per the Public Health Department and the CDC.

14-Day Self Isolation (without symptoms)

When exposure to COVID-19 is suspected (i.e. traveling, working closely/living with a suspected COVID-19 person), the 14 days of self-isolation (quarantine) is required to ensure you do not expose others while you "wait to see" if you come down with symptoms. If symptoms develop during this timeframe, you will need to follow the above criteria before returning to work.

Other

If ill from a different illness, everyone needs to obtain clearance before returning to work.

1. Return to work determinations
    a. For influenza A/B – fever-free for 24 hours
    b. Other illnesses under doctor's care – follow doctor's guidance

Your understanding of, and adherence to, this criteria is expected and appreciated.

BSDC
COVID-19 PANDEMIC PLAN
SUPPLY INVENTORY

AREA	Gowns (each)	Goggles (each)	Face Shields (each)	Gloves (50 pairs per box)					N-95 Masks (50/pkg)	Surgical Mask (Non N-95) (50/pkg)	Hand Sanitizer 4 oz.	Hand Sanitizer 8 oz.	Food Surface Wipes (containers)	Sani-Wipes (containers)	Additional Comments
				Sm	Med	Lg	XL	2XL							
Dental	68	2	2	9	14	4	5	0	0	112	5	0			plus 3 hand sanitizer replacement containers for free-standing and wall-mounted machines
PHC	25	8	75	45 assorted sizes					320	200		11		10	(200 N95 masks + 120 N95 cone mask = 320 total)
Storeroom	750	20	150	103	193	82	94	54		1200	16	191	126	260	plus 34 hand sanitizer replacement containers for free-standing and wall-mounted machines
2nd floor south, A Bldg										50		3		7	storage closets
TOTAL	**843**	**30**	**227**	**112**	**207**	**86**	**99**	**54**	**320**	**1562**	**21**	**205**	**126**	**277**	
418	300		50	8	14	12	6	4		200					
420	285			12	9	6	6	16							
422	25			3	9	10	15	9		73					
424	60			10	9	7	7	6		408					
3052	200			16	1	2	19			150					
3056	90			7	8	10	11	4		175					
3060				4	9	9	2								
3070				5	9	10	8	4		50					
3060 & F Building	200		91							620					
402				3	2	0	0	0							
406				9	5	4	2	9							
408				10	10	15	10	6							
103	0			1	10	5	11	4		2					
104	30			0	0	6	9	14		1					
205	0			0	1	6	8	5		0					
206	10			0	6	2	2	0		0					
TOTAL	1200		141	88	102	104	116	81		1676					
GRAND TOTAL	**2043**	**30**	**368**	**200**	**309**	**190**	**215**	**135**	**320**	**3238**	**21**	**205**	**126**	**277**	plus an additional 45 boxes of various sizes of gloves in the Health Clinic

Glove Total: 1049 plus 45 = **1094** boxes

On-going monitoring and re-ordering of supplies identified in inventory will continue.

All homes have open boxes of different size gloves in the bathrooms in addition to supplies indicated above.

Operational guidelines

Beatrice State Developmental Center
Operational Guideline

COVID-19 Environmental Controls
Breakroom

Purpose	As part of campus environmental controls during the COVID-19 Pandemic, an Operational Guideline (OG) impacting how we control the spread of COVID-19 as applicable to staff and/or residents to ensure CDC/Public Health protocols along with Beatrice State Developmental Center (BSDC) Infection Control Policy and OGs are being adhered to in order to protect residents and staff from transmission of infection and exposure to and control of the spread of COVID-19 while utilizing breakrooms.
Guidelines	1. Only two chairs allowed at a table in order to maintain social distancing. 2. If breakroom has more than one table, then no two tables located next to each other should be utilized at one time as to maintain social distancing. 3. All staff will continue to wear a mask with the exception only briefly when eating/drinking. 4. When applicable, staff will direct residents to maintain social distancing guidelines. 5. All high touch surfaces such as tables, chairs, microwave, and vending machines should be disinfected before and after each use according to CDC and BSDC Infection Control Pandemic Guidelines. 6. All staff and residents will maintain appropriate hand hygiene practices before entering and exiting the area.

Beatrice State Developmental Center
Operational Guideline

COVID-19 Environmental Controls
Computer Cleaning

Purpose	As part of campus environmental controls during the COVID-19 Pandemic, an Operational Guideline (OG) impacting how we control the spread of COVID-19 during utilization of computer equipment is in place to ensure CDC/Public Health protocols and Beatrice State Developmental Center (BSDC) Infection Control Policy and OGs are being adhered to in order to protect staff and residents, as applicable, from transmission of infection and exposure to potential COVID-19.
Guidelines	General Cleaning Tips: • Use a lint-free cloth, such as a screen wipe or a cloth made from microfiber. • Avoid excessive wiping and submerging item in cleanser to avoid damage. • Unplug all external power sources and cables. • Do not use aerosol sprays, bleach, or abrasive cleaners. • Ensure moisture does not get into any openings. • Never spray cleaner directly on an item.
Approved COVID-19 Disinfectants Safe for Computers, Accessories, and Electronics	• Using a Sani-Cloth, gently and carefully wipe the hard, nonporous surface of the item. This includes the display, keyboard, mouse, and the exterior surface of the item. If you have concerns about the cleaning product being used, please refer to the manufacturer's recommendations and warning label. • When using a disinfectant wipe, it is important to follow the contact time found on the label. It may be necessary to use more than one wipe to keep the surface wet for the recommended contact time. • Do not use fabric or leather surfaces on items, as this can scratch or damage the items. • Do not use bleach to disinfect computers and electronics.

Beatrice State Developmental Center
Operational Guideline

COVID-19 Environmental Controls
Gym

Purpose	As part of campus environmental controls during the COVID-19 Pandemic, an Operational Guideline (OG) is in place to ensure CDC/Public Health protocols along with Beatrice State Developmental Center (BSDC) Infection Control Policy and OGs are being adhered to in order to protect residents and staff from transmission of infection, and exposure to and control of the spread of COVID-19 while utilizing the gym and fitness equipment.
Guidelines	1. Scheduled appointments to utilize gym/equipment as identified by the IDT will ensure that individuals are cohorting in groups of six or less, to include staff, at any one time. 2. No two pieces of gym equipment that are located next to each other, should be utilized at the same time in order to maintain social distancing. 3. All staff will wear a mask as per the BSDC COVID-19 Pandemic Plan while at work. 4. Staff will monitor and direct residents to maintain social distancing guidelines. 5. All gym equipment (or other therapeutic equipment) used should be disinfected before and after each use. 6. Hard to clean surfaces, such as foam rollers and yoga blocks, if applicable, will not be available. 7. After each resident or cohort group exits the gym, all high touch surfaces will be disinfected according to BSDC Infection Control Policy and OGs. 8. All Staff and residents will maintain appropriate hand hygiene practices before entering and exiting the area.

Beatrice State Developmental Center
Operational Guideline

COVID-19 Environmental Controls
Rec Room

Purpose:	As part of campus environmental controls during the COVID-19 Pandemic, an Operational Guideline (OG) impacting how we control the spread of COVID-19 during utilization of the rec room is in place to ensure CDC/Public Health protocols and Beatrice State Developmental Center (BSDC) Infection Control Policy and OGs are being adhered to in order to protect residents and staff from transmission of infection and exposure to and control of the spread of COVID-19 while attending rec room activities.
Guidelines	1. Individuals will cohort by home with advanced schedule in place to ensure that social distancing is able to be maintained. 2. No two pieces of equipment or furniture should be used at the same time as to maintain social distancing. 3. All staff will wear a mask and residents may wear a mask if requested and previously assessed for tolerance. 4. Staff will direct residents to maintain social distancing guidelines if possible. 5. All equipment should be disinfected before and after each use. 6. Hard to clean surfaces, such as foam, etc., will not be available. 7. After each cohort group exits the rec room, all high touch surfaces will be disinfected according to BSDC Infection Control Policy and OGs and COVID-19 Pandemic Plan. 8. All staff and residents will maintain appropriate hand hygiene practices before entering and exiting the area.

Beatrice State Developmental Center
Operational Guideline

COVID-19 Environmental Controls
Salon Services

Purpose	As part of campus environmental controls during the COVID-19 Pandemic, an Operational Guideline (OG) impacting salon services is provided to ensure CDC/Public Health protocols and Beatrice State Developmental Center (BSDC) Infection Control Policy and OG are being adhered to in order to prevent residents and staff from transmission of infection and exposure to potential COVID-19.
Guidelines	1. Only one resident and one staff will be in the salon with the beautician at one time based on previously scheduled appointment. 2. Staff, including beautician, will wear a mask as per established protocols. **NOTE**: If determined by previous assessment that resident can tolerate wearing of face mask, then this will also be expected. 3. Resident will be provided with a disposable or reusable cape replaced with a clean cape for each resident's use. a. Launder porous or disinfect non-porous capes according to instructions on disinfectant used. b. Wash non-disposable capes in hot water and dry on high heat. 4. Keep clean towels separate from resident station in airtight bin when possible. Do not stack towels at each station. 5. Immediately following resident's exit from the salon, all high touch surfaces and tools used will be disinfected according to BSDC Infection Control Policy and OG as well as CDC and Public Health Guidelines for Environmental Cleaning during the COVID-19 Pandemic. 6. All staff, residents, and beautician will maintain appropriate hand hygiene before and after utilizing salon services.

Teammate letter

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 11, 2020

Dear BSDC Teammates:

As the COVID-19 pandemic began to impact Nebraska, the Beatrice State Developmental Center (BSDC) recognized that it was crucial for our team to take extra precautions within campus. As a long-term care facility, our individuals are at heightened risk, and efforts were implemented to mitigate those risks.

As Nebraska moves forward with easing pandemic restrictions and people move toward resuming their normal lifestyles, the risk of exposure may increase.

I want to say thank you for your commitment to continuing to provide support to the individuals we serve and to your teammates. Your willingness to adapt to changes in protocols as the pandemic began to impact Nebraska and BSDC is appreciated. Because we required masking of staff, initiated temperature checks of residents and staff, and transitioned to virtual visitation, these steps have contributed greatly to mitigating the spread of COVID-19. Thank you to all teammates who contacted their supervisors and did not come in to work when they believed they may have been symptomatic. This step is key to identifying and eliminating possible exposures.

We are currently working with our local public health authority to move to the next phase of expanded testing. BSDC is being provided with COVID-19 testing kits. The test kits will be available for testing residents and staff. All tests will be administered by our nursing staff. When the testing dates become available, notification will be provided in regards to location and scheduling times.

If a resident tests positive, the BSDC Emergency Preparedness Pandemic Plan will be enacted and the resident will be isolated in a separate room and/or designated home. If a staff tests positive, they will not return to work until they have appropriately isolated and are asymptomatic for at least 72 hours.

In an effort to ensure we continue to provide the safest environment for both you as employees and our residents, employees are strongly encouraged to take advantage of this testing option. Thank you for your continued service to the BSDC community.

Sincerely,

Corina Harrison
Facility Administrator

Testing

Fralin, Russell

From: Fralin, Russell
Sent: Monday, December 7, 2020 12:43 PM
To: Adam, Marilyn; Blythe, Geana; Bruhn, Robert; Buss, Cathy; Buss, Nate; Chelewski, Lynn; Clark, Sandy; Collmann, Keriann; Corey, Doug; DHHS BSDC BST; DHHS BSDC Clinical Staff; DHHS BSDC Compliance Specialists; DHHS BSDC Dental; DHHS BSDC DevTherapy; DHHS BSDC DTStaff; DHHS BSDC Facility Operations Management Staff; DHHS BSDC FinanceResp; DHHS BSDC HCC; DHHS BSDC Health Information Systems; DHHS BSDC HelpDesk; DHHS BSDC Home Managers; DHHS BSDC HR; DHHS BSDC ICF Administrative Supervisors; DHHS BSDC Medical; DHHS BSDC Nurse; DHHS BSDC PBX; DHHS BSDC QDDP; DHHS BSDC Recreation; DHHS BSDC Recreation Therapy; DHHS BSDC Shift Supervisor; DHHS BSDC Speech; DHHS BSDC Staff Assistants; DHHS BSDC Voc; Dorn, Mike; Duntz, Janice; Engel, Melba; Fulton, Shannon; Gowen, Monica; Grof, James; Harrison, Corina; Hofeling, Ricky; Izer, Mike; Jurgens, Gary; Karas, Richard; Lopez, Leroy; Lovitt, Gary; Lux, William; Ojeda, Grace; Penner, Holli; Ramsey, Patrick; Robertson, Steve; Robinson, James; Vogel, Rick; Walker, Bonny; Wenzl, Danny L; Wieden, Daniel
Cc: Bartels, Shawn; Brown, Terry; Hightower, Michael
Subject: COVID-19 Testing

With the recent surge in COVID-19 cases in the Beatrice/Gage County area; teammates and individuals are being affected; BSDC has obtained COVID-19 testing kits and will conduct testing this week.

- On Tuesday, December 8, 2020, BSDC employees who have not recently tested positive since November 1, 2020 can be re-tested.
- Employee testing will take place in the last two rooms at the end of the hall past the Public Health Clinic
    - **Time frames for employee testing on December 8, 2020 are as follows:**
        - **7-11 AM**
        - **1-3 PM**
- **People Leaders:** when scheduling your employees for testing, **PLEASE** spread the employees throughout the day and at different time frames.
- While testing remains voluntary, it is extremely important as **People Leaders** to encourage all applicable employees to receive testing.

Russell Fralin | *Staff Assistant II*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-223-6600 x2236827
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Fralin, Russell

From: Fralin, Russell
Sent: Friday, January 15, 2021 9:46 AM
To: Adam, Marilyn; Blythe, Geana; Bruhn, Robert; Buss, Cathy; Buss, Nate; Chelewski, Lynn; Clark, Sandy; Collmann, Keriann; Corey, Doug; DHHS BSDC BST; DHHS BSDC Clinical Staff; DHHS BSDC Compliance Specialists; DHHS BSDC Dental; DHHS BSDC DevTherapy; DHHS BSDC DTStaff; DHHS BSDC Facility Operations Management Staff; DHHS BSDC FinanceResp; DHHS BSDC HCC; DHHS BSDC Health Information Systems; DHHS BSDC HelpDesk; DHHS BSDC Home Managers; DHHS BSDC HR; DHHS BSDC ICF Administrative Supervisors; DHHS BSDC Medical; DHHS BSDC Nurse; DHHS BSDC PBX; DHHS BSDC QDDP; DHHS BSDC Recreation; DHHS BSDC Recreation Therapy; DHHS BSDC Shift Supervisor; DHHS BSDC Speech; DHHS BSDC Staff Assistants; DHHS BSDC Voc; Dorn, Mike; Duntz, Janice; Engel, Melba; Fulton, Shannon; Gowen, Monica; Grof, James; Harrison, Corina; Hofeling, Ricky; Izer, Mike; Jurgens, Gary; Karas, Richard; Lopez, Leroy; Lovitt, Gary; Lux, William; Ojeda, Grace; Penner, Holli; Ramsey, Patrick; Robertson, Steve; Robinson, James; Vogel, Rick; Walker, Bonny; Wenzl, Danny L; Wieden, Daniel
Subject: COVID update for employees
Attachments: Vaccine Key Messages 1 11 21.docx; Moderna-VIS.pdf; Patient COVID 19 Vaccination Consent Form 12-2020.doc

Sent on behalf of Corina Harrison, Facility Administrator

Hello,

Wanted to update all of you on what has been happening here at BSDC and in the State of Nebraska. Attached for your information is the Vaccine Key Message from DHHS for the State of Nebraska. I know that parts of the Key Message may seem confusing as BSDC is a long-term-care facility. However, BSDC is a state owned and operated LTCF and we are partnering with Public Health Solutions, Gage County Department of Public Health for our vaccine. BSDC received the Moderna Vaccine and does not take part in the Federal Pharmacy – LTCF program. I have attached the Vaccine Key Message so that you have the most current vaccine information for the entire State of Nebraska.

I am happy to announce that our first 100 doses of COVID vaccine have been administered to those employees in our first priority group. Helaine Dominguez, BSDC Director of Nursing and infection control lead has provided the following information;

Sent on behalf of Helaine Dominguez, RN, DON

105* Staff received 1st dose of COVID-19 vaccine over 2 days

- Day #1 – 1/13/2021 – 62* Staff
- Day #2 – 1/14/2021 – 43* Staff

***NOTE: 5 extra doses from overfill**

- All Staff received post-immunization monitoring by Nursing. No adverse outcomes.
- Staff scheduled for 2nd dose of COVID-19 vaccine on 2/10/2021 and 2/11/2021

Per Public Health Solutions, Public Health Dept. Gage Co., BSDC will receive second doses within the required 28 days, by 2/10/2021. BSDC will be tracking NESIIS for impending transfers. BSDC may also receive notification from McKesson as they are the company sending vaccines right now.

Public Health Solutions has not been told when BSDC will receive another shipment of **1st doses.** BSDC has been told the supply of vaccine should open more widely the first week of February.

Once we have employees vaccinated we will begin vaccinating BSDC individuals. Before vaccinating individuals we will be contacting guardians to provide vaccine fact sheet and to get consent forms signed. Our communication plan for guardians will be similar to the one used for COVID-19 testing.

QDDPs will be calling and emailing guardians first, letting them know we are getting ready to vaccinate individuals. Nursing and Primary Care Practitioners will be available to answer any medical questions guardians may have about vaccine and side effects.

Attached are Moderna vaccine fact sheet and patient consent form for your review. Below is the CDC guidance BSDC is following to prioritize employee groups for vaccination.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/hcp.html

> ***Vaccinating healthcare personnel protects healthcare capacity***
> *When healthcare personnel get sick with COVID-19, they are not able to work and provide key services for patients or clients. Given the evidence of ongoing COVID-19 infections among healthcare personnel*

All infection control protocols remain in place. All employees are expected to wear masks while working at BSDC. Being vaccinated does not change mask wearing requirement. BSDC will be conducting audits for mask wearing employee compliance to ensure everyone's health and safety.

Thank you for your patience and support as we work on getting everyone vaccinated at BSDC.

Regards,
Corina

Corina Harrison | *Facility Administrator*
DEVELOPMENTAL DISABILITIES
Beatrice State Developmental Center
OFFICE: 402-223-6858
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Recent Protocols

New Requirement for ICF/DDs	Regulatory Authority	What does CMS expect?	Effective date
Facility must educate staff regarding the benefits, risks, and potential side effects of the COVID-19 vaccine	42 CFR § 483.430(f)(1)	1. Facility must educate staff, which CMS defines as "individuals who work in the facility on a regular basis (that is, at least once a week)." 86 Fed. Reg. at 26317. 2. Staff also includes individuals under contract who provide services on-site on a regular basis, including, e.g. physical therapists, mental health professionals, etc. *Id*. New staff should be screened to determine vaccination status and potential need for education during onboarding. 86 Fed. Reg. at 26318. 3. Education must cover benefits and possible side effects of vaccination, the bolstered protection offered by full series of multi-dose vaccines, other benefits as research continues, and potential side effects, including low likelihood of severe side effects. 86 Fed. Reg. at 26318. 4. Education must also cover "culturally appropriate ways to educate and share information with clients to prevent misinformation, confusion, or loss of credibility." *Id.* 5. Facilities must document educational efforts, which could include sign in sheets, flyers/posters announcing training, notes from Q&A sessions, etc. *Id*.	May 21, 2021
Facility must educate residents or their	42 CFR § 483.460(a)(4)(iii)	1. Clients/representatives must be offered education about vaccine immunization	May 21, 2021

representatives about COVID-19 vaccination		development, administration, and evaluation. 86 Fed. Reg. at 26318. 2. Education must inform client/rep that all ICF/DD clients are able to receive vaccine without any copays or out-of-pocket costs. 86 Fed. Reg. at 26319. 3. Education must "be conducted in a manner that is reasonably understood by clients and representatives." Information should be made available in accessible formats, such as large print, braille, ASL, etc. *Id.*	
Facility must offer and provide vaccine to clients and staff	42 CFR § 483.460(a)(4)(i)	1. Facility must offer clients and staff vaccination against COVID-19, either directly by the ICF or indirectly, such as through local health department, pharmacy, or doctor's office. 86 Fed. Reg. at 26317. 2. Facility is not required to offer where individual has already received the vaccine or has a known medical contraindication. *Id.* 3. Client, guardian, or staff have the right to refuse treatment. 4. If resident or staff requests vaccination but missed earlier opportunities, facility records must show efforts were made to acquire vaccination opportunity for that individual. 86 Fed. Reg. at 26319. 5. Personnel records for staff and health records for residents should reflect appropriate administration of any multi-dose vaccine series, including efforts to acquire subsequent doses as necessary. *Id.*	May 21, 2021

Fralin, Russell

From: Fralin, Russell
Sent: Friday, October 29, 2021 7:54 AM
To: Adam, Marilyn; Blythe, Geana; Bruhn, Robert; Buss, Nate; Clark, Sandy; Collmann, Keriann; Corey, Doug; DHHS BSDC BST; DHHS BSDC Clinical Staff; DHHS BSDC Compliance Specialists; DHHS BSDC Dental; DHHS BSDC DevTherapy; DHHS BSDC DTStaff; DHHS BSDC Facility Operations Management Staff; DHHS BSDC FinanceResp; DHHS BSDC HCC; DHHS BSDC Health Information Systems; DHHS BSDC HelpDesk; DHHS BSDC Home Managers; DHHS BSDC HR; DHHS BSDC ICF Administrative Supervisors; DHHS BSDC Medical; DHHS BSDC Nurse; DHHS BSDC PBX; DHHS BSDC QDDP; DHHS BSDC Recreation; DHHS BSDC Recreation Therapy; DHHS BSDC Shift Supervisor; DHHS BSDC Speech; DHHS BSDC Staff Assistants; DHHS BSDC Voc; Dorn, Mike; Engel, Melba; Fulton, Shannon; Gowen, Monica; Green, Tiffanie; Grof, James; Harrison, Corina; Hofeling, Ricky; Izer, Mike; Jurgens, Gary; Karas, Richard; Keuten, Sara; Lopez, Leroy; Lovitt, Gary; Lux, William; Murdock, Christina; Ojeda, Grace; Penner, Holli; Ramsey, Patrick; Robertson, Steve; Robinson, James; Walker, Bonny; Wieden, Daniel
Subject: INFORMATIONAL: COVID Update
Attachments: Covid Booster Flow Chart.docx

Sent on behalf of Corina Harrison, Facility Administrator

Good morning,

It is hard to believe that we are already at the end of October. Weather once again tried to dampen an event at BSDC. Thank you to all staff that made Trunk-or-Treat a success even though it rained all day. Seeing everyone in costume was a lot of fun. Having the kids there made it very special and they had some amazing costumes.

I have an important change I'd like to share. BSDC leadership is currently taking into consideration how to provide health and safety for the individuals we support, while continuing to provide a therapeutic environment. We are taking steps to remove all current COVID restrictions except for masking. Masking will continue at BSDC for now.

BSDC will be resuming open, unrestricted visitation. Before we are able to open visitation, we need to make sure we are using the best practices available to help ensure a safe environment for individuals and the staff that support them.

These are some of the steps we are taking as we move toward opening of visitation with no restrictions:

For our individuals and staff

- All facility mask mandate will continue to be in place. BSDC staff have a mask mandate – masks are worn by staff in contact with the individuals, when in meetings, when outside of their office or in shared office space that does not allow for social distancing.
- Visitors will be required to mask when inside buildings. Masks are not required outdoors and able to socially distance.
- Continue awareness and expectations for hand hygiene and cleaning within the facility.
- Reminding staff to stay home if they are sick or showing any signs of illness.
- Encouraging staff to self-quarantine if they believe they have been exposed to COVID-19 variants.

For family members

- A continuation of virtual visits for those families that are unable to visit in person.

- Begin in-person visitation available in all areas, including individuals' homes to begin as early as November 1, 2021.
- Availability of face masks for all visitors to the program if they are not able to provide their own.
- A focus on social distancing and limiting physical contact as able.

Other restrictions to be lifted are;

- IDT meetings:
    - In person meetings are open to all participate that want to attend. Attending via phone will continue to be an option.
    - Should guardian wish to participate in person, please ensure to have a mask properly in place upon entering buildings and meeting rooms.
- On campus activities:
    - Once again, individuals will be participating in activities freely without having to be in cohort groups with their housemates.
    - All on-campus jobs will resume.
- Off campus activities:
    - Recreation/Leisure activities will resume.
    - Jobs and volunteer work will resume.

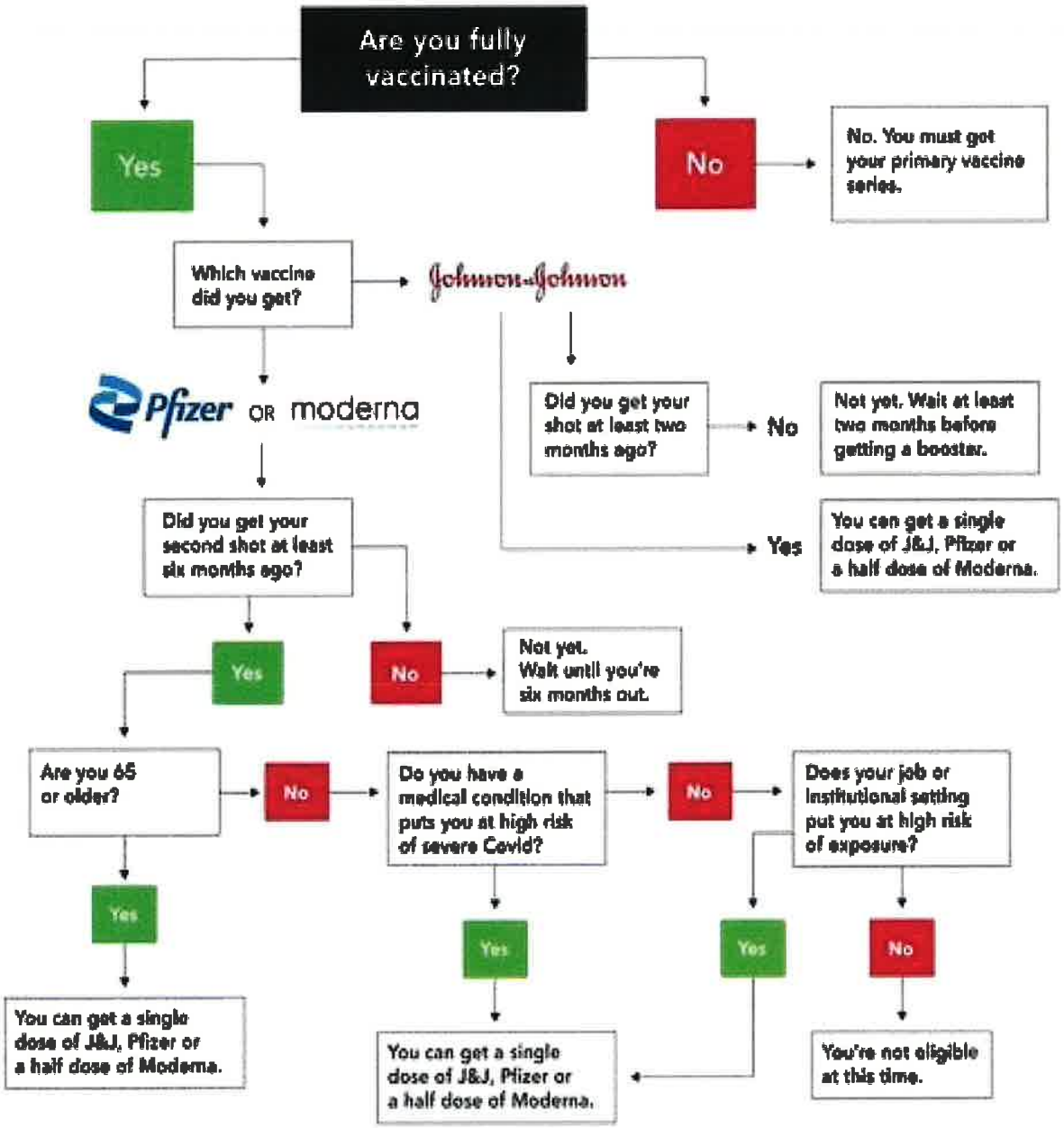
BSDC leadership is checking on booster shot availability for individuals. I'll update as we learn more from our public health partners. **Employees wishing to get their booster shots may go to Deines Pharmacy on Thursdays from 9am to 4pm for walk in vaccinations. Deines is carrying all three vaccinations.**

Vaccinations are also available through Public Health Solutions on the following dates/times in November:

***Attached is a flow chart from Public Health Solutions to aid in determining if you are eligible for a booster vaccination.

Corina Harrison | *Facility Administrator*
DEVELOPMENTAL DISABILITIES
Beatrice State Developmental Center
OFFICE: 402-223-6858
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Can I Get a Covid-19 Booster Shot?



Family/Guardian/Individual letter

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

November 1, 2021

Dear Family/Guardians,

BSDC leadership is currently taking into consideration how to provide health and safety for the individuals we support, while continuing to provide a therapeutic environment.

The following is information regarding current decisions, and we will continue to keep you informed as we move forward. We are taking steps to remove all current COVID restrictions.

BSDC will be resuming open, unrestricted visitation. Before we are able to open visitation, we need to make sure we are using the best practices available to help ensure a safe environment for your family member and the staff that support them.

These are some of the steps we are taking as we move toward opening of visitation with no restrictions:

<u>For our residents and staff</u>

- All facility mask mandate will continue to be in place. BSDC staff have a mask mandate – masks are worn by staff in contact with the individuals, when in meetings, when outside of their office or in shared office space that does not allow for social distancing.
- Visitors will be required to mask when inside buildings. Masks are not required outdoors and able to socially distance.
- Continue awareness and expectations for hand hygiene and cleaning within the facility
- Reminding staff to stay home if they are sick or showing any signs of illness
- Encouraging staff to self-quarantine if they believe they have been exposed to COVID-19 variants

<u>For family members</u>

- A continuation of virtual visits for those families that are unable to visit in person.
- Begin in-person visitation available in all areas, including individuals' homes to begin as early as November 1, 2021
- Availability of face masks for all visitors to the program if they are not able to provide their own
- A focus on social distancing and limiting physical contact as able.

Other restrictions to be lifted are;

- IDT meetings:
    - In person meetings are open to all participate that want to attend. Attending via phone will continue to be an option.
    - Should guardian wish to participate in person, please ensure to have a mask properly in place upon entering buildings and meeting rooms.

- On campus activities:
    - Once again, individuals will be participating in activities freely without having to be in cohort groups with their housemates
    - All on-campus jobs will resume
- Off campus activities:
    - Recreation/Leisure activities will resume
    - Jobs and volunteer work will resume

Please do not hesitate to contact your QDDP if you have questions about the lifting these restrictions.

As this pandemic continues, we will keep you informed of any changes regarding restrictions. Should there be an increase in exposure and positive testing, we may need to re-evaluate our practices with little to no prior notice.

Thank you for your continued support, assistance, and understanding.

Sincerely,

Corina Harrison
Facility Administrator

Fralin, Russell

From: Fralin, Russell
Sent: Friday, November 5, 2021 8:35 AM
To: Drummond, Molly M
Cc: Weishahn, Beth
Subject: BSDC Covid Data

Number of patients/residents currently positive with covid-19 = 0
Number of staff currently positive with covid-19 = 0

Russell Fralin | *Administrative Specialist*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-223-6600 x2236827
DHHS.ne.gov | Facebook | Twitter | LinkedIn

Fralin, Russell

From: Dominguez, Helaine
Sent: Thursday, November 4, 2021 12:13 PM
To: Harrison, Corina
Cc: Fralin, Russell
Subject: FW: Paperwork and EUA for Moderna COVID-19 Vaccine *** Booster
Attachments: Moderna Screening_Consent-English 11042021.pdf; 11042021 Fact-sheet-pi-providers-booster-clean (1).pdf; final2-fact-sheet-recipients-booster-clean 10.20.21.pdf

Hello,

I wanted to share the below response from PHS with you. The following has to happen: guardian consent (5 individuals did not receive initial vaccine because of guardian declination); PCP must put in orders for Booster shots (identify anyone she thinks should not have it) it is established that benefits far outweigh any risks.

If you agree I will f/u by sending applicable detail information to PCP requesting order entry and Alecia for f/u with Q'sfor consents. The attached will be filled as applicable.

Thanks,
H.

Helaine Dominguez | *Director of Nursing*
DEVELOPMENTAL DISABILITIES
Nebraska Department of Health and Human Services
OFFICE: 402-223-6600 | CELL: 402-239-1512 | FAX: 402-223-7528
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Kate Lange <klange@phsneb.org>
Sent: Thursday, November 4, 2021 11:23 AM
To: Dominguez, Helaine <Helaine.Dominguez@nebraska.gov>
Subject: Paperwork and EUA for Moderna COVID-19 Vaccine

Hi Helaine:
Here are the documents we discussed over the phone this morning. The first fact sheet is for providers. The second is for recipients. We will put in an order for your doses today. They should be delivered by next week. If they have not arrived by the time you are ready to proceed with vaccination, the department will give you doses we have in house. Please don't hesitate to contact me or Jackie if you have any questions. Thank you for partnering with Public Health Solutions to protect Gage County residents from COVID-19.
Sincerely,

Kate Lange, RN, BSN

Kate Lange, RN, BSN
Clinical Services Manager
Childhood Lead Poisoning Prevention Program Manager
CATCH Partnership Program Manager

NEW ADDRESS 830 E. 1st Street, Suite 300.

Phone: 402-826-3880
Direct Line: 402-826-6691
Fax: 402-826-4101
Toll Free: 844-830-0813
klange@phsneb.org

Public Health
Prevent. Promote. Protect.

I GOT MY COVID-19 VACCINE!

Lead Free KIDS for a Healthy Future

PHS Vision Statement: "Healthy opportunities for everyone where we live, learn, work, and play."

BSDC Inspection Documentation

Fire Extinguisher

Sprinkler

Boiler

Attachment B7

Fire Extinguisher

GT FIRE & SECURITY, INC.

3630 W Old Hwy 30
Grand Island, NE, 68803
(308) 389-3981

Work Order

Start Date: 1/9/20 PO #:
Customer: B S D C
Contact Person:
Address:
City: Beatrice
State: NE Zip:
Phone:
Email:
Type of System:

Worked Performed							
Fire Extinguisher Delivery & Inspection							
*1 due for Recharge. 4[illegible] due for hydro, No loaners left							
216 - Tags were used							
1 - 5# ABC Rck & TAG							
1 - 10# ABC Recharge							
Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	**Total Hours**

Quantity	Part #	Materials
1	20# ABC	Hydro test
1	20# ABC	Recharge
12	10# ABC	6yr Maint
18	5# ABC	Hydro test
7	10# ABC	Hydro test

Work Completed By: [signature] Date: 1-4-2020
I hereby acknowledge the satisfactory completion of the above described work.
Signature: [signature] **Title:** Safety

We Appreciate Your Business!

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

usiness Name **Bsdc Administration Bldg**

ervice Address **843 Wallman Drive**

ontact Person _____ /Phone Number _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP

Size	Manufacturer	Model No.	Serial No.
4.0	Watts	757	Fd-1534

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP

Size	Manufacturer	Model No.	Serial No.

☐ Domestic ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

Containment

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location **BASEMENT MECH ROOM**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
eld at 4.0 PSID	Held at 3.6 PSID	Opened at ____ PSID	Air Inlet
eaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at ____ PSID
leaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
eplaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off		Held at ____ PSID
	Closed Tight ☒ Yes ☐ No		Leaked ☐ Yes ☐ No
			Cleaned ☐
			Replaced

INAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID
			Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

ravis Billesbach	8466	531-220-1687
ate Certified Technician (please print)	Grade 6 Certificate #	Cell / Phone No.
ate Certified Technician Signature	☐ Customer Signature	Monday, October 05, 2020 Date of Test
Midwest	01172391	4.3.2020
est Gauge Manufacturer	Test Gauge Serial #	Date of Calibration

omment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc Bldg 17 South Wing**

Service Address: **834 Sheridan Drive**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check	☐ RPP	**4.0** Size	**Febco** Manufacturer	**850** Model No.	**970521181257** Serial No.

☐ New Installation	☐ Replacement				
☐ Double Check	☐ RPP	Size	Manufacturer	Model No.	Serial No.

☐ Domestic Containment ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **BASEMENT SOUTH CRAWL SPACE**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **1.2** PSID	Held at **1.4** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID Leaked ☐ Yes ☐ No Cleaned ☐ Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach	8466	531-220-1687
State Certified Technician (please print)	Grade 6 Certificate #	Cell / Phone No.
State Certified Technician Signature	☐ Customer Signature	**Monday, October 05, 2020** Date of Test
Midwest Test Gauge Manufacturer	**01172391** Test Gauge Serial #	**4.3.2020** Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc (North)**

Service Address: **834 Sheridan Drive**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **6.0** | Manufacturer: **Wilkins** | Model No.: **350a** | Serial No.: **U05250**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: | Manufacturer: | Model No.: | Serial No.:

☐ Domestic ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

Containment

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **BASEMENT MECH ROOM**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at 3.0 PSID	Held at 3.2 PSID	Opened at ____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at ____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off		Held at ____ PSID
	Closed Tight ☒ Yes ☐ No		Leaked ☐ Yes ☐ No
			Cleaned ☐
			Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID
			Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach — State Certified Technician (please print)

8466 — Grade 6 Certificate #

531-220-1687 — Cell / Phone No.

State Certified Technician Signature

☐ Customer Signature

Monday, October 05, 2020 — Date of Test

Midwest — Test Gauge Manufacturer

01172391 — Test Gauge Serial #

\4.3.2020 — Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc L Building**

Service Address: **748 Wallman**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **6.0** | Manufacturer: **Watts** | Model No.: **709** | Serial No.: **253042**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: _____ | Manufacturer: _____ | Model No.: _____ | Serial No.: _____

☐ Domestic Containment ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc): (Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **BASEMENT MECH**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **1.5** PSID	Held at **1.6** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID Leaked ☐ Yes ☐ No Cleaned ☐ Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID / Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach — State Certified Technician (please print)

8466 — Grade 6 Certificate #

531-220-1687 — Cell / Phone No.

State Certified Technician Signature

☐ Customer Signature

Monday, October 05, 2020 — Date of Test

Midwest — Test Gauge Manufacturer

01172391 — Test Gauge Serial #

4.3.2020 — Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc Bldg D**

Service Address: **941 Sheridan Drive**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **4.0** | Manufacturer: **Wilkins** | Model No.: **350a** | Serial No.: **U13283**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: _____ | Manufacturer: _____ | Model No.: _____ | Serial No.: _____

☐ Domestic ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

Containment

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **BASEMENT MECH**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **3.3** PSID	Held at **2.9** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID Leaked ☐ Yes ☐ No Cleaned ☐ Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID / Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach — State Certified Technician (please print)

8466 — Grade 6 Certificate #

531-220-1687 — Cell / Phone No.

State Certified Technician Signature

☐ Customer Signature

Monday, October 05, 2020 — Date of Test

Midwest — Test Gauge Manufacturer

01172391 — Test Gauge Serial #

4.3.2020 — Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc State Bldg**

Service Address: **3104 State Avenue**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **4.0** | Manufacturer: **Watts** | Model No.: **709** | Serial No.: **179984**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: _____ | Manufacturer: _____ | Model No.: _____ | Serial No.: _____

☐ Domestic ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

Containment

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **BASEMENT MECH**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **1.6** PSID	Held at **2.4** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID
			Leaked ☐ Yes ☐ No
			Cleaned ☐
			Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID / Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach — State Certified Technician (please print)

8466 — Grade 6 Certificate #

531-220-1687 — Cell / Phone No.

State Certified Technician Signature

☐ Customer Signature

Monday, October 05, 2020 — Date of Test

Midwest — Test Gauge Manufacturer

01172391 — Test Gauge Serial #

4.3.2020 — Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Bsdc East Apartment**

Service Address: **667 31st Street**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **6.0** | Manufacturer: **Wilkins** | Model No.: **350a** | Serial No.: **U06345**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: _____ | Manufacturer: _____ | Model No.: _____ | Serial No.: _____

☐ Domestic ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc):

Containment

(Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **basement mech room**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **3.1** PSID	Held at **2.9** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID
			Leaked ☐ Yes ☐ No
			Cleaned ☐
			Replaced

INAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID
			Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach	8466	531-220-1687
tate Certified Technician (please print)	Grade 6 Certificate #	Cell / Phone No.
tate Certified Technician Signature	☐ Customer Signature	**Monday, October 05, 2020** Date of Test
Midwest	**01172391**	**4.3.2020**
est Gauge Manufacturer	Test Gauge Serial #	Date of Calibration

Comment: _____

NIFCO MECHANICAL SYSTEMS, LLC.

500 Blue Heron Drive • Lincoln, NE 68522 • (402) 477-0666

Backflow Preventer

MAINTENANCE TEST FORM

Business Name: **Beatrice State Dev Carstens Center**

Service Address: **3000 Carstens Drive**

Contact Person: _____ /Phone Number: _____

☒ Annual Test ☐ Repair

☒ Double Check ☐ RPP | Size: **4** | Manufacturer: **Deringer** | Model No.: **dc** | Serial No.: **G29341**

☐ New Installation ☐ Replacement

☐ Double Check ☐ RPP | Size: _____ | Manufacturer: _____ | Model No.: _____ | Serial No.: _____

☐ Domestic Containment ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc): (Other Cont'd)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location: **NORTH MIDDLE OF BUILDING IN CLOSET**

Check Valve #1 INITIAL TEST	Check Valve #2	Pressure Relief Valve	PVB/SVB
Held at **2.6** PSID	Held at **2.4** PSID	Opened at _____ PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed tight ☒ Yes ☐ No	Did not open ☐	Opened at _____ PSID
Cleaned ☐	Leaked ☐ Yes ☒ No	Cleaned ☐	Did Not Open ☐
Replaced:	Cleaned ☐	Replaced:	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at _____ PSID Leaked ☐ Yes ☐ No Cleaned ☐ Replaced

FINAL TEST

PSID	Closed tight ☐ Yes ☐ No PSID	Opened at PSID	Check Valve PSID / Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordance with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System, Title 17, and that all readings are true and accurate to the best of my ability.

Travis Billesbach — State Certified Technician (please print)

8466 — Grade 6 Certificate #

531-220-1687 — Cell / Phone No.

State Certified Technician Signature

☐ Customer Signature

Monday, October 05, 2020 — Date of Test

Midwest — Test Gauge Manufacturer

01172391 — Test Gauge Serial #

4.3.2020 — Date of Calibration

Comment: _____

Sprinkler

Sprinkler Inspection Certificate

For

Beatrice State Development West
Wing
834 Sheridan
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development West Wing
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development East
Apartment
667 31st Street
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development East Apartment
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Carstens Center
3000 Carstens Drive
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Carstens Center
Contact: Rick Vogel
Title: Contact

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development F
building
3104 State Street
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development F building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development L
Building
748 Wallman
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development L Building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development D
Building
941 Sheridan Dr.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development D Building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development Food Service
884 Sheridan Dr.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Food Service
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #411
3071 State Street
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #411
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #412
3070 stste ave.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #412
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #413
3060 Peterson Blvd.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #413
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #418
753 Solar Dr.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #418
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #414
3056 Peterson Street
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #414
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #416
3052 Peterson Street
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #416
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #422
723 Solar Dr.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Mar 18, 2021

Building: Beatrice State Development Cottage #422
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #416
3052 Peterson Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #416
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development West
Wing
834 Sheridan
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development West Wing
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development East
Apartment
667 31st Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development East Apartment
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Administration
843 Wallman Dr.
LINCOLN, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Administration
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development Food
Service
884 Sheridan Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Food Service
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Laundry/Warehouse
3363 Goldenrod Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Laundry/Warehouse
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #422
723 Solar Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #422
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #420
743 Solar Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #420
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #412
3070 stste ave.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #412
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #414
3056 Peterson Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #414
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #418
753 Solar Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #418
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #413
3060 Peterson Blvd.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #413
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #411
3071 State Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #411
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #415
3054 Peterson Strret
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #415
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development F
building
3104 State Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development F building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Cottage #424
715 Solar Dr.
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Cottage #424
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development
Carstens Center
3000 Carstens Drive
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development Carstens Center
Contact: Rick Vogel
Title: Contact

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development East
Apartment
667 31st Street
Beatrice, Nebraska 68310

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.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development East Apartment
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development D
Building
941 Sheridan Dr.
Beatrice, Nebraska 68310

Tested to NFPA 25 Standards

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.

Inspection Date
Oct 5, 2020

Building: Beatrice State Development D Building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Sprinkler Inspection Certificate

For

Beatrice State Development L
Building
748 Wallman
Beatrice, Nebraska 68310

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.

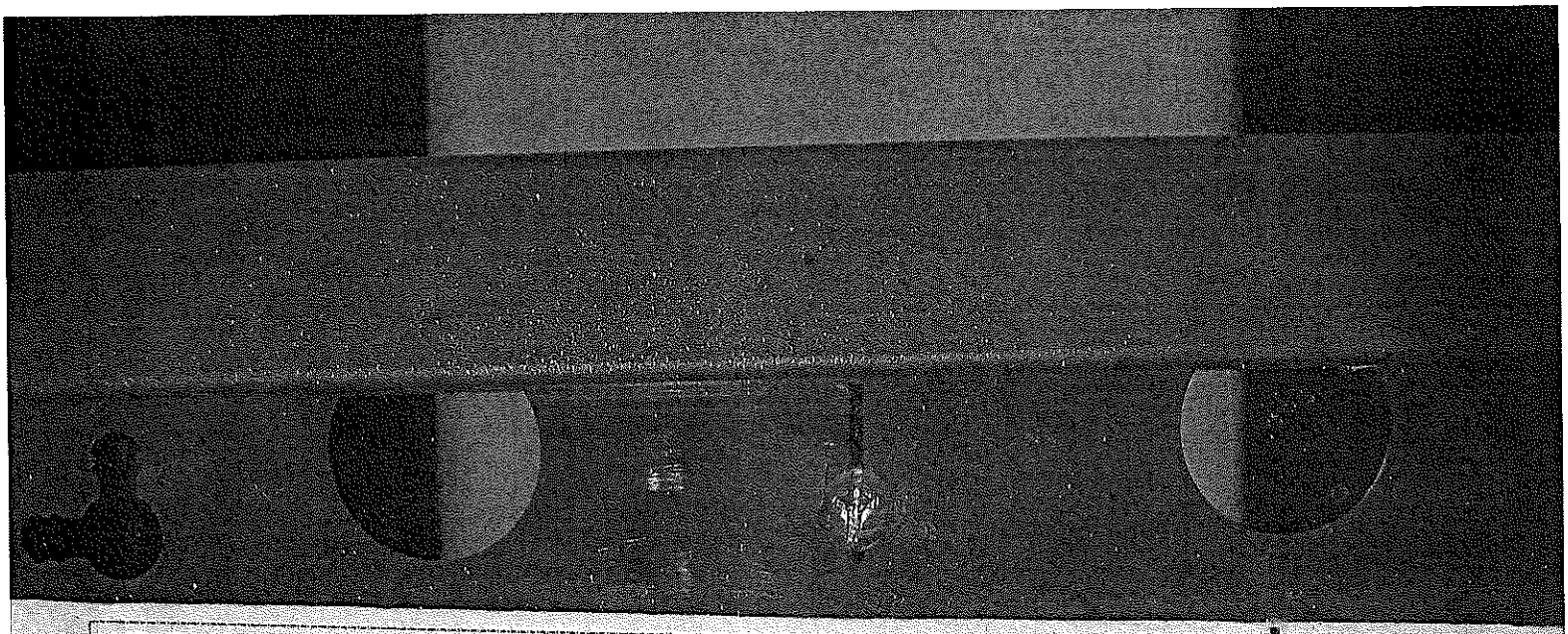
This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Inspection Completion Date
Oct 5, 2020

Building: Beatrice State Development L Building
Contact: Rick Vogel
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Boiler



CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th St.
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

Location **614588**

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

State ID Number: NE22887
Type: FTHT - Firetube Horizontal
Last External Inspection: 02/25/2021
Expiration Date: 09/30/2021
Inspected By: Robert Graham
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 03/19/2021
National Board Number: 18449

Pressure Allowed: 15 PSI
Safety-Relief Valves Setting: 15 PSI
Manufacturer: Hurst
Year Built: 2012
Print Date: 04/01/2021
Next Internal Due Date: 03/19/2023
Serial Number: 1200259
Owner's Equip ID: 600 HP

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

Christopher B. Cantrell

CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th St.
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

Location **614588**

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

State ID Number: NE24656
Type: FTWB - FTS Marine Wet Back
Last External Inspection: 02/25/2021
Expiration Date: 09/30/2021
Inspected By: Robert Graham
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 03/19/2021
National Board Number: 18656

Pressure Allowed: 15 PSI
Safety-Relief Valves Setting: 15 PSI
Manufacturer: Hurst
Year Built: 2012
Print Date: 04/01/2021
Next Internal Due Date: 03/19/2023
Serial Number: 32000-15-11
Owner's Equip ID:

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

C.B. Cantrell

Christopher B. Cantrell

CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th St.
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

Location **614588**

State Development Center
3000 Lincoln St
Beatrice, NE 68310-3319

State ID Number: NE24116
Type: FTHT - Firetube Horizontal
Last External Inspection: 03/19/2021
Expiration Date: 09/30/2021
Inspected By: Robert Graham
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 10/03/2019
National Board Number: 18714

Pressure Allowed: 15 PSI
Safety-Relief Valves Setting: 15 PSI
Manufacturer: Hurst
Year Built: 2013
Print Date: 04/01/2021
Next Internal Due Date: 10/11/2021
Serial Number: S1000-15-58
Owner's Equip ID: 200 HP

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

Christopher B. Cantrell

ICF Licensure renewals

Attachment B8

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

February 17, 2021

ICFDD Renewals
DHHS Public Health Licensure Unit
301 Centennial Mall
P.O. Box 94986
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 (**ICFDD07**), Lake Street ICF (**ICFDD16**), and Solar Cottages ICF (**ICFDD14**).

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	87	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
		$5,050.00	Total Approved

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

Expiration Date 3/31/2021

Intermediate Care Facility For Intellectually Disabled Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

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

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

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

LICENSE NO: ICFDD07
TELEPHONE NUMBER: (402) 239-0993
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: DAWN URBASCHEK

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: 470491233

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

OWNERSHIP INFORMATION

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

MAILING ADDRESS: P O BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

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

CERTIFICATION

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

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

Corina Harrison, Facility Administrator	[signature]	02/17/21
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10684

Name of Facility:	**BSDC-400 Building 3070 State Ave-Bldg 12**
Type of Facility:	**ICF/MR**
Location:	**3070 State Ave Beatrice**
Maximum Occupancy:	**10 Beds**
Date Issued:	**7/20/2020**

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10679

Name of Facility:	**BSDC-400 Building 3071 State Ave**
Type of Facility:	**ICF/MR**
Location:	**3071 State Ave Beatrice**
Maximum Occupancy:	**12 Beds**
Date Issued:	**7/20/2020**

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10683

Name of Facility:	**BSDC-F Bldg-Apts 402, 404,406, 408**
Type of Facility:	**ICF/MR**
Location:	**3000 Lincoln Blvd Beatrice**
Maximum Occupancy:	**36 Beds**
Date Issued:	**7/20/2020**

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

DHHS NEBRASKA

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

Expiration Date 3/31/2021

Intermediate Care Facility For Intellectually Disabled Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

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

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

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

LICENSE NO: ICFDD16
TELEPHONE NUMBER: (402) 239-0993
FAX NUMBER: (402) 223-6192
ADMINISTRATOR: DAWN URBASCHEK

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: 470491233

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

OWNERSHIP INFORMATION

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

MAILING ADDRESS: P O BOX 95044
LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

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

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		02/17/21
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11215

Name of Facility:	**Lake Street ICF ID**
Type of Facility:	**ICF/MR**
Location:	**667 31st St Apt 103, 104, 205, 206 Beatrice**
Maximum Occupancy:	**24 Beds**
Date Issued:	**8/5/2020**

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

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

Expiration Date 3/31/2021

Intermediate Care Facility For Intellectually Disabled Licensure Renewal Application

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

   Solar Cottages
   3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR
   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
   3000 LINCOLN BLVD.
   BEATRICE NE 68310

LICENSE NO: ICFDD14
TELEPHONE NUMBER: (402) 223-6142
FAX NUMBER: (402) 223-7560
ADMINISTRATOR: GREG PENNER

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: 470491233

4. TOTAL NUMBER OF BEDS TO BE LICENSED: ___ 87 _____

OWNERSHIP INFORMATION

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

   MAILING ADDRESS: P O BOX 95044
   LINCOLN, NE 68509

7. BUSINESS ORGANIZATION: (Check one):

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

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		02/17/21
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE - TYPE OR PRINT	SIGNATURE	DATE

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10270

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10269

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10268

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10267

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10265

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 405009

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

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

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10264

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

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

Approved By: C. B. Gruell
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 10266

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

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

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

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

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

400 State Building

MEETS STATUTORY REQUIREMENTS AS
INTERMEDIATE CARE FAC/MR
Lic # ICFDD07

Gary J Anthone, MD

SEAL

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

EXPIRES
3/31/2022

Cut on heavy line and place on license.

400 State Building
ADDRESS: 3104, 3070, 3071 STATE AVE , 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.

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

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

LAKE STREET ICF/ID

MEETS STATUTORY REQUIREMENTS AS
INTERMEDIATE CARE FAC/MR
Lic # ICFDD16

Gary J. Anthone, MD

SEAL

EXPIRES
3/31/2022

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.

LAKE STREET ICF/ID
ADDRESS: 667 31ST ST, APT 103, 104, 205, 206, 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.

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

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

Solar Cottages

MEETS STATUTORY REQUIREMENTS AS
INTERMEDIATE CARE FAC/MR
Lic # ICFDD14

Gary J. Anthone, MD

SEAL

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

EXPIRES
3/31/2022

Cut on heavy line and place on license.

Solar Cottages
ADDRESS: 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.

Licenses Verification

Attachment L1

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

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

Lincoln Regional Center

MEETS STATUTORY REQUIREMENTS AS
PSYCHIATRIC HOSPITAL
Lic # 500004

EXPIRES
12/31/2021

SEAL

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

Cut on heavy line and place on license.

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

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

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

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

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

Lincoln Regional Center

MEETS STATUTORY REQUIREMENTS AS
MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER
Lic # MHSU030

EXPIRES
9/30/2022

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

Cut on heavy line and place on license.

Lincoln Regional Center
ADDRESS: 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.

Major Projects

Attachment L2

From: Beckman, Brent <Brent.Beckman@nebraska.gov>
Sent: Tuesday, November 2, 2021 11:55 AM
To: Flynn, Bevan <Bevan.Flynn@nebraska.gov>; Vogel, Barbara <Barbara.Vogel@nebraska.gov>; DeVries, Joan <Joan.Devries@nebraska.gov>; Weyer, John <John.Weyer@nebraska.gov>; Glenn, Shanda <Shanda.Glenn@nebraska.gov>; Collier, Scott <Scott.Collier@nebraska.gov>; Mitten, Scott <Scott.Mitten@nebraska.gov>; Paz, David <David.Paz@nebraska.gov>; Bartels, Kevin <Kevin.Bartels@nebraska.gov>; Weyer, John <John.Weyer@nebraska.gov>; Kahl, Larry <Larry.Kahl@nebraska.gov>
Cc: Glenn, Shanda <Shanda.Glenn@nebraska.gov>; Miller, Andy <Andy.Miller@nebraska.gov>
Subject: RE: Ombudsman's Contact

All,

Included are a list of my projects under construction between December 2020 through November 2021. These projects are all nearly completed and expected to be substantially completed by the end of 2021.

1. LRC B10 Ligature Risks Mitigation Project
2. LRC B10 Emergency Generator Replacements Project
3. LRC B10 Fan Coil Unit Replacements Project
4. LRC B14 Chiller Replacement Project

Thanks,

Brent Beckman, PE, LEED AP, CLSSYB

Facilities Construction Coordinator II | State Building Division
Nebraska Department of Administrative Services
1526 K Street | Suite 160 | Lincoln, NE 68508
Mobile: 402-417-3043
brent.beckman@nebraska.gov

Surveys

Complaint

CMS Finding Letter

Facility Statement of Compliance

Plan of Correction

Evidence of Standards Compliance

Attachment L3

Complaint

The Joint Commission Connect™ / Quality Monitoring System for Healthcare Organizations

Logged-in, Barbara Vogel
State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949
Lincoln NE, 68522
HCO ID:1640/Incident ID:368379

Back to *Incident Selection*

Organization response to a safety event

Print

Incident Number: 368379

Incident Date: 3/15/2021

Programs: Hospital Accreditation Program

Incident Sites

Site Name	Address
Lincoln Regional Center	801 West Prospector Place Lincoln, NE 68522

Document Upload

Upload documents to be attached to your incident

File Description
General Event

Did you contact Reporter?

(•) No ( ) Yes ( ) N/A

Safety Event Summary

Patient admitted to the Lincoln Regional Center for an assessment and evaluation. The patient (male) was placed in a gymnasium to sleep and reside in "quarantine". When he was finally let out of those horrible conditions, he was admitted to a unit where they have limited to no access to physical exercise because the gym is now a 'new hospital ward".

Staff state it is because "The Joint Commission cited us so we are stuck." and that "The Joint Commission threatened to close us down."

Other family members also stated that the Directors of the hospital and directors of nursing are all telling them the same thing and blaming everything on the Joint Commission.

Just because patients are mentally ill does not mean they should be thrown to the wolves and not receive the same care and compassion that others get. This is disgusting.

****

Attached is an event analysis guide to ensure that all systems-based factors are considered as potential contributors and to assist you with completing a thorough analysis of the safety allegations provided. Please ensure that all areas identified as contributing factors to the event are included as part of your response. This list is not all inclusive, and you may wish to provide any additional information or factors identified.
?
We are implementing use of this tool with all our accredited customers to help provide a systems approach to evaluation of patient safety concerns.?

You may also refer to the organization response guidelines within your extranet site for further guidance on preparing your response. Please feel free to reach out to me with any questions you may have.

Address the Specific allegation(s) and provide an analysis and review of related systems and processes:

During LRC's 2019 triennium Joint Commission survey LRC was cited as non-compliant with NPSG.15.01.01, requiring the development of an extensive mitigation plan and its implementation prior to the end of the JC survey. Additionally, due to the volume and expense to mitigate the identified ligatures risks LRC completed and submitted Ligature Risk Extension Request (LRER) to CMS for approval. Construction to mitigate the ligature risks began in January 2021, resulting in LRC temporarily closing 30 beds.

Due to the ligature mitigation project and the addition of the COVID 19 pandemic, there was a need to identify an area to insulate newly admitted patients. The gymnasium was the only area with appropriate toilet and shower facilities, in addition to a private sleeping area where newly admitted patients can reside until they are tested and screened for COVID prior to admitting to one of the regular patient care areas. Patients are typically, housed in the gym for a very short period of time (1-2 days) while waiting COVID test results. The only other immediate option available, is to admit potentially contagious patients to regular patient care units or discontinue new admissions.

Utilization of the gymnasium as a temporary insulation unit is identified in LRC's pandemic plan as an alternative care space. Additionally, the State of Nebraska Governor's Executive Order 20-12 provides hospitals with the flexibility to use alternatives spaces for patient care, as necessary, due to the COVID 19 pandemic.

Exercise equipment was moved to the Recreational Therapy area in the building and patient schedules were developed to provide an opportunity for physical activity. Twice a day, every day the patients are given the opportunity to go to the courtyard as a recreation option, if they are appropriate and safe to be in the courtyard or other recreation areas.

A review of patient grievances and complaints in the Men's programs since the beginning of construction, indicated zero (0) complaints or grievances were filed related to utilization of the gymnasium as a patient care housing area, or the availability of alternative physical activities and/or space for patients.

Systems Improvements and/or Follow-up Actions:

1. Continue to try to identify admission insulation and testing options, which could include the potential for utilizing other facilities.
2. Continue to utilize alternative recreation areas while the gymnasium is utilized as an insulation unit for new admissions.
3. Investigate scheduling new admissions so the gymnasium is available at time for patient activities.

Measurement/sustainability of compliance to related standards:

1. Complete ligature mitigation project as soon as possible.
2. LRER reporting to CMS through Joint Commission.
3. Monitor patient grievances, complaints and resolutions for patient satisfaction.

Request for Additional Information (First):

Additional Information (First):

Request for Additional Information (Second):

Additional Information (Second):

CMS Finding Letter

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

April 1, 2021

Peter Snyder, Administrator
Lincoln Regional Center
801 W Prospector
Lincoln, NE 68522-4949

Dear Mr. Snyder:

An unannounced visit was made to Lincoln Regional Center on March 18 - 22, 2021, by representatives of this Department. The purpose of the visit was to investigate complaints on non-compliance with regulatory requirements received by our office.

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

ALLEGATION:
The facility failed to ensure the Medical service needs of patients are met.

FINDINGS:
Based on record review, staff interviews, policy reviews and review of security video's the facility was found to provide medical service to patients having a medical emergency. The facility assesses the patient, notifies the doctor and transfers the patients to an Acute Care Hospital for evaluation as needed. The facility staff failed to prevent a patient from swallowing objects while on 1:1 supervision. There was a related deficiency cited at 9-006.06 for patient care and treatment by staff.

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,

Jean Ellis, RN, BSN - Program Manager II
DHHS Public Health - Licensure Unit
Office of Acute Care Facilities
PO Box 94986, Lincoln, NE 68509-4986

JE/lc

Facility Statement of Compliance

FACILITY STATEMENT OF COMPLIANCE

PROVIDER NAME:	Lincoln Regional Center	Survey Date	Survey Date
STREET ADDRESS, CITY, ZIP:	801 W Prospector, Lincoln, NE 68522	3/22/2021	3/22/2021
	Provider License Number:	500004	500004
	PROVIDER'S STATEMENT OF COMPLIANCE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)	**COMPLETION DATE(S)**	**4/19/2021**
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Review and revise the following policies to include STPR documentation requirements and managing swallowing patients.	4/16/2021	
	PC -16 (LRC) Treatment Planning Process		Approved by Policy Committee 4/19/2021
	PC-14 (LRC) Patient Safety Precautions		Approved by Policy Committee 4/19/2021
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	Policies revisions will be completed and presented to the Policy Committee at the meeting on 4/19/2021. Policies will be distributed through the Employee Development Center, discussed at Change of Shift and Just in Time trainings by Team Leads and Compliance and/or Safety Specialists.	5/5/2021	Policies are approved, need signatures and submitted into EDC.
	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:		
	Audit STPR and team notes to ensure compliance with policy updates related to STPR documentation and management of swallowing patients.	5/5/2021	Will finalize by 4/20/2021
	Compliance/Safety staff will complete rounding's and review/audit staff assigned to a patient with a safety precaution status. Compliance/Safety staff will ensure safety status is occurring in accordance with policy and established protocols outlined by the Treatment Team (when appropriate). Compliance/Safety Specialists will provide Just in Time training as needed. All reviews, audits and trainings will be documented and corrective		
	Audit the use of Personal Safety Plan to ensure plans being utilized by the Treatment Team and the staff in accordance with policy.		
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Develop training plan for revised policies and procedures and facilitate training to appropriate staff.	4/19/20201	\\Bf210d00\lrc_admin\Risk Management\CMS\Women's Program\3.22.2021\Policy Revision Training Plan.docx
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	Create and utilize a training tracking system to ensure all staff are trained. This tool will allow LRC to track training progress ensuring compliance with established plan.	5/5/2021	

	Implement training tracking tool and utilize to identify obstacles and barriers to training progress, developing strategies to mitigate obstacles.	5/5/2021	
	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 training schedule and tracker will be utilized to ensure the training schedule is being followed. If trainings are not being completed the QAC will follow up to determine any barriers and action plans to mitigate these barriers.	5/5/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Designated staff will be required to attend Self Harm training and complete post test. Training and testing will be tracked and documented.	5/5/2021	Training in person for designated staff with sign in sheets.
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	A schedule will be developed to ensure all staff attend the training and complete the required test. Should the staff member not meet the minimum score for the post test, they will attend the training again and take the test again, this will continue until the minimum score is reached.	5/5/2021	
	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:		
	Create and utilize a training tracking system to ensure all designated staff attend training and pass post training test. This tool will allow LRC to track the progress in training and ensure the training is being completed according to the established plan. The QAC will review the tracker and ensure the designated staff are being trained, QAC will complete any follow up that is required.	5/5/2021	
	A minimum score of 90% will be required to pass the test, these scores will be tracked to ensure the minimum is met by all LRC staff. Staff not achieving the minimun test score, will attend training and test until they pass.	5/5/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #	1210		
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Review and revise LD-01 (LRC) Critical Incident - Sentinel Event policy to include Administrative review as a routine part of the process.	4/16/2021	Completed on 4/16/2021. Will be presented at Policy Committee meeting 4/19/2021.
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		

	Policies revisions will be completed and presented to the Policy Committee at the meeting on 4/19/2021. Policies will be distributed through the Employee Development Center, discussed at Change of Shift and Just in Time trainings by Compliance and/or Safety Specialists.	5/5/2021	Policy has been presented and approved by committee on 4/19/2021. Traning plan for policy revisions is in draft format.
	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:		
	EDC will track staff who have completed reading the new policy. EDC will notify supervisors if their assigned staff have not completed the training and the deadline is approaching. This report will be monitored to ensure staff review this policy is accordance with the timeframe established in EDC. Supervisor follow up will be completed with staff who have not completed the training and the deadline is approaching.	5/5/2021	
	The QAC will review the report weekly and follow up with supervisors who have staff still needing to complete the policy review in EDC. Should the deadline pass without the policy being reviewed additional follow up will occur with that staff and their supervisor.	5/5/2021	
	Documentation of the Change of Shift and Just in Time Trainings will be submitted to ensure and document the staff who were present at these trainings.	5/5/2021	
	Track CIR's and initiate a review of a patient if incidents require (number of incidents in a set amount of time, one major event, etc.)	5/5/2021	
	Patient Safety Workgroup will review Patient Safety incidents (not already being reviewed by other workgroups) and document any follow up on an incident as needed. This will be reported to Risk Management for an incident review.	5/5/2021	
	Patient Safety Workgroup reviews patient injury data and will report to the Risk Management Department any patterns, concerns,etc identified during this data review. The Risk Management Department will complete a more in-depth review of the data and escalate for an incident review if warranted	5/5/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Revise Safety, Quality, Delivery, Inventory, Productivity (SQDIP) Huddle procedure to include tracking corrective actions and any needed follow up on patient safety events.	5/01/20201	\\Bf210d00\lrc_admin\WARD OBS GROUNDSWIDE\2021\Qdip Dashboard Draft.xlsx
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	When format has been finalized, those responsible for reporting information during SDIP will be provided a copy and new expectations for this meeting. They will be provided the information early enough to ensure they have ample time to review the document and expectations and raise any questions or concerns they have prior to the implementation.	5/01/20201	
	Once implemented, on May 1, 2021, the expectations and new format will be followed during every meeting. If more information is needed during the meeting follow up will either occur during the meeting or after, depending on which is more appropriate	5/01/20201	

	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:		
	This will be reviewed and evaluated during safety huddle meetings. Revisons will be completed based on the needs of the patient and facility. If additional follow up is needed with individual reporters this will occur either during the safety huddle or with a scheduled ad hoc meeting.	5/01/20201	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Performance and Risk Management Administrator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Implement changes in patient care for a specific high risk patient through a special treatment plan review. This treatment plan review include compressive audit of all previous behavioral incidents. Recommendations and treatment plan modifications included; trained core staff facilitate safety precautions; when available, increased use of diversional activities, change in nutrition plan to include more frequent snack provision, implement utilization of additional protective equipment to prevent acting out behavior, Behavioral Improvement Plan.	4/9/2021	
	By April 9, 2021, the revised treatment plan and interventions will be evaluated for effectiveness in a STPR. Additional modifications will be made as needed and appropriate.	4/9/2021	
	By April 16, 2021, the revised treatment plan and interventions will be evaluated for effectiveness in a STPR. Additional modifications will be made as needed and appropriate.	4/16/2021	
	By April 23, 2021, the revised treatment plan and interventions will be evaluated for effectiveness in a STPR. Additional modifications will be made as needed and appropriate.	4/23/2021	
	By April 30, 2021, the revised treatment plan and interventions will be evaluated for effectiveness in a STPR. Additional modifications will be made as needed and appropriate.	4/30/2021	
	By May 5, 2021, the revised treatment plan and interventions will be evaluated for effectiveness in a STPR. Additional modifications will be made as needed and appropriate.	5/6/2021	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	The Treatment Team will review the patients treatment plan and interventions weekly. This review will include the patients behavior and the effectiveness of the interventions. Based on the review, the Treatment Team will make any modifications needed to the treatment plan.	4/9/2021	
	This weekly meeting will be scheduled with all Treatment Team members and will be a standing agenda item during the meeting.	4/9/2021	
	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:		
	Reviewing Special Treatment Plan Review documents, incident data bases, cir to evaluate the interventions being utilized with this patient and their effectiveness	4/9/2021	
	Audit STPR's , team notes, treatement plans, and hand off communication to ensure the review of behavioral incidents.	4/9/2021	
	Audit Behavioral Improvement Plans to ensure they are being followed and updated appropriately.	4/9/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		

	Treatment Team		
	Compliance Team		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Additional clinical training for core unit staff related to behavioral management strategies (BIPs) and techniques, when available. Completion of training will be documented with sign in sheets.	4/9/2021	Date and times of training?
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	Create a list of staff needing to be trained in this area.	4/9/2021	
	Create a training tracker with all the staff identified, to ensure their completion of the training and identification of the staff still needing to receive the training.	4/9/2021	
	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:		
	A tracker will be created and utilized to ensure all assigned LRC staff are scheduled for the training, receive the training and pass the test. The tracker will be used to ensure LRC stays on scheduled with the training of staff as well ensuring all designated LRC staff attend the training.	4/9/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Contraband searches on the entire unit will be completed and documented 2 times per shift.	3/29/2021	Need documentation submitted weekly
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	A standard search record will be created and used to document the searches. This document will be utilized to document all unit searches daily and per shift.	4/9/2021	
	Expectations will be completed and provided to staff regarding their responsibilities in regards to the searches. These expectations will be provided to staff assigned to the living unit and posted for their on-going review.	4/9/2021	
	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 assigned Safety Specialist will review the search logs weekly as an audit for the procedure. Any variations or concerns will be reported to the Program Leadership Team and submitted to the Patient Safety Workgroup	4/9/2021	
	The Patient Safety Workgroup will review and follow up on the concerns received from the Safety Specialist. This could include an incident review if deemed appropriate by the Risk Management Department	4/9/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		

	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		
CITED TAG #			
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY:		
1210	Patient room searches for contraband one time per shift.	3/29/2021	Need documentation submitted weekly
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):		
	A standard search record will be created and utilized to document the room searches. This document will be utilized to document all room searches daily and per shift.	4/9/2021	
	Expectations will be completed and provided to staff regarding their responsibilities in regards to the searches. These expectations will be provided to staff assigned to the living unit and posted for their on-going review.	4/9/2021	
	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 assigned Safety Specialist will review the search logs weekly as an audit for the procedure. Any variations or concerns will be reported to the Program Leadership Team and submitted to the Patient Safety Workgroup	4/9/2021	
	The Patient Safety Workgroup will review and follow up on the concerns received from the Safety Specialist. This could include a incident review if deemed appropriate by the Risk Management Department	4/9/2021	
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (By JOB TITLE, not by NAME) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:		
	Quality Assurance Coordinator		
	NOTE: Please remember to attach any supporting documentation - education provided; auditing tools; new or revised policies and procedures, etc.		

Plan of Correction

Subject: Acceptable Plan of Correction

DHHS Acute Care Facilities <DHHS.AcuteCareFacilities@nebraska.gov>
to DHHS LRC Licensure, Ellis, Jean

Important Notice - please read carefully

Good Morning Mr. Snyder:

RE: Lincoln – Lincoln Regional Center – License # 500004.

This correspondence is to acknowledge receipt of your acceptable plan of correction for the investigative survey e by a representatives of this Department.

A revisit inspection may be conducted to verify correction and determine compliance with the regulations. If you ha feel free to contact Jean Ellis, RN BSN - Program Manager at Jean.Ellis@nebraska.gov.

Sincerely,

Luana Collins | *Staff Assistant II*

PUBLIC HEALTH

Nebraska Department of Health and Human Services

OFFICE: 402-471-2110

DHHS.ne.gov | **Facebook** | **Twitter** | **LinkedIn**

Evidence of Standards Compliance

Joint Commission Health Care Organization

Organization ID: 1640-State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949 Lincoln, NE 68522

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 7/9/2021

Hospital Accreditation Program PC.02.01.11 EP 2
Likelihood: Moderate Scope: Limited

Standard Text: Resuscitation services are available throughout the hospital.

EP Text: Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

Finding(s): 1) Observed in Building Tour at Lincoln Regional Center (801 West Prospector Place, Lincoln, NE) site .
In 1 of 3 AEDs checked, In 1 of 3 AEDs checked, the defibrillator pads were expired for the AED in Building #3. This was corroborated by the IC Nurse.

2) Observed in Building Tour at Lincoln Regional Center (801 West Prospector Place, Lincoln, NE) site .
In 1 of 3 Emergency equipment checks, In 1 of 3 Emergency equipment checks, the AED in Building #3 had not been checked since January 2021. Hospital policy requires the AEDs be checked once a month. This was corroborated by the CNO.

Assigning Accountability

The Risk Management Administrator is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

Policy EC-Medical Equipment-03 was revised to include Safety Specialists completing and documenting monthly inspections of AED machines and pads. Inspections will be documented on the Monthly AED check sheet and electronically filed in the medical equipment inspections folder. If items are in need of repair, Safety Specialist will notify the staff person responsible for contacting Bio Electronics Medical Equipment and report problem; including date they were notified, and date issue was resolved and/or repaired. Repair ticket will be included in the medical equipment inspection folder. New policy with updates will be distributed to staff through the education development center (EDC) and the Medical Equipment Plan was updated.

Q. All corrective actions described above were completed by

Jun 21, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

Safety specialist has added the AED audit results to the EOC monthly rounding report and will review the AED checklist on a monthly basis.

Q. What is the frequency of the monitoring activities?

Audits will conducted on a monthly basis and results analyzed on a monthly basis.

Q. What data will be collected from these activities?

The number of audits in compliance with the new policy, compared to the number of AED checks completed.

Q. To who, and how often, will this data be reported?

Audit results will be reported to Safety Specialist Supervisor on a monthly basis.

Final Accreditation Report

State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949
Lincoln, NE 68522

Organization Identification Number: 1640
60-day Evidence of Standards Compliance Submitted: 7/9/2021

ESC Programs Reviewed
Hospital

Final Report: Posted 7/15/2021

The Joint Commission
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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	7/9/2021	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Hospital

Standard	Level of Compliance
PC.02.01.11	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Hospital

Standard	EP	Standard Text	EP Text
PC.02.01.11	2	Resuscitation services are available throughout the hospital.	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

Award letters

Accreditation Manual for Behavioral health Care

Accreditation Manual for Hospital

Attachment L4

Accreditation Manual for Behavioral health Care

Attachment L4

December 18, 2019

Ashley Sacriste
Hospital Administrator
State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949
Lincoln , NE 68509-4949

Joint Commission ID #: 1640
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 12/18/2019

Dear Ms. Sacriste:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Behavioral Health Care**

This accreditation cycle is effective beginning September 19, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Accreditation Manual for Hospital

Attachment L4

December 27, 2019

Ashley Sacriste
Hospital Administrator
State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949
Lincoln , NE 68509-4949

Joint Commission ID #: 1640
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 12/27/2019

Dear Ms. Sacriste:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Hospital**

This accreditation cycle is effective beginning September 21, 2019 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

The Joint Commission

December 27, 2019

Re: # 1640
CCN: #284003
Program: Psychiatric Hospital
Accreditation Expiration Date: September 21, 2022

Ashley Sacriste
Hospital Administrator
State of Nebraska Dept. of Admin Services
801 West Prospector Place PO Box 94949
Lincoln, Nebraska 68509-4949

Dear Ms. Sacriste:

This letter confirms that your September 17, 2019 - September 20, 2019 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals, as well as the special Conditions for psychiatric hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on December 17, 2019 and December 23, 2019 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on October 31, 2019, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of September 21, 2019. We congratulate you on your effective resolution of these deficiencies.

§482.13 Patient's Rights

The Joint Commission is also recommending your organization for continued Medicare certification effective September 21, 2019. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Lincoln Regional Center
801 West Prospector Place, Lincoln, NE, 68509-4949

Lincoln Regional Center Whitehall Program
5845 Huntington Ave, Lincoln, NE, 68504

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

The Joint Commission

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 7 /Survey and Certification Staff

Facility Staff Information

Staffing levels

Number of Assaults on staff

Attachment L5

Staffing levels

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data

12/1/2020 - 11/30/2021

Facility: LRC Lincoln Regional Center

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		422	187	609	464	107	148	2%	26%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
A19211	ACCOUNTANT I	0	0	0	1	0	0	0%	0%
A19011	ACCOUNTANT I (NEW)	2	0	2	0	0	0		
S19111	ACCOUNTING CLERK I	0	0	0	1	0	0	0%	0%
S19112	ACCOUNTING CLERK II	0	0	0	1	0	0	0%	0%
H77023	ACTIVITY SPECIALIST	14	3	17	15	0	2	1%	13%
V77024	ACTIVITY SUPERVISOR	1	1	2	1	1	1	4%	50%
A09121	ADMINISTRATIVE ASSISTANT I	0	0	0	1	0	0	0%	0%
H75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	1	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	6	0	6	6	0	0	0%	0%
A01014	ADMINISTRATIVE SPECIALIST (NEW)	2	0	2	0	0	0		
S01013	ADMINISTRATIVE TECHNICIAN (NEW)	5	0	5	0	0	1		
V75016	ASSOCIATE DIRECTOR OF NURSING (NEW)	5	0	5	5	1	1	1%	17%
I79510	BARBER/BEAUTICIAN	0	1	1	0	0	0		
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	6	0	6	0	3	0	0%	0%
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	5	4	9	0	0	0		
H72554	BEHAVIORAL HEALTH PRACTITIONER IV (NEW)	4	0	4	0	0	0		
V72556	BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II (NEW)	2	0	2	0	0	0		
V09213	BUSINESS MANAGER III	1	0	1	1	0	0	0%	0%
C72342	CERTIFIED MASTER SOCIAL WORKER	8	4	12	8	2	2	2%	20%
V72343	CERTIFIED MASTER SOCIAL WORKER SUPERVISOR	1	0	1	0	0	0		
H75321	CLINICAL NURSE TRAINER (NEW)	2	1	3	2	0	0	0%	0%
V72460	CLINICAL PROGRAM MANAGER	3	0	3	3	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	4	1	5	5	0	1	2%	20%
M82122	CUSTODIAL LEADER	0	0	0	1	0	0	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	0	0	0	8	0	2	2%	25%
I74110	DENTAL ASSISTANT	1	0	1	1	0	0	0%	0%
D74150	DENTIST	1	0	1	1	0	0	0%	0%
N78560	DHHS FACILITY ADMINISTRATOR	0	1	1	0	1	1	8%	100%
C73210	DHHS PROGRAM SPECIALIST	1	0	1	1	0	0	0%	0%
V73210	DHHS PROGRAM SPECIALIST	1	0	1	1	0	0	0%	0%
G73280	DHHS QUALITY ASSURANCE COORDINATOR	1	0	1	1	0	0	0%	0%
S09130	DHHS SCHEDULING COORDINATOR	0	0	0	3	0	0	0%	0%
V19732	DHHS TRUST OFFICER SUPERVISOR	1	0	1	1	0	0	0%	0%
G75017	DIRECTOR OF NURSING (NEW)	1	0	1	1	0	0	0%	0%
N00700	DISCRETIONARY NON-CLASSIFIED	0	0	0	1	0	0	0%	0%
N00750	FACILITY OPERATING OFFICER	1	0	1	1	0	0	0%	0%
M80121	FOOD SERVICE AIDE	0	0	0	3	0	0	0%	0%
M80011	FOOD SERVICE ASSISTANT (NEW)	3	0	3	0	0	0		
M80123	FOOD SERVICE COOK	0	0	0	21	2	5	2%	22%
R80123	FOOD SERVICE COOK (INACTIVE)	0	1	1	0	0	0		
V80312	FOOD SERVICE DIRECTOR II	1	0	1	1	0	0	0%	0%
V80220	FOOD SERVICE SUPERVISOR	2	0	2	2	0	0	0%	0%
M80012	FOOD SERVICE WORKER (NEW)	21	4	25	0	4	1	2%	26%
V02202	HEALTH INFORMATION MANAGER	1	0	1	1	0	0	0%	0%
S02201	HEALTH INFORMATION TECHNICIAN	0	0	0	7	0	0	0%	0%
H76311	HUMAN SERVICES TREATMENT SPECIALIST I	5	1	6	5	1	1	1%	17%
I75013	LICENSED PRACTICAL NURSE (NEW)	7	10	17	8	0	1	1%	13%
R75013	LICENSED PRACTICAL NURSE (NEW)	1	1	2	0	1	1	8%	100%
M84012	MAINTENANCE SPECIALIST I (NEW)	4	0	4	0	0	0		
M84011	MAINTENANCE TECHNICIAN (NEW)	6	4	10	0	2	3	13%	150%
C72341	MASTER SOCIAL WORKER	1	1	2	3	2	3	5%	60%

H72431	MENTAL HEALTH PRACTITIONER I	0	0	0	3	0	0	0%	0%
H72432	MENTAL HEALTH PRACTITIONER II	0	0	0	11	0	3	2%	27%
V72433	MENTAL HLTH PRACTITIONER SUPERVISOR	0	0	0	2	0	0	0%	0%
P76142	MENTAL HLTH SECURITY SPECIALIST II	165	71	236	206	66	91	3%	33%
R76142	MENTAL HLTH SECURITY SPECIALIST II	22	19	41	22	16	13	3%	34%
V76154	MENTAL HLTH SECURITY UNIT SUPERVISOR	14	5	19	19	0	3	1%	16%
D75350	NURSE PRACTITIONER	6	0	6	5	0	0	0%	0%
H77312	OCCUPATIONAL THERAPIST	3	0	3	3	0	0	0%	0%
S01113	OFFICE CLERK III	0	0	0	2	0	1	4%	50%
V03351	OFFICE SERVICES MANAGER I	1	0	1	1	0	0	0%	0%
S01012	OFFICE SPECIALIST (NEW)	14	2	16	0	0	1		
S01011	OFFICE TECHNICIAN (NEW)	5	0	5	0	0	0		
K17122	PERSONNEL MANAGER I	1	0	1	0	0	0		
V17123	PERSONNEL MANAGER II	1	0	1	1	0	0	0%	0%
R74731	PHARMACIST	0	2	2	0	0	0		
N74740	PHARMACIST/CLINICAL	3	0	3	3	0	0	0%	0%
I74712	PHARMACY INVENTORY TECHNICIAN	1	0	1	1	0	0	0%	0%
N74732	PHARMACY MANAGER	1	0	1	1	0	0	0%	0%
I74711	PHARMACY TECHNICIAN	3	0	3	3	0	0	0%	0%
D75420	PHYSICIAN	1	0	1	1	0	0	0%	0%
G11900	PRINCIPAL	1	0	1	0	0	0		
V04011	PROCUREMENT SPECIALIST (NEW)	1	0	1	0	0	0		
N74213	PSYCHIATRIC DIRECTOR	0	1	1	0	0	0		
G76700	PSYCHIATRIC FACILTY RISK MNGMT ADMIN	1	0	1	0	0	0		
D74211	PSYCHIATRIST	1	0	1	1	0	0	0%	0%
N74211	PSYCHIATRIST	2	4	6	2	0	0	0%	0%
N74823	PSYCHOLOGIST/LICENSED	6	1	7	6	1	0	0%	0%
N74825	PSYCHOLOGY DIRECTOR	1	0	1	1	0	0	0%	0%
N74824	PSYCHOLOGY SUPERVISOR	3	0	3	0	0	0		
H75014	REGISTERED NURSE (NEW)	15	22	37	18	4	6	2%	27%
R75014	REGISTERED NURSE (NEW)	2	10	12	3	1	2	4%	50%
S19710	REIMBURSEMENT CLERK	0	0	0	1	0	0	0%	0%
C79920	RELIGIOUS COORDINATOR	1	0	1	1	0	0	0%	0%
V82330	SAFETY COORDINATOR	1	0	1	1	0	1	8%	100%
A82310	SAFETY SPECIALIST	0	0	0	4	0	0	0%	0%
S01841	STAFF ASSISTANT I	0	0	0	4	0	1	2%	25%
S01842	STAFF ASSISTANT II	0	0	0	2	0	0	0%	0%
A13252	STATISTICAL ANALYST II	1	0	1	1	0	0	0%	0%
V13253	STATISTICAL ANALYST III	1	0	1	1	0	0	0%	0%
S05012	SUPPLY TECHNICIAN II (NEW)	3	0	3	0	0	0		
S05211	SUPPLY WORKER I	0	0	0	1	0	0	0%	0%
S05212	SUPPLY WORKER II	0	0	0	2	0	0	0%	0%
S01511	SWITCHBOARD OPERATOR/RECEPTIONIST	0	0	0	4	0	0	0%	0%
R11380	TEACHER/TEMPORARY	0	1	1	0	0	0		
A11011	TRAINING SPECIALIST (NEW)	3	0	3	0	0	0		
A11122	TRAINING SPECIALIST I	0	0	0	3	0	0	0%	0%
P76752	YOUTH SECURITY SPECIALIST II	3	9	12	1	-1	0		
V76753	YOUTH SECURITY SUPERVISOR	3	2	5	0	0	0		
		422	**187**	**609**	**464**	**107**	**148**	**2%**	**26%**

Assaults on staff

Data below is for the period of 12/1/20 – 11/8/21

Patient-to-staff assaults: 51

Staff injury incidents occurring during the application of patient seclusion or restraint: 84 (Note that these are not considered assaults and are referred to as seclusion or restraint-related injury incidents)

COVID -19 Impact

Leadership update

Families/Guardians and Visitors Letter

Teammates Letter

Pandemic Plan

Attachment L6

Leadership Update

Weekly Update

11/24/2021

Leadership Team Update

The leadership team met this week at different times to discuss a variety of topics, including:

- There continues to be a significant amount of efforts to recruit and on-board new team members. There are nine mental health specialist interviews scheduled for this week and may be as many as ten interviews for next week. I believe we have a significant number of other staff who will be attending the new employee orientation sessions in December. This will include the MHS, nurses, social workers and other positions.
- In addition to nurses and MHS, we are also recruiting for the following positions:
  - Activity specialists
  - Mental health security unit supervisor
  - Behavioral health practitioner II/ LMHP
  - Certified master social workers
  - Compliance specialists
  - Food service cooks and workers
  - Human services treatment specialists
  - Psychologist
- We are continuing to move forward with training and educational projects including the two evidence-based therapy systems, which are dialectical behavioral therapy and motivational interviewing.
- There continue to be discussions and plans to further clarify the NAPE and FOP contracts. There are also additional discussions about compensation options for team members who are not covered by either of the contracts.
- Identifying provider recruitment and the need for additional psychiatrists and APRNs, especially when the ligature mitigation project is completed and we are operating 100% of our beds.
- Quality improvement initiatives, including improvements related to staff safety, reduction or patient injuries; reduction of seclusion and restraints; reduction of time in seclusion and restraints, and reduction in medication errors.
- Our projection is that we will be able to move patients back to Building 10 in December. The fire marshal inspection was on Tuesday and we hope to be sent the Certificate of Occupancy next week. We will then start making specific plans for the relocation of patients and team members to Building 10.

Message from Governor Ricketts

I hope you had the opportunity to see the e-mail and watch the video message from Governor Ricketts. In case you did not see that e-mail and video the following is the message that was included in the e-mail.

Teammates:

Thank you for all of your incredible work this past year, especially in response to the ongoing challenges from the pandemic. Since the spring of 2020, our teammates throughout state government have stepped up to help combat COVID-19 and provide vital services to the citizens of Nebraska. As we enter the holiday season and approach the end of 2021, it's amazing to look back at everything we've accomplished.

Now, because of efficient management of the system and a lower amount of claims, the State is providing a one-time Premium Holiday on your medical benefits, returning some of your hard-earned money to you.

This means that no teammate healthcare insurance deduction will occur for any payrolls in the month of December 2021. This is across the board for all teammates that are on a State of Nebraska healthcare plan and will also include teammates covered under the State Law Enforcement Bargaining Council (SLEBC) healthcare plan.

We are also able to hold flat our health care premium costs next year, which is the first time this has happened since 2015. What this means for you is that you will not see an increase next year in your payments into the state insurance system, if you keep the same plan.

Make sure to reach out to your HR partner if you have any questions.

Thank you again for your continued hard work and dedication to public service. I hope you have a Merry Christmas, a Happy New Year, and a wonderful holiday season. God bless you all and God bless the great State of Nebraska!

Pete Ricketts
Governor of Nebraska

Office of the Governor
State of Nebraska
OFFICE 402-471-2244
FAX 402-471-6031
governor.nebraska.gov | Facebook | Twitter

Happy Thanksgiving

On behalf of the LRC leadership team I would like to wish everyone a very Happy Thanksgiving! I am very thankful that we have such an exceptional group of people associated with LRC and the DHHS. I am also very thankful we are here to provide the care and treatment for the people who we have the privilege of serving. I am also very thankful we have the opportunity to take care of each other in many different ways.

COVID-19

To date, we have 321 fully vaccinated teammates and an additional 9 teammates who have received their first dose, for a total of 391 team members vaccinated. This is approximately 70% of our staff population. If you have NOT been vaccinated and are interested in getting vaccinated, please visit your local Walmart or Hy-Vee Pharmacy. If you are having trouble locating a vaccination site, please call John Weyer for assistance. When taking patients off campus for medical appointments, they may be asked if they would like to be vaccinated. If the patient is compliant, please allow them to proceed with the vaccination process. Please request Moderna, if it is available, so we can provide the follow-up dose if needed. Below is the updated COVID-19 information for last week. We appreciate the entire team's diligence in continuing all expected preventative measures necessary to keep risk as low as possible. This has been an exceptional team effort. Going forward, all of us will need to be extremely diligent and comply with all infection control practices to mitigate COVID-19.

Total count of pts. confirmed positive to date	Number of pts. active/ in isolation	Total count of staff confirmed positive to date:	Current count of staff recovered / returned to work:	Current quarantine unit(s)	Current pts. in insolation unit(s)
75	0	97	96	N/A	N/A

If you are being tested for COVID-19, especially if you are experiencing symptoms and suspect it may be COVID-19 related, be sure you are consulting with our infection control manager, John Weyer. He will help you navigate through the situation and help you create a return-to-work plan with safety in mind.

Staff must continue to be very diligent with patient monitoring, observing for any symptoms and taking immediate steps as necessary. We must immediately address any patients who demonstrate any concerning or potential symptoms related to COVID-19 or influenza. If any of the following symptoms are noted, please contact Dr. Connolly immediately: Fever, cough, shortness of breath or difficulty breathing, chills, muscle pain, sore throat, new loss of taste or smell, runny nose/congestion, nausea, vomiting or diarrhea.

Influenza

LRC continues to offer free on-site influenza vaccinations for all staff and patients. We have the quadrivalent influenza vaccine, the egg-free hypoallergenic influenza vaccine, and the high-dose influenza vaccine for those over the age of 65. Watch your email for ongoing clinic schedules. If you receive your influenza vaccine from an outside source, please scan a verification, along with the influenza declination sheet, to John Weyer, per LRC policy. As always, please contact John Weyer with any questions or concerns. If 90% of our staff get vaccinated for influenza, everyone who is vaccinated will be put into a drawing for prizes. Let's encourage each other to get vaccinated. Stay healthy and WIN PRIZES!

From: Weyer, John <John.Weyer@nebraska.gov>
Sent: Tuesday, November 2, 2021 12:29 PM
To: Glenn, Shanda <Shanda.Glenn@nebraska.gov>
Subject: report for ombudsman

Covid Vaccine Info (12/2020 – 11/2021):

- During the outlined time frame we had 25 positive patients during the month of December 2020. No covid positive patients during the year of 2021 as of 11/2/2021.
- During the outlined time frame we have had 33 staff members confirmed positive for Covid-19
- 70% (381/541) of staff are vaccinated
- Patient Vaccinations:
    - Bldg 14 S.O. Program: 38/42, 91% Vaccinated
    - Bldg 14 Men's Acute Program: 4/7, 57% Vaccinated
    - Bldg 5 Men's Acute Program: 7/18, 39% Vaccinated
    - Bldg 5 FMHS Program: 39/48, 81% Vaccinated
    - Bldg 3 Women's Acute: 12/20, 60% Vaccinated
    - Total of LRC's Campus: 100/135, 74% Vaccinated
    - Covid Vaccines are offered on a continual bases to all unvaccinated patients and new admits
    - Boosters will be offered during the month of Nov and Dec for all patients and staff.
- No communication Letters have been sent out to family during the outlined time frame
- Admission Process
    - Fully Vaccinated New Admissions
        - Are rapid tested upon admission and assessed by medical doctor
        - If negative and passes assessment by medical doctor, patient is allowed to join the general population
    - Unvaccinated New Admissions
        - Rapid test conducted upon admission and assessed by medical doctor
            - If negative and passes assessment by medical doctor patient is quarantined for 10 days
            - If positive patient is placed in an isolation unit until cleared by medical doctor
- Attached is LRC's Pandemic plan that is reviewed monthly during LRC's infection control Committee.

John Weyer, RN-BC | *Infection Control Manager*
BEHAVIORAL HEALTH
Nebraska Department of Health and Human Services
Cell: 531-530-7140
DHHS.ne.gov | **Facebook** | **Twitter** | **LinkedIn**

"Helping People Rebuild Their Lives"

Families/Guardians and Visitors Letter

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 11, 2021

Dear Families, Guardians and Visitors of Lincoln Regional Center patients:

Once again, we would like to thank all of you for your understanding over the past year while we have worked to eradicate COVID-19 from the LRC campus. We fully appreciate the difficulty and disappointment that necessary interventions, such as suspending visits, may have created for you and your loved one or ward. Please know these interventions have worked and that the diligent use of preventive measures and vaccination efforts have continued to be successful. In fact, there are currently no active cases of COVID-19 for LRC patients!

We continue to screen staff members for fever and other symptoms prior to beginning their shifts, and we are performing those same screens on patients. Staff are required to wear masks at all times when in the presence of others and also practice social distancing and hand hygiene protocols. These steps are key in helping us identify potential exposures and mitigate spread of the virus.

Given the reduction of COVID-19 for LRC and the current downward trend of community spread in the Lincoln area, we are excited to announce that we will be resuming in-person visitation on the LRC campus, effective 6/15/2021. Please know that virtual visits will still be offered in addition to or, when preferred or necessary, as an alternative to in-person visits. Visits will be conducted differently than in the past to help mitigate risk of exposure and to allow for full implementation of precautionary measures that are recommended by national and local public health officials.

Visits will need to be scheduled at least 24 hours in advance and will be limited to no more than two (2) visitors per patient. This will ensure all patients and their visitors have ample space to allow for social distancing during visits. LRC will continue to prioritize the use of standing visitation times for visits from relatives and friends, which are noted below.

- Tuesdays and Thursdays from 7:00 pm to 9:00 pm.
- Sundays and holidays from 1:30 pm – 3:30 pm and Saturday, Sundays, and Holidays at 7:00 pm-9:00 pm.
- Family visiting with children 13 and under in Building 5 1:30 pm-3:30 pm on Saturdays.
- Family visiting with children 13 and under on Saturday from 9:00 to 11:00 am for patients in Building 14.

We ask for your understanding if a preferred visitation date or time cannot immediately be accommodated due to space limitations. Special considerations, such as visitation that includes young children, may impact the date and times offered for visitation as well. As has been the case previously, if these times do not work for a patient's family, an alternative visitation time can be arranged. In order to not impede access to visitation between patients and their relatives and friends, professional visits will be scheduled during alternative times. Families, guardians, and professional contacts can schedule visits by contacting the patient's assigned social worker.

All visitors will be screened upon arrival to LRC. The screening will include a temperature check for all visitors as well as documentation of visitor responses to a list of symptoms. The list of current symptoms is noted below. Please understand that specific screening questions may change without notice to align with changing guidance. For the time being, if a visitor, or the patient being seen, has any of the following, the visit will be rescheduled:

- Fever of 100.0 or higher
- Cough
- Sore throat
- Difficulty breathing / shortness of breath
- Chills
- Muscle pain
- New loss of taste or smell
- Runny nose / congestion
- Nausea, vomiting or diarrhea
- Have been in close contact with someone, including a health care worker, confirmed to have the coronavirus disease

Visitors will be required to wear either a cloth or surgical mask for the entire duration of the visit; if you do not have a mask, one will be provided for you. During this time, no food or drink will be allowed in the visitation areas. Additionally, visitors and patients will need to practice social distancing during the entire duration of the visit; LRC staff supporting visit monitoring will ensure that visitation space accommodates a minimum of six (6) feet between each individual. We understand social distancing requirements do not allow for physical affection such as hugs or handshakes to be exchanged during the visit; however, strict enforcement of social distancing provides the best prevention for you and your loved one. The attached also provides some additional protocols. We appreciate your understanding during this very difficult time.

We genuinely appreciate your patience and understanding as we continue to update our response strategies to keep in line with best practice standards. While we are excited to resume in-person visitation, please know we continue to monitor risks associated with COVID-19 and should there be an increase in exposure and/or positive tests at LRC, we may need to re-evaluate our visitation practices with little to no prior notice. As we move forward, we are committed to keeping families and guardians aware of additional updates or necessary changes to protocol.

If you have questions, please contact your family member's or ward's assigned social worker.

Sincerely,

Peter Snyder, M.Ed.; C.T.R.S.
Hospital Operating Officer
Division of Behavioral Health
Department of Health and Human Services

Teammates Letter

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 11, 2021

Dear LRC Teammates:

Thank you for the work you continue to do on behalf of the patients we serve. As you know, with the arrival of the COVID-19 pandemic, the Lincoln Regional Center (LRC) had to take critical precautions to maintain the health and safety of patients, teammates and visitors. This included the suspension of on-campus visits for visitors and a significant reduction in off-campus transports for patients, limited only to necessary medical appointments. We continue to thoroughly evaluate best practices to ensure the safety of LRC patients, staff and guests. LRC teammates, like you, have been instrumental in helping to prevent a re-introduction of COVID-19; thank you for what you do each and every day to help prevent the spread of COVID-19.

Given the diligence shown and the downward trend of COVID-19 in the community, we are prepared to resume some previous activities such as in-person visitation and additional, but still limited, off-campus activities. We plan to begin offering both starting 6/14/2021. Please know that the protocols outlined below may need to change with little to no notice, as necessary, to implement future best practice guidance or in response to changes in risk of spread.

Please know that virtual visits will still be offered in addition to or, when preferred or necessary, as an alternative to in-person visits. Visits will be conducted differently than in the past to help mitigate risk of exposure and to allow for full implementation of precautionary measures that are recommended by national and local public health officials.

Visits will need to be scheduled at least 24-hours in advance and will be limited to no more than two (2) visitors per patient. The number of visitation groups allowed at one time will be dependent on each visitation space used. This will allow LRC to ensure all patients and their visitors have ample space to allow for social distancing during visits. LRC will continue to prioritize the use of standing visitation times for visits from relatives and friends, which are noted below.

- Tuesdays and Thursdays from 7:00 pm to 9:00 pm;
- Saturdays, Sundays and holidays from 1:30 pm – 3:30 pm and 7:00 pm-9:00 pm
- Family visiting with children 13 and under will continue to be on Saturday from 9:00 to 11:00 am for the SOS and Psychiatric Transition patients in Building 14.

Special considerations, such as visitation that includes young children, may impact the date and times offered for visitation as well. As has been the case previously, if these times do not work for a patient's family, an alternative visitation time can be arranged. In order to not impede access to visitation between patients and their relatives and friends, professional visits will be scheduled during alternative times. Families, guardians, and professional contacts can schedule visits by contacting the patient's assigned social worker.

All visitors will be screened upon arrival to LRC, just as patients and LRC teammates are. The screening will include a temperature check for all visitors as well as documentation of visitor responses to a list of symptoms. Visitors will be required to wear either a cloth or surgical mask for the entire duration of the visit; if they do not have a mask, one will be provided to them. Additionally, visitors and patients will need to practice social distancing during the entire duration of the visit; LRC staff supporting visit monitoring will ensure that visitation space accommodates a minimum of six (6) feet between each individual. A more detailed visitation protocol will be distributed to all patient care units.

Additionally, off-campus activities for patients will be expanded to include transitional visits, when necessary, to support discharge planning activities. Patients and staff will be required to follow strict guidelines during transportation and when out in the community during any off-campus activity. This includes, but is not limited to, wearing of masks during the entire duration of the off-campus activity, sanitizing of vehicles before and after the transport occurs, ensuring social distancing standards are adhered to and practicing of hand hygiene in accordance with current guidance. Other off-campus activities, such as off-campus employment, will be considered on a case-by-case basis.

As the COVID-19 pandemic continues to evolve, we will keep you informed of changes to visitation and off- and on-campus activities. We will continue with all other preventative measures currently in place including, but not limited to, frequent cleaning and sanitizing of the environment, temperature and symptom screening of staff upon arrival at work and patient screenings three times per day, wearing of masks, and adhering to social distancing and hand hygiene standards.

You make a difference in the lives of our patients and our team and we thank you for your continued commitment!

Sincerely,

Peter Snyder, M.Ed.; C.T.R.S.
Hospital Operating Officer
Division of Behavioral Health
Department of Health and Human Services

Pandemic Plan

Lincoln Regional Center (LRC)

SUBJECT: COVID-19 PANDEMIC PLAN

Effective Date: February 28, 2020 Page No. 1 of 11
Revision Date: Sept 01, 2021
Infection Prevention & Control Committee Review: February 28, 2020

STANDARD: Center for Disease Control (CDC), American Practitioners of Infection Control (APIC)

POLICY: The Lincoln Regional Center will ensure a sustainable healthcare response to Pandemic COVID-19 in accordance with the Lincoln Regional Center Policy IC-01.

PURPOSE: To provide early detection and containment of Pandemic COVID-19 while maintaining the overall operation of LRC and meet basic needs of the facility.

RESPONSIBILITY: All staff

EQUIPMENT: Personal Protective Equipment (PPE), N-95 filter masks, Surgical Masks, Clean Isolation Gown, Eye Protection, Emergency Operations Manual, Infection Control Manual, Contingency Staffing Plan

PROCEDURE:

I. INITIAL IMPLEMENTATION

A. LRC will work with State, Lancaster County Health Department and other local Health Departments.
B. Contingency Staffing Plan for Managing Widespread Outbreaks / Disaster, as detailed in the Emergency Operations Manual, will go into effect.
C. Designated LRC leadership will meet daily via Huddle and as needed to address essential needs and emergent situations as they arise.
D. Identification of Essential Personnel can be reassessed daily by designated LRC leadership and are as follows:
    1. All employees will be considered essential for anti-viral therapy when available and these staff will be identified daily, based on availability, potential for exposure, and the need to meet minimal departmental staffing requirements, as per contingency staffing plan. This includes allowing for rotation of specific departmental staff in order to meet the essential services of the facility and care of the Patients.
    2. Ancillary staff will be rotated to areas of need.
    3. Once a vaccine is available, staff designated to receive the vaccine will be identified at time of availability of vaccine, based on employees who have had the Pandemic COVID-19 and available staff.
E. LRC will follow all directed health measures, and progressions, related to COVID-19 as outlined by the local health department.

II. CONTAINMENT

A. Signs and Symptoms associated with COVID-19. Severity ranges from little to no symptoms to being severely ill and dying. Symptoms may appear 2-14 days after exposure to the virus:
    1. Fever or Chills
    2. Dry Cough

3. Shortness of Breath or difficulty breathing
4. Fatigue
5. Sore Throat
6. Body Aches
7. Headache
8. New loss of taste or smell
9. Congestion or Runny Nose
10. Nausea or vomiting
11. Diarrhea

All staff will be screened prior to their shift and all patients will be screened 2 times daily for COVID-19 symptoms and temperatures greater than 100°F so possible infections can be identified in their earliest stages. If identified Dr. Connolly is notified immediately for further consultation. All staff are required to wear a cloth/surgical while working with patients or working in patient care areas to control the spread.

B. If above signs and symptoms are identified, they have recently traveled outside of the United States, or had close contact (within 6 feet) with a person who is under investigation/has laboratory confirmed COVID-19 place patient in Airborne/Droplet precaution IMMEDIATELY until Lab Test can confirm a diagnosis. Follow directions within the Infection Control Manual related to Airborne/Droplet precautions.
1. Signs will be placed at each entrance notifying visitors, to each building, that if they have symptoms of respiratory illness they will need to reschedule their visit until a time they are not symptomatic. All Visitors will be screened for fever, other related symptoms, and travel history before being allowed in the building. Once a Local Outbreak has been confirmed, all visitation may be restricted until further notice.
2. Staff returning to work from any illness will be cleared by Infection Control Nurse and will need to pass the staff screening prior to being allowed in the building. If no staff screenings are taking place they will complete an employee assessment form while being assessed by an on duty nurse before being allowed back on the unit.
3. Staff returning from vacation time where they have traveled outside of the United States, were possibly exposed, or have been having symptoms of COVID-19 will consult with the Infection Control Manager or Nurse in their building for an assessment before entering their respective building.
    a. Staff may be asked to wear PPE appropriate to the situation while working
    b. Staff may be asked to visit their doctor and obtain a return to work note
    c. Staff may be asked to return home for up to 14 days for safety
    d. Staff may be asked to provide a doctor's note clearing them to return to work

C. If Signs and Symptoms indicate an infectious agent in our patient population:
1. Call Dr. Connolly immediately for consultation and orders
2. Notify Infection Control Nurse, if not available call Director of Nursing
3. Quarantine patient pending lab results
4. Confirmed positive test results require isolation

D. If a confirmed positive test result within our patient population occurs:

1. Call Dr. Connolly for orders to transfer patient to isolation for safety
2. The Unit of residence will be quarantined for 14 days due to the likelihood of peer to peer exposure.
3. Quarantined Units will require all staff working that respective unit to wear Face Shields, N-95 Masks, and Gloves at all times while utilizing an appropriate Donning and doffing procedure.
   a. If no further positive tests are obtained and there are no further patients exhibiting sign or symptoms, the quarantine status expires after 14 days.

4. Isolation Units will require all staff working that respective unit to wear Face Shield, N-95 Mask, Gown, Shoe Covers, and Gloves at all times while utilizing an appropriate donning and doffing procedure.
   b. After 10 days post symptoms or 10 days post positive test for asymptomatics, the patient(s) can be tested to assess whether discontinuation of isolation is appropriate. The patient(s) will need 2 negative tests results a minimum of 24 hours apart to be deemed recovered, at which time they can rejoin the general population.

E. Appropriate lab procedures will be used to perform diagnostic testing.
   1. Testing is available through the Nebraska Public Health Lab (NPHL) and Physician's Lab
   2. BINAX Rapid Testing is available on site
   3. Test Nebraska can be utilized during times of mass testing
   4. Results will be obtained within in 1-7 days.

F. Director of the Division of Behavioral Health, Medical Director, Infection Control Doctor, Director of Nursing, Hospital Operating Officer, Infection Control Nurse, and, as needed, the Safety Coordinator, and Risk Administrator will be involved in decision to cohort all ill patients together away from non-ill Patients, if needed. During outbreaks, confine patients with confirmed illness to the isolation area for their building/campus Patients with suspected Covid-19 should be placed in the quarantine area of their building until lab test confirms a diagnosis. This may be expanded to all patients being served meals in their rooms and closing down communal areas to dining and other gatherings. Due to medical limitations of LRC, patients needing immediate rehydration or emergency medical attention may need to be transported to a Medical Hospital for treatment. If transfer of a patient is required, record and communicate the transfer to LRC Health Information Management staff for tracking purposes.
   1. Quarantine Areas for each building are as follows, if the entire building is not under quarantine status. Note that beds will need to be added to these areas until the diagnosis is confirmed. Quarantine areas will only be utilized if testing can occur for patients that are suspected of being COVID-19 positive due to exposure or are showing symptoms. If testing is unavailable, utilization of isolation areas is necessary.

      a. Building 10 will Quarantine patients in either of the following areas.
         Canteen Area 1440 sq ft = 20 patient capacity
         Activity Room in Basement Area 720 sq ft = 10 patient capacity

b. Building 3 will Quarantine patients in the Garden Level or 2W.
2229 sq ft = 30 patient capacity

c. Building 5 will Quarantine patients in the Gymnasium or specific units
3840 sq ft = 51 patient capacity

d. Building 14 will Quarantine patients in the 2 West unit
24 single person rooms are available

e. Available areas on the 3rd floor of B-14 if needed
Wayne George Training Room: 1682 sq ft = 23 patient capacity
Conference Room 5: 928 sq ft = 13 patient capacity

f. Total patient Quarantine capacity in these areas is 171 patients

As Units become smaller due to patient movement, additional quarantine areas can be added in the wings of patient area and/or patients will be quarantined to their room if quarantine space is unavailable.

2. The following areas can be used for Isolation, if needed, due to the ability to circulate fresh air through the air handlers. These areas are to be utilized for COVID-19 positive patients or if testing is not adequate:

a. Building 5's S-3 Unit has a 35 bed capacity.

b. Building 10's East Hall can be closed off from the unit and has a 16 bed capacity.

c. Building 3's 2 West Unit has a 25 bed maximum capacity.

d. Isolation space of up to 100 patient capacity, given allowances offered in Executive Order 20-12

A patient's bed can be moved from their room to the Isolation area if needed. As unit census reduces, due to patient movement, Isolation areas can be added in the wings of patient areas..

G. **Personal Protective Equipment (PPE)**

1. **Caring for Patients with pandemic infections**

Healthcare personnel should be particularly vigilant to AVOID:

a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.

b. Contaminating environmental surfaces that are not directly related to Patient care (e.g., door knobs, light switches).
c. Encourage patients in isolation and quarantine to wear a surgical mask if deemed appropriate by the mask clinical assessment. AIIR's single patient rooms at negative pressure relative to the surrounding areas and with a minimum of 6 air changes per hour, are UNAVAILABLE on campus.

2. **Masks (N-95 if available or surgical/procedure or Cloth if needed):**
   - If N-95 is back ordered or out of stock, LRC will consult with the SEMRS coalition and Public Health Department to obtain emergency supplies through the SNS and Department of Public Health. If N-95 is not available surgical or cloth masks will then be utilized.

   a. Wear an N-95 mask when entering an isolation unit. If N-95 in unavailable a surgical mask should be worn once and then discarded. If pandemic COVID-19 patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask, gown, and eye protection for the duration of their shift while changing gloves in between patients/activities and performing hand hygiene.
   b. Change surgical masks when they become moist. N-95 can last for 8 hours or 1 shift.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.
   e. Procedural or cloth masks are to be worn in patient care areas at all times unless the risk level indicates a more protective mask is needed.

3. **Gloves:**
   a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.
   e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids.
   f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. **Gowns:**
   a. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most Patient interactions do not necessitate the use of gowns. A disposable gown made of synthetic fiber or a washable cloth gown may be used.
   c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.
   d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
   e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

5. **Goggles or Face Shield:**
   a. In general, wearing goggles or a face shield for routine contact with patients with pandemic COVID-19 is necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet precaution.

6. **PPE for Special Circumstances**
   a. **PPE for aerosol - generating procedures**
   During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., nebulizer treatment), healthcare personnel should wear gloves, gown, face/eye protection, and an N-95 respirator if fit tested by the Infection Control Manager.

H. **Hand Hygiene**
1. Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based or non-alcohol based products (gels, rinses, foams) containing an emollient that do not require the use of water.
2. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
3. In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based or non-alcohol based products for hand disinfection are preferred.
4. Always perform hand hygiene between patient contacts and after removing PPE.
5. Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels)

and hand disinfection (i.e., alcohol-based or non-alcohol based products) are readily accessible in areas in which patient care is provided.

I. **Disposal of Solid Waste**

1. Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus:
2. Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste. Directions for disposing of medical waste found in Infection Control Manual.
3. Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
4. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

J. **Linen and Laundry**

1. Standard precautions are followed for linen and laundry that might be contaminated with respiratory secretions from Patients with pandemic COVID-19:
2. Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area. Please follow-direction per LRC Infection Control Manual.
3. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
4. Wear gloves for transporting bagged linen and laundry.
5. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
6. Wash and dry linen according to routine standards and procedures.

K. **Dishes and Eating Utensils**

Standard precautions are followed for handling dishes and eating utensils used by a patient with known or possible pandemic COVID-19:

1. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of Patients) should be discarded with other general waste per Emergency Disaster Manual.
2. Wear gloves when handling Patient trays, dishes, and utensils.

L. **Patient-care equipment**

Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

1. Wear gloves when handling and transporting used patient-care equipment.
2. Wipe heavily soiled equipment with an LRC approved surface disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection of reusable care equipment.

3. Wipe external surfaces of portable equipment for performing x-rays and other procedures in the area with an LRC approved surface disinfectant upon removal from the Patient's room.

M. **Environmental cleaning and disinfection**

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Multiguard and Sani Cloths (if unavailable due to supply shortages other assessable disinfectants indicated on the approved COVID-19 Disinfectant List will be procured) will be used for disinfection. Often touched areas will be disinfected at mid-shift and at the end of each shift.

N. **Cleaning and disinfection of Patient-occupied rooms**

1. Wear gloves in accordance with facility policies for environmental cleaning, an N-95 mask, Eye Protection, and Gowns are necessary for routine cleaning of an infection positive room.
2. Keep areas around the Patient room free of unnecessary supplies and equipment to facilitate daily cleaning.
3. Use any LRC approved hospital detergent-disinfectant
4. Follow facility procedures for regular cleaning of Patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.
5. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions and per LRC Small and Large Spill Cleanup Policy found in the Infection Control Manual.

O. **Cleaning and disinfection after Patient discharge or transfer**

1. Close off room for at least 3 hours prior to entry and follow standard facility cleaning policy for post-discharge cleaning of a room.
2. Clean and disinfect all surfaces that were in contact with the Patient or might have become contaminated during care.
3. Disinfectants utilized will be Multiguard Spray and Sani-Cloth wipes (if unavailable due to supply shortages other assessable disinfectants indicated on the approved COVID-19 Disinfectant List will be procured)

P. **Postmortem care**

1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.
2. The Health Department will provide body bags for deceased Patients who will then be placed in the Grounds building to await transport.

Q. **Laboratory specimens and practices**

1. Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

III. OUTBREAK NOTIFICATION

A. All doors will remain locked. Only employees with access cards will be allowed to enter. Vendors/suppliers will be screened by nursing staff prior to entering building to deliver or stock supplies. Vendors/suppliers may be instructed to drop off all supplies at the Dock if outbreak has decreased onsite work population and staff are unavailable to screen and assist them prior to entering the buildings.

B. Infection Control Manager will direct all means of media notification in connection with Public Information Officer if public announcements are needed.
   1. Visual alerts will be at entrances advising visitors that visitation is restricted.
   2. Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:
      a. Use elbow or sleeve to cover your cough or sneeze.
      b. Wear PPE deemed appropriate for situation by Infection Control Dept.
      c. Follow Social Distancing Guidelines
      d. Perform hand hygiene often.

C. Individual activities and Unit activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the Patients.

D. Clinical Director, Infection Control Doctor, Infection Control Manager, and Director of Nursing will decide what departments and activities continue during the duration of the outbreak.

E. Department Heads/Supervisors will contact the Infection Control Manager for any clarification of memos/orders/notifications/questions.

F. Remain vigilant for another outbreak of pandemic COVID-19.

G. All Admissions will be screened by Infection Control Manager or Infection Control Doctor before being admitted to LRC, unless admissions are suspended during active outbreak
   1. 14 days of Vitals and access to their medical record will be requested for screening prior to admission. Additionally, COVID testing pre-admission may also be requested.
   2. When admission arrives the Infection Control Doctor will assess patient for signs/symptoms of COVID-19 before being admitted. If admitted the admitting nurse under consultation of the Infection Control Doctor will complete a COVID-19 Screening Assessment in AVATAR.

H. All Transfers between LRC's programs will be screened by Infection Control Manager or Infection Control Doctor prior to transfer.
   1. 3 days of Vitals and access to their medical record will be required for screening prior to transfer.
   2. When transfer arrives to their respective program, the admitting nurse under the consultation of the Infection Control Doctor will assess the patient for signs/symptoms of COVID-19 before being admitted. The admitting nurse will complete a COVID-19 Screening Assessment in AVATAR.

IV. MONITORING OF HEALTH CARE PERSONNEL

A. Employees who report to work will be screened, in the lobby of their respective buildings, for signs and symptoms of the COVID-19 before reporting for duty. Staff may be given antiviral therapy if necessary and available especially with staff working in isolation and quarantine areas.

B. Screening of all employees will be done by Nursing Administration, RN Supervisor, Infection Control Manager, HCP, or trained designee before being allowed on the unit. Staff who are exhibiting signs/symptoms associated with COVID-19 or who have a temperature greater than 100°F will be sent home and required to consult with the Infection Control Nurse before being cleared to return to work. If a supply shortage restricts this practice, staff will be asked to self–monitor at home prior to coming to work. If staff do not have a thermometer at home they will check in with a nurse before reporting for duty.

C. Infection Control Manager will track all staff exhibiting symptoms of COVID-19 and will give clearance for them to return to work based on the following requirements
   1. It has been 10 days since the onset of symptoms with marked improvement in symptoms AND they have been fever free for 24 hours without the aid of a fever reducing medication (i.e. Acetaminophen, Motrin)
   2. Or they provide a doctor's note clearing them to return to work.

D. Staff at high risk for complications of pandemic COVID-19 (i.e. pregnant, immuno-compromised, and older in age) should be informed about this medical risk and offered an alternative work assignment away from COVID-19 patient care or considered for administrative leave, if available

E. Staff age will be assessed when staffing quarantine and isolation areas due to increased age increasing risk of Acute Respiratory Distress Syndrome.
   1. Staff under the age of 39 with no compromising issues will be asked to staff the quarantine and isolation areas first if possible.
   2. If more staff are needed, staff from the age of 40-49 with no compromising issues will then be asked to staff the quarantine and isolation areas if possible.

F. Non-essential staff may be able to work from home or work in a low risk area of the hospital. Essential staff will be needed to continue operations at LRC and are defined as:
   1. Nursing Staff
   2. Security Specialists including Team Leaders
   3. Licensed Independent Providers
   4. 1 Psychologist per Building
   5. Dietary Staff
   6. Environmental Services Staff
   7. Safety Personnel of each building
   8. Manager On-Call
   9. 1 Social Worker per Building
   10. Pharmacy Staff

V. **TREATMENT**

A. No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated. COVID-19 Vaccines are available on site for staff and patients on a voluntary bases.

VI. **Maintaining Operations/Programming**

A. The following Tools/Protocols offer further guidance with continuing operations during the COVID-19 Pandemic. The Tools/Protocols can be found using the following hyperlink: S:\LRC POLICY MANUAL\Infection Control\COVID-19 Tools and Protocols

1. Insulation Unit Guidelines
2. Quarantine Unit Guidelines
3. Isolation Unit Guidelines
4. Visitation Protocol
5. Café Protocol
6. Canteen Protocol
7. Computer Cleaning Protocol
8. Dental Services Protocol
9. GYM Protocol
10. Library Services Protocol
11. LRC Applicant Interview Protocol
12. Medical Clinic Protocol
13. Recreational Room Protocol
14. Salon Services Protocol
15. Outpatient Competency Restoration Services Protocol
16. LRC's Phasing Document

Please note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

Corrigo Tracking E-mail

Attachment L7

From: Beckman, Brent <Brent.Beckman@nebraska.gov>
Sent: Tuesday, November 2, 2021 11:55 AM
To: Flynn, Bevan <Bevan.Flynn@nebraska.gov>; Vogel, Barbara <Barbara.Vogel@nebraska.gov>; DeVries, Joan <Joan.Devries@nebraska.gov>; Weyer, John <John.Weyer@nebraska.gov>; Glenn, Shanda <Shanda.Glenn@nebraska.gov>; Collier, Scott <Scott.Collier@nebraska.gov>; Mitten, Scott <Scott.Mitten@nebraska.gov>; Paz, David <David.Paz@nebraska.gov>; Bartels, Kevin <Kevin.Bartels@nebraska.gov>; Weyer, John <John.Weyer@nebraska.gov>; Kahl, Larry <Larry.Kahl@nebraska.gov>
Cc: Glenn, Shanda <Shanda.Glenn@nebraska.gov>; Miller, Andy <Andy.Miller@nebraska.gov>
Subject: RE: Ombudsman's Contact

All,

Included are a list of my projects under construction between December 2020 through November 2021. These projects are all nearly completed and expected to be substantially completed by the end of 2021.

1. LRC B10 Ligature Risks Mitigation Project
2. LRC B10 Emergency Generator Replacements Project
3. LRC B10 Fan Coil Unit Replacements Project
4. LRC B14 Chiller Replacement Project

Thanks,

Brent Beckman, PE, LEED AP, CLSSYB

Facilities Construction Coordinator II | State Building Division
Nebraska Department of Administrative Services
1526 K Street | Suite 160 | Lincoln, NE 68508
Mobile: 402-417-3043
brent.beckman@nebraska.gov

Inspection Reports

Fire Alarm

Fire sprinkler

Attachment L8

Fire Alarm

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg # 3- Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68506
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2nd Semi-Annual Inspection Summary

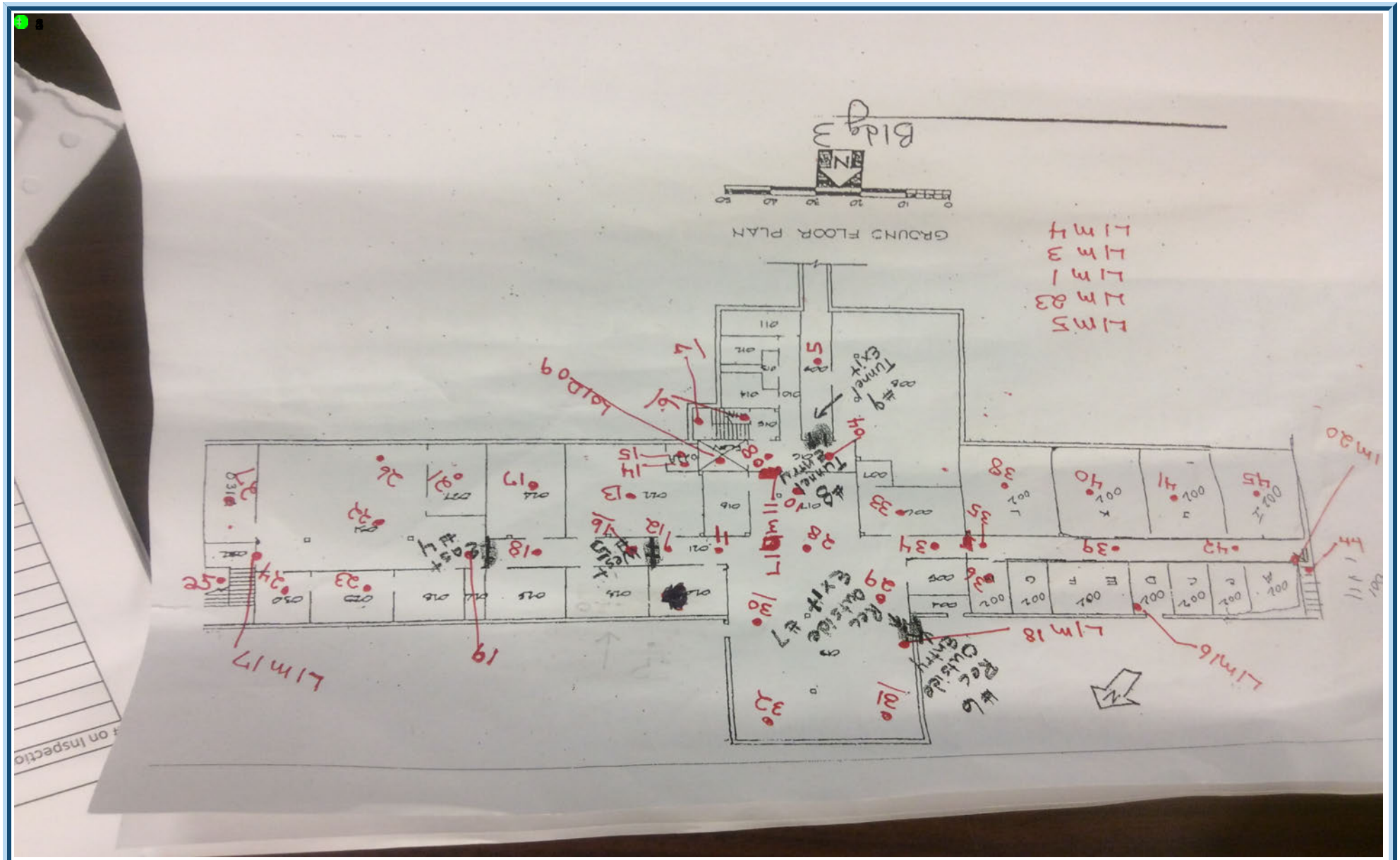
Result Totals

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 8/3/2021 in accordance with applicable requirements.

BASEMENT TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Control Valve Switch	L1M01	rm 008	Passed			8/3/2021 1:54 PM
2	Standpipe Water Flow	L1M05	Rm 008	Passed			8/3/2021 1:54 PM
3	Control Valve Switch	L1M04	rm 08	Passed			8/3/2021 1:53 PM
4	Control Valve Switch	L1M01	Craft Rm	Passed			8/3/2021 1:53 PM
5	Standpipe Water Flow	L1M32	Rm 008	Passed			8/3/2021 1:53 PM



✣ Control Valve Switch	⛸ PIV	◑ Standpipe Water Flow	✹ Water Flow Vane Switch
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

BASEMENT
TJC EP2 Tampers Waterflows

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SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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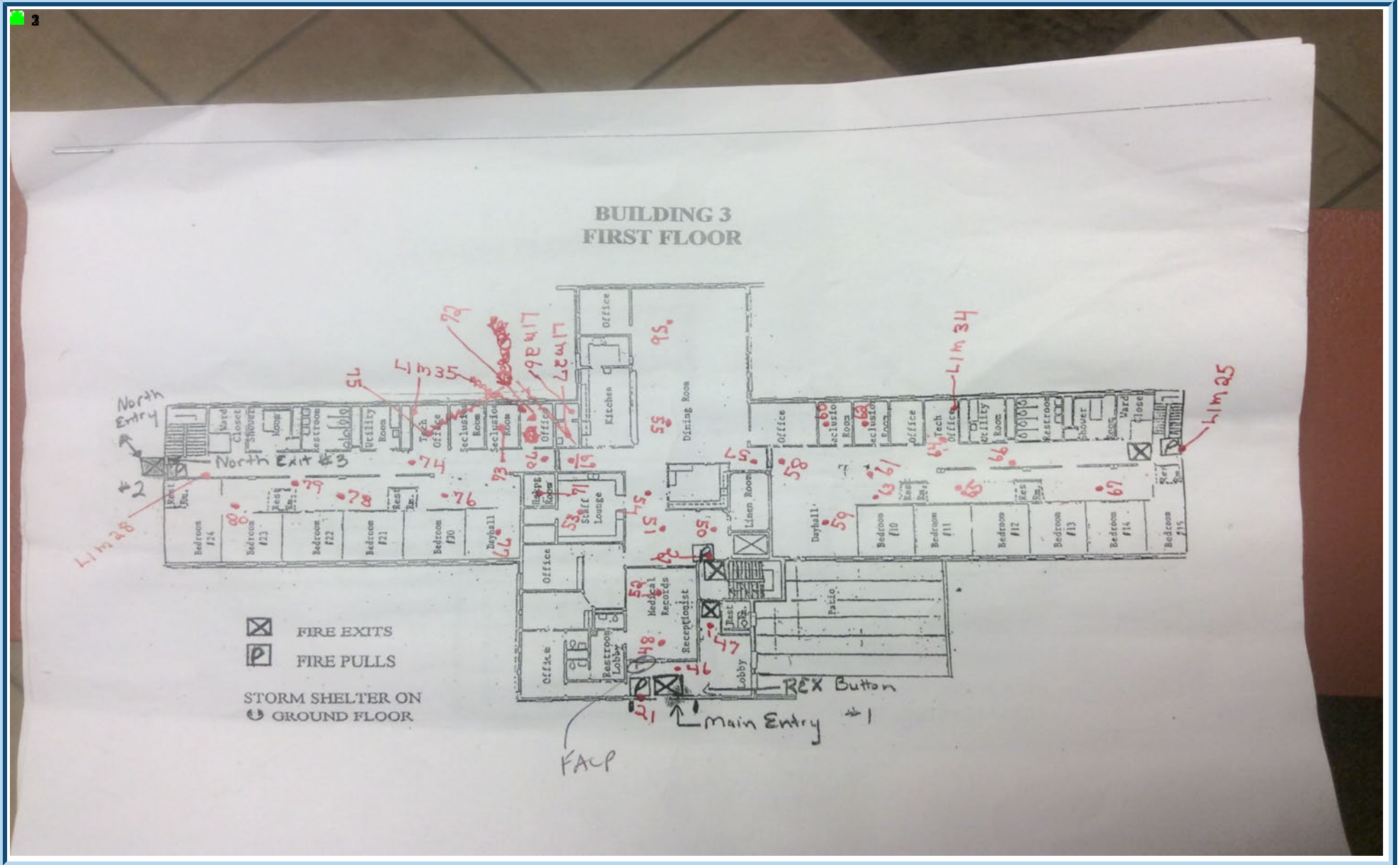
800-274-0888

1st FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M26	116	Passed			8/3/2021 1:53 PM
2	Water Flow Vane Switch	L1M32	116	Passed			8/3/2021 1:51 PM
3	PIV	L1M02	Outside	Passed			8/3/2021 1:51 PM



Control Valve Switch	PIV	Standpipe Water Flow	Water Flow Vane Switch
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR
TJC EP2 Tampers Waterflows

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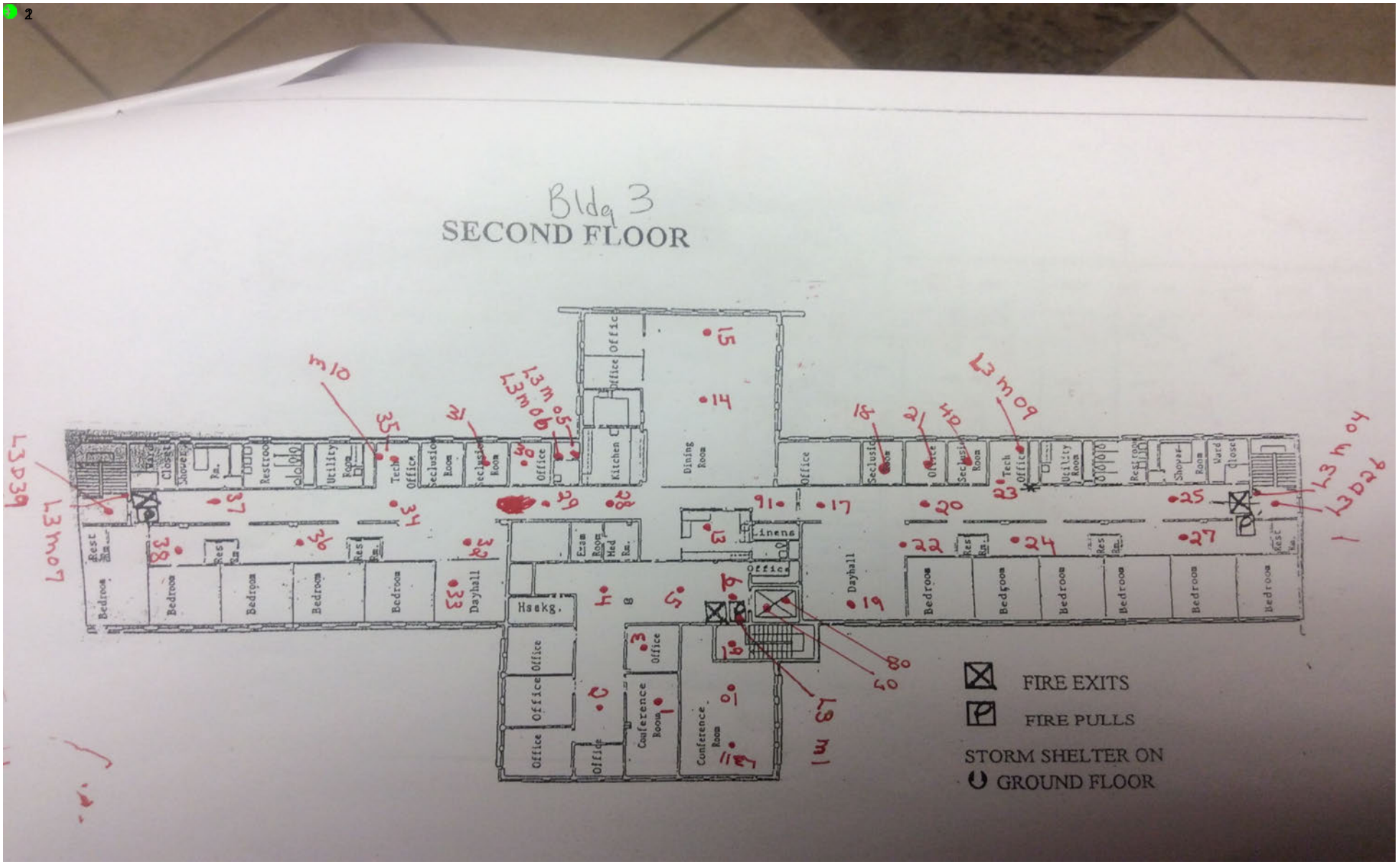
2nd FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Control Valve Switch	L3M06	Riser Rm 216	Passed			8/3/2021 1:51 PM
2	Standpipe Water Flow	L3M05	Riser rm 216	Passed			8/3/2021 1:51 PM



Control Valve Switch	PIV	Standpipe Water Flow	Water Flow Vane Switch
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR
TJC EP2 Tampers Waterflows

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP3 Initiating Devices 2nd Semi-Annual Inspection Summary

Result Totals

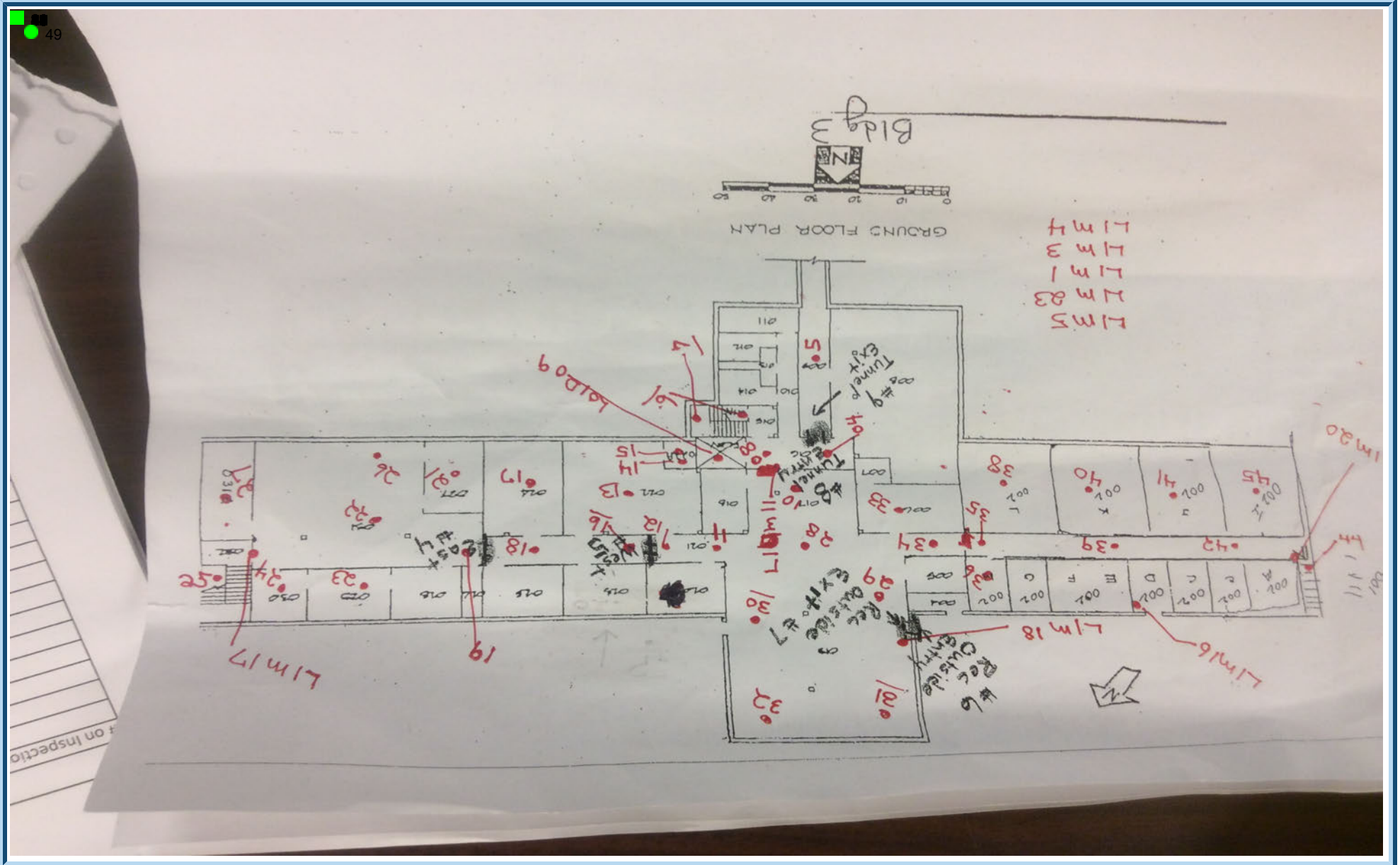
Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	4	3	15	111
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	4	3	15	111

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

BASEMENT TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D27	Notifier	FSP-851	031A	Passed		8/3/2021 1:17 PM
2	Manual Pull Station	L1M17	Notifier		east Exit 032	Passed		8/3/2021 1:17 PM
3	Smoke Detector	L1D24	Notifier	FSP-851	030	Passed		8/3/2021 1:17 PM
4	Smoke Detector	L1D22	Notifier	FSP-851	Hall by rm 30	Passed		8/3/2021 1:17 PM
5	Smoke Detector	L1D23	Notifier	FSP-851	029	Passed		8/3/2021 1:17 PM
6	Smoke Detector	L1D26	Notifier	FSP-851	031	Passed		8/3/2021 1:16 PM
7	Smoke Detector	L1D19	Notifier	FSP-851	Hall by 28	Passed		8/3/2021 1:16 PM
8	Smoke Detector	L1D21	Notifier	FSP-851	Hall by 27	Passed		8/3/2021 1:16 PM
9	Smoke Detector	L1D18	Notifier	FSP-851	Hall by 25	Passed		8/3/2021 1:16 PM
10	Smoke Detector	L1D16	Notifier	FSP-851	Hall by 23	Passed		8/3/2021 1:16 PM
11	Smoke Detector	L1D13	Notifier	FSP-851	Rm 22	Passed		8/3/2021 1:16 PM
12	Smoke Detector	L1D17	Notifier	FSP-851	Rm 024	Passed		8/3/2021 1:16 PM
13	Smoke Detector	L1D12	Notifier	FSP-851	Pharmacy Entrance	Passed		8/3/2021 1:15 PM
14	Smoke Detector	L1D11	Notifier	FSP-851	Hall by Rm 020	Passed		8/3/2021 1:15 PM
15	Smoke Detector	L1D28	Notifier	FSP-851	Hall by Rm 005	Passed		8/3/2021 1:15 PM
16	Smoke Detector	L1D32	Notifier	FSP-851	Day rm 019	Passed		8/3/2021 1:15 PM
17	Smoke Detector	L1D30	Notifier	FSP-851	Day rm 019 SE	Passed		8/3/2021 1:15 PM
18	Smoke Detector	L1D31	Notifier	FSP-851	Day rm 019 NW	Passed		8/3/2021 1:14 PM
19	Smoke Detector	L1D29	Notifier	FSP-851	Day rm 019 SW	Passed		8/3/2021 1:14 PM
20	Smoke Detector	L1D34	Notifier	FSP-851	Hall by 006	Passed		8/3/2021 1:14 PM
21	Smoke Detector	L1D35	Notifier	FSP-851	Hall by Mech 002	Passed		8/3/2021 1:14 PM
22	Smoke Detector	L1D10	Notifier	FSP-851	Day rm 017	Passed		8/3/2021 1:14 PM
23	Smoke Detector	L1D33	Notifier	FSP-851	Rm 006	Passed		8/3/2021 1:13 PM
24	Smoke Detector	L1D38	Notifier	FSP-851	Rm 002L	Passed		8/3/2021 1:13 PM
25	Smoke Detector	L1D40	Notifier	FSP-851	Rm 002K	Passed		8/3/2021 1:13 PM
26	Smoke Detector	L1D39	Notifier	FSP-851	Hall by rm 002E	Passed		8/3/2021 1:13 PM
27	Smoke Detector	L1D42	Notifier	FSP-851	Hall by rm 002J	Passed		8/3/2021 1:13 PM
28	Smoke Detector	L1D41	Notifier	FSP-851	Hall by rm 002J	Passed		8/3/2021 1:12 PM
29	Smoke Detector	L1D45	Notifier	FSP-851	Hall by rm 002I	Passed		8/3/2021 1:12 PM
30	Smoke Detector	L1D05	Notifier	FSP-851	Hall by rm 14	Passed		8/3/2021 1:12 PM
31	Smoke Detector	L1D81	Notifier	FSP-851	005 rec Room	Passed		8/3/2021 1:12 PM
32	Smoke Detector	L1D08	Notifier	FSP-851	Elevator Lobby	Passed		8/3/2021 1:12 PM
33	Heat Detector	L1D09	Notifier		Elevator Pit	Passed		8/3/2021 1:12 PM
34	Smoke Detector	L1D15	Notifier	FSP-851	Elevator Equipment rm	Passed		8/3/2021 1:12 PM
35	Heat Detector	L1D14	Notifier		Elevator Equipment Rm	Passed		8/3/2021 1:11 PM
36	Smoke Detector	L1D06	Notifier	FSP-851	Storage 015A	Passed		8/3/2021 1:11 PM
37	Smoke Detector	L1D25	Notifier	FSP-851	Basement Stairs E	Passed		8/3/2021 1:11 PM
38	Smoke Detector	L1D44	Notifier	FSP-851	Basement Stairs W	Passed		8/3/2021 1:11 PM
39	Smoke Detector	L1D07	Notifier	FSP-851	Basement Stairs Center	Passed		8/3/2021 1:11 PM
40	Smoke Detector	L1D37	Notifier	FSP-851	Above Hall ceiling West	Passed		8/3/2021 1:10 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L1D43	Notifier	FSP-851	Above Hall ceiling West	Passed		8/3/2021 1:10 PM
42	Duct Detector	L1D01	Innovair		Return air	Passed		8/3/2021 1:10 PM
43	Duct Detector	L1D02	Innovair		AHU-1	Passed		8/3/2021 1:10 PM
44	Duct Detector	L1D03	Innovair		AHU-2	Passed		8/3/2021 1:10 PM
45	Duct Detector	L1D36	Innovair		Rm 002H	Passed		8/3/2021 1:10 PM
46	Manual Pull Station	L1M18	Notifier		Dayroom 019	Passed		8/3/2021 1:10 PM
47	Manual Pull Station	L1M20	Notifier		West Exit	Passed		8/3/2021 1:09 PM
48	Manual Pull Station	L1M11	Notifier		Elevator Lobby	Passed		8/3/2021 1:09 PM
49	Manual Pull Station	L1M16	Notifier		North Exit	Passed		8/3/2021 1:09 PM
49	Smoke Detector	L1D04	Notifier	FSP851	By tunnel doors	Passed		8/3/2021 1:09 PM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

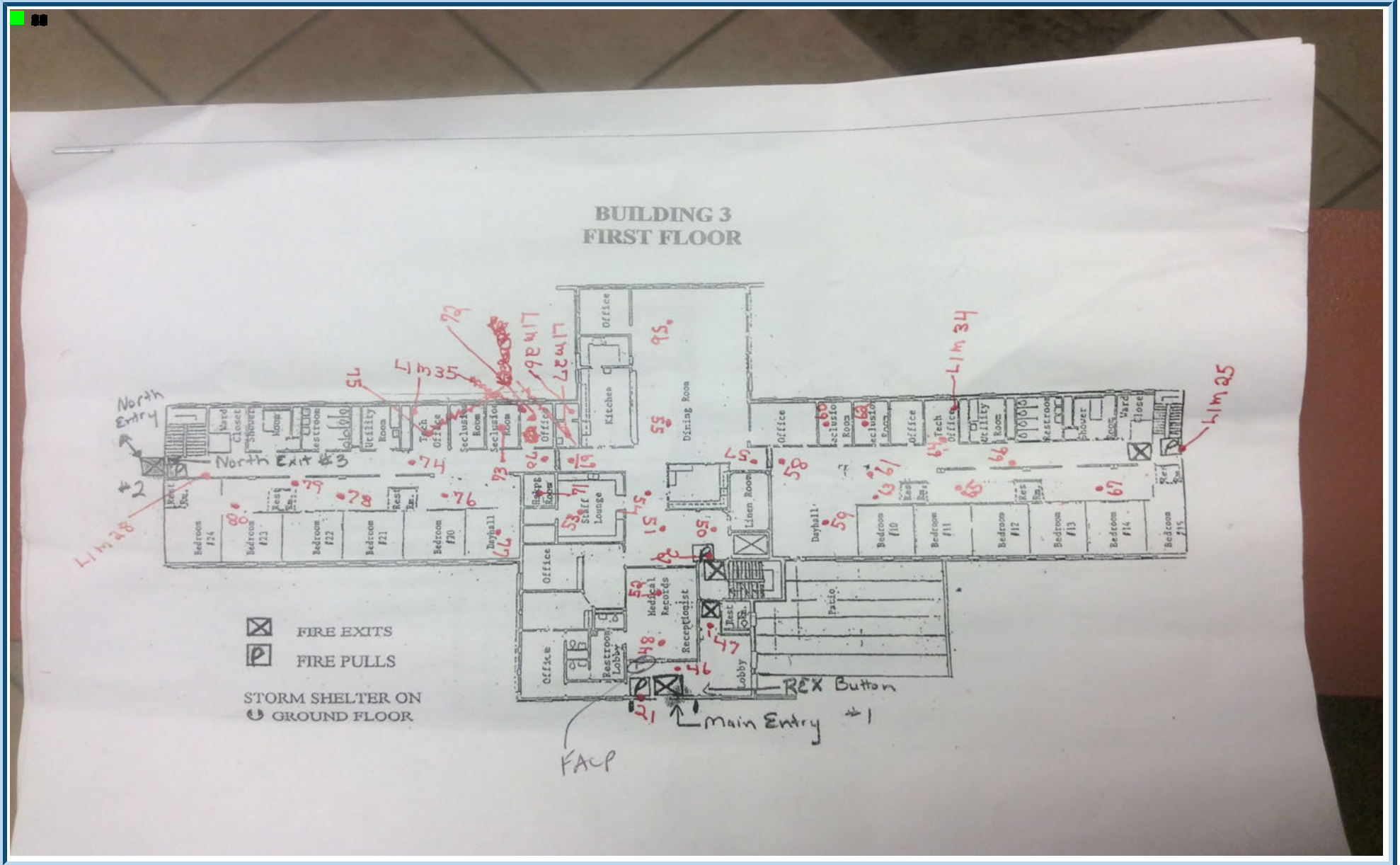
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

BASEMENT
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D50	Notifier	FSP-851	Elevator Lobby	Passed		8/3/2021 1:09 PM
2	Smoke Detector	L1D51	Notifier	FSP-851	Elevator Lobby	Passed		8/3/2021 1:09 PM
3	Smoke Detector	L1D52	Notifier	FSP-851	Mail Rm	Passed		8/3/2021 1:09 PM
4	Smoke Detector	L1D48	Notifier	FSP-851	Reception office	Passed		8/3/2021 1:08 PM
5	Smoke Detector	L1D46	Notifier	FSP-851	Main Entrance	Passed		8/3/2021 1:08 PM
6	Smoke Detector	L1D67	Notifier	FSP-851	Hall by 160	Passed		8/3/2021 1:08 PM
7	Smoke Detector	L1D66	Notifier	FSP-851	Hall by 154	Passed		8/3/2021 1:08 PM
8	Smoke Detector	L1D65	Notifier	FSP-851	Hall by 153	Passed		8/3/2021 1:08 PM
9	Smoke Detector	L1D61	Notifier	FSP-851	152C	Passed		8/3/2021 1:08 PM
10	Smoke Detector	L1D60	Notifier	FSP-851	147	Passed		8/3/2021 1:07 PM
11	Smoke Detector	L1D64	Notifier	FSP-851	Tech station	Passed		8/3/2021 1:07 PM
12	Smoke Detector	L1D59	Notifier	FSP-851	Dayroom 152C	Passed		8/3/2021 1:07 PM
13	Smoke Detector	L1D57	Notifier	FSP-851	Hall by 144	Passed		8/3/2021 1:07 PM
14	Smoke Detector	L1D55	Notifier	FSP-851	Dining Rm	Passed		8/3/2021 1:07 PM
15	Smoke Detector	L1D56	Notifier	FSP-851	Dining Rm	Passed		8/3/2021 1:07 PM
16	Smoke Detector	L1D54	Notifier	FSP-851	Nurse 139	Passed		8/3/2021 1:07 PM
17	Smoke Detector	L1D82	Notifier	FSP-851	Rm 144	Passed		8/3/2021 1:06 PM
18	Smoke Detector	L1D69	Notifier	FSP-851	Hall by 116	Passed		8/3/2021 1:06 PM
19	Smoke Detector	L1D53	Notifier	FSP-851	main med rm	Passed		8/3/2021 1:06 PM
20	Smoke Detector	L1D71	Notifier	FSP-851	wiring closet	Passed		8/3/2021 1:06 PM
21	Smoke Detector	L1D72	Notifier	FSP-851	114	Passed		8/3/2021 1:06 PM
22	Smoke Detector	L1D70	Notifier	FSP-851	Dayroom 108	Passed		8/3/2021 1:06 PM
23	Smoke Detector	L1D73	Notifier	FSP-851	113	Passed		8/3/2021 1:06 PM
24	Smoke Detector	L1D77	Notifier	FSP-851	Day Rm 108C	Passed		8/3/2021 1:06 PM
25	Smoke Detector	L1D76	Notifier	FSP-851	Hall by 111	Passed		8/3/2021 1:05 PM
26	Smoke Detector	L1D74	Notifier	FSP-851	Day Rm 108C	Passed		8/3/2021 1:05 PM
27	Smoke Detector	L1D75	Notifier	FSP-851	110	Passed		8/3/2021 1:05 PM
28	Smoke Detector	L1D80	Notifier	FSP-851	Hall by 102	Passed		8/3/2021 1:05 PM
29	Smoke Detector	L1D47	Notifier	FSP-851	Main lobby	Passed		8/3/2021 1:05 PM
30	Smoke Detector	L1D58	Notifier	FSP-851	Hall by Dayroom 152C	Passed		8/3/2021 1:05 PM
31	Smoke Detector	L1D63	Notifier	FSP-851	Hall by 145	Passed		8/3/2021 1:04 PM
32	Smoke Detector	L1D78	Notifier	FSP-851	Hall by 109	Passed		8/3/2021 1:04 PM
33	Smoke Detector	L1D79	Notifier	FSP-851	Hall by 104	Passed		8/3/2021 1:04 PM
34	Manual Pull Station	L1M21	Notifier		Main Entrance	Passed		8/3/2021 1:04 PM
35	Manual Pull Station	L1M25	Notifier		East Stairs	Passed		8/3/2021 1:03 PM
37	Manual Pull Station	L1M35	Notifier		Tech 110	Passed		8/3/2021 1:03 PM
38	Manual Pull Station	L1M28	Notifier		West Stairs	Passed		8/3/2021 1:02 PM
39	Manual Pull Station	L1M22	Notifier		Elevator Lobby	Passed		8/3/2021 1:02 PM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

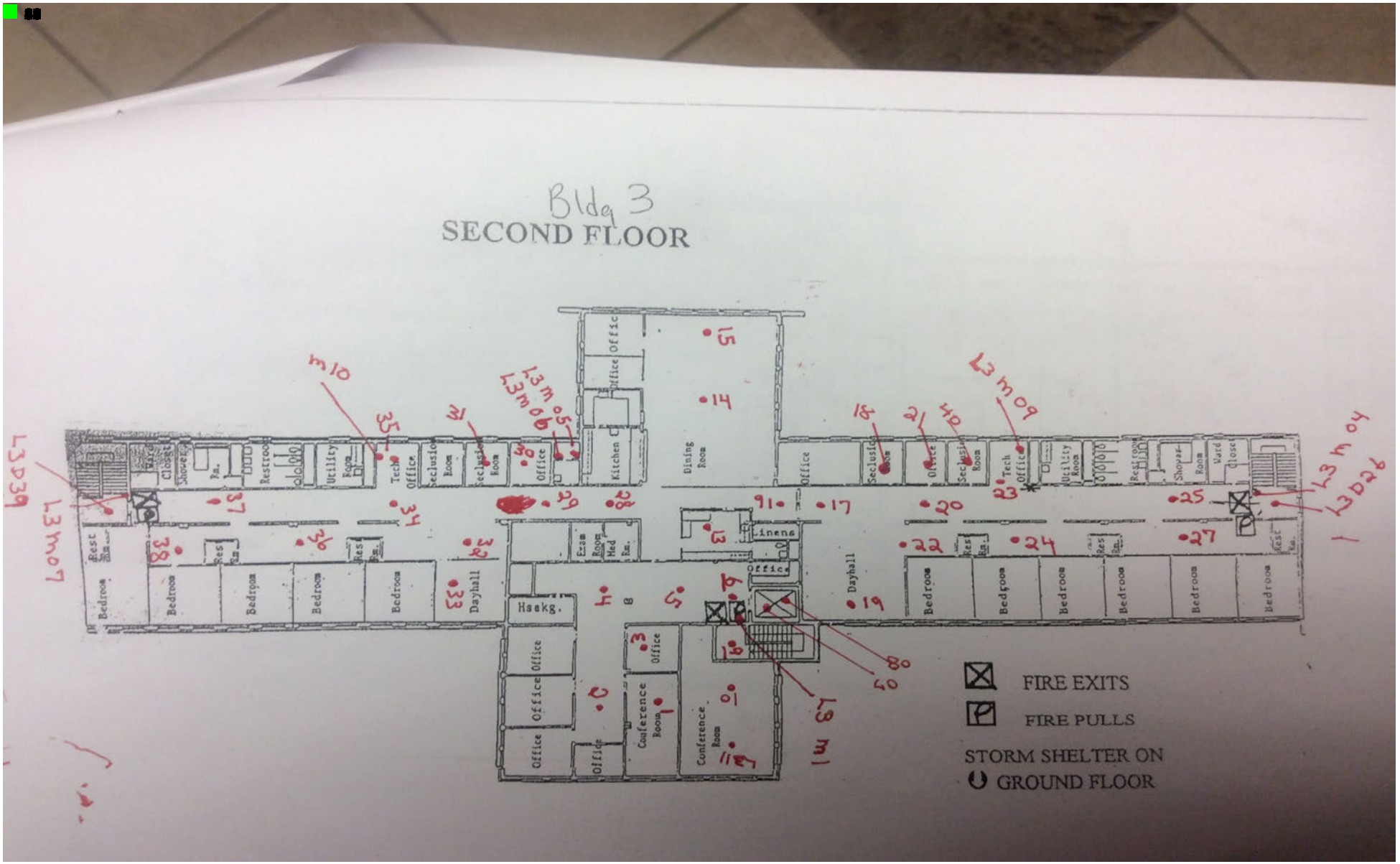
1st FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D07	Notifier	FSP-851	Top of Shaft	Passed		8/3/2021 1:02 PM
2	Heat Detector	L3D08	Notifier		Top of Shaft	Passed		8/3/2021 1:02 PM
3	Smoke Detector	L3D06	Notifier	FSP-851	Elevator lobby	Passed		8/3/2021 1:02 PM
4	Smoke Detector	L3D09	Notifier	FSP-851	Top of Stairs	Passed		8/3/2021 1:01 PM
5	Smoke Detector	L3D27	Notifier	FSP-851	Hall by 250	Passed		8/3/2021 1:01 PM
6	Smoke Detector	L3D25	Notifier	FSP-851	Hall by 245	Passed		8/3/2021 1:01 PM
7	Smoke Detector	L3D24	Notifier	FSP-851	Hall by 249	Passed		8/3/2021 1:01 PM
8	Smoke Detector	L3D23	Notifier	FSP-851	241	Passed		8/3/2021 1:01 PM
9	Smoke Detector	L3D26	Notifier	FSP-851	Top of stairs E	Passed		8/3/2021 1:01 PM
10	Smoke Detector	L3D22	Notifier	FSP-851	Hall by 238	Passed		8/3/2021 1:00 PM
11	Smoke Detector	L3D19	Notifier	FSP-851	Day rm 232	Passed		8/3/2021 1:00 PM
12	Smoke Detector	L3D21	Notifier	FSP-851	237	Passed		8/3/2021 1:00 PM
13	Smoke Detector	L3D18	Notifier	FSP-851	236	Passed		8/3/2021 1:00 PM
14	Smoke Detector	L3D17	Notifier	FSP-851	242C	Passed		8/3/2021 12:59 PM
15	Smoke Detector	L3D12	Notifier	FSP-851	235	Passed		8/3/2021 12:59 PM
16	Smoke Detector	L3D14	Notifier	FSP-851	Dining Rm	Passed		8/3/2021 12:59 PM
17	Smoke Detector	L3D13	Notifier	FSP-851	230	Passed		8/3/2021 12:59 PM
18	Smoke Detector	L3D28	Notifier	FSP-851	Hall by 216	Passed		8/3/2021 12:59 PM
19	Smoke Detector	L3D29	Notifier	FSP-851	Hall by 214	Passed		8/3/2021 12:59 PM
20	Smoke Detector	L3D30	Notifier	FSP-851	214	Passed		8/3/2021 12:59 PM
21	Smoke Detector	L3D31	Notifier	FSP-851	213	Passed		8/3/2021 12:59 PM
22	Smoke Detector	L3D33	Notifier	FSP-851	208C	Passed		8/3/2021 12:59 PM
23	Smoke Detector	L3D32	Notifier	FSP-851	Hall by 211	Passed		8/3/2021 12:58 PM
24	Smoke Detector	L3D36	Notifier	FSP-851	Hall by 205	Passed		8/3/2021 12:58 PM
25	Smoke Detector	L3D37	Notifier	FSP-851	outside 204	Passed		8/3/2021 12:58 PM
26	Smoke Detector	L3D39	Notifier	FSP-851	Top of Stairs W	Passed		8/3/2021 12:58 PM
27	Smoke Detector	L3D05	Notifier	FSP-851	Elevator lobby	Passed		8/3/2021 12:58 PM
28	Smoke Detector	L3D04	Notifier	FSP-851	Hall by 220	Passed		8/3/2021 12:57 PM
29	Smoke Detector	L3D01	Notifier	FSP-851	228	Passed		8/3/2021 12:57 PM
30	Smoke Detector	L3D02	Notifier	FSP-851	Hall by 223	Passed		8/3/2021 12:57 PM
31	Smoke Detector	L3D03	Notifier	FSP-851	227	Passed		8/3/2021 12:57 PM
32	Smoke Detector	L3D10	Notifier	FSP-851	226	Passed		8/3/2021 12:57 PM
33	Smoke Detector	L3D11	Notifier	FSP-851	226	Passed		8/3/2021 12:57 PM
34	Smoke Detector	L3D15	Notifier	FSP-851	Dining Rm 233	Passed		8/3/2021 12:57 PM
35	Smoke Detector	L3D16	Notifier	FSP-851	Hall by 235	Passed		8/3/2021 12:56 PM
36	Smoke Detector	L3D20	Notifier	FSP-851	Hall by Dayroom 237	Passed		8/3/2021 12:56 PM
37	Smoke Detector	L3D34	Notifier	FSP-851	Hall by Dayroom 208C	Passed		8/3/2021 12:56 PM
38	Smoke Detector	L3D35	Notifier	FSP-851	Tech Station 210	Passed		8/3/2021 12:56 PM
39	Smoke Detector	L3D38	Notifier	FSP-851	Hall by 202	Passed		8/3/2021 12:56 PM
40	Manual Pull Station	L3M10	Notifier		210	Passed		8/3/2021 12:56 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Manual Pull Station	L3M01	Notifier		Elevator Lobby	Passed		8/3/2021 12:56 PM
42	Manual Pull Station	L3M09	Notifier		Tech 241	Passed		8/3/2021 12:56 PM
43	Manual Pull Station	L3M04	Notifier		East Stairs	Passed		8/3/2021 12:55 PM
44	Manual Pull Station	L3M07	Notifier		West Stairs	Passed		8/3/2021 12:55 PM
45	Smoke Detector	L3D40	Notifier	FSP-851	239	Passed		8/3/2021 12:55 PM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP4 Notification 2nd Semi-Annual Inspection Summary

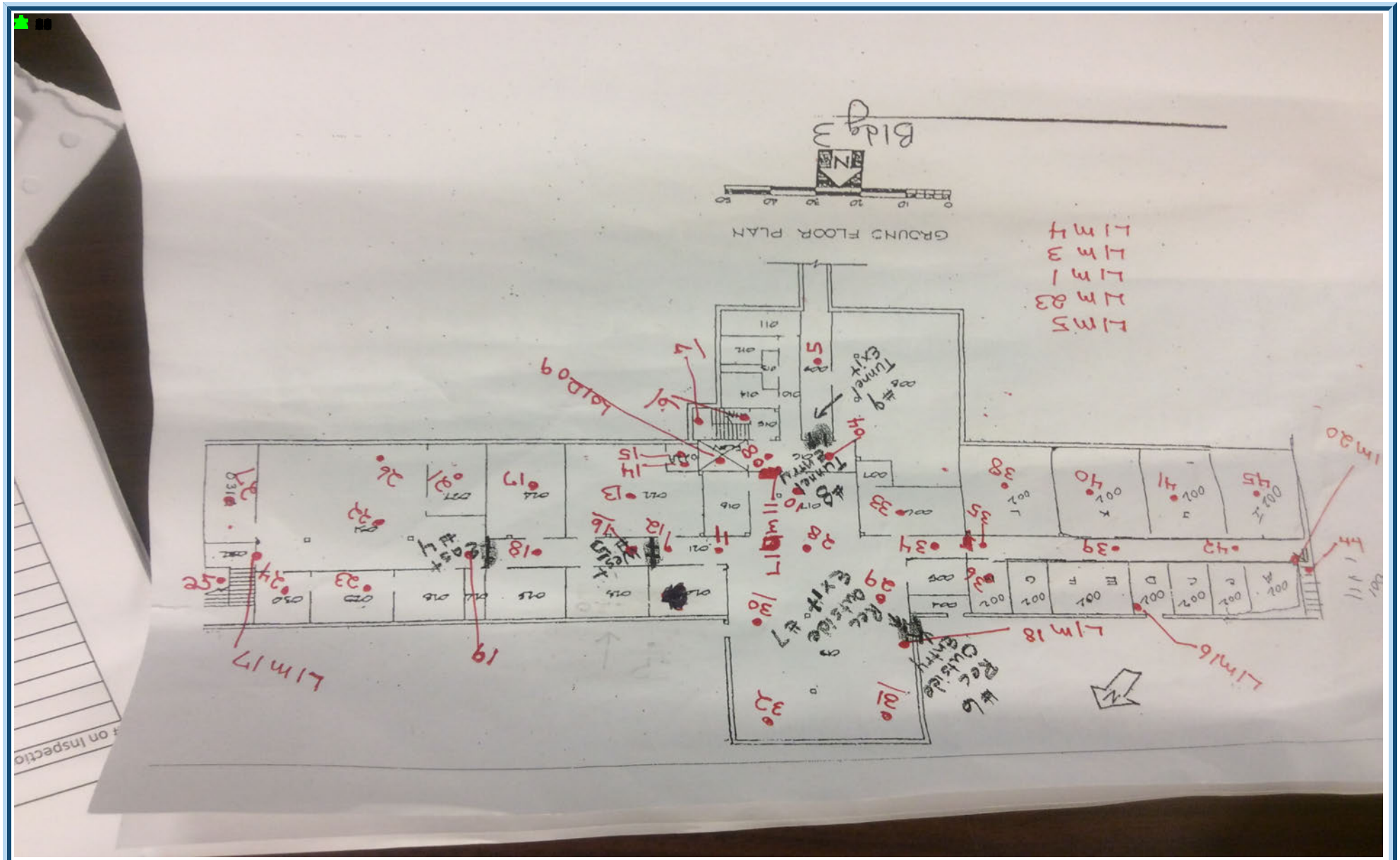
Result Totals

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 8/3/2021 in accordance with applicable requirements.

BASEMENT TJC EP4 Notification Results

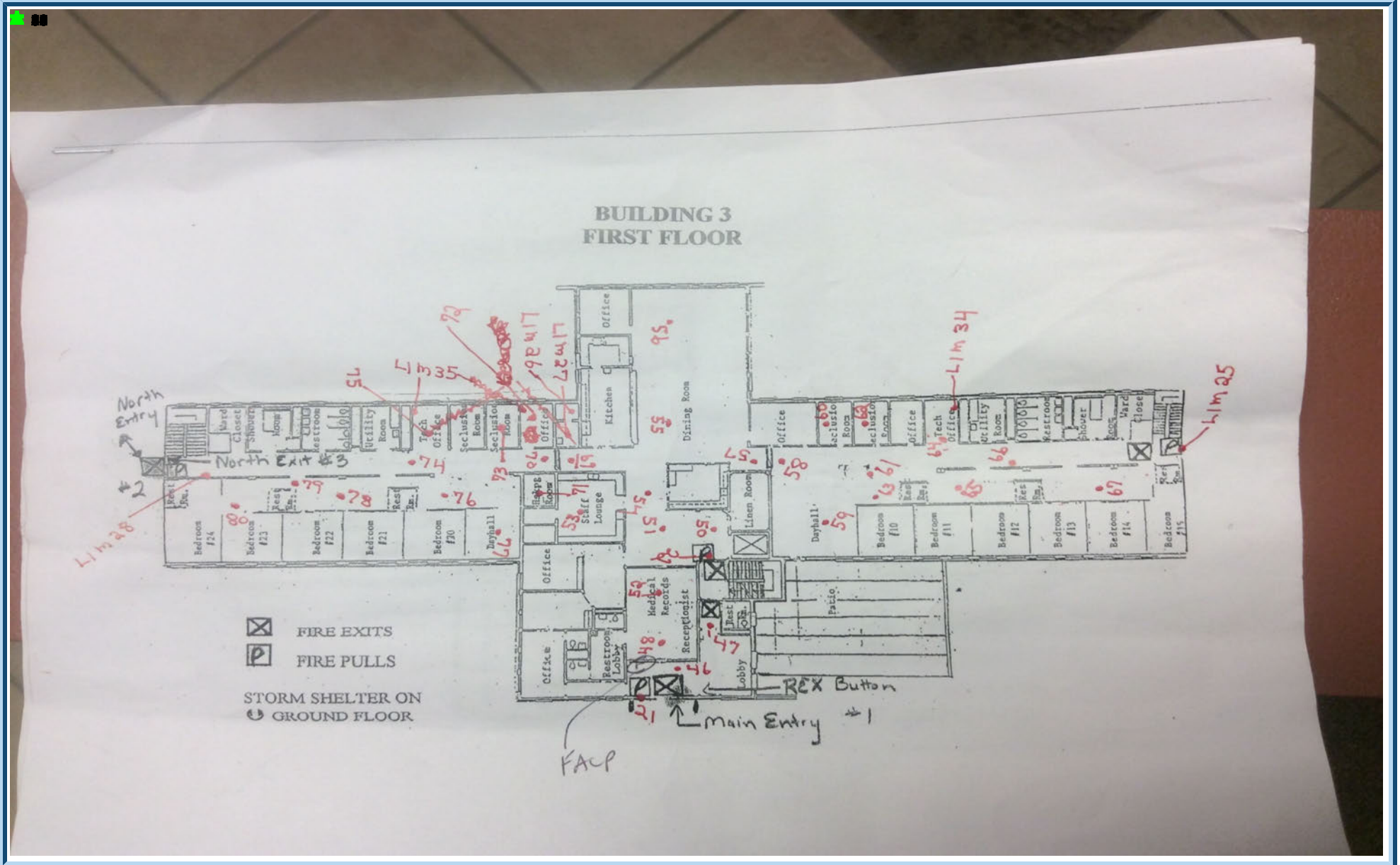
Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P1224MCW	Outside Room 031	Passed		8/3/2021 1:49 PM
2	Horn Strobe		P1224MCW	Outside Room 023	Passed		8/3/2021 1:48 PM
3	Strobe			022	Passed		8/3/2021 1:48 PM
4	Strobe			022	Passed		8/3/2021 1:48 PM
5	Horn Strobe		P1224MCW	Outside Room 020	Passed		8/3/2021 1:48 PM
6	Horn Strobe		P1224MCW	Rm 019	Passed		8/3/2021 1:48 PM
7	Horn Strobe		P1224MCW	Rm 019	Passed		8/3/2021 1:48 PM
8	Strobe		S1224MCW	019	Passed		8/3/2021 1:48 PM
9	Strobe		S1224MCW	019	Passed		8/3/2021 1:48 PM
10	Horn Strobe		P1224MCW	Outside Rm 018	Passed		8/3/2021 1:47 PM
11	Strobe		S1224MCW	Outside 018	Passed		8/3/2021 1:46 PM
12	Strobe		S1224MCW	Outside 006	Passed		8/3/2021 1:46 PM
13	Strobe		S1224MCW	006	Passed		8/3/2021 1:46 PM
14	Strobe		S1224MCW	006 RR	Passed		8/3/2021 1:46 PM
15	Horn Strobe		P1224MCW	Outside Rm 002G	Passed		8/3/2021 1:46 PM
16	Horn Strobe		P1224MCW	Outside Rm 002B	Passed		8/3/2021 1:45 PM
17	Strobe		S1224MCW	002I	Passed		8/3/2021 1:45 PM
18	Strobe		S1224MCW	002J	Passed		8/3/2021 1:45 PM
19	Strobe		S1224MCW	002K	Passed		8/3/2021 1:45 PM
20	Strobe		S1224MCW	002L	Passed		8/3/2021 1:42 PM
21	Horn Strobe		P1224MCW	Outside Rm 014	Passed		8/3/2021 1:42 PM
22	Strobe		S1224MCW	014	Passed		8/3/2021 1:42 PM
23	Strobe		S1224MCW	012	Passed		8/3/2021 1:41 PM
24	Horn			Boiler Mech Rm	Passed		8/3/2021 1:41 PM



▲ Horn	⧋ Horn Strobe	☆ Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

1st FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P1224MCW	Lobby	Passed		8/3/2021 1:41 PM
3	Strobe		S1224MCW	136	Passed		8/3/2021 1:41 PM
4	Strobe		S1224MCW	131	Passed		8/3/2021 1:40 PM
5	Strobe		S1224MCW	127	Passed		8/3/2021 1:40 PM
6	Strobe		S1224MCW	128	Passed		8/3/2021 1:40 PM
7	Strobe		S1224MCW	125	Passed		8/3/2021 1:39 PM
8	Strobe		S1224MCW	Outside Rm 142	Passed		8/3/2021 1:39 PM
9	Horn Strobe		P1224MCW	outside rm 124	Passed		8/3/2021 1:38 PM
10	Horn Strobe		P1224MCW	Dining Rm	Passed		8/3/2021 1:38 PM
11	Strobe		S1224MCW	Rm 120	Passed		8/3/2021 1:38 PM
11	Strobe		S1224MCW	Rm 120	Passed		8/3/2021 1:38 PM
12	Strobe		S1224MCW	Rm 142	Passed		8/3/2021 1:38 PM
13	Strobe		S1224MCW	Rm 142	Passed		8/3/2021 1:38 PM
14	Strobe		S1224MCW	Outside Rm 116	Passed		8/3/2021 1:37 PM
15	Strobe		S1224MCW	Rm 114	Passed		8/3/2021 1:37 PM
16	Horn Strobe		P1224MCW	Outside Rm 114	Passed		8/3/2021 1:37 PM
17	Strobe		S1224MCW	Kitchen 140	Passed		8/3/2021 1:37 PM
18	Strobe		S1224MCW	108C	Passed		8/3/2021 1:36 PM
19	Strobe		S1224MCW	110	Passed		8/3/2021 1:36 PM
20	Strobe		SC2415W	106	Passed	Ceiling	8/3/2021 1:36 PM
21	Horn Strobe		P1224MCW	108	Passed		8/3/2021 1:36 PM
22	Strobe		SC2415W	104	Passed	Ceiling	8/3/2021 1:36 PM
23	Strobe		S1224MCW	101A	Passed		8/3/2021 1:35 PM
24	Strobe		S1224MCW	108A	Passed		8/3/2021 1:35 PM
25	Strobe		S1224MCW	108B	Passed		8/3/2021 1:35 PM
26	Horn Strobe		P1224MCW	Outside 147	Passed		8/3/2021 1:35 PM
27	Strobe		S1224MCW	152C	Passed		8/3/2021 1:33 PM
28	Strobe		S1224MCW	152B	Passed		8/3/2021 1:33 PM
29	Strobe		S1224MCW	152A	Passed		8/3/2021 1:33 PM
30	Strobe		S1224MCW	151	Passed		8/3/2021 1:32 PM
31	Strobe		SC2415W	155	Passed	Ceiling	8/3/2021 1:32 PM
32	Strobe		SC2415W	157	Passed	Ceiling	8/3/2021 1:32 PM
33	Strobe		S1224MCW	162	Passed		8/3/2021 1:32 PM
34	Horn Strobe		P1224MCW	Outside 157	Passed		8/3/2021 1:30 PM
35	Horn			Outside 152A	Passed		8/3/2021 1:30 PM



▲ Horn | ⧋ Horn Strobe | ☆ Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

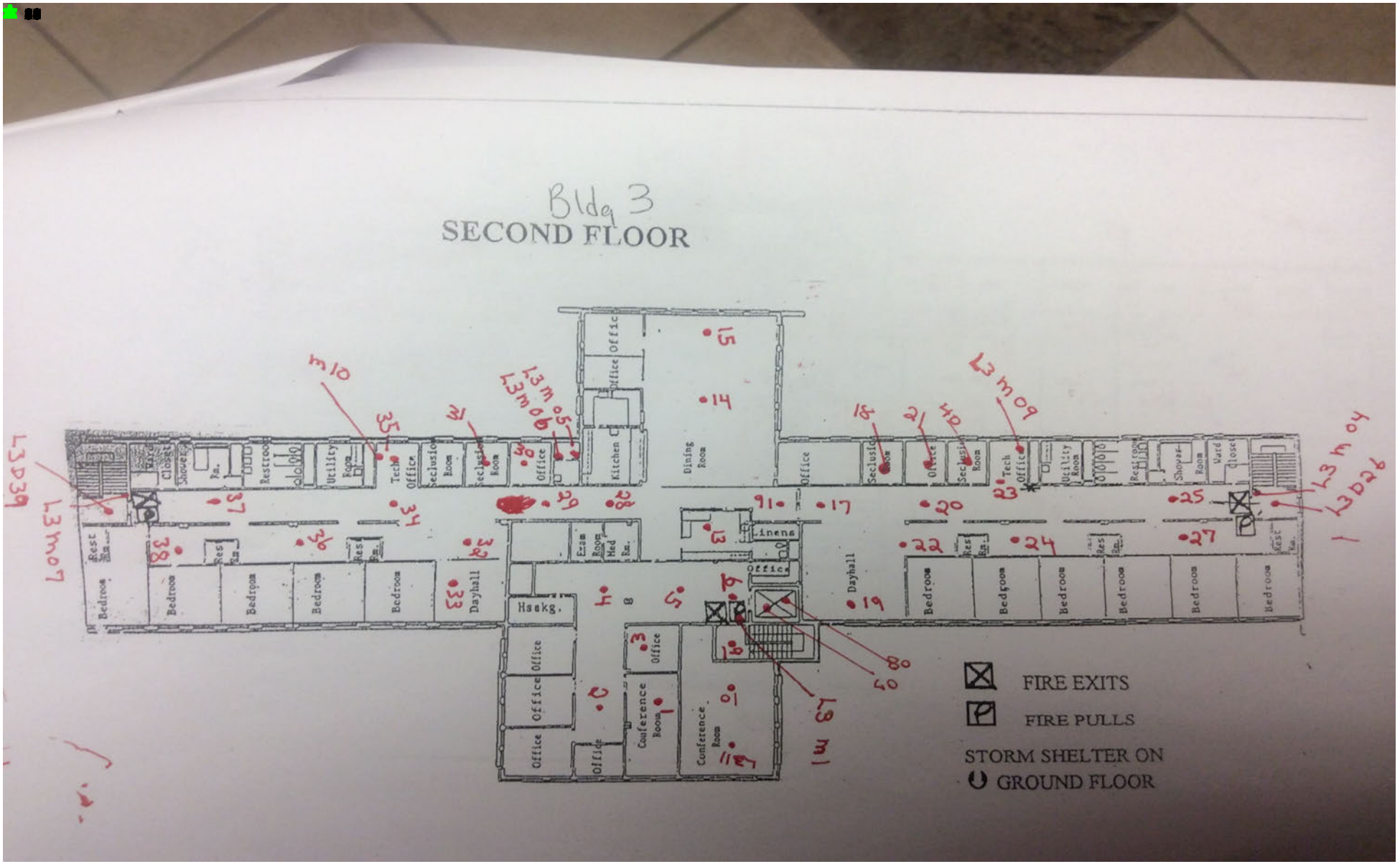
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR
TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		S1224MCW	254	Passed		8/3/2021 1:30 PM
2	Horn Strobe		P1224MCW	242	Passed		8/3/2021 1:29 PM
3	Strobe		SC2415W	247	Passed		8/3/2021 1:29 PM
4	Strobe		SC2415W	245	Passed		8/3/2021 1:29 PM
5	Horn			242	Passed		8/3/2021 1:29 PM
6	Strobe		S1224MCW	242A	Passed		8/3/2021 1:29 PM
7	Strobe		S1224MCW	241	Passed		8/3/2021 1:29 PM
8	Strobe		S1224MCW	242B	Passed		8/3/2021 1:29 PM
9	Horn Strobe		P1224MCW	242C	Passed		8/3/2021 1:28 PM
10	Strobe		S1224MCW	242C	Passed		8/3/2021 1:28 PM
11	Strobe		S1224MCW	236	Passed		8/3/2021 1:27 PM
12	Strobe		S1224MCW	Dining rm	Passed		8/3/2021 1:27 PM
13	Strobe		S1224MCW	Dining rm	Passed		8/3/2021 1:27 PM
14	Horn Strobe		P1224MCW	Dining Rm	Passed		8/3/2021 1:27 PM
15	Strobe		S1224MCW	Dining rm Staff RR	Passed		8/3/2021 1:27 PM
16	Strobe		S1224MCW	Outside 216	Passed		8/3/2021 1:26 PM
17	Strobe		S1224MCW	231	Passed		8/3/2021 1:26 PM
18	Horn Strobe		P1224MCW	Outside 213	Passed		8/3/2021 1:26 PM
19	Strobe		S1224MCW	214	Passed		8/3/2021 1:26 PM
20	Strobe		S1224MCW	208 C	Passed		8/3/2021 1:26 PM
21	Strobe		S1224MCW	210	Passed		8/3/2021 1:25 PM
22	Strobe		S1224MCW	208B	Passed		8/3/2021 1:25 PM
23	Horn			208	Passed		8/3/2021 1:25 PM
24	Strobe		SC2415W	206	Passed		8/3/2021 1:24 PM
25	Strobe		S1224MCW	208A	Passed		8/3/2021 1:24 PM
26	Strobe		SC2415W	204	Passed		8/3/2021 1:24 PM
27	Horn Strobe		P1224MCW	Outside 204	Passed		8/3/2021 1:24 PM
28	Strobe		S1224MCW	201 rr	Passed		8/3/2021 1:23 PM
29	Strobe		S1224MCW	220	Passed		8/3/2021 1:23 PM
30	Horn Strobe		P1224MCW	220	Passed		8/3/2021 1:23 PM
31	Strobe		S1224MCW	228	Passed		8/3/2021 1:23 PM
32	Horn Strobe		P1224MCW	212	Passed		8/3/2021 1:22 PM



▲ Horn	⧋ Horn Strobe	☆ Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR
TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg # 3- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP5 FA Equipment Signals 2nd Semi-Annual Inspection Summary

Result Totals

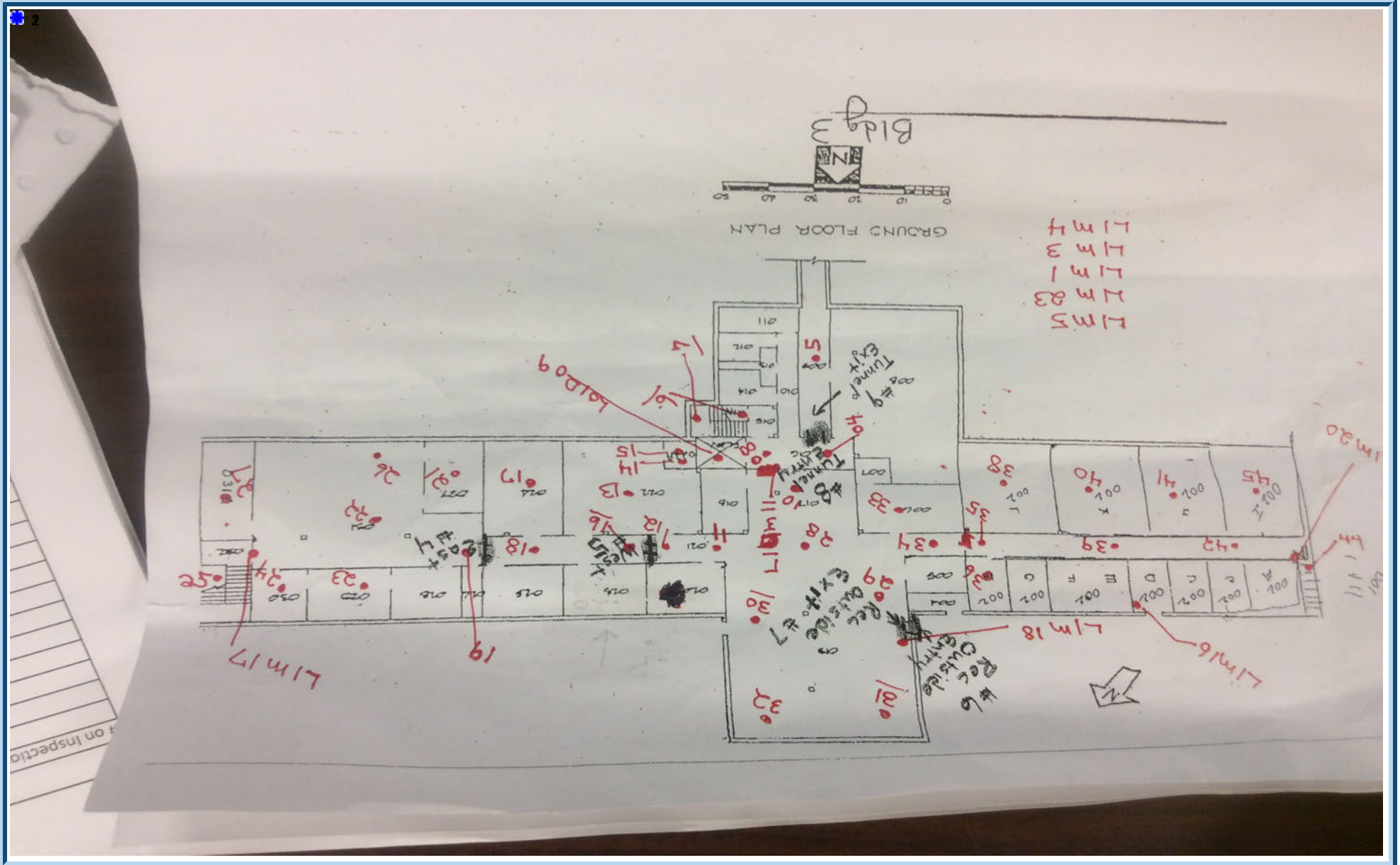
Devices	Annuciator	Power Supply
Passed	-	3
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	3	-
Total	3	3

Supercomponent Information	
Type	2 - FACP
Location	1st FLOOR Main Entrance
Model	AFP1010
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

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	Passed		8/13/2021 4:42 PM
2	Annuciator	Notifier			By Elevator	Not Inspected		



Annunciator	FACP	Power Supply
Passed = Green	Mitigated = Green	Failed = Red
		Not Tested = Blue

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BASEMENT
TJC EP5 FA Equipment Signals

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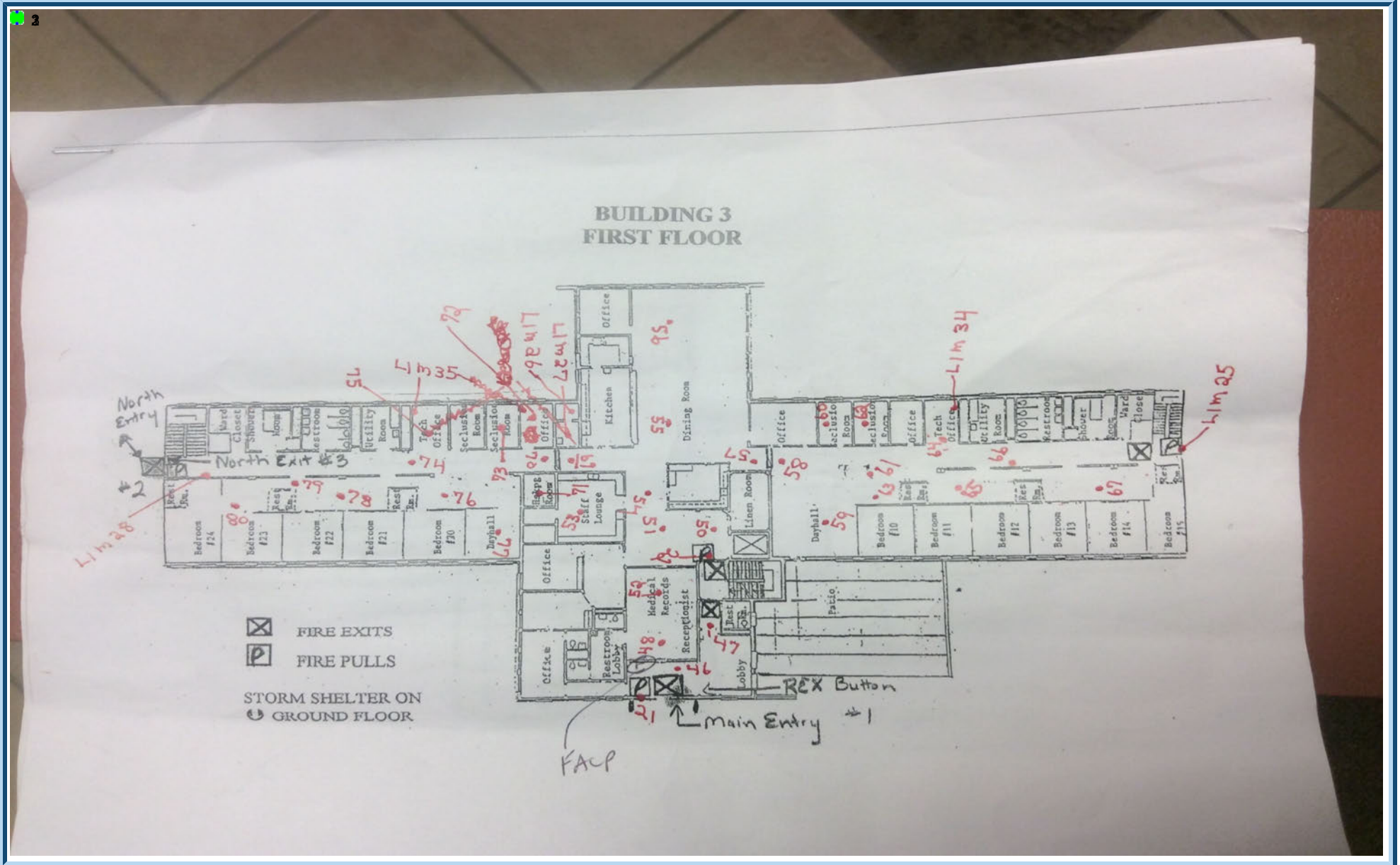
1st FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Dining Rm	Not Inspected		
2	FACP	Notifier	AFP1010		Main Entrance	Passed		8/13/2021 4:44 PM
3	Power Supply	Notifier	FCPS-24S8	L1M24	Rm 144	Passed		8/13/2021 4:44 PM



Annuciator	FACP	Power Supply
Passed = Green	Mitigated = Green	Failed = Red
		Not Tested = Blue

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1st FLOOR
TJC EP5 FA Equipment Signals

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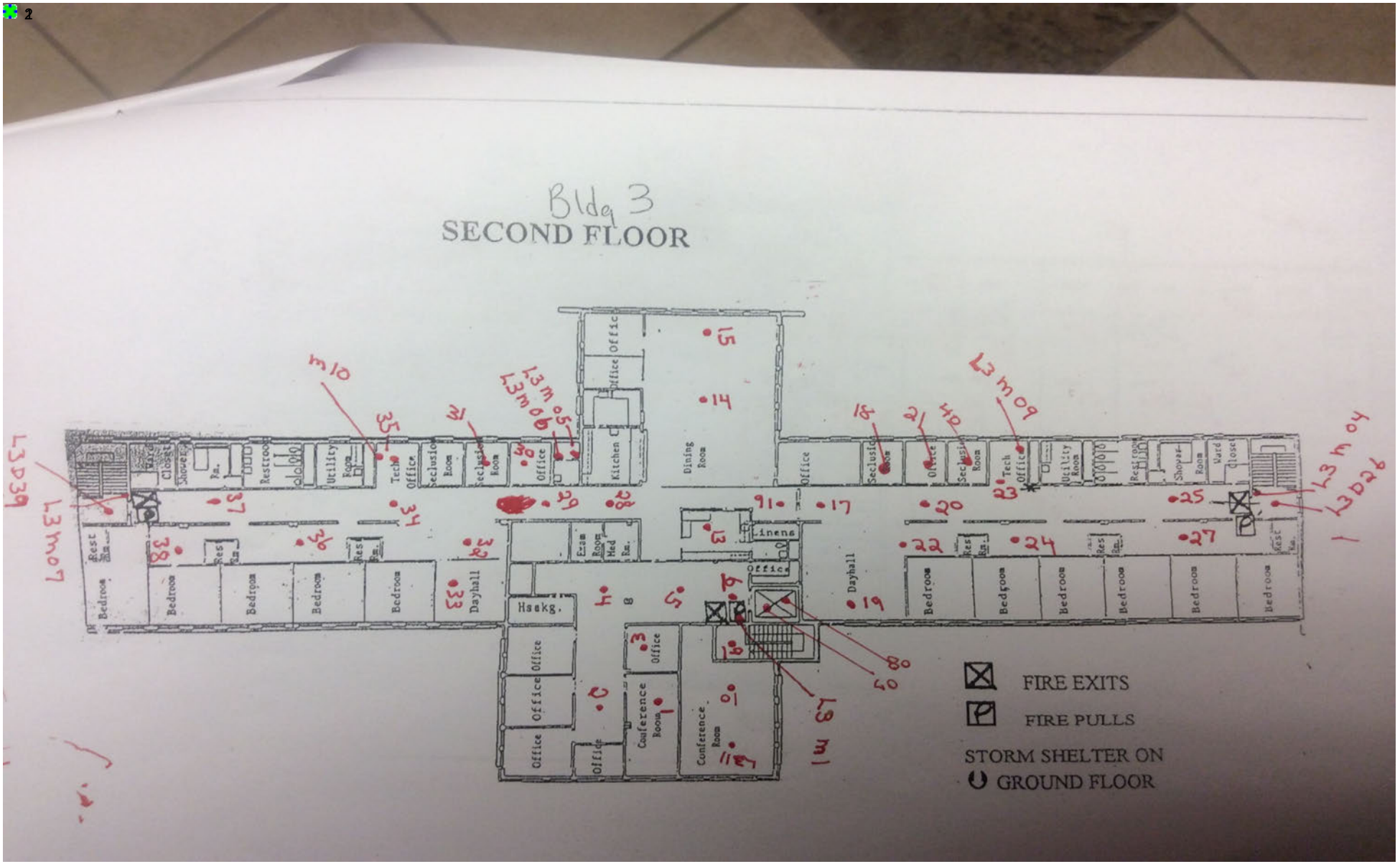
2nd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Dining Room	Not Inspected		
2	Power Supply	Notifier	FCPS-24S8	L3M03	235	Passed		8/13/2021 4:46 PM



Annuciator	FACP	Power Supply
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

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2nd FLOOR
TJC EP5 FA Equipment Signals

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Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V8AH			9-11-19	BASEMENT 005	Passed	Left
1	12V8AH			9-11-19	BASEMENT 005	Passed	Right
2	12V26AH	Notifier	AFP1010	12-12-18	1st FLOOR Main Entrance	Passed	Left
2	12V26AH	Notifier	AFP1010	12-12-18	1st FLOOR Main Entrance	Passed	Right
3	12V8AH			1-30-20	1st FLOOR Rm 144	Passed	Left
3	12V8AH			1-30-2020	1st FLOOR Rm 144	Passed	Right
2	12V8AH	Notifier	FCPS-24S8	9-11-19	2nd FLOOR 235	Passed	Left
2	12V8AH	Notifier	FCPS-24S8	9-11-2019	2nd FLOOR 235	Passed	Right

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1	L1M12	Power Supply	Notifier	FCPS-24S8		005	BASEMENT	Passed		
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	Passed	24hr 5min	
3	L1M24	Power Supply	Notifier	FCPS-24S8	120	Rm 144	1st FLOOR	Passed		
1		Annuciator	Notifier			Dining Room	2nd FLOOR	Not Inspected		
2	L3M03	Power Supply	Notifier	FCPS-24S8	120	235	2nd FLOOR	Passed	24/5	

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INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg # 3- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

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800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property: LRC Bldg # 3- Lincoln Regional Center

Inspection Date: 8/13/2021

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

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg # 3- Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	(402) 479-5451
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
AHJ Phone Number	402-471-2027
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	2900 S 70th St #330
Monitoring Org Phone	(402) 474-3737
Monitoring Org Email	gordon.tebo@nebraska.gov
Monitoring Acct Number	Customer Provided
Phone Line one or IP	Customer Supplied

Phone Line two or IP	Customer Supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maint.

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		
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.	8-3-21

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Bevan flynn
Title:	
Phone:	
Date:	8-3-21

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2021 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 5- Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68506
Scope: Full
Frequency: Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows Annual Inspection Summary

Result Totals

Devices	Control Valve Switch	PIV	Standpipe Water Flow	Water Flow Pressure Switch
Passed	9	1	1	5
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	9	1	1	5

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Water Flow Pressure Switch	L1M30	Janitor Closet	Passed			8/6/2021 10:50 AM
2	Water Flow Pressure Switch	L3M23	S-2 Mop closet	Passed			8/6/2021 10:50 AM
3	Control Valve Switch	L1M31	Janitor Closet	Passed			8/6/2021 10:51 AM
4	Control Valve Switch	L3M24	S-2 Janitor Closet	Passed			8/6/2021 10:51 AM
5	PIV	L1M35	Outside	Passed			8/6/2021 10:51 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			8/6/2021 10:51 AM
2	Water Flow Pressure Switch	L3M21	S-4 Mop closet	Passed			8/6/2021 10:52 AM
3	Control Valve Switch	L2M03	S-5 Sprinkler closet	Passed			8/6/2021 10:52 AM
4	Control Valve Switch	L3M22	S-4 Janitor Closet	Passed			8/6/2021 10:52 AM
5	Water Flow Pressure Switch	L3M21	S-4 Mop closet	Passed			8/6/2021 10:53 AM
6	Control Valve Switch	L3M22	S-4 Janitor Closet	Passed			8/6/2021 10:53 AM

Basement TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1m32	main Flow switch	Passed			8/6/2021 9:38 AM
2	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/6/2021 9:39 AM
3	Control Valve Switch	L1M36	Basement Elev. Eq	Passed		Main Tamper	8/6/2021 9:39 AM
4	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/6/2021 10:50 AM
5	Control Valve Switch	L1M33	Basement	Passed		Main Tamper	8/6/2021 9:39 AM

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2021 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP3 Initiating Devices Annual Inspection Summary

Result Totals

Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	18	59	18	238
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	-	-	-	-
Total	18	59	18	238

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D65	notifier	SDX-551	gym stairs	Passed		8/6/2021 12:53 PM
2	Smoke Detector	L1D41	notifier	SDX-551	tunnel stairs	Passed		8/6/2021 12:53 PM
3	Smoke Detector	L1D44	notifier	SDX-551	elevator lobby	Passed		8/6/2021 12:53 PM
4	Smoke Detector	L1D45	notifier	SDX-551	Hall by office door	Passed		8/6/2021 12:52 PM
5	Smoke Detector	L1D47	notifier	SDX-551	Hall by reception	Passed		8/6/2021 12:52 PM
6	Smoke Detector	L1D48	notifier	SDX-551	Hall by med rm	Passed		8/6/2021 12:52 PM
7	Heat Detector	L1D49	notifier	FDX-551	mop closet	Passed		8/6/2021 12:51 PM
8	Heat Detector	L1D50	notifier	FDX-551	medication rm	Passed		8/6/2021 12:51 PM
9	Smoke Detector	L1D52	notifier	SDX-551	reception center	Passed		8/6/2021 12:51 PM
10	Heat Detector	L1D54	notifier	FDX-551	reception center	Passed		8/6/2021 12:50 PM
11	Heat Detector	L1D55	notifier	FDX-551	reception center	Passed		8/6/2021 12:50 PM
12	Smoke Detector	L1D56	notifier	SDX-551	medical records	Passed		8/6/2021 12:50 PM
13	Smoke Detector	L1D57	notifier	SDX-551	medical records	Passed		8/6/2021 12:50 PM
14	Smoke Detector	L1D58	notifier	SDX-551	Hall s stairs	Passed		8/6/2021 12:50 PM
15	Smoke Detector	L1D53	notifier	SDX-551	Hall by reception	Passed		8/6/2021 12:49 PM
16	Heat Detector	L1D62	notifier	FDX-551	conf. rm	Passed		8/6/2021 12:49 PM
17	Smoke Detector	L1D59	notifier	SDX-551	Hall by dish rm	Passed		8/6/2021 12:49 PM
18	Heat Detector	L1D61	notifier	FDX-551	dish rm	Passed		8/6/2021 12:49 PM
19	Heat Detector	L1D60	notifier	FDX-551	cooking Area	Passed		8/6/2021 12:48 PM
20	Heat Detector	L1D63	notifier	FDX-551	dining rm	Passed		8/6/2021 12:48 PM
21	Heat Detector	L1D64	notifier	FDX-551	dining rm	Passed		8/6/2021 12:48 PM
22	Smoke Detector	L1D42	notifier	SDX-551	Hall by delivery	Passed		8/6/2021 12:48 PM
23	Heat Detector	L1D43	notifier	FDX-551	janitor closet	Passed		8/6/2021 12:47 PM
24	Smoke Detector	L1D37	notifier	SDX-551	Hall by O.T	Passed		8/6/2021 12:47 PM
25	Smoke Detector	L1D30	notifier	SDX-551	Hall by canteen	Passed		8/6/2021 12:47 PM
26	Heat Detector	L1D31	notifier	FDX-551	by t.r. office	Passed		8/6/2021 12:47 PM
27	Heat Detector	L1D33	notifier	FDX-551	T.R.	Passed		8/6/2021 12:47 PM
28	Heat Detector	L1D38	notifier	FDX-551	O.T.	Passed		8/6/2021 12:46 PM
29	Heat Detector	L1D35	notifier	FDX-551	T.R. storage rm	Passed		8/6/2021 12:46 PM
30	Heat Detector	L1D28	notifier	FDX-551	canteen	Passed		8/6/2021 12:46 PM
31	Heat Detector	L1D25	notifier	FDX-551	canteen cooking Area	Passed		8/6/2021 12:44 PM
32	Heat Detector	L1D26	notifier	FDX-551	laundry rm	Passed		8/6/2021 12:44 PM
33	Smoke Detector	L1D27	notifier	SDX-551	Hall by canteen kit	Passed		8/6/2021 12:44 PM
34	Smoke Detector	L3D18	notifier	SDX-551	Hall by housekeeping storage	Passed		8/6/2021 12:44 PM
35	Heat Detector	L3D50	notifier	FDX-551	laundry shoot	Passed		8/6/2021 12:44 PM
36	Heat Detector	L3D61	notifier	FDX-551	laundry shoot	Passed		8/6/2021 12:44 PM
37	Smoke Detector	L3D17	notifier	SDX-551	south end of hall	Passed		8/6/2021 12:34 PM
38	Smoke Detector	L3D16	notifier	SDX-551	big yard corridor	Passed		8/6/2021 12:34 PM
39	Smoke Detector	L4D04	notifier	SDX-551	stairwell	Passed		8/6/2021 12:34 PM
40	Smoke Detector	L4D05	notifier	SDX-551	stairwell	Passed		8/6/2021 12:34 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L3D21	notifier	SDX-551	s-1 day Room	Passed		8/6/2021 12:34 PM
42	Smoke Detector	L3D22	notifier	SDX-551	s-1 day Room	Passed		8/6/2021 12:34 PM
43	Heat Detector	L3D19	notifier	FDX-551	S-1 Custodial Closet	Passed		8/6/2021 12:33 PM
44	Smoke Detector	L3D20	notifier	SDX-551	s-1 coat closet by tech	Passed		8/6/2021 12:33 PM
45	Smoke Detector	L3D23	notifier	SDX-551	s-1 program mgr. off.	Passed		8/6/2021 12:33 PM
46	Smoke Detector	L3D24	notifier	SDX-551	s-1 day Room	Passed		8/6/2021 12:33 PM
47	Smoke Detector	L3D25	notifier	SDX-551	s-1 day Room	Passed		8/6/2021 12:33 PM
48	Smoke Detector	L3D27	notifier	SDX-551	s-1 tech office	Passed		8/6/2021 12:33 PM
49	Heat Detector	L3D28	notifier	FDX-551	S-1 Hall by Room 28	Passed		8/6/2021 12:32 PM
50	Smoke Detector	L3D29	notifier	SDX-551	s-1 laundry Room	Passed		8/6/2021 12:32 PM
51	Smoke Detector	L3D31	notifier	SDX-551	s-1 Hall by Room 1	Passed		8/6/2021 11:59 AM
52	Smoke Detector	L3D32	notifier	SDX-551	s-1 hall by Room 4	Passed		8/6/2021 11:59 AM
53	Smoke Detector	L3D34	notifier	SDX-551	s-1 hall by Room 7	Passed		8/6/2021 11:59 AM
54	Smoke Detector	L3D35	notifier	SDX-551	s-1 hall by Room 11	Passed		8/6/2021 11:57 AM
55	Smoke Detector	L4D08	notifier	SDX-551	s-1 above FCPS	Passed		8/6/2021 11:57 AM
56	Smoke Detector	L1D73	notifier	SDX-551	s-1 Rm 08	Passed		8/6/2021 11:55 AM
57	Smoke Detector	L1D74	notifier	SDX-551	s-1 Rm 09	Passed		8/6/2021 11:55 AM
58	Smoke Detector	L1D75	notifier	SDX-551	s-1 Rm 10	Passed		8/6/2021 11:55 AM
59	Smoke Detector	L1D76	notifier	SDX-551	s-1 Rm 11	Passed		8/6/2021 11:54 AM
60	Smoke Detector	L1D77	notifier	SDX-551	s-1 Rm 12	Passed		8/6/2021 11:54 AM
61	Smoke Detector	L1D78	notifier	SDX-551	s-1 Rm 13	Passed		8/6/2021 11:54 AM
62	Smoke Detector	L1D79	notifier	SDX-551	s-1 Rm 14	Passed		8/6/2021 11:53 AM
63	Smoke Detector	L1D80	notifier	SDX-551	s-1 Rm 15	Passed		8/6/2021 11:53 AM
64	Smoke Detector	L1D81	notifier	SDX-551	s-1 Rm 16	Passed		8/6/2021 11:53 AM
65	Smoke Detector	L1D82	notifier	SDX-551	s-1 Rm 17	Passed		8/6/2021 11:52 AM
66	Smoke Detector	L1D83	notifier	SDX-551	s-1 Rm 18	Passed		8/6/2021 11:52 AM
67	Smoke Detector	L1D84	notifier	SDX-551	s-1 Rm 19	Passed		8/6/2021 11:45 AM
68	Smoke Detector	L1D85	notifier	SDX-551	s-1 Rm 20	Passed		8/6/2021 11:44 AM
69	Smoke Detector	L1D86	notifier	SDX-551	s-1 Rm 21	Passed		8/6/2021 11:44 AM
70	Smoke Detector	L1D87	notifier	SDX-551	s-1 Rm 22	Passed		8/6/2021 11:44 AM
71	Smoke Detector	L1D88	notifier	SDX-551	s-1 Rm 23	Passed		8/6/2021 11:44 AM
72	Smoke Detector	L1D66	notifier	SDX-551	s-1 Rm 01	Passed		8/6/2021 11:44 AM
73	Smoke Detector	L1D67	notifier	SDX-551	s-1 Rm 02	Passed		8/6/2021 11:43 AM
74	Smoke Detector	L1D68	notifier	SDX-551	s-1 Rm 03	Passed		8/6/2021 11:43 AM
75	Smoke Detector	L1D69	notifier	SDX-551	s-1 Rm 04	Passed		8/6/2021 11:43 AM
76	Smoke Detector	L1D70	notifier	SDX-551	s-1 Rm 05	Passed		8/6/2021 11:42 AM
77	Smoke Detector	L1D71	notifier	SDX-551	s-1 Rm 06	Passed		8/6/2021 11:42 AM
78	Smoke Detector	L1D72	notifier	SDX-551	s-1 Rm 07	Passed		8/6/2021 11:42 AM
79	Smoke Detector	L1D89	notifier	SDX-551	s-1 Rm 24	Passed		8/6/2021 11:41 AM
80	Smoke Detector	L1D90	notifier	SDX-551	s-1 conference Room	Passed		8/6/2021 11:41 AM
81	Smoke Detector	L1D91	notifier	SDX-551	s-1 conference Room	Passed		8/6/2021 11:41 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Heat Detector	L1D92	notifier	FDX-551	S-1 RM 27	Passed		8/6/2021 11:41 AM
83	Smoke Detector	L1D93	notifier	SDX-551	s-1 RM 28	Passed		8/6/2021 11:40 AM
84	Smoke Detector	L3D30	notifier	SDX-551	s-1 linen rm	Passed		8/6/2021 11:40 AM
85	Manual Pull Station	L4M01	Notifier	BGX-101L	Main Entrance	Passed		8/6/2021 11:40 AM
86	Manual Pull Station	L1M07	Notifier	BGX-101L	Sta Exit S 5 Stairs	Passed		8/6/2021 11:39 AM
87	Manual Pull Station	L1M05	Notifier	BGX-101L	Sta Dining Rm Exit	Passed		8/6/2021 11:39 AM
88	Manual Pull Station	L1M13	Notifier	BGX-101L	Delivery Exit Area	Passed		8/6/2021 11:39 AM
89	Manual Pull Station	L1M04	Notifier	BGX-101L	Sta Gym Exit	Passed		8/6/2021 11:38 AM
90	Manual Pull Station	L3M07	Notifier	BGX-101L	s-1 Tech office	Passed		8/6/2021 11:38 AM
91	Manual Pull Station	L3M10	Notifier	BGX-101L	S-1 Fire Exit Yard	Passed		8/6/2021 11:38 AM
92	Manual Pull Station	L4M02	Notifier	BGX-101L	S-1 Sta Vest 1039 A	Passed		8/6/2021 11:37 AM
93	Manual Pull Station	L4M03	Notifier	BGX-101L	S-1 Sta Vest 1039 B	Passed		8/6/2021 11:37 AM
94	Manual Pull Station	L3M01	Notifier	BGX-101L	S-2Fire Exit to yard	Passed		8/6/2021 11:36 AM
95	Manual Pull Station	L3M04	Notifier	BGX-101L	S-2 Tech office	Passed		8/6/2021 11:36 AM
96	Smoke Detector	L4D03	notifier	SDX-551	1 flr s Ele lobby	Passed		8/6/2021 11:35 AM
97	Smoke Detector	L4D06	notifier	SDX-551	S ELE Pit 1st floor	Passed		8/6/2021 11:35 AM
98	Heat Detector	L4D07	notifier	FDX-551	S ELE Pit 1ST floor	Passed		8/6/2021 11:34 AM
99	Smoke Detector	L4D01	notifier	SDX-551	N ELE Shaft Top North Basmt.	Passed		8/6/2021 11:34 AM
100	Heat Detector	L4D02	notifier	FDX-551	N ELE Shaft Top North Bart.	Passed		8/6/2021 11:34 AM
101	Heat Detector	L4D29	notifier	FDX-551	N ELE Pit	Passed		8/6/2021 11:34 AM
102	Duct Detector	L1D32		SDX-551	Duct Det. T. Rec.	Passed		8/6/2021 11:33 AM
103	Heat Detector	L1D50	notifier	FDX-551	Bathroom Main Lobby	Passed		8/6/2021 11:33 AM
104	Duct Detector	L1D39		SDX-551	Duct Det. O.T.	Passed		8/6/2021 11:32 AM
105	Duct Detector	L1D24		SDX-551	Duct Det. Canteen Kitchen	Passed		8/6/2021 11:32 AM
106	Duct Detector	L1D36		SDX-551	T. Rec. Storage Duct Det.	Passed		8/6/2021 11:32 AM
107	Heat Detector	L4D28	notifier	FDX-551	N ELE Pit	Passed		8/6/2021 11:31 AM

2nd Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D48	notifier	SDX-551	S-4 Dayroom	Passed		8/6/2021 11:31 AM
2	Heat Detector	L3D47	notifier	FDX-551	west stairs	Passed		8/6/2021 11:31 AM
3	Heat Detector	L3D49	notifier	FDX-551	S-4 custodial Closet	Passed		8/6/2021 11:31 AM
4	Smoke Detector	L3D46	notifier	SDX-551	S-4 Dayroom	Passed		8/6/2021 11:31 AM
5	Smoke Detector	L3D45	notifier	SDX-551	S-4 Dayroom	Passed		8/6/2021 11:30 AM
6	Smoke Detector	L4D24	notifier	SDX-551	S-4 pipe chase	Passed		8/6/2021 11:30 AM
7	Smoke Detector	L3D44	notifier	SDX-551	S-4 by tech office	Passed		8/6/2021 11:30 AM
8	Smoke Detector	L3D73	notifier	SDX-551	S-4 coat closet	Passed		8/6/2021 11:30 AM
9	Smoke Detector	L3D43	notifier	SDX-551	S-4 Hall by rm 1	Passed		8/6/2021 11:29 AM
10	Smoke Detector	L3D41	notifier	SDX-551	S-4 Hall by rm 5	Passed		8/6/2021 11:29 AM
11	Smoke Detector	L3D39	notifier	SDX-551	S-4 Hall by rm 8	Passed		8/6/2021 11:29 AM
12	Smoke Detector	L3D38	notifier	SDX-551	S-4 Hall by rm 12	Passed		8/6/2021 11:28 AM
13	Smoke Detector	L3D37	notifier	SDX-551	S-4 Hall by rm 16	Passed		8/6/2021 11:28 AM
14	Smoke Detector	L3D36	notifier	SDX-551	S-4 stairs to yard	Passed		8/6/2021 11:28 AM
15	Smoke Detector	L2D93	notifier	SDX-551	S-4 rm 17	Passed		8/6/2021 11:28 AM
16	Smoke Detector	L2D92	notifier	SDX-551	S-4 rm 16	Passed		8/6/2021 11:27 AM
17	Smoke Detector	L2D94	notifier	SDX-551	S-4 rm 18	Passed		8/6/2021 11:27 AM
18	Smoke Detector	L2D95	notifier	SDX-551	S-4 rm 19	Passed		8/6/2021 11:26 AM
19	Smoke Detector	L2D91	notifier	SDX-551	S-4 rm 15	Passed		8/6/2021 11:26 AM
20	Smoke Detector	L2D90	notifier	SDX-551	S-4 rm 14	Passed		8/6/2021 11:26 AM
21	Smoke Detector	L2D96	notifier	SDX-551	S-4 rm 20	Passed		8/6/2021 11:26 AM
22	Smoke Detector	L2D97	notifier	SDX-551	S-4 rm 21	Passed		8/6/2021 11:25 AM
23	Smoke Detector	L2D89	notifier	SDX-551	S-4 rm 13	Passed		8/6/2021 11:25 AM
24	Smoke Detector	L2D98	notifier	SDX-551	S-4 rm 22	Passed		8/6/2021 11:22 AM
25	Smoke Detector	L2D88	notifier	SDX-551	S-4 rm 12	Passed		8/6/2021 11:22 AM
26	Smoke Detector	L2D99	notifier	SDX-551	S-4 rm 23	Passed		8/6/2021 11:22 AM
27	Smoke Detector	L2D87	notifier	SDX-551	S-4 rm 11	Passed		8/6/2021 11:21 AM
28	Smoke Detector	L3D96	notifier	SDX-551	S-4 rm 24	Passed		8/6/2021 11:21 AM
29	Smoke Detector	L2D86	notifier	SDX-551	S-4 rm 10	Passed		8/6/2021 11:21 AM
30	Smoke Detector	L2D85	notifier	SDX-551	S-4 rm 09	Passed		8/6/2021 11:20 AM
31	Smoke Detector	L2D84	notifier	SDX-551	S-4 rm 08	Passed		8/6/2021 11:20 AM
32	Smoke Detector	L3D97	notifier	SDX-551	S-4 rm 25	Passed		8/6/2021 11:20 AM
33	Smoke Detector	L3D98	notifier	SDX-551	S-4 rm 26	Passed		8/6/2021 11:20 AM
34	Smoke Detector	L3D99	notifier	SDX-551	S-4 rm 27	Passed		8/6/2021 11:20 AM
35	Smoke Detector	L2D82	notifier	SDX-551	S-4 rm 06	Passed		8/6/2021 11:18 AM
36	Smoke Detector	L2D81	notifier	SDX-551	S-4 rm 05	Passed		8/6/2021 11:18 AM
37	Smoke Detector	L3D51	notifier	SDX-551	S-4 rm 28	Passed		8/6/2021 11:18 AM
38	Smoke Detector	L2D80	notifier	SDX-551	S-4 rm 04	Passed		8/6/2021 11:18 AM
39	Smoke Detector	L2D79	notifier	SDX-551	S-4 rm 03	Passed		8/6/2021 11:18 AM
40	Smoke Detector	L2D78	notifier	SDX-551	S-4 rm 02	Passed		8/6/2021 11:17 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L2D77	notifier	SDX-551	S-4 rm 01	Passed		8/6/2021 11:17 AM
42	Smoke Detector	L3D73	notifier	SDX-551	S-4 coat closet	Passed		8/6/2021 11:17 AM
43	Smoke Detector	L3D55	notifier	SDX-551	S-5 mech rm	Passed		8/6/2021 11:16 AM
44	Smoke Detector	L3D52	notifier	SDX-551	S-5 south end of hall	Passed		8/6/2021 11:16 AM
45	Smoke Detector	L3D53	notifier	SDX-551	S-5 south end of hall	Passed		8/6/2021 11:16 AM
46	Smoke Detector	L3D57	notifier	SDX-551	S-3 Day Room	Passed		8/6/2021 11:15 AM
47	Smoke Detector	L3D58	notifier	SDX-551	S-3 day Room	Passed		8/6/2021 11:15 AM
48	Smoke Detector	L3D59	notifier	SDX-551	S-3 day Room	Passed		8/6/2021 11:15 AM
49	Heat Detector	L3D60	notifier	FDX-551	S-3 custodial Closet	Passed		8/6/2021 11:14 AM
50	Heat Detector	L3D62	notifier	FDX-551	S-3 Med. Room	Passed		8/6/2021 11:14 AM
51	Smoke Detector	L3D63	notifier	SDX-551	S-3 by tech office	Passed		8/6/2021 11:14 AM
52	Smoke Detector	L3D64	notifier	SDX-551	S-3 Hall by Room 28	Passed		8/6/2021 11:14 AM
53	Smoke Detector	L3D65	notifier	SDX-551	S-3 Hall by Room 1	Passed		8/6/2021 11:13 AM
54	Smoke Detector	L3D67	notifier	SDX-551	S-3 Hall by Room 4	Passed		8/6/2021 11:13 AM
55	Smoke Detector	L3D69	notifier	SDX-551	S-3 Hall by Room 7	Passed		8/6/2021 11:13 AM
56	Smoke Detector	L3D70	notifier	SDX-551	S-3 Hall by Room 11	Passed		8/6/2021 11:13 AM
57	Smoke Detector	L3D71	notifier	SDX-551	S-3 stairs to yard	Passed		8/6/2021 11:12 AM
58	Smoke Detector	L3D72	notifier	SDX-551	S-3 closet by tech	Passed		8/6/2021 11:11 AM
59	Smoke Detector	L4D22	notifier	SDX-551	S-3 above FCPS	Passed		8/6/2021 11:11 AM
60	Smoke Detector	L2D70	notifier	SDX-551	S-3 Rm 22	Passed		8/6/2021 11:11 AM
61	Smoke Detector	L2D51	notifier	SDX-551	S-3 Rm 03	Passed		8/6/2021 11:11 AM
62	Smoke Detector	L2D71	notifier	SDX-551	S-3 conference room	Passed		8/6/2021 11:10 AM
63	Smoke Detector	L2D72	notifier	SDX-551	S-3 conference room	Passed		8/6/2021 11:10 AM
64	Smoke Detector	L2D50	notifier	SDX-551	S-3 Rm 02	Passed		8/6/2021 11:09 AM
65	Smoke Detector	L2D49	notifier	SDX-551	S-3 Rm 01	Passed		8/6/2021 11:09 AM
66	Smoke Detector	L2D73	notifier	SDX-551	S-3 Rm 25	Passed		8/6/2021 11:09 AM
67	Heat Detector	L3D66	notifier	FDX-551	S-3 linen room	Passed		8/6/2021 11:08 AM
68	Smoke Detector	L2D74	notifier	SDX-551	S-3 Rm 26	Passed		8/6/2021 11:08 AM
69	Heat Detector	L2D75	notifier	FDX-551	S-3 Smoking RM	Passed		8/6/2021 11:08 AM
70	Smoke Detector	L2D76	notifier	SDX-551	S-3 RM 28	Passed		8/6/2021 11:08 AM
71	Manual Pull Station	L3M18	Notifier	BGX-101L	S-3 Fire Exit to yard	Passed		8/6/2021 11:07 AM
72	Manual Pull Station	L3M11	Notifier	BGX-101L	S-4 Fire Exit to yard	Passed		8/6/2021 11:07 AM
73	Manual Pull Station	L2M01	Notifier	BGX-101L	S-5 Stair Door	Passed		8/6/2021 11:07 AM
74	Manual Pull Station	L3M14	Notifier	BGX-101L	S-4 Day Room	Passed		8/6/2021 11:07 AM
75	Manual Pull Station	L3M16	Notifier	BGX-101L	S-3 Day Room	Passed		8/6/2021 11:07 AM
76	Smoke Detector	L2D44	notifier	SDX-551	S-5 top of stairs	Passed		8/6/2021 11:06 AM
77	Smoke Detector	L2D47	notifier	SDX-551	S-5 day Room	Passed		8/6/2021 11:06 AM
78	Smoke Detector	L2D48	notifier	SDX-551	S-5 day Room	Passed		8/6/2021 11:06 AM
79	Smoke Detector	L2D05	notifier	SDX-551	S-5 by janitor closet	Passed		8/6/2021 11:06 AM
80	Heat Detector	L2D19	notifier	FDX-551	S-5 Janitors closet	Passed		8/6/2021 11:06 AM
81	Smoke Detector	L2D18	notifier	SDX-551	S-5 linen Room	Passed		8/6/2021 11:06 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Heat Detector	L2D20	notifier	FDX-551	S-5 Bathroom	Passed		8/6/2021 11:06 AM
83	Smoke Detector	L2D08	notifier	SDX-551	S-5 rm 18	Passed		8/6/2021 11:05 AM
84	Smoke Detector	L2D17	notifier	SDX-551	S-5 rm 25	Passed		8/6/2021 11:05 AM
85	Smoke Detector	L2D06	notifier	SDX-551	S-5 Hall by rm 23	Passed		8/6/2021 11:04 AM
86	Smoke Detector	L2D16	notifier	SDX-551	S-5 rm 24	Passed		8/6/2021 11:04 AM
87	Smoke Detector	L2D09	notifier	SDX-551	S-5 rm 19	Passed		8/6/2021 11:03 AM
88	Smoke Detector	L2D15	notifier	SDX-551	S-5 rm 23	Passed		8/6/2021 11:02 AM
89	Smoke Detector	L2D14	notifier	SDX-551	S-5 rm 22	Passed		8/6/2021 11:02 AM
90	Smoke Detector	L2D07	notifier	SDX-551	S-5 Hall by Room 21	Passed		8/6/2021 11:01 AM
91	Smoke Detector	L2D10	notifier	SDX-551	S-5 med. Room	Passed		8/6/2021 11:00 AM
92	Smoke Detector	L2D11	notifier	SDX-551	S-5 rm 21	Passed		8/6/2021 10:59 AM
93	Smoke Detector	L2D13	notifier	SDX-551	S-5 group Room	Passed		8/6/2021 10:59 AM
94	Smoke Detector	L2D12	notifier	SDX-551	S-5 group Room	Passed		8/6/2021 10:59 AM
95	Smoke Detector	L2D23	notifier	SDX-551	S-5 tech office	Passed		8/6/2021 10:59 AM
96	Smoke Detector	L2D22	notifier	SDX-551	S-5 Staff bathroom	Passed		8/6/2021 10:58 AM
97	Heat Detector	L2D25	notifier	FDX-551	S-5 smoking rm	Passed		8/6/2021 10:58 AM
99	Smoke Detector	L2D41	notifier	SDX-551	S-5 rm 17	Passed		8/6/2021 10:57 AM
100	Heat Detector	L2D42	notifier	FDX-551	S-5 fan rm	Passed		8/6/2021 10:57 AM
101	Smoke Detector	L2D43	notifier	SDX-551	S-5 Hall by rm 1	Passed		8/6/2021 10:56 AM
102	Smoke Detector	L2D16	notifier	SDX-551	S-5 rm 26	Passed		8/6/2021 10:56 AM
103	Smoke Detector	L2D26	notifier	SDX-551	S-5 rm 02	Passed		8/6/2021 10:56 AM
104	Smoke Detector	L2D27	notifier	SDX-551	S-5 rm 03	Passed		8/6/2021 10:55 AM
105	Smoke Detector	L2D28	notifier	SDX-551	S-5 rm 04	Passed		8/6/2021 10:54 AM
106	Smoke Detector	L2D29	notifier	SDX-551	S-5 rm 05	Passed		8/6/2021 10:54 AM
107	Smoke Detector	L2D30	notifier	SDX-551	S-5 rm 06	Passed		8/6/2021 10:54 AM
108	Smoke Detector	L2D31	notifier	SDX-551	S-5 rm 07	Passed		8/6/2021 10:54 AM
109	Smoke Detector	L2D32	notifier	SDX-551	S-5 rm 08	Passed		8/6/2021 10:54 AM
110	Smoke Detector	L2D34	notifier	SDX-551	S-5 rm 10	Passed		8/6/2021 10:54 AM
111	Smoke Detector	L2D35	notifier	SDX-551	S-5 rm 11	Passed		8/6/2021 10:53 AM
112	Smoke Detector	L2D36	notifier	SDX-551	S-5 rm 12	Passed		8/6/2021 10:53 AM
113	Smoke Detector	L2D37	notifier	SDX-551	S-5 rm 13	Passed		8/6/2021 10:53 AM
114	Smoke Detector	L2D38	notifier	SDX-551	S-5 rm 14	Passed		8/6/2021 10:53 AM
115	Smoke Detector	L2D39	notifier	SDX-551	S-5 rm 15	Passed		8/6/2021 10:52 AM
116	Smoke Detector	L2D40	notifier	SDX-551	S-5 rm 16	Passed		8/6/2021 10:52 AM
117	Smoke Detector	L2D41	notifier	SDX-551	S-5 rm 17	Passed		8/6/2021 10:51 AM
118	Smoke Detector	L2D33	notifier	SDX-551	S-5 rm 09	Passed		8/6/2021 10:51 AM
119	Smoke Detector	L2D43	notifier	SDX-551	S-5 Hall by rm 1	Passed		8/6/2021 10:51 AM
120	Smoke Detector	L2D45	notifier	SDX-551	S-5 Hall by rm 4	Passed		8/6/2021 10:50 AM
121	Smoke Detector	L2D46	notifier	SDX-551	S-5 Hall by rm 8	Passed		8/6/2021 10:50 AM
122	Smoke Detector	L2D04	notifier	SDX-551	S-5 by back Hall	Passed		8/6/2021 10:49 AM
123	Smoke Detector	L2D03	notifier	SDX-551	S-5 back Hall	Passed		8/6/2021 10:49 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
124	Smoke Detector	L2D02	notifier	SDX-551	S-5 back Hall by bell	Passed		8/6/2021 10:49 AM
125	Smoke Detector	L2D01	notifier	SDX-551	S-5 back Hall by roof	Passed		8/6/2021 10:48 AM
126	Heat Detector	L4D19	notifier	FDX-551	S-5 EQ rm 2040 A 1 floor long Hall	Passed		8/6/2021 10:48 AM
127	Smoke Detector	L4D17	notifier	SDX-551	S-5 2ND Ele lobby	Passed		8/6/2021 10:47 AM
128	Smoke Detector	L4D18	notifier	SDX-551	S-5 ELE EQ RM 2040 A	Passed		8/6/2021 10:47 AM
129	Heat Detector	L4D15	notifier	FDX-551	S-5 S ELE Shaft Top	Passed		8/6/2021 10:47 AM
130	Smoke Detector	L4D14	notifier	SDX-551	S-5 S ELE Shaft Top	Passed		8/6/2021 10:47 AM
131	Heat Detector	L3D20	notifier	FDX-551	S-4 med. RM	Passed		8/6/2021 10:47 AM
132	Duct Detector	L4D13	Notifier		S4 Duct Smoke	Passed		8/6/2021 10:46 AM
133	Duct Detector	L4D10	Notifier		Duct Det S-3 2nd Floor	Passed		8/6/2021 10:46 AM
134	Manual Pull Station	L4M02	Notifier	BGX-101L	Vestibule 1039A	Passed		8/6/2021 10:46 AM
135	Manual Pull Station	L4M03	Notifier	BGX-101L	Vestibule 1039B	Passed		8/6/2021 10:45 AM

Basement TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Heat Detector	L1D05	Notifier	FDX-551	air handling rm	Passed		8/5/2021 1:53 PM
2	Heat Detector	L1D02	Notifier	FDX-551	Pt. storage	Passed		8/5/2021 1:54 PM
3	Heat Detector	L1D03	Notifier	FDX-551	nonflammable storage	Passed		8/5/2021 1:54 PM
4	Heat Detector	L1D01	Notifier	FDX-551	PT storage	Passed		8/5/2021 1:54 PM
5	Smoke Detector	L1D09	Notifier	SDX-551	elevator lobby	Passed		8/5/2021 1:54 PM
6	Smoke Detector	L1D08	Notifier	SDX-551	utilities rm	Passed		8/5/2021 1:55 PM
7	Heat Detector	L1D11	Notifier	FDX-551	transformer rm	Passed		8/5/2021 1:55 PM
8	Heat Detector	L1D14	Notifier	FDX-551	Gym vestibule	Passed		8/5/2021 1:55 PM
9	Heat Detector	L1D13	Notifier	FDX-551	weight rm	Passed		8/5/2021 1:55 PM
10	Heat Detector	L1D12	Notifier	FDX-551	weight rm	Passed		8/5/2021 1:56 PM
11	Heat Detector	L1D15	Notifier	FDX-551	gym kitchen	Passed		8/5/2021 1:57 PM
12	Smoke Detector	L4D26	Notifier	SDX-551	N ELE EQ RM	Passed		8/5/2021 1:57 PM
13	Heat Detector	L4D27	Notifier	FDX-551	N ELE EQ Rm	Passed		8/5/2021 1:58 PM
14	Smoke Detector	L4D28	Notifier	SDX-551	N ELE Pit	Passed		8/5/2021 1:58 PM
15	Heat Detector	L1D19	Notifier	FDX-551	Gym North East	Passed		8/5/2021 1:58 PM
16	Heat Detector	L1D18	Notifier	FDX-551	Gym North Center	Passed		8/5/2021 1:58 PM
17	Heat Detector	L1D17	Notifier	FDX-551	Gym North West	Passed		8/5/2021 1:59 PM
18	Heat Detector	L1D20	Notifier	FDX-551	Gym South East	Passed		8/5/2021 1:59 PM
19	Heat Detector	L1D21	Notifier	FDX-551	Gym South Center	Passed		8/5/2021 1:59 PM
20	Heat Detector	L1D22	Notifier	FDX-551	Gym South West	Passed		8/5/2021 2:00 PM
21	Duct Detector	L1D23	Notifier		S Gym Duct Det	Passed		8/5/2021 2:00 PM
22	Duct Detector	L1D06	Notifier		Duct Det. AHU 1	Passed		8/5/2021 2:00 PM
23	Duct Detector	L1D07	Notifier		Duct Det. RAF 1	Passed		8/5/2021 2:00 PM

Roof TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Duct Detector	L1D29	Notifier		Duct Det. Canteen Roof	Passed		8/5/2021 2:01 PM
2	Duct Detector	L2D41	Notifier		Duct Det RTU-5	Passed		8/5/2021 2:01 PM
3	Duct Detector	L2D42	Notifier		Duct Det RTU-5 return	Passed		8/5/2021 2:01 PM
4	Duct Detector	L3D26	Notifier		Duct Det RTU-4 supply	Passed		8/5/2021 2:02 PM
5	Duct Detector	L3D27	Notifier		Duct Det RTU-4 return	Passed		8/5/2021 2:02 PM
6	Duct Detector	L3D29	Notifier		Duct Det RTU-2 supply	Passed		8/5/2021 2:02 PM
7	Duct Detector	L3D30	Notifier		Duct Det RTU-2 return	Passed		8/5/2021 2:03 PM
8	Duct Detector	L3D32	Notifier		Duct Det RTU-3 supply	Passed		8/5/2021 2:03 PM
9	Duct Detector	L3D33	Notifier		Duct Det RTU-3 return	Passed		8/6/2021 9:37 AM

2nd Floor Continued TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D23	Notifier	FSP-851	Program Managers Office S-4	Passed		8/6/2021 10:45 AM
2	Smoke Detector	L2D83	Notifier	FSP-851	S-4 Rm 07	Passed		8/6/2021 10:45 AM
3	Smoke Detector	L2D99	Notifier	FSP-851	S-4 Rm 23	Passed		8/6/2021 10:44 AM
4	Smoke Detector	L2D60	Notifier	FSP-851	S-3 Rm 12	Passed		8/6/2021 10:41 AM
5	Smoke Detector	L2D61	Notifier	FSP-851	S-3 Rm 13	Passed		8/6/2021 10:40 AM
6	Smoke Detector	L2D62	Notifier	FSP-851	S-3 Rm 14	Passed		8/6/2021 10:39 AM
7	Smoke Detector	L2D63	Notifier	FSP-851	S-3 Rm 15	Passed		8/6/2021 10:38 AM
8	Smoke Detector	L2D64	Notifier	FSP-851	S-3 Rm 16	Passed		8/6/2021 10:38 AM
9	Smoke Detector	L2D65	Notifier	FSP-851	S-3 Rm 17	Passed		8/6/2021 10:38 AM
11	Smoke Detector	L2D67	Notifier	FSP-851	S-3 Rm 19	Passed		8/6/2021 10:38 AM
12	Smoke Detector	L3D66	Notifier	FSP-851	S-3 linen	Passed		8/6/2021 9:38 AM
13	Smoke Detector	L2D69	Notifier	FSP-851	S-3 Rm 21	Passed		8/6/2021 9:38 AM
14	Smoke Detector	L2D52	Notifier	FSP-851	S-3 Rm 04	Passed		8/6/2021 9:38 AM
15	Smoke Detector	L2D53	Notifier	FSP-851	S-3 Rm 05	Passed		8/6/2021 9:37 AM
16	Smoke Detector	L2D54	Notifier	FSP-851	S-3 Rm 06	Passed		8/6/2021 9:37 AM
17	Smoke Detector	L2D55	Notifier	FSP-851	S-3 Rm 07	Passed		8/6/2021 9:37 AM
18	Smoke Detector	L2D56	Notifier	FSP-851	S-3 Rm 08	Passed		8/6/2021 9:37 AM
19	Smoke Detector	L2D57	Notifier	FSP-851	S-3 Rm 09	Passed		8/6/2021 9:37 AM
20	Smoke Detector	L2D58	Notifier	FSP-851	S-3 Rm 10	Passed		8/6/2021 9:37 AM
21	Smoke Detector	L2D59	Notifier	FSP-851	S-3 Rm 11	Passed		8/6/2021 9:37 AM

1st floor continued TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D01	Notifier	FSP851	S-2 Hall by Room 214	Passed		8/6/2021 1:03 PM
2	Smoke Detector	L3D02	Notifier	FSP851	S-2 Hall by Room 221	Passed		8/6/2021 1:03 PM
3	Smoke Detector	L3D03	Notifier	FSP851	S-2 Hall by Room 223	Passed		8/6/2021 1:02 PM
4	Smoke Detector	L3D04	Notifier	FSP851	S-2 Hall by Room 203	Passed		8/6/2021 1:02 PM
5	Smoke Detector	L3D07	Notifier	FSP851	S-2 Hall by Room 232	Passed		8/6/2021 1:01 PM
6	Smoke Detector	L3D08	Notifier	FSP851	S-2 by tech office	Passed		8/6/2021 1:01 PM
7	Smoke Detector	L3D09	Notifier	FSP851	S-2 Day Room	Passed		8/6/2021 1:01 PM
8	Smoke Detector	L3D10	Notifier	FSP851	S-2 Day Room	Passed		8/6/2021 1:01 PM
9	Smoke Detector	L3D11	Notifier	FSP851	S-2 Day Room	Passed		8/6/2021 1:01 PM
10	Smoke Detector	L3D12	Notifier	FSP851	S-2 Day Room	Passed		8/6/2021 1:00 PM
11	Smoke Detector	L3D76	Notifier	FSP851	S-2 Room 224	Passed		8/6/2021 1:00 PM
12	Smoke Detector	L3D77	Notifier	FSP851	S-2 Room 223	Passed		8/6/2021 1:00 PM
13	Smoke Detector	L3D78	Notifier	FSP851	S-2 Room 222	Passed		8/6/2021 1:00 PM
14	Smoke Detector	L3D79	Notifier	FSP851	S-2 Room 221	Passed		8/6/2021 1:00 PM
15	Smoke Detector	L3D80	Notifier	FSP851	S-2 Room 220	Passed		8/6/2021 12:59 PM
16	Smoke Detector	L3D81	Notifier	FSP851	S-2 Room 219	Passed		8/6/2021 12:59 PM
17	Smoke Detector	L3D82	Notifier	FSP851	S-2 Room 218	Passed		8/6/2021 12:59 PM
18	Smoke Detector	L3D83	Notifier	FSP851	S-2 Room 217	Passed		8/6/2021 12:59 PM
19	Smoke Detector	L3D84	Notifier	FSP851	S-2 Room 216	Passed		8/6/2021 12:59 PM
20	Smoke Detector	L3D85	Notifier	FSP851	S-2 Room 214	Passed		8/6/2021 12:59 PM
21	Smoke Detector	L3D86	Notifier	FSP851	S-2 Room 213	Passed		8/6/2021 12:58 PM
22	Smoke Detector	L3D87	Notifier	FSP851	S-2 Room 212	Passed		8/6/2021 12:58 PM
23	Smoke Detector	L3D88	Notifier	FSP851	S-2 Room 211	Passed		8/6/2021 12:57 PM
24	Smoke Detector	L3D89	Notifier	FSP851	S-2 Room 210	Passed		8/6/2021 12:57 PM
25	Smoke Detector	L3D90	Notifier	FSP851	S-2 Room 209	Passed		8/6/2021 12:57 PM
26	Smoke Detector	L3D91	Notifier	FSP851	S-2 Room 208	Passed		8/6/2021 12:57 PM
27	Smoke Detector	L3D92	Notifier	FSP851	S-2 Room 206	Passed		8/6/2021 12:57 PM
28	Smoke Detector	L3D93	Notifier	FSP851	S-2 Room 205	Passed		8/6/2021 12:56 PM
29	Smoke Detector	L3D94	Notifier	FSP851	S-2 Room 204	Passed		8/6/2021 12:56 PM
30	Smoke Detector	L3D95	Notifier	FSP851	S-2 Room 203	Passed		8/6/2021 12:56 PM
31	Heat Detector	L3D05	Notifier		S-2 Linen 202	Passed		8/6/2021 12:56 PM
32	Heat Detector	L3D14	Notifier		S-2 custodial Closet	Passed		8/6/2021 12:56 PM
33	Heat Detector	L3D15	Notifier		S-2 chart room	Passed		8/6/2021 12:56 PM
34	Smoke Detector	L1D94	Notifier	FSP851	S-2 Room 232	Passed		8/6/2021 12:55 PM
35	Smoke Detector	L1D95	Notifier	FSP851	S-2 Room 231	Passed		8/6/2021 12:55 PM
36	Smoke Detector	L1D96	Notifier	FSP851	S-2 Room 230	Passed		8/6/2021 12:55 PM
37	Smoke Detector	L1D97	Notifier	FSP851	S-2 Room 229	Passed		8/6/2021 12:54 PM
38	Smoke Detector	L1D98	Notifier	FSP851	S-2 Room 228	Passed		8/6/2021 12:54 PM
39	Smoke Detector	L1D99	Notifier	FSP851	S-2 Room 227	Passed		8/6/2021 12:54 PM
40	Smoke Detector	L3D13	Notifier	FSP851	S-2 Cora closet by tech	Passed		8/6/2021 12:54 PM

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2021 INSPECTION

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801 West Prospector PL., Lincoln, NE 68506

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Des Moines, IA
Hastings, NE
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Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP4 Notification 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 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe			Main entrance	Passed	Ceiling	8/6/2021 1:18 PM
2	Horn Strobe		P2W	Main Entrance	Passed		8/6/2021 1:17 PM
3	Horn Strobe		P2W	Main Hall	Passed		8/6/2021 1:17 PM
4	Strobe			Men's RR	Passed	Ceiling	8/6/2021 1:16 PM
5	Strobe			Women's RR	Passed	Ceiling	8/6/2021 1:15 PM
6	Horn Strobe		P2W	Him	Passed		8/6/2021 1:14 PM
7	Horn Strobe		P2W	Cafeteria	Passed		8/6/2021 1:14 PM
8	Horn Strobe		P2W	Gym Stairs entrance	Passed		8/6/2021 1:14 PM
9	Horn Strobe		P2W	Hall outside RT	Passed		8/6/2021 1:14 PM
10	Strobe		SW	RT	Passed		8/6/2021 1:13 PM
11	Horn Strobe		P2W	OT	Passed		8/6/2021 1:13 PM
12	Strobe		SW	Canteen	Passed		8/6/2021 1:12 PM
13	Horn Strobe		P2W	Outside S2	Passed		8/6/2021 1:12 PM
14	Horn Strobe		P2W	S2 Main Area	Passed		8/6/2021 1:12 PM
15	Strobe			S-2 restroom	Passed	Ceiling	8/6/2021 1:12 PM
16	Strobe			S-2 restroom	Passed	Ceiling	8/6/2021 1:11 PM
17	Strobe		SW	S-2 Confrence rm	Passed		8/6/2021 1:11 PM
18	Horn Strobe		P2W	S2 Hall	Passed		8/6/2021 1:11 PM
19	Horn Strobe		P2W	S2 Hall Main	Passed		8/6/2021 1:11 PM
20	Horn Strobe		P2W	S1 Main Area	Passed		8/6/2021 1:09 PM
21	Strobe		SW	S-2 laundry bath	Passed		8/6/2021 1:08 PM
22	Strobe		SW	S-1 laundry bath	Passed		8/6/2021 1:08 PM
23	Horn Strobe		P2W	S1 Main Hall	Passed		8/6/2021 1:08 PM
24	Strobe			S-1 restroom	Passed	Ceiling	8/6/2021 1:08 PM
25	Strobe			S-1 restroom	Passed	Ceiling	8/6/2021 1:08 PM
26	Strobe		SW	S-1 nurse station	Passed		8/6/2021 1:08 PM
27	Strobe		SW	S-1 nurse office	Passed		8/6/2021 1:08 PM
28	Horn Strobe		P2W	S1 Main Hall	Passed		8/6/2021 1:07 PM
29	Strobe		SW	S-2 nurse station	Passed		8/6/2021 1:07 PM
30	Strobe		SW	S-2 nurse office	Passed		8/6/2021 1:07 PM
31	Strobe		SW	S- 1 Confrence rm	Passed		8/6/2021 1:07 PM

2nd Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Horn Strobe		P2W	Elevator lobby	Passed		8/6/2021 1:07 PM
2	Strobe		SW	Hall outside S-5 entrance	Passed		8/6/2021 1:07 PM
3	Horn Strobe		P2W	S-4 Main Area	Passed		8/6/2021 1:07 PM
4	Strobe		SW	S-4 Tech RR	Passed		8/6/2021 1:07 PM
5	Strobe		SW	S-4 RR	Passed		8/6/2021 1:06 PM
6	Strobe		SW	S-4 RR	Passed		8/6/2021 1:06 PM
7	Horn Strobe		P2W	S-4 Conference rm	Passed		8/6/2021 1:06 PM
8	Horn Strobe		P2W	S-4 Main Hall	Passed		8/6/2021 1:06 PM
9	Horn Strobe		P2W	S-3Main Area	Passed		8/6/2021 1:06 PM
10	Strobe		SW	S-4 Tech RR	Passed		8/6/2021 1:05 PM
11	Strobe			S-3 RR	Passed		8/6/2021 1:05 PM
12	Strobe			S-3 RR	Passed		8/6/2021 1:05 PM
13	Horn Strobe		P2W	S-3 conference rm	Passed		8/6/2021 1:05 PM
14	Horn Strobe		P2W	S-3 Main Hall	Passed		8/6/2021 1:05 PM
15	Horn Strobe		P2W	Hall to S-5	Passed		8/6/2021 1:05 PM
16	Horn Strobe		P2W	S-5 Entrance	Passed		8/6/2021 1:04 PM
17	Horn Strobe		P2W	S-5 Main Hall	Passed		8/6/2021 1:04 PM
18	Horn Strobe		P2W	S-5 Main Area	Passed		8/6/2021 1:04 PM
19	Horn Strobe		P2W	S-5 Office Hall	Passed		8/6/2021 1:03 PM
20	Horn Strobe		P2W	S-5 conference rm	Passed		8/6/2021 1:03 PM
21	Strobe			S-5 RR	Passed		8/6/2021 1:03 PM

Basement TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SW	North ELE Lobby	Passed		8/6/2021 1:19 PM
2	Horn Strobe		P2W	Basement Mech Ent	Passed		8/6/2021 1:19 PM
3	Horn Strobe		P2W	Basement Mech	Passed		8/6/2021 1:19 PM
4	Horn Strobe		P2W	Basement Mech outside elevator rm	Passed		8/6/2021 1:19 PM
5	Horn Strobe		P2W	Gym	Passed		8/6/2021 1:18 PM
6	Horn Strobe		PC2R	weight arm	Passed		8/6/2021 1:18 PM

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Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 5- Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68506

TJC EP5 FA Equipment Signals 2nd Semi-Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	-	5
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	5	1
Total	5	6

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Control room
Model	AFP1010
Voltage/Current	120VAC
s/Communication	Yes Passed

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	AFP1010		Control room	Passed		8/13/2021 12:07 PM
2	Power Supply	Notifier	FCPS-24	L1M09	Above panel	Passed	Batteries were replaced 1-14-2019 voltage is running a little low charger on power supply might be going bad.	8/13/2021 12:07 PM
3	Power Supply	Notifier	FCPS-24	L3M03	S2 Electrical Closet	Passed		8/13/2021 12:08 PM
5	Power Supply	Notifier	FCPS	L4M07	S-1 Closet	Passed		8/13/2021 12:09 PM
6	Annuciator	Notifier			S1 ward	Not Inspected		
7	Annuciator	Notifier			S2 ward	Not Inspected		
8	Annuciator	Notifier			S3 ward	Not Inspected		
9	Annuciator	Notifier			S4 ward	Not Inspected		
10	Annuciator	Notifier			S5 ward	Not Inspected		
11	Power Supply	Notifier	FCPS24S8		s-2 closet	Passed		8/13/2021 12:10 PM

2nd Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L4M08	S-3 Closet	Not Inspected		

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		8/13/2021 12:06 PM

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH	Notifier	AFP1010	9-7-2019	1st Floor Control room	Passed	Left
1	12V26AH	Notifier	AFP1010	9-27-2019	1st Floor Control room	Passed	Right
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	Not Inspected	
1	12V8AH	Notifier	FCPS-24	1-13-2019	2nd Floor S-3 Closet	Not Inspected	
1	12V8AH	Notifier	FCPS-24	9-5-2019	Basement Rm 02	Passed	
1	12V8AH	Notifier	FCPS-24	9-5-2019	Basement Rm 02	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	AFP1010	120VAC	Control room	1st Floor	Passed	24hr 5min	
2	L1M09	Power Supply	Notifier	FCPS-24	120	Above panel	1st Floor	Passed	24/15	Batteries were replaced 1-14-2019 voltage is running a little low charger on power supply might be going bad.
3	L3M03	Power Supply	Notifier	FCPS-24	120VAC	S2 Electrical Closet	1st Floor	Passed		
5	L4M07	Power Supply	Notifier	FCPS		S-1 Closet	1st Floor	Passed		
6		Annuciator	Notifier			S1 ward	1st Floor	Not Inspected		
7		Annuciator	Notifier			S2 ward	1st Floor	Not Inspected		
8		Annuciator	Notifier			S3 ward	1st Floor	Not Inspected		
9		Annuciator	Notifier			S4 ward	1st Floor	Not Inspected		
10		Annuciator	Notifier			S5 ward	1st Floor	Not Inspected		
11		Power Supply	Notifier	FCPS24S8	120	s-2 closet	1st Floor	Passed	24/15	
1	L4M08	Power Supply	Notifier	FCPS-24	120	S-3 Closet	2nd Floor	Not Inspected	24-15	
1	L4M22	Power Supply	Notifier	FCPS-24	120	Rm 02	Basement	Passed	24-15	

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Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 5- Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68506
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP19 Shutdown 2nd Semi-Annual Inspection Summary

Result Totals

Devices	Fan	Relays
Passed	-	28
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	13	-
Total	13	28

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder Kitchen RM 100	Passed		8/13/2021 12:17 PM
2	Relays				Door Holder 132 N. East	Passed		8/13/2021 12:17 PM
3	Relays				Door Holder 132 N. West	Passed		8/13/2021 12:18 PM
4	Relays				Door Holder 132 S. East	Passed		8/13/2021 12:18 PM
5	Relays				Door Holder 132 S. West	Passed		8/13/2021 12:18 PM
6	Relays				Door Holder Canteen Hall Door	Passed		8/13/2021 12:18 PM
7	Relays				Door Holder 135 S-1 Entrane	Passed		8/13/2021 12:19 PM
8	Relays				Door Holder 155 S.	Passed		8/13/2021 12:19 PM
9	Relays				Door Holder 155 N.	Passed		8/13/2021 12:19 PM
10	Relays				Door Holder RM 1012 S-2 Entrance	Passed		8/13/2021 12:20 PM
11	Relays				Door Holder 192 S.	Passed		8/13/2021 12:20 PM
12	Relays				Door Holder 192 N.	Passed		8/13/2021 12:20 PM

2nd Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder RM 278 Entrance	Passed		8/13/2021 12:21 PM
2	Relays				Door Holder 243 S.	Passed		8/13/2021 12:21 PM
3	Relays				Door Holder 243 N.	Passed		8/13/2021 12:21 PM
4	Relays				Door Holder 280 S-4 Entrance	Passed		8/13/2021 12:29 PM
5	Relays				Door Holder 284 S.	Passed		8/13/2021 12:35 PM
6	Relays				Door Holder 284 N.	Passed		8/13/2021 12:40 PM
7	Fan	L4M05			2nd flr s-3	Not Inspected		
8	Relays	L3M02			Smoke relay damper	Passed		8/13/2021 12:36 PM
9	Relays	L3M08			Smoke relay damper	Passed		8/13/2021 12:37 PM
10	Relays	L4M04			Smoke relay damper S-4	Passed		8/13/2021 12:37 PM
11	Relays	L4M20			Smoke relay elevator lobby	Passed		8/13/2021 12:37 PM

Basement TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder tunnel door	Passed		8/13/2021 12:15 PM
2	Relays				Door Holder electrical vestibule	Passed		8/13/2021 12:16 PM
3	Relays				Door Holder Steam vestibule	Passed		8/13/2021 12:16 PM
4	Relays	L1M58			Door Holders	Passed		8/13/2021 12:16 PM
5	Relays	L4M23			Door Holders LL	Passed		8/13/2021 12:16 PM
6	Fan	L1M01			AHU 1	Not Inspected		
7	Fan	L1M02			RAF 1	Not Inspected		
8	Fan	L1M14			AHU 4	Not Inspected		
9	Fan	L1M16			AHU 10	Not Inspected		
10	Fan	L1M17			AHU S Gym	Not Inspected		
11	Fan	L1M18			AHU 8	Not Inspected		
12	Fan	L1M19			AHU 9	Not Inspected		
13	Fan	L1M20			AHU 7	Not Inspected		
14	Fan	L1M21			AHU 3	Not Inspected		
15	Fan	L1M22			AHU 6	Not Inspected		
16	Fan	L1M23			AHU 2	Not Inspected		
17	Fan	L1M24			AHU 5	Not Inspected		
18	Relays	L4M21			Basement Damper	Passed		8/13/2021 12:17 PM

Supercomponent Results

Number	Type	Zone/address	Make	Model	Location	Layout	Result	Comments
7	Fan	L4M05			2nd flr s-3	2nd Floor	Not Inspected	
6	Fan	L1M01			AHU 1	Basement	Not Inspected	
7	Fan	L1M02			RAF 1	Basement	Not Inspected	
8	Fan	L1M14			AHU 4	Basement	Not Inspected	
9	Fan	L1M16			AHU 10	Basement	Not Inspected	
10	Fan	L1M17			AHU S Gym	Basement	Not Inspected	
11	Fan	L1M18			AHU 8	Basement	Not Inspected	
12	Fan	L1M19			AHU 9	Basement	Not Inspected	
13	Fan	L1M20			AHU 7	Basement	Not Inspected	
14	Fan	L1M21			AHU 3	Basement	Not Inspected	
15	Fan	L1M22			AHU 6	Basement	Not Inspected	
16	Fan	L1M23			AHU 2	Basement	Not Inspected	
17	Fan	L1M24			AHU 5	Basement	Not Inspected	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 5- Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68506

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property: LRC Bldg. # 5- Lincoln Regional Center

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

Inspection Date: 8/13/2021

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 5- Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68506
Account Phone	(402) 479-5453
Main Account Email	
Authority Having Juristiction	Nebraska state Fire Marshall
AHJ Phone Number	402-471-2027
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	2900 S 70th St #330
Monitoring Org Phone	40-474-3737
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied
Phone Line one or IP	Customer Supplied

Phone Line two or IP	Customer Supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maint.

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		
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.	8-3-21

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Bevan flynn
Title:	
Phone:	
Date:	8-3-21

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

Lincoln Regional Center - Building 9

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: Lincoln Regional Center - Building 9
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2nd Semi-Annual Inspection Summary

Result Totals

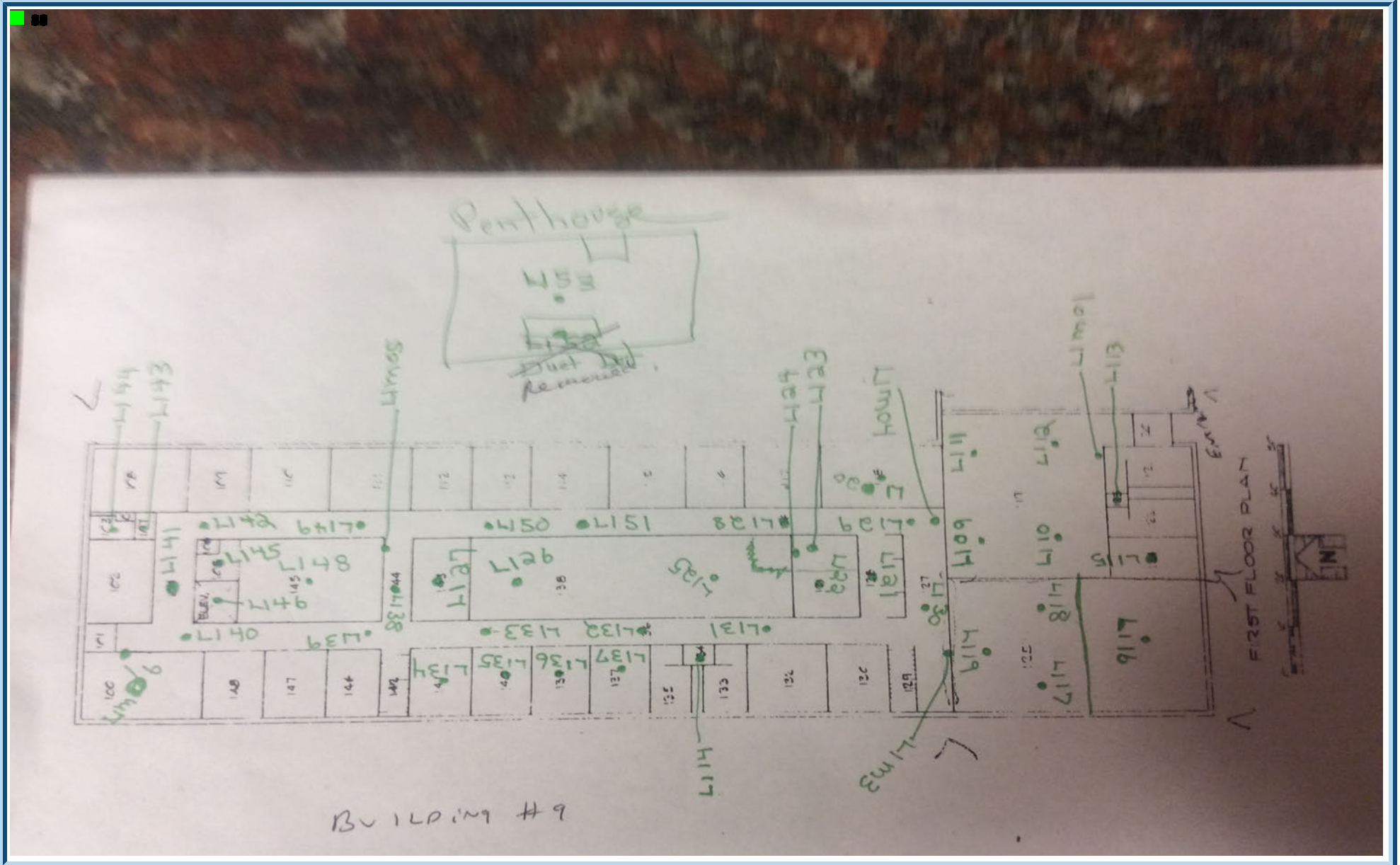
Devices	Heat Detector	Manual Pull Station	Smoke Detector
Passed	27	5	22
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	27	5	22

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D20	Notifier	SDX-551	Main office	Passed		8/3/2021 2:27 PM
2	Smoke Detector	L1D28	Notifier	SDX-551	Hall by Mech Rm	Passed		8/3/2021 2:27 PM
3	Smoke Detector	L1D51	Notifier	SDX-551	Hall by 115	Passed		8/3/2021 2:28 PM
4	Heat Detector	L1D23	Notifier	FDX-551	Mech Rm	Passed		8/3/2021 2:29 PM
5	Smoke Detector	L1D50	Notifier	SDX-551	Hall by 113	Passed		8/3/2021 2:30 PM
6	Smoke Detector	L1D42	Notifier	SDX-551	Hall by 108	Passed		8/13/2021 5:18 PM
7	Smoke Detector	L1D49	Notifier	SDX-551	Hall by 110	Passed		8/3/2021 2:30 PM
8	Heat Detector	L1D45	Notifier	FDX-551	Admin Cloak Rm	Passed		8/13/2021 5:18 PM
9	Heat Detector	L1D48	Notifier	FDX-551	Large Conference	Passed		8/3/2021 2:30 PM
10	Smoke Detector	L1D38	Notifier	SDX-551	North Corridor	Passed		8/3/2021 2:30 PM
11	Heat Detector	L1D46	Notifier	FDX-551	Admin Storage	Passed		8/3/2021 2:31 PM
12	Smoke Detector	L1D40	Notifier	SDX-551	Admin Reception Area	Passed		8/13/2021 5:18 PM
13	Smoke Detector	L1D41	Notifier	SDX-551	Reception Area	Passed		8/13/2021 5:19 PM
14	Smoke Detector	L1D39	Notifier	SDX-551	Hall by 147	Passed		8/13/2021 5:19 PM
15	Smoke Detector	L1D33	Notifier	SDX-551	Hall by 130	Passed		8/13/2021 5:20 PM
16	Heat Detector	L1D34	Notifier	FDX-551	Rm 130	Passed		8/3/2021 2:31 PM
17	Heat Detector	L1D35	Notifier	FDX-551	Rm 141	Passed		8/13/2021 5:20 PM
18	Heat Detector	L1D36	Notifier	FDX-551	Rm 140	Passed		8/13/2021 5:20 PM
19	Smoke Detector	L1D32	Notifier	SDX-551	Hall by Lounge	Passed		8/13/2021 5:21 PM
20	Heat Detector	L1D37	Notifier	FDX-551	Lounge	Passed		8/13/2021 5:21 PM
21	Heat Detector	L1D14	Notifier	FDX-551	Mop Closet West	Passed		8/13/2021 5:21 PM
22	Smoke Detector	L1D31	Notifier	SDX-551	Hall by bus storage	Passed		8/13/2021 5:22 PM
23	Heat Detector	L1D22	Notifier	FDX-551	Business Storage	Passed		8/13/2021 5:22 PM
24	Smoke Detector	L1D21	Notifier	SDX-551	Copy machine area	Passed		8/13/2021 5:22 PM
25	Smoke Detector	L1D30	Notifier	SDX-551	Hall by Stairs	Passed		8/13/2021 5:22 PM
26	Heat Detector	L1D19	Notifier	FDX-551	patient accounts	Passed		8/13/2021 5:23 PM
27	Heat Detector	L1D18	Notifier	FDX-551	patient accounts	Passed		8/13/2021 5:23 PM
28	Heat Detector	L1D17	Notifier	FDX-551	patient accounts	Passed		8/13/2021 5:23 PM
29	Smoke Detector	L1D29	Notifier	SDX-551	Hall by Lobby Door	Passed		8/13/2021 5:24 PM
30	Heat Detector	L1D15	Notifier	FDX-551	vending machine rm	Passed		8/13/2021 5:24 PM
31	Heat Detector	L1D16	Notifier	FDX-551	museum	Passed		8/13/2021 5:24 PM
32	Heat Detector	L1D53	Notifier	FDX-551	Penthouse Equipment rm	Passed		8/13/2021 5:25 PM
33	Heat Detector	L1D25	Notifier	FDX-551	medical records	Passed		8/13/2021 5:25 PM
34	Heat Detector	L1D26	Notifier	FDX-551	medical records	Passed		8/13/2021 5:25 PM
35	Heat Detector	L1D43	Notifier	FDX-551	North RR	Passed		8/13/2021 5:26 PM
36	Heat Detector	L1D44	Notifier	FDX-551	North RR	Passed		8/13/2021 5:26 PM
37	Smoke Detector	L1D09	Notifier	SDX-551	lobby nw	Passed		8/13/2021 5:26 PM
38	Smoke Detector	L1D11	Notifier	SDX-551	lobby ne	Passed		8/13/2021 5:27 PM
39	Smoke Detector	L1D12	Notifier	SDX-551	lobby Se	Passed		8/13/2021 5:27 PM
40	Smoke Detector	L1D10	Notifier	SDX-551	lobby Sw	Passed		8/13/2021 5:28 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L1D13	Notifier	FDX-551	Lobby Storage	Passed		8/13/2021 5:28 PM
42	Heat Detector	L1D27	Notifier	FDX-551	med records manager office	Passed		8/13/2021 5:28 PM
43	Manual Pull Station	L1M04	Notifier	BGX-101L	south Hall by lobby	Passed		8/13/2021 5:28 PM
44	Manual Pull Station	L1M01	Notifier	BGX-101L	southeast lobby exit	Passed		8/13/2021 5:29 PM
45	Manual Pull Station	L1M03	Notifier	BGX-101L	West Exit south Hall	Passed		8/13/2021 5:29 PM
46	Manual Pull Station	L1M06	Notifier	BGX-101L	North End west Hall	Passed		
47	Manual Pull Station	L1M05	Notifier	BGX-101L	North End east Hall	Passed		



Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red
		Not Tested = Blue

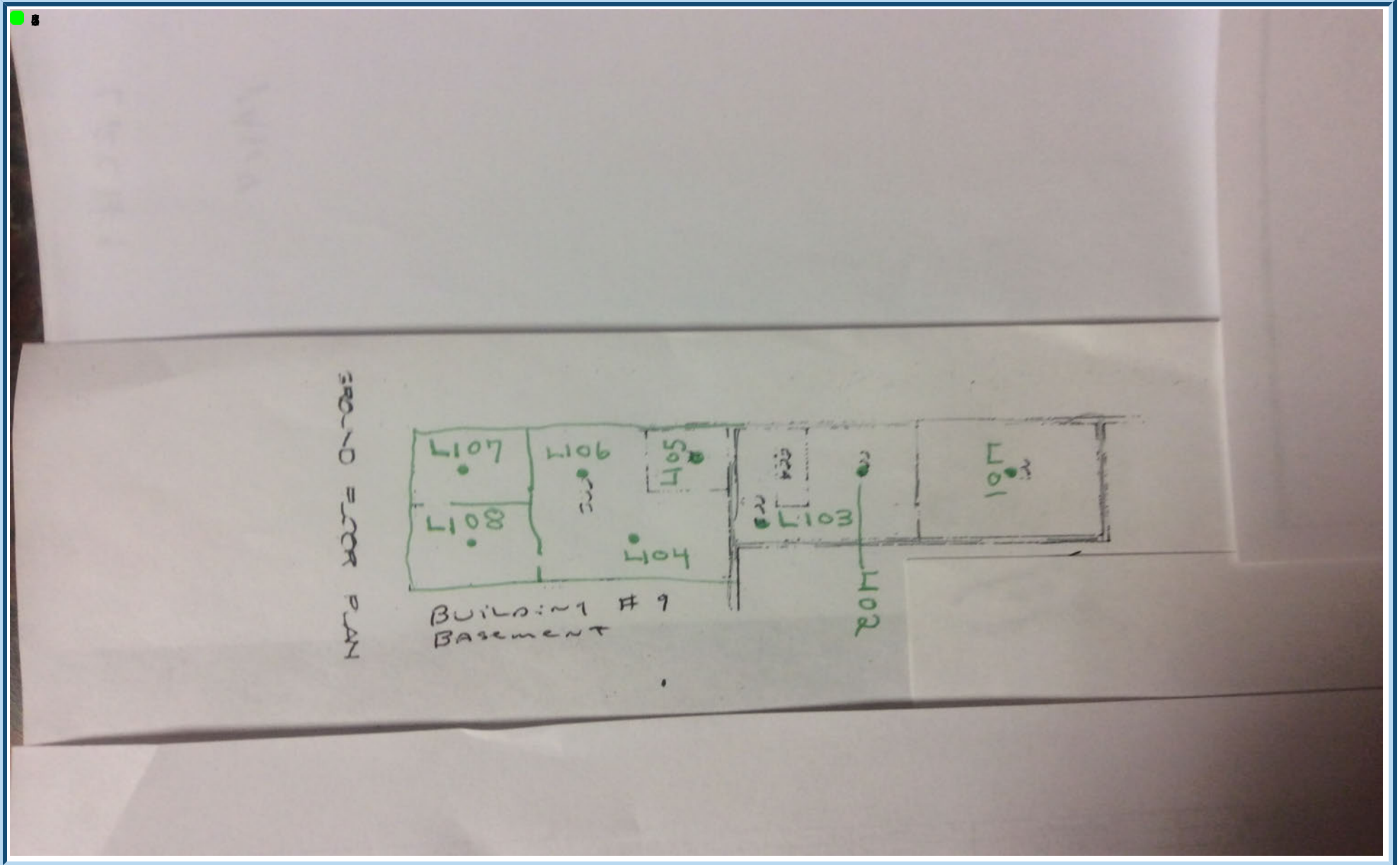
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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		8/3/2021 2:23 PM
2	Smoke Detector	L1D04	Notifier	SDX-551	processing	Passed		8/3/2021 2:23 PM
3	Heat Detector	L1D05	Notifier		Processing	Passed		8/3/2021 2:24 PM
4	Heat Detector	L1D06	Notifier		Processing	Passed		8/3/2021 2:24 PM
5	Heat Detector	L1D08	Notifier		Records Storage	Passed		8/3/2021 2:25 PM
6	Heat Detector	L1D07	Notifier		Equipment Rm	Passed		8/3/2021 2:25 PM
7	Heat Detector	L1D02	Notifier	FDX-551	Telephone rm	Passed		8/3/2021 2:26 PM



Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red
		Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

BASEMENT
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

Lincoln Regional Center - Building 9

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: Lincoln Regional Center - Building 9
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2nd Semi-Annual Inspection Summary

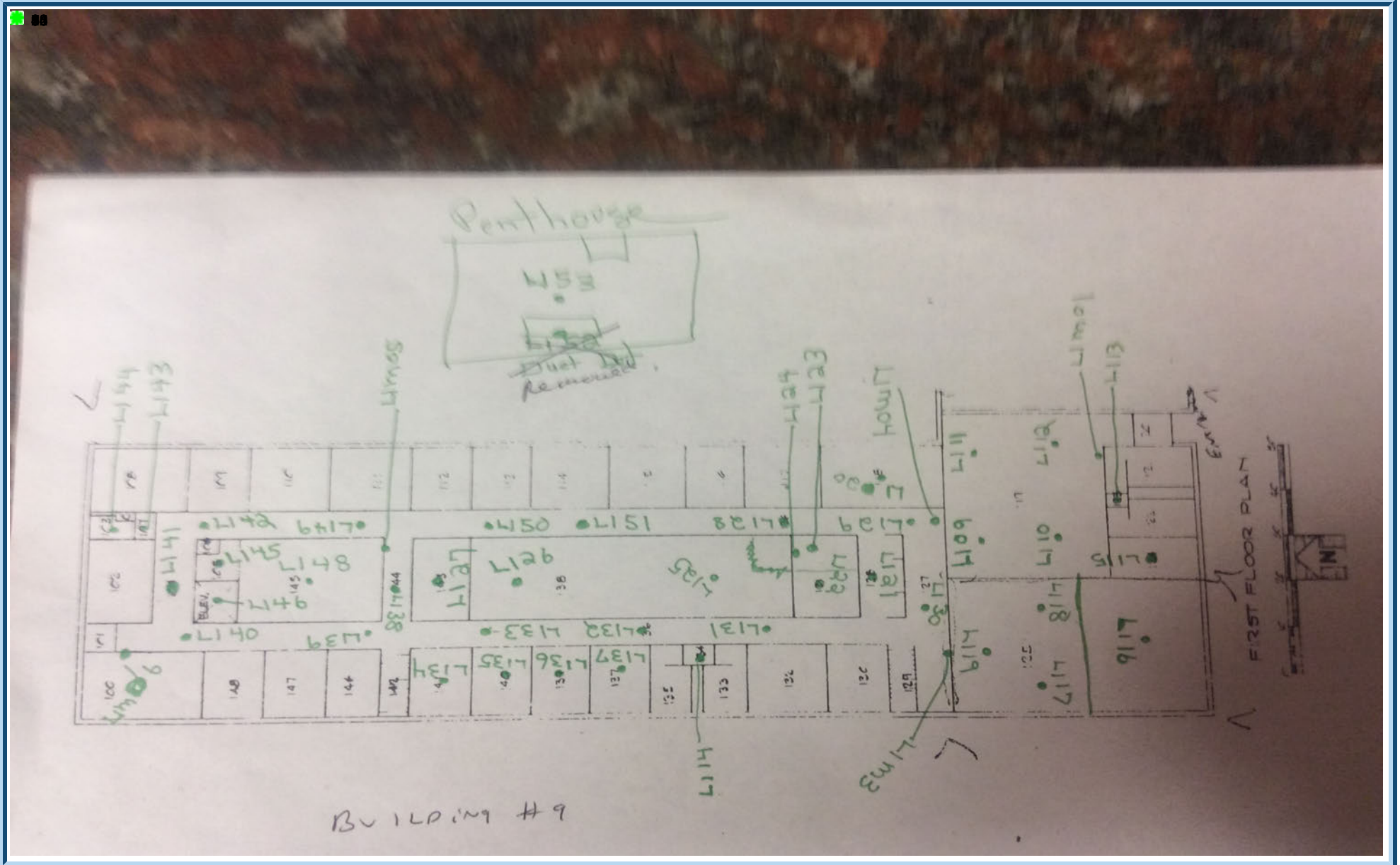
Result Totals

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 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	statistics analyst	Passed		
2	Horn Strobe			statistics analyst	Passed		
3	Bell		KMS-8-24VDC/P	Lobby	Passed		
4	Strobe		SS24110ADA	Lobby	Passed		
5	Strobe		SS24110ADA	men’s rr	Passed		
6	Strobe		SS24110ADA	women’s rr	Passed		
7	Strobe		SS24110ADA	Medical records	Passed		
8	Strobe		SS24110ADA	conference rm	Passed		
9	Strobe		SS24110ADA	across from health info manager	Passed		
10	Bell		KMS-8-24VDC/P	Across from health info manager	Passed		
11	Strobe		SS24110ADA	men’s RR	Passed		
12	Strobe		SS24110ADA	Women’s RR	Passed		
13	Bell		KMS-8-24VDC/P	Financial	Passed		
14	Strobe		SS24110ADA	Financial	Passed		
15	Bell		KMS-8-24VDC/P	basement Hall	Passed		
16	Strobe		SS24110ADA	basement hall	Passed		



Bell	Horn Strobe	Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor
TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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North Platte, NE
Omaha, NE
Scottsbluff, NE
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

Lincoln Regional Center - Building 9

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: Lincoln Regional Center - Building 9
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2nd Semi-Annual Inspection Summary

Result Totals

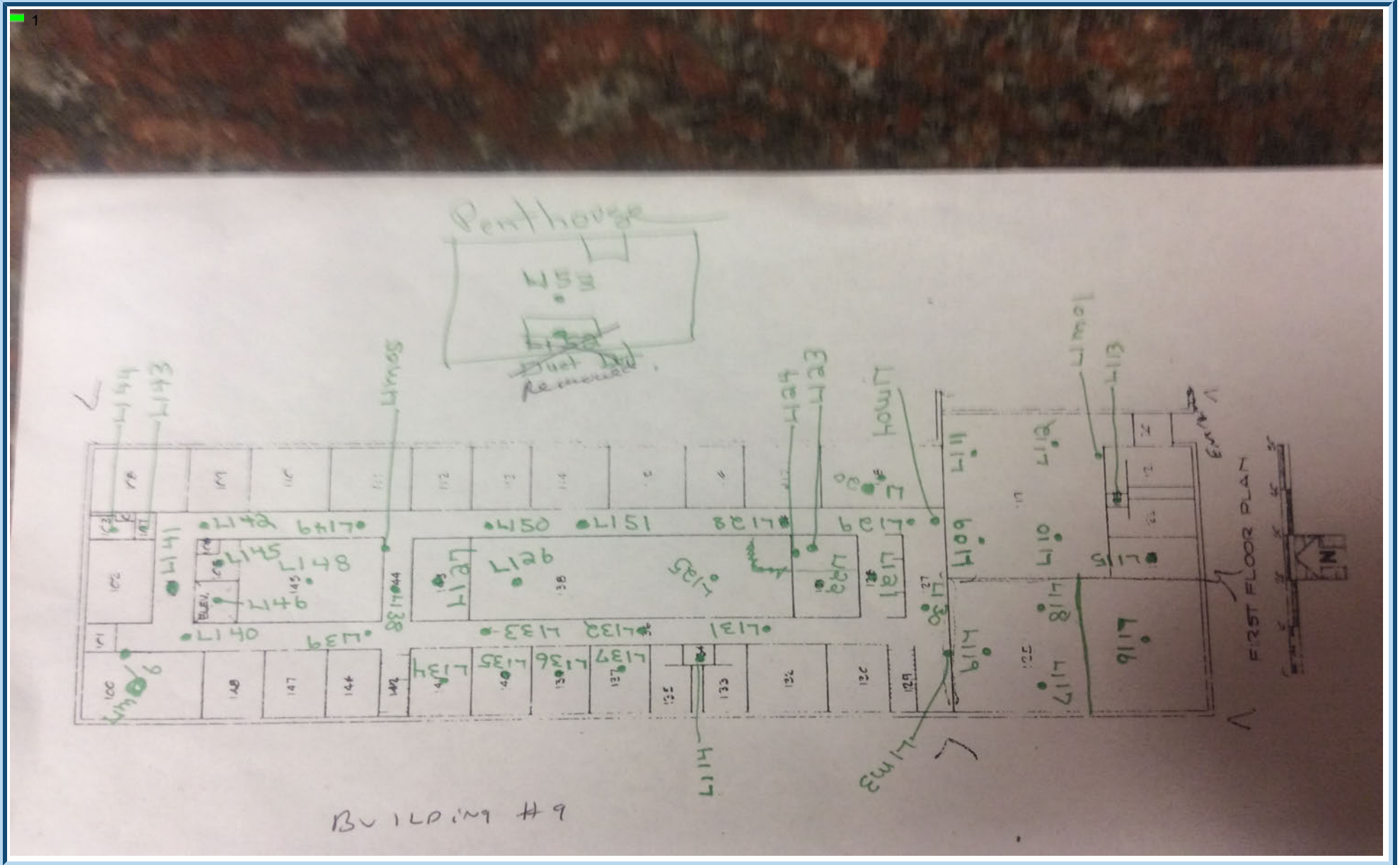
Devices	Power Supply
Passed	1
Mitigated	-
New - Passed	-
Failed	-
Removed	-
Not Inspected	-
Total	1

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Main hallway
Model	nfs2 640
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	nfs2 640		Main hallway	Passed		



▬ FACP

✖ Power Supply

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

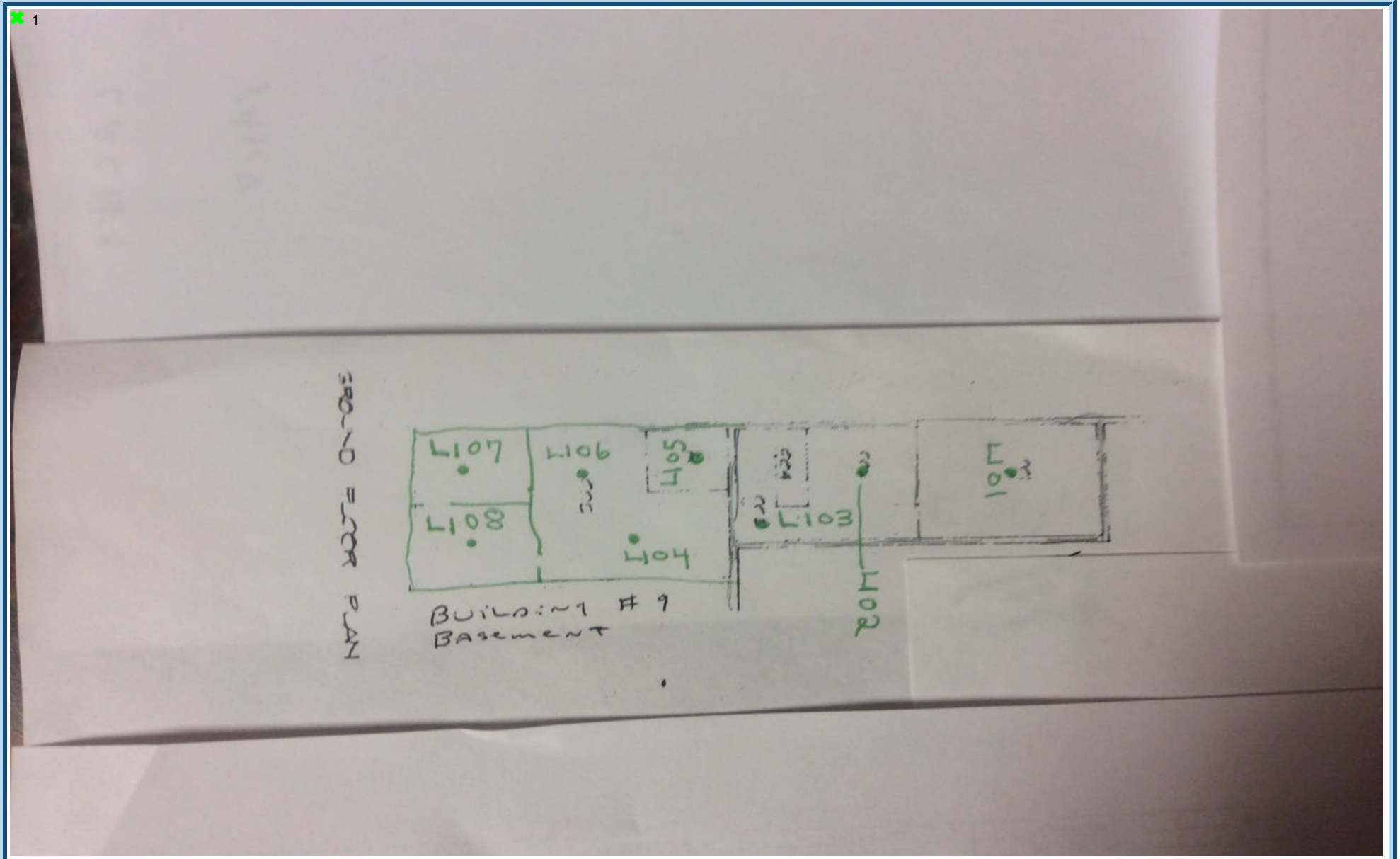
TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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		



▬ FACP

✖ Power Supply

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

BASEMENT

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

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Omaha, NE
Scottsbluff, NE
800-274-0888

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH			9-6-2017	1st Floor Main hallway	Passed	Left
1	12V26AH			9-6-2017	1st Floor Main hallway	Passed	Right
1	12V8AH			3-7-2018	BASEMENT mech rm	Passed	Left
1	12V8AH			3-7-2018	BASEMENT mech rm	Passed	Right

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	nfs2 640	120	Main hallway	1st Floor	Passed		
1	L1M10	Power Supply	Notifier	FCPS-24		mech rm	BASEMENT	Passed		

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

Lincoln Regional Center - Building 9

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property: Lincoln Regional Center - Building 9

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

Inspection Date: 8/13/2021

1. PROPERTY INFORMATION

Account Name or Property Name	Lincoln Regional Center - Building 9
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	(402) 479-5453
Main Account Email	
Authority Having Juristiction	Nebraska state fire marshall
AHJ Phone Number	402-471-2027
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	2900 S 70th st #330
Monitoring Org Phone	(402) 474-3737
Monitoring Org Email	gordon.tebo@nebraska.gov
Monitoring Acct Number	(800) 274-0888
Phone Line one or IP	Customer supplied
Phone Line two or IP	customer supplied

Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maint.

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		
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.	8-3-21

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	Gordon Tebo
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Bevan flynn
Title:	
Phone:	
Date:	8-3-21

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 10 - Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2nd Semi-Annual Inspection Summary

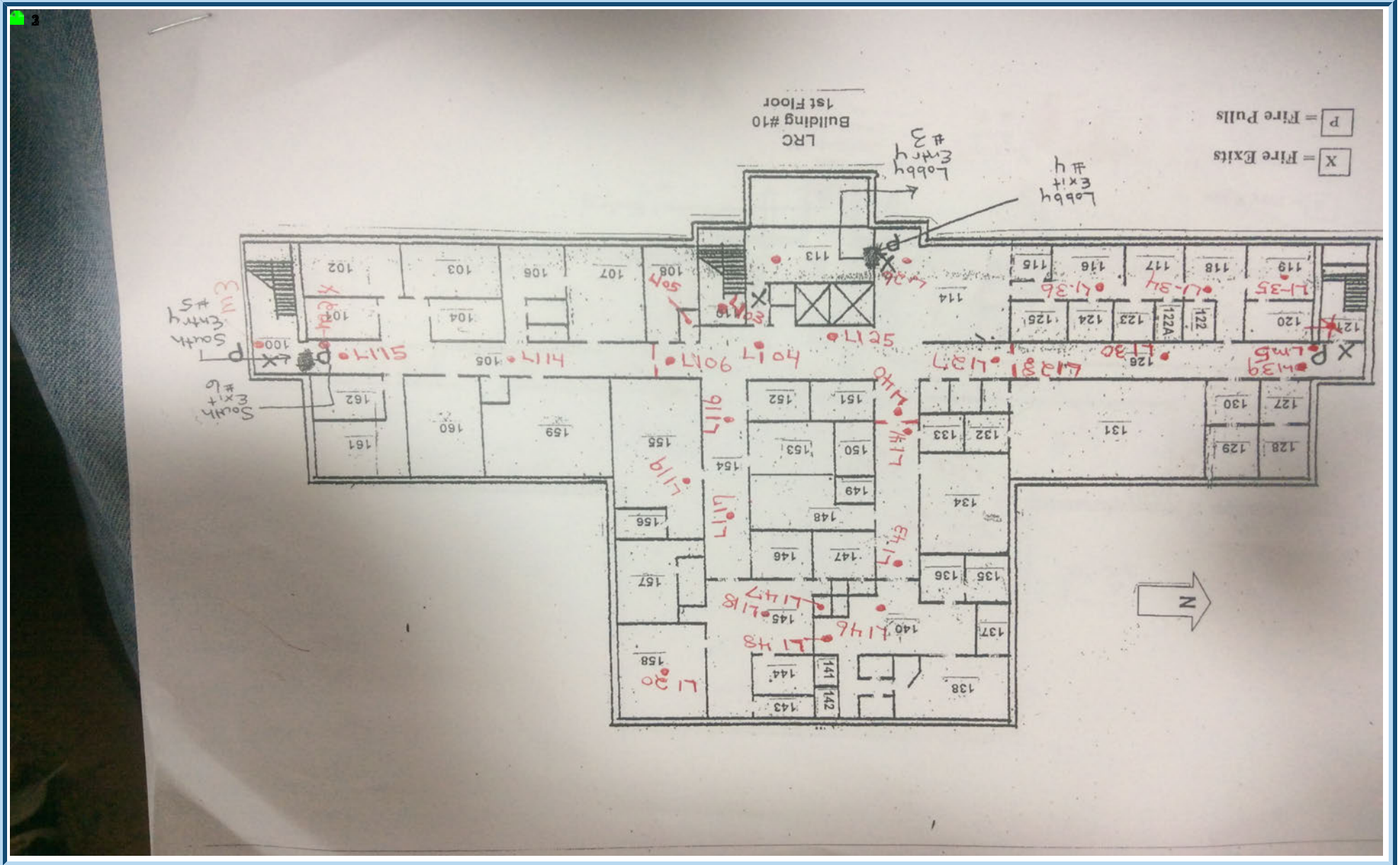
Result Totals

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 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M32	1st Floor Flow	Passed			8/9/2021 12:26 PM
2	Control Valve Switch	L1M33	1st floor valve	Passed			8/9/2021 12:27 PM
3	PIV	L1M23	outside	Passed			8/9/2021 12:27 PM



✣ Control Valve Switch — Passed = Green

⛸ PIV — Mitigated = Green

◑ Standpipe Water Flow — Failed = Red — Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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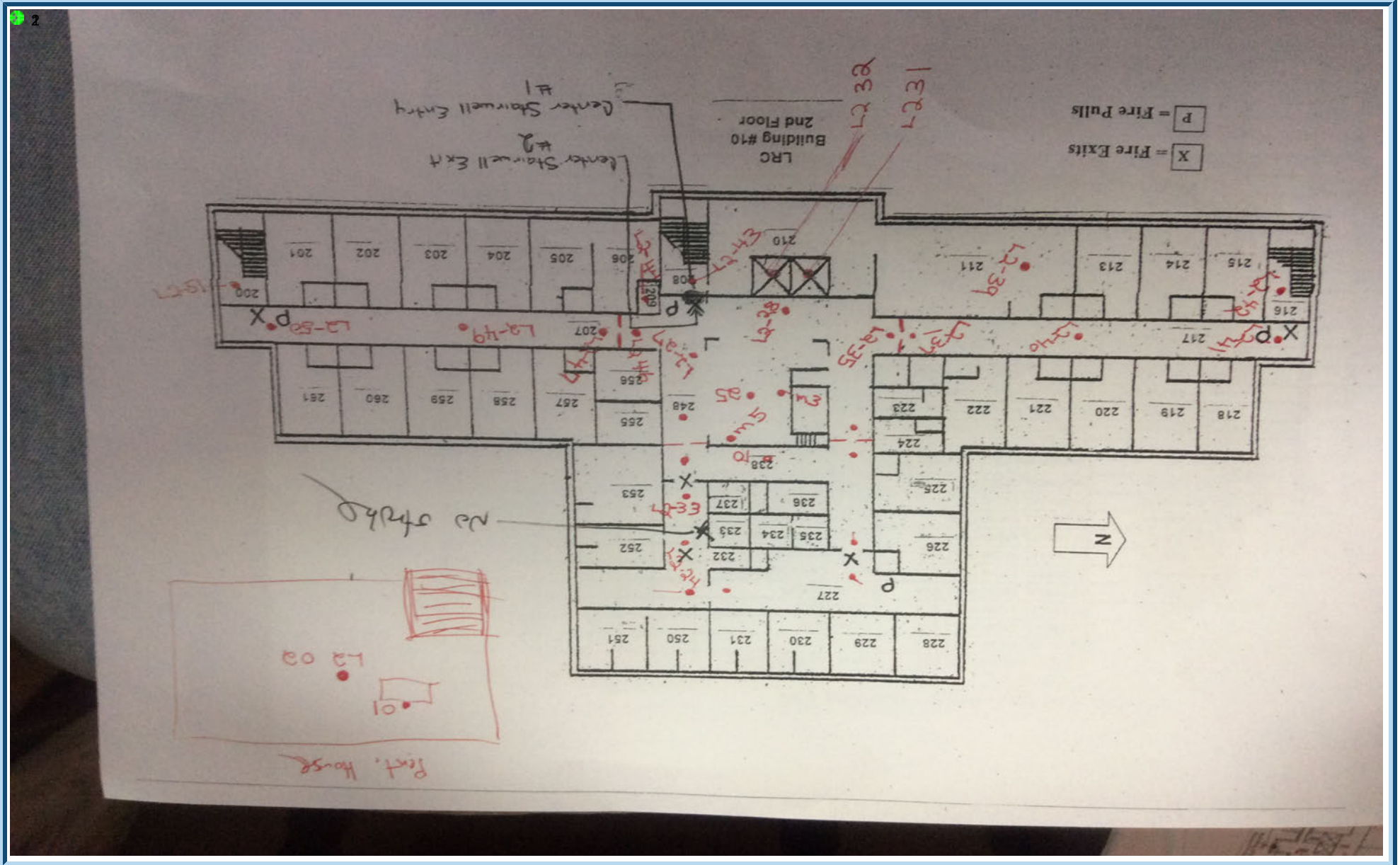
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd Floor TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L2M20	2nd Floor Flow	Passed			8/9/2021 12:27 PM
2	Control Valve Switch	L2M21	2 Floor valve	Passed			8/9/2021 12:27 PM



✛ Control Valve Switch — Passed = Green

▟ PIV — Mitigated = Green

◑ Standpipe Water Flow — Failed = Red — Not Tested = Blue

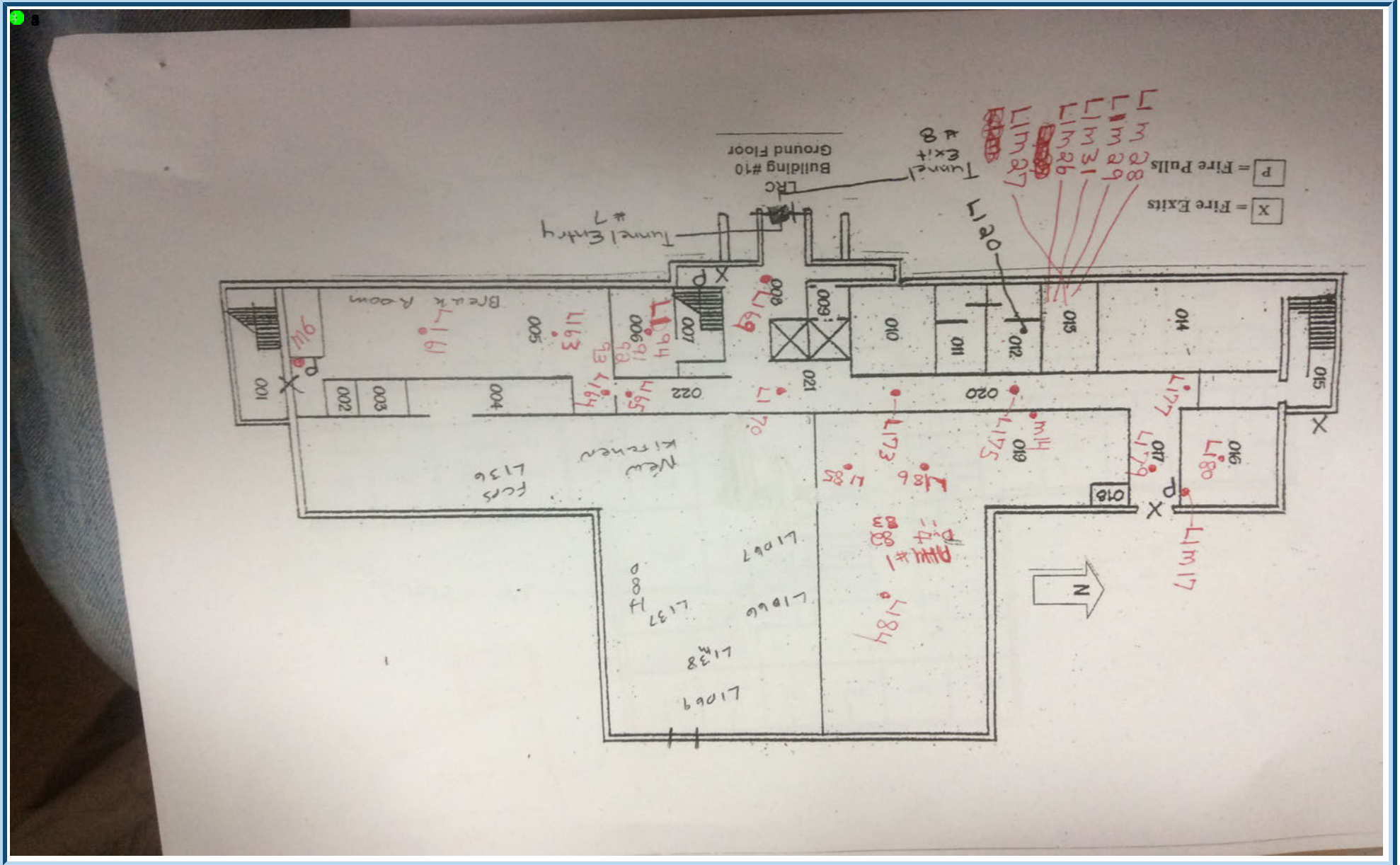
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd Floor
TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

LOWER LEVEL TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M28	Riser room	Passed			8/9/2021 12:29 PM
2	Control Valve Switch	L1M29	Basement valve	Passed			8/9/2021 12:29 PM
3	Control Valve Switch	L1M26	Sprinkler drain	Passed			8/9/2021 12:28 PM
4	Control Valve Switch	L1M27	1st and second isolation	Passed			8/9/2021 12:28 PM
5	Standpipe Water Flow	L1M31	Riser room	Passed			8/9/2021 12:28 PM



✣ Control Valve Switch

Passed = Green

⛸ PIV

Mitigated = Green

◑ Standpipe Water Flow

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

LOWER LEVEL

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

TJC EP3 Initiating Devices 2nd Semi-Annual Inspection Summary

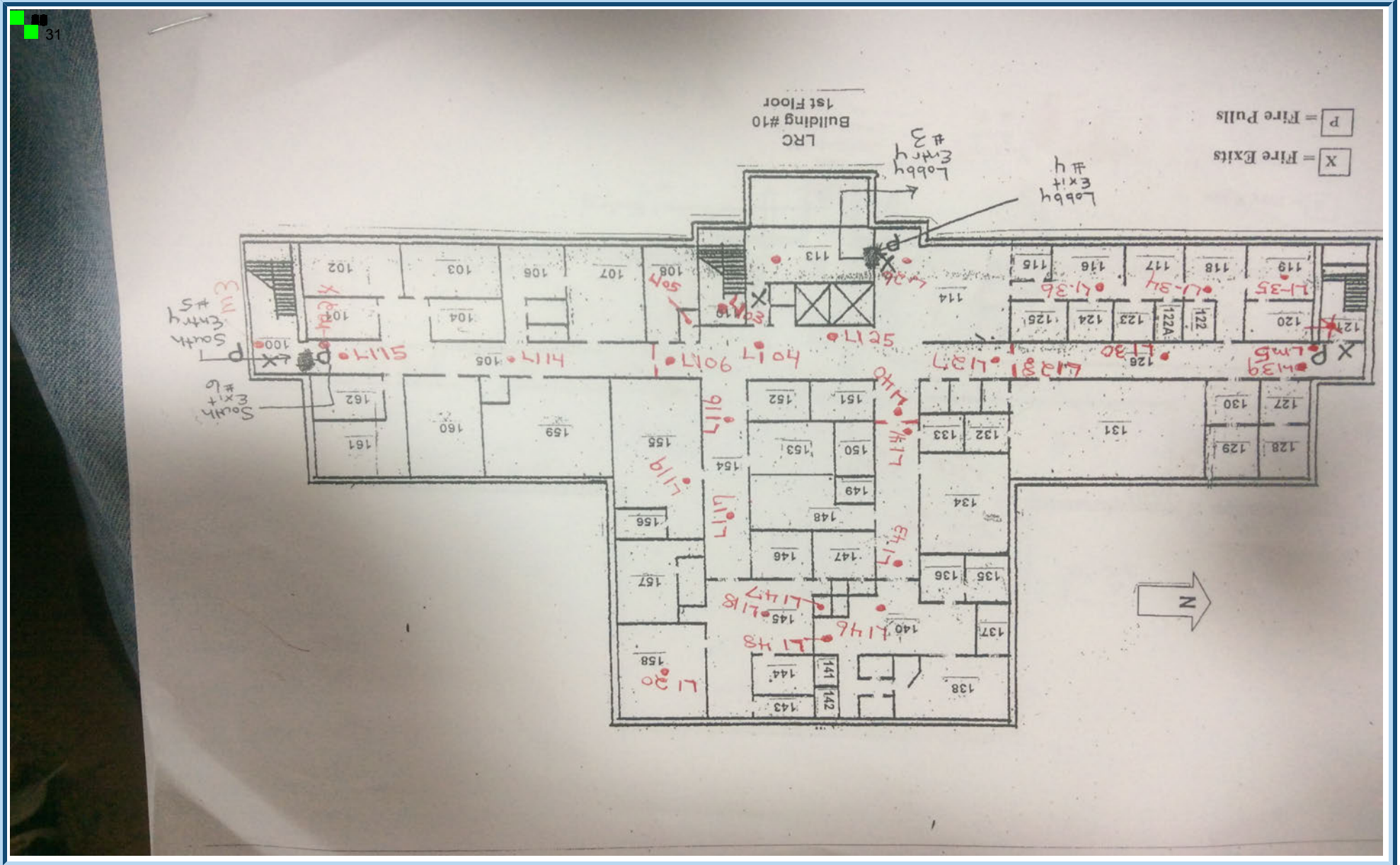
Result Totals

Devices	Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed	5	14	10	32
Mitigated	-	-	-	-
New - Passed	-	-	-	-
Failed	-	-	-	-
Removed	-	-	-	-
Not Inspected	1	2	2	29
Total	6	16	12	61

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

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		8/9/2021 12:57 PM
2	Smoke Detector	L1D03	notifier	FSP-851	Hall by center stair	Passed		8/9/2021 12:57 PM
3	Heat Detector	L1D05	Notifier	FDX-551	Maintenance Room	Passed		8/9/2021 12:57 PM
4	Smoke Detector	L1D06	notifier	FSP-851	Hall by Rm 133	Passed		8/9/2021 12:56 PM
5	Smoke Detector	L1D14	notifier	FSP-851	Hall by Rm 135	Passed		8/9/2021 12:56 PM
6	Smoke Detector	L1D15	notifier	FSP-851	Hall by South Exit	Passed		8/9/2021 12:55 PM
7	Smoke Detector	L1D16	notifier	FSP-851	Hall by rm 150	Passed		8/9/2021 12:55 PM
8	Smoke Detector	L1D17	notifier	FSP-851	Hall by rm 149	Passed		8/9/2021 12:55 PM
9	Smoke Detector	L1D18	notifier	FSP-851	Hall by rm 158	Passed		8/9/2021 12:55 PM
10	Smoke Detector	L1D19	notifier	FSP-851	149	Passed		8/9/2021 12:55 PM
11	Heat Detector	L1D20	Notifier	FDX-551	Rm 158	Passed		8/9/2021 12:54 PM
12	Smoke Detector	L1D26	notifier	FSP-851	Hall by reception	Passed		8/9/2021 12:54 PM
13	Smoke Detector	L1D27	notifier	FSP-851	Hall by Lobby	Passed		8/9/2021 12:54 PM
14	Smoke Detector	L1D28	notifier	FSP-851	Hall by 105	Passed		8/9/2021 12:54 PM
15	Smoke Detector	L1D30	notifier	FSP-851	Hall by 102	Passed		8/9/2021 12:53 PM
16	Smoke Detector	L1D34	notifier	FSP-851	Dental Hallway	Passed		8/9/2021 12:53 PM
17	Smoke Detector	L1D36	notifier	FSP-851	reception Hallway	Passed		8/9/2021 12:53 PM
18	Smoke Detector	L1D39	notifier	FSP-851	Hall by North Exit	Passed		8/9/2021 12:52 PM
19	Smoke Detector	L1D40	notifier	FSP-851	Hall by Rm 128	Passed		8/9/2021 12:52 PM
20	Smoke Detector	L1D41	notifier	FSP-851	Hall by Rm 161	Passed		8/9/2021 12:52 PM
21	Smoke Detector	L1D43	notifier	FSP-851	Hall by Rm 165	Passed		8/9/2021 12:52 PM
22	Smoke Detector	L1D46	notifier	FSP-851	Hall by Rm 167	Passed		8/9/2021 12:51 PM
23	Heat Detector	L1D47	Notifier	FDX-551	Janitor closet	Passed		8/9/2021 12:51 PM
24	Smoke Detector	L1D48	notifier	FSP-851	Hall by Rec storage	Passed		8/9/2021 12:51 PM
25	Manual Pull Station	L1M03	Notifier	BGX-101L	South Exit	Passed		8/9/2021 12:51 PM
26	Manual Pull Station	L1M05	Notifier	BGX-101L	North Exit	Passed		8/9/2021 12:50 PM
27	Manual Pull Station	L1M24	Notifier	BGX-101L	South Exit	Passed		8/9/2021 12:50 PM
28	Manual Pull Station	L1M01	Notifier	BGX-101L	Front Entrance	Passed		8/9/2021 12:49 PM
29	Smoke Detector	L1D25	notifier	FSP-851	elevator lobby	Passed		8/9/2021 12:49 PM
30	Heat Detector	L1D35	Notifier	FDX-551	Dental Exam	Passed		8/9/2021 12:48 PM
31	Manual Pull Station	L1M04	Notifier	BGX-101L	Lobby Exit	Passed		8/9/2021 12:48 PM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

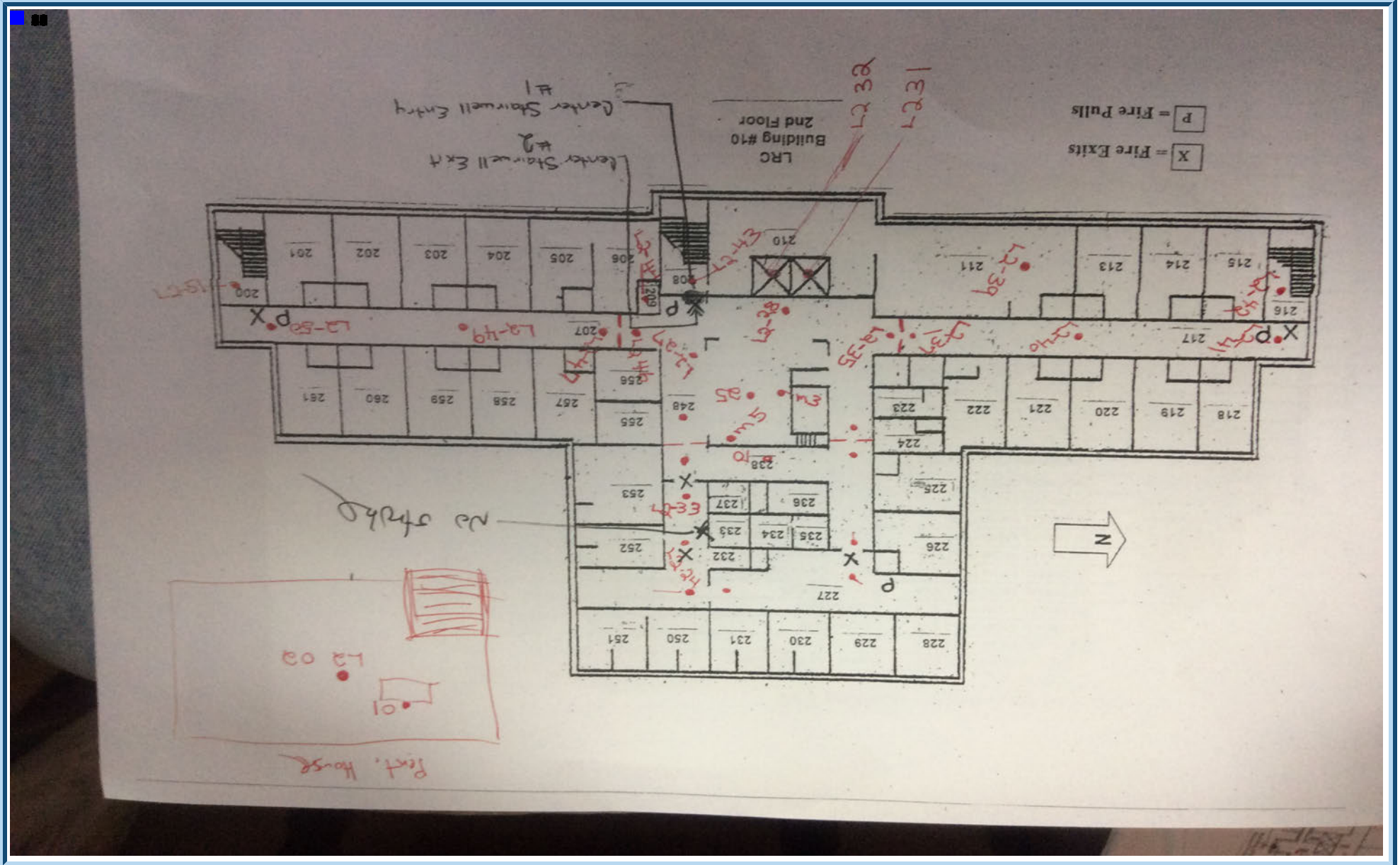
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd Floor TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L2D33	Notifier	FSP-851	Hall by Rm 223	Not Inspected		8/3/2021 9:29 AM
2	Smoke Detector	L2D35	Notifier	FSP-851	Hall by N Fire Doors	Not Inspected		8/3/2021 9:29 AM
3	Smoke Detector	L2D37	Notifier	FSP-851	Hall by Room 216	Not Inspected		8/3/2021 9:29 AM
4	Smoke Detector	L2D38	Notifier	FSP-851	room 222	Not Inspected		8/3/2021 9:29 AM
5	Smoke Detector	L2D39	Notifier	FSP-851	room 204	Not Inspected		8/3/2021 9:29 AM
6	Smoke Detector	L2D40	Notifier	FSP-851	Hall by rm 214	Not Inspected		8/3/2021 9:29 AM
7	Smoke Detector	L2D41	Notifier	FSP-851	Hall by rm 212	Not Inspected		8/3/2021 9:29 AM
8	Smoke Detector	L2D42	Notifier	FSP-851	North stairway	Not Inspected		8/3/2021 9:29 AM
9	Smoke Detector	L2D28	Notifier	FSP-851	Elevator lobby	Not Inspected		8/3/2021 9:29 AM
10	Smoke Detector	L2D31	Notifier	FSP-851	Elevator top of shaft	Not Inspected		8/3/2021 9:29 AM
11	Smoke Detector	L2D32	Notifier	FSP-851	Elevator top of shaft	Not Inspected		8/3/2021 9:29 AM
12	Manual Pull Station	L2M03	Notifier		Tech station	Not Inspected		8/3/2021 9:29 AM
13	Manual Pull Station	L2M05	Notifier		Tech station	Not Inspected		8/3/2021 9:29 AM
14	Heat Detector	L2D02	notifier	FDX-551	Penthouse	Not Inspected		8/3/2021 9:29 AM
15	Heat Detector	L2D44	notifier	FDX-551	Maintenance 236	Not Inspected		8/3/2021 9:29 AM
16	Smoke Detector	L2D03	Notifier	FSP-851	Hall by RM 222	Not Inspected		8/3/2021 9:29 AM
17	Smoke Detector	L2D05	Notifier	FSP-851	RM 295	Not Inspected		8/3/2021 9:29 AM
18	Smoke Detector	L2D09	Notifier	FSP-851	Hall by RM 226	Not Inspected		8/3/2021 9:29 AM
19	Smoke Detector	L2D10	Notifier	FSP-851	Hall by RM 278	Not Inspected		8/3/2021 9:29 AM
20	Smoke Detector	L2D15	Notifier	FSP-851	Hall by RM 287	Not Inspected		8/3/2021 9:29 AM
21	Smoke Detector	L2D16	Notifier	FSP-851	Hall by RM 289	Not Inspected		8/3/2021 9:29 AM
22	Smoke Detector	L2D17	Notifier	FSP-851	RM 265	Not Inspected		8/3/2021 9:29 AM
23	Smoke Detector	L2D19	Notifier	FSP-851	Hall By RM 269	Not Inspected		8/3/2021 9:29 AM
24	Smoke Detector	L2D21	Notifier	FSP-851	Hall By RM 261	Not Inspected		8/3/2021 9:29 AM
25	Smoke Detector	L2D24	Notifier	FSP-851	Hall By RM 260	Not Inspected		8/3/2021 9:29 AM
26	Smoke Detector	L2D25	Notifier	FSP-851	Nurse Station	Not Inspected		8/3/2021 9:29 AM
27	Smoke Detector	L2D27	Notifier	FSP-851	Hall by med room	Not Inspected		8/3/2021 9:29 AM
28	Smoke Detector	L2D43	Notifier	FSP-851	Center Stairway	Not Inspected		8/3/2021 9:29 AM
29	Smoke Detector	L2D46	Notifier	FSP-851	Hall by RM 237	Not Inspected		8/3/2021 9:29 AM
30	Smoke Detector	L2D47	Notifier	FSP-851	Hall by RM 258	Not Inspected		8/3/2021 9:29 AM
31	Smoke Detector	L2D49	Notifier	FSP-851	Hall by RM 256	Not Inspected		8/3/2021 9:29 AM
32	Smoke Detector	L2D50	Notifier	FSP-851	Hall by RM 254	Not Inspected		8/3/2021 9:29 AM
33	Smoke Detector	L2D51	Notifier	FSP-851	South Stairwell	Not Inspected		8/3/2021 9:29 AM
34	Duct Detector	L2D01	Notifier		Penthouse	Not Inspected		8/3/2021 9:29 AM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

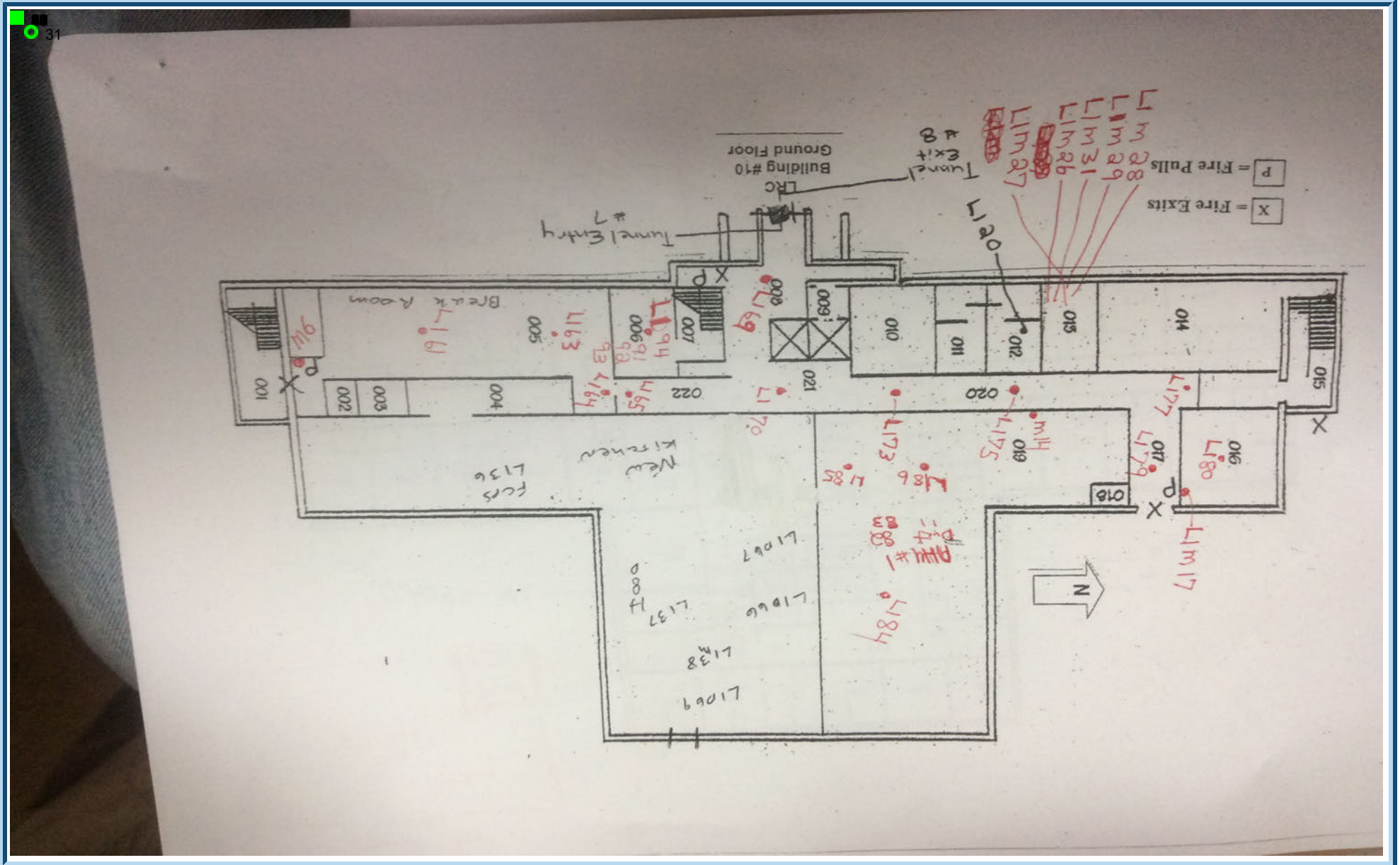
2nd Floor
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

LOWER LEVEL TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Duct Detector	L1D58	Notifier		Equipment Rm	Passed		8/9/2021 1:12 PM
2	Heat Detector	L1D61	Notifier	FDX-551	Canteen South	Passed		8/9/2021 1:11 PM
3	Heat Detector	L1D63	Notifier	FDX-551	Canteen North	Passed		8/9/2021 1:11 PM
4	Smoke Detector	L1D64	Notifier	SDX-551	Canteen by doors	Passed		8/9/2021 1:11 PM
5	Smoke Detector	L1D65	Notifier	SDX-551	Canteen by doors	Passed		8/9/2021 1:11 PM
6	Smoke Detector	L1D66	Notifier	SDX-551	Kitchen Laundry	Passed		8/9/2021 1:10 PM
7	Duct Detector	L1D67	Notifier		S Mech rm	Passed		8/9/2021 1:10 PM
8	Smoke Detector	L1D69	Notifier	SDX-551	Tunnel Hallway	Passed		8/9/2021 1:10 PM
9	Smoke Detector	L1D73	Notifier	SDX-551	Hall by pool rm	Passed		8/9/2021 1:09 PM
10	Smoke Detector	L1D75	Notifier	SDX-551	Hall by mech rm	Passed		8/9/2021 1:09 PM
11	Smoke Detector	L1D77	Notifier	SDX-551	Hall by north Exit	Passed		8/9/2021 1:09 PM
12	Smoke Detector	L1D79	Notifier	SDX-551	Hall by generator	Passed		8/9/2021 1:05 PM
13	Heat Detector	L1D80	Notifier	FDX-551	generator rm	Passed		8/9/2021 1:05 PM
14	Duct Detector	L1D82	Notifier		AHU 1	Passed		8/9/2021 1:04 PM
15	Duct Detector	L1D87	Notifier		AHU 2	Passed		8/9/2021 1:04 PM
16	Manual Pull Station	L1M06	Notifier	BGX-101L	South Stairs	Passed		8/9/2021 1:01 PM
17	Manual Pull Station	L1M13	Notifier	BGX-101L	Hall by center Stairs	Passed		8/9/2021 1:00 PM
18	Manual Pull Station	L1M14	Notifier	BGX-101L	Mech Equipment Rm	Passed		8/9/2021 1:00 PM
19	Manual Pull Station	L1M17	Notifier	BGX-101L	Generator Rm Hall	Passed		8/9/2021 1:00 PM
20	Manual Pull Station	L1M38	Notifier	BGX-101L	Kitchen E Door	Passed		8/9/2021 1:00 PM
21	Smoke Detector	L1D70	Notifier	SDX-551	basement elevator lobby	Passed		8/9/2021 1:00 PM
22	Heat Detector	L1D91	Notifier	FDX-551	Elevator machine room	Passed		8/9/2021 12:59 PM
23	Heat Detector	L1D92	Notifier	FDX-551	Elevator machine room	Passed		8/9/2021 12:59 PM
24	Heat Detector	L1D93	Notifier	FDX-551	Elevator machine room	Passed		8/9/2021 12:59 PM
25	Smoke Detector	L1D94	Notifier	SDX-551	Elevator machine rm	Passed		8/9/2021 12:59 PM
27	Heat Detector	L1DD84	Notifier	FDX-551	Equipment Maintenance Rm	Passed		8/9/2021 12:59 PM
28	Heat Detector	L1D85	Notifier	FDX-551	Equipment Maintenance	Passed		8/9/2021 12:59 PM
29	Heat Detector	L1D86	Notifier	FDX-551	Equipment Maintenance	Passed		8/9/2021 12:58 PM
30	Duct Detector	L1D83	Notifier		AHU 1 E	Passed		8/9/2021 12:58 PM
31	Heat Detector	L1D80	Notifier	FDX-551	Generator Rm	Passed		8/9/2021 12:58 PM



Duct Detector	Heat Detector	Manual Pull Station	Smoke Detector
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

LOWER LEVEL
TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

TJC EP4 Notification 2nd Semi-Annual Inspection Summary

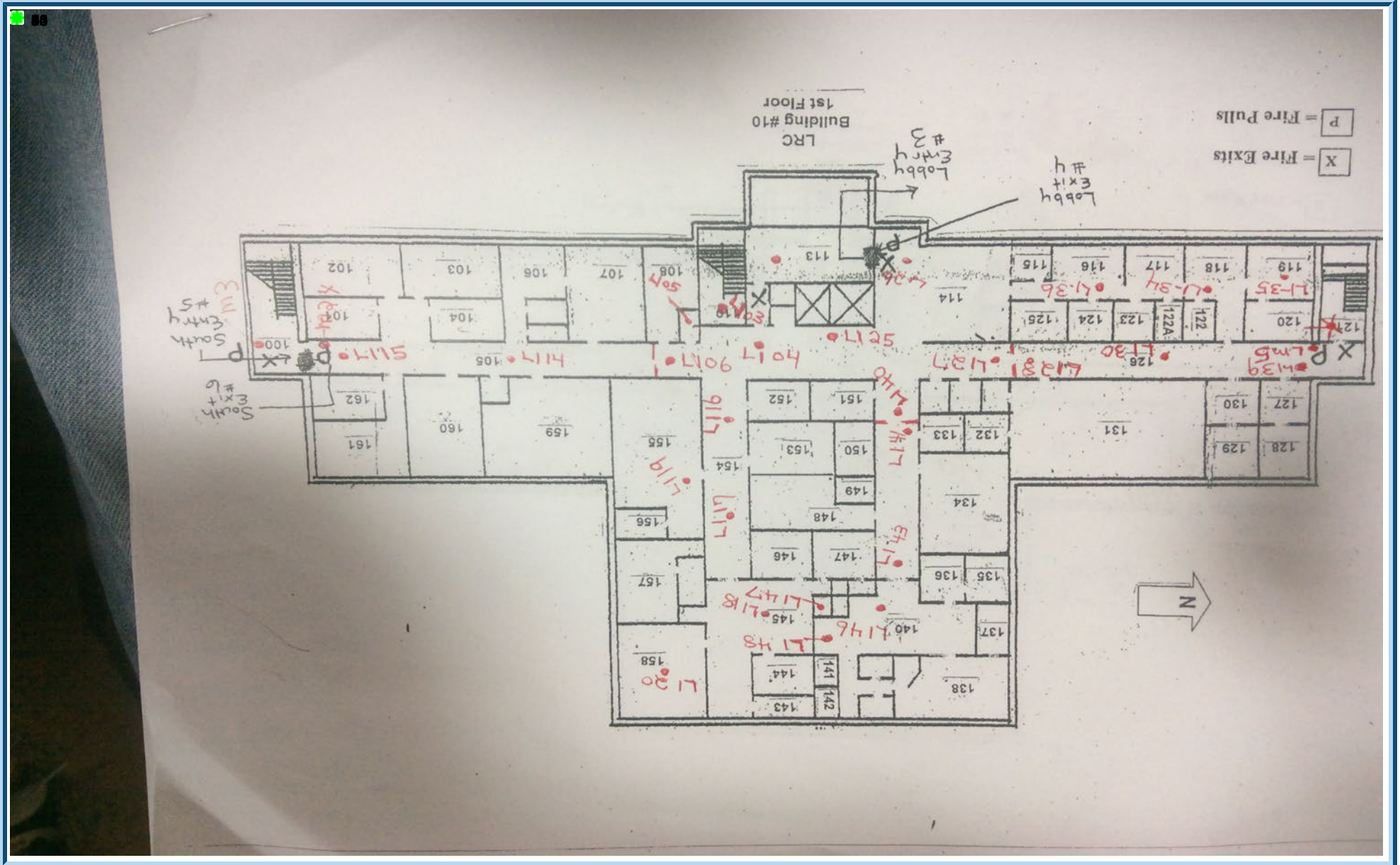
Result Totals

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 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Outside 110	Passed		8/9/2021 1:45 PM
2	Strobe		SS24110ADA	Outside 110	Passed		8/9/2021 1:45 PM
3	Strobe		SS24110ADA	126C	Passed		8/9/2021 1:45 PM
4	Strobe		SS24110ADA	126B	Passed		8/9/2021 1:45 PM
5	Strobe		SS24110ADA	outside 150	Passed		8/9/2021 1:45 PM
6	Bell		KMS-8-24VDC/P	Outside 150	Passed		8/9/2021 1:44 PM
7	Bell		KMS-8-24VDC/P	Outside 138	Passed		8/9/2021 1:44 PM
8	Strobe		SS24110ADA	outside 138	Passed		8/9/2021 1:43 PM
9	Strobe		SS24110ADA	outside 140	Passed		8/9/2021 1:43 PM
10	Bell		KMS-8-24VDC/P	Outside 140	Passed		8/9/2021 1:42 PM
11	Bell		KMS-8-24VDC/P	Outside 155	Passed		8/9/2021 1:42 PM
12	Strobe		SS24110ADA	outside 155	Passed		8/9/2021 1:42 PM
13	Bell		KMS-8-24VDC/P	Outside 160	Passed		8/9/2021 1:42 PM
14	Strobe		SS24110ADA	outside 160	Passed		8/9/2021 1:41 PM
15	Strobe			outside 130	Passed		8/9/2021 1:40 PM
16	Bell		KMS-8-24VDC/P	Outside 130	Passed		8/9/2021 1:40 PM



Bell	Horn	Horn Strobe	Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

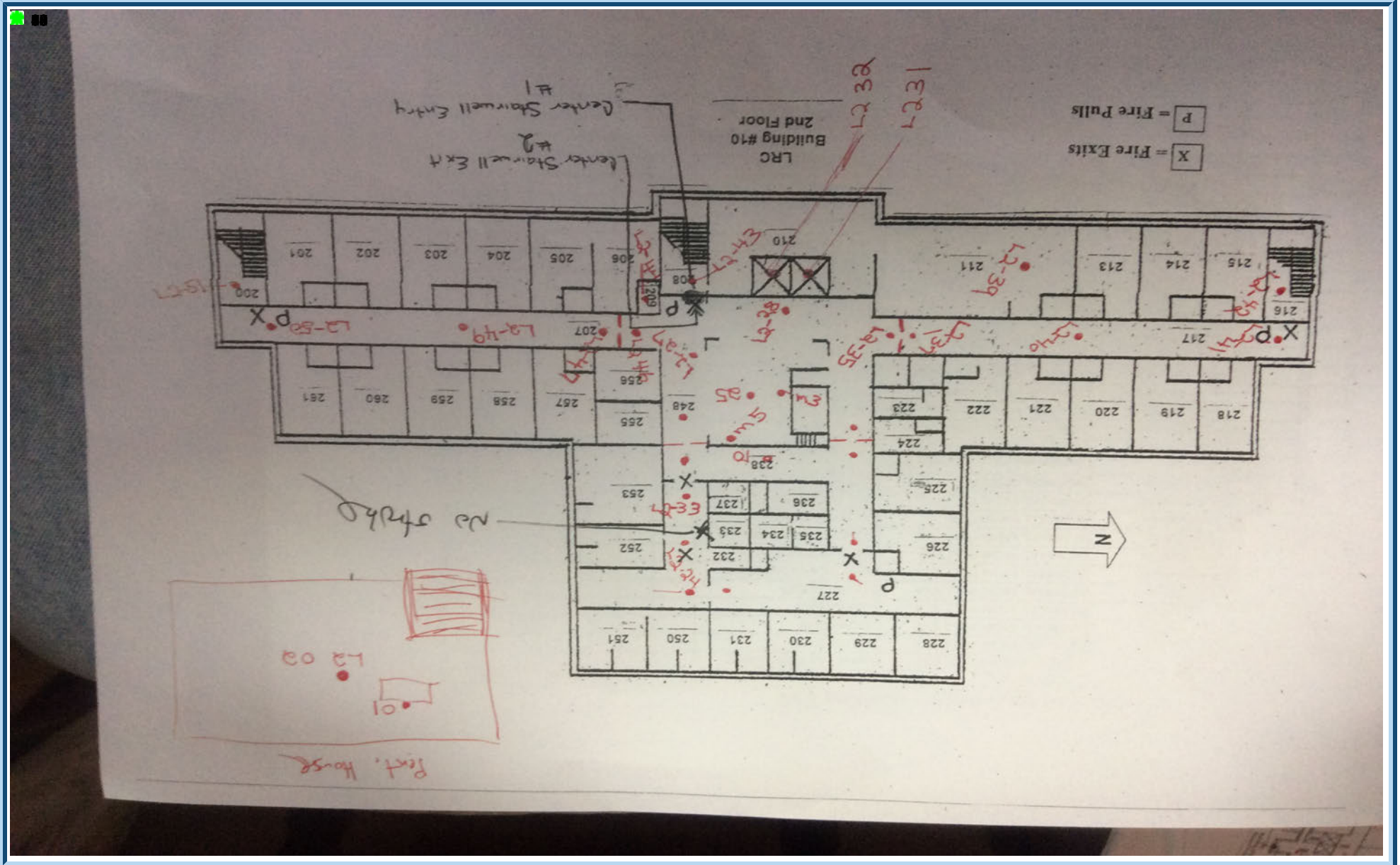
TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor
TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Penthouse	Passed		8/9/2021 1:38 PM
2	Strobe		SS24110ADA	Penthouse	Passed		8/9/2021 1:37 PM
3	Bell		KMS-8-24VDC/P	Outside 235	Passed		8/9/2021 1:37 PM
4	Strobe		SS24110ADA	Outside 235	Passed		8/9/2021 1:36 PM
5	Bell		KMS-8-24VDC/P	Outside 233	Passed		8/9/2021 1:36 PM
6	Strobe		SS24110ADA	Outside 233	Passed		8/9/2021 1:36 PM
7	Bell		KMS-8-24VDC/P	Outside 210	Passed		8/9/2021 1:35 PM
8	Strobe		SS24110ADA	Outside 210	Passed		8/9/2021 1:35 PM
9	Bell		KMS-8-24VDC/P	Outside 203	Passed		8/9/2021 1:34 PM
10	Strobe		SS24110ADA	Outside 203	Passed		8/9/2021 1:34 PM
11	Horn			Tech Station	Passed		8/9/2021 1:34 PM
12	Strobe		SS24110ADA	tech station	Passed		8/9/2021 1:28 PM
13	Bell		KMS-8-24VDC/P	Outside 213	Passed		8/9/2021 1:21 PM
14	Strobe		SS24110ADA	outside 213	Passed		8/9/2021 1:20 PM
15	Bell		KMS-8-24VDC/P	Rm 210 kitchen	Passed		8/9/2021 1:20 PM
16	Strobe		SS24110ADA	Rm 210 kitchen	Passed		8/9/2021 1:19 PM
17	Strobe		SS24110ADA	Shower 223A	Passed		8/9/2021 1:18 PM
18	Strobe		SS24110ADA	Shower 223B	Passed		8/9/2021 1:18 PM
19	Strobe		SS24110ADA	Shower 223	Passed		8/9/2021 1:16 PM



Bell	Horn	Horn Strobe	Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd Floor
TJC EP4 Notification

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SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Omaha, NE
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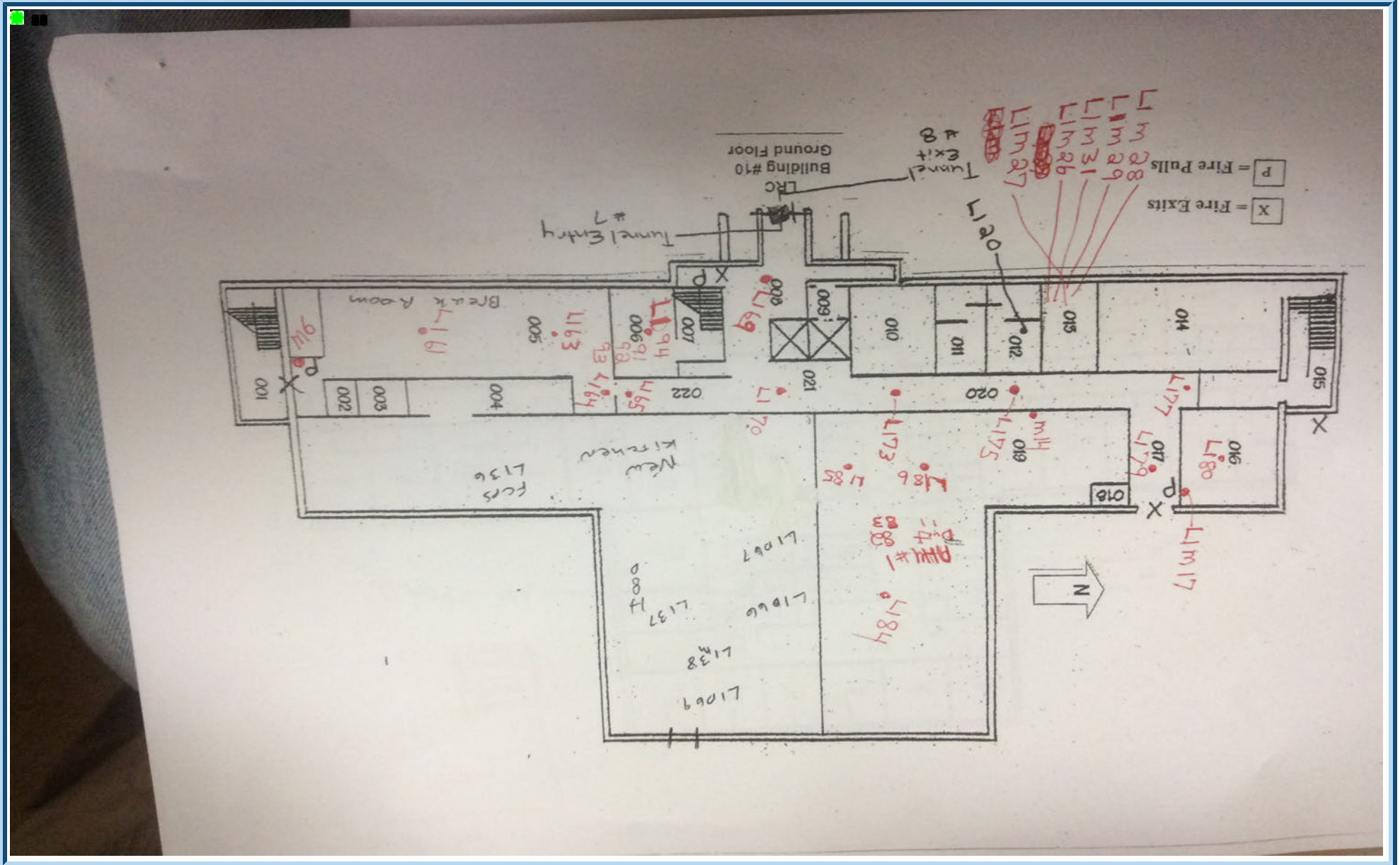
800-274-0888

LOWER LEVEL TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Elevator Lobby	Passed		8/9/2021 1:54 PM
2	Strobe		SS24110ADA	Elevator Lobby	Passed		8/9/2021 1:54 PM
3	Bell		KMS-8-24VDC/P	Outside 002	Passed		8/9/2021 1:53 PM
4	Strobe		SS24110ADA	outside 002	Passed		8/9/2021 1:53 PM
5	Horn Strobe		P2W	Outside Canteen	Passed		8/9/2021 1:53 PM
6	Horn Strobe		P2W	mech rm	Passed		8/9/2021 1:52 PM
7	Horn Strobe		P2W	Kitchen offices	Passed		8/9/2021 1:52 PM
8	Strobe		SCW	Kitchen offices RR	Passed	Ceiling	8/9/2021 1:52 PM
9	Strobe		SCW	Kitchen offices RR	Passed	Ceiling	8/9/2021 1:51 PM
10	Horn Strobe		P2W	Kitchen	Passed		8/9/2021 1:51 PM
11	Horn Strobe		P2W	Kitchen	Passed		8/9/2021 1:51 PM
12	Horn Strobe		P2W	Kitchen a Dock	Passed		8/9/2021 1:51 PM
13	Horn Strobe		P2W	Dry Storage	Passed		8/9/2021 1:51 PM
14	Horn Strobe		P2W	Dish wash Area	Passed		8/9/2021 1:50 PM
15	Strobe		SW	kitchen fridge Area	Passed		8/9/2021 1:50 PM
16	Strobe		SS24110ADA	RM 011	Passed		8/9/2021 1:50 PM
17	Strobe		SS24110ADA	RM 012	Passed		8/9/2021 1:49 PM
18	Strobe		SS24110ADA	Outside Rm 13	Passed		8/9/2021 1:49 PM
19	Bell		KMS-8-24VDC/P	Outside Rm 13	Passed		8/9/2021 1:49 PM
20	Strobe		SS24110ADA	RM 014	Passed		8/9/2021 1:48 PM
21	Bell		KMS-8-24VDC/P	AHU Rm	Passed		8/9/2021 1:48 PM
22	Strobe		SS24110ADA	AHU Rm	Passed		8/9/2021 1:48 PM



Bell	Horn	Horn Strobe	Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

LOWER LEVEL
TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

TJC EP5 FA Equipment Signals 2nd Semi-Annual Inspection Summary

Result Totals

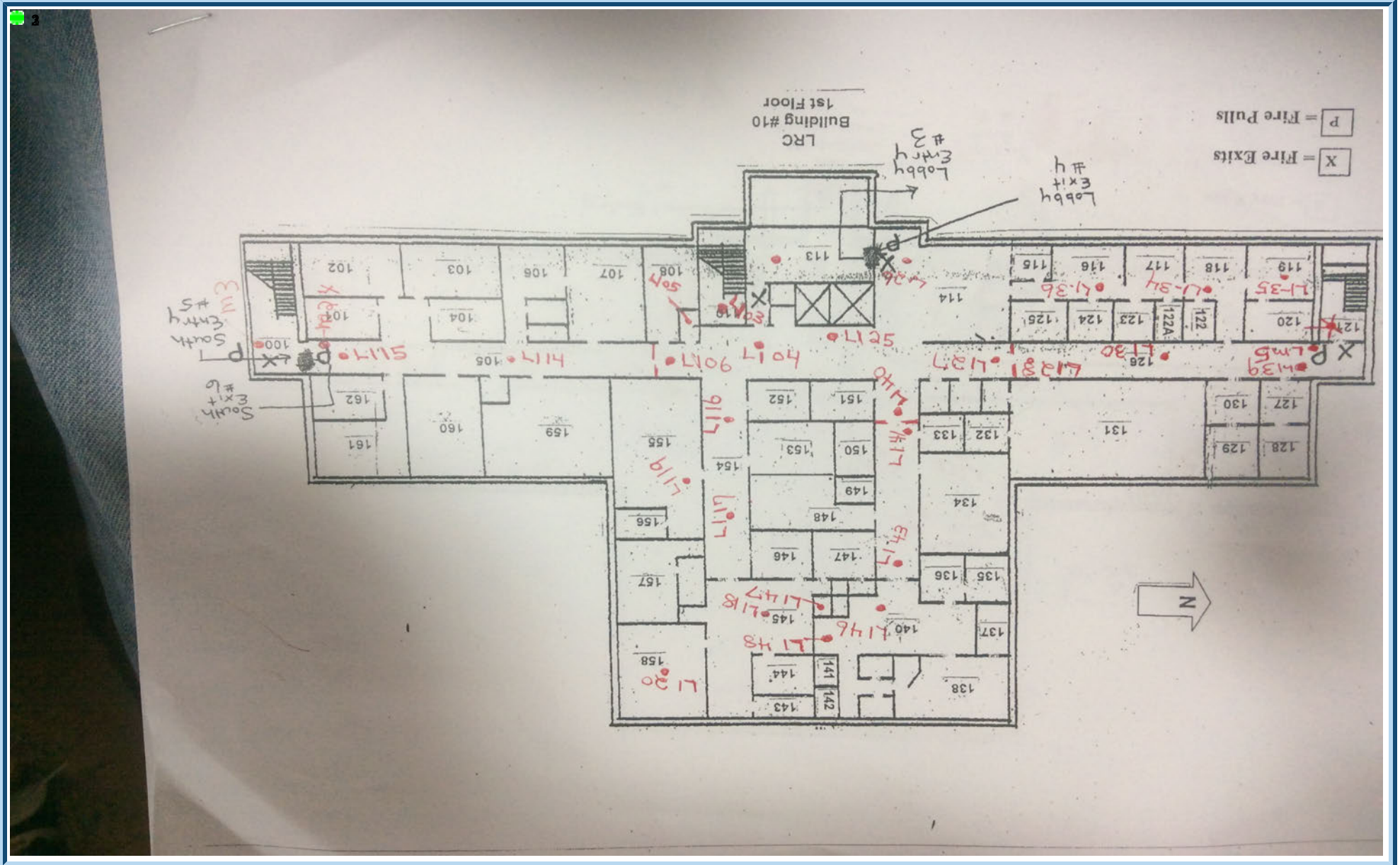
Devices	Annuciator	Power Supply
Passed	1	1
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	1	2
Total	2	3

Supercomponent Information	
Type	3 - FACP
Location	1st Floor Front Entrance
Model	AFP-1010
Voltage/Current	120VAC
s/Communication	Yes Passed

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

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		8/13/2021 4:16 PM
2	Annuciator	Notifier			Front lobby	Passed		8/13/2021 4:16 PM
3	FACP	Notifier	AFP-1010		Front Entrance	Passed		8/13/2021 4:17 PM



Annunciator | FACP | Power Supply

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

TJC EP5 FA Equipment Signals

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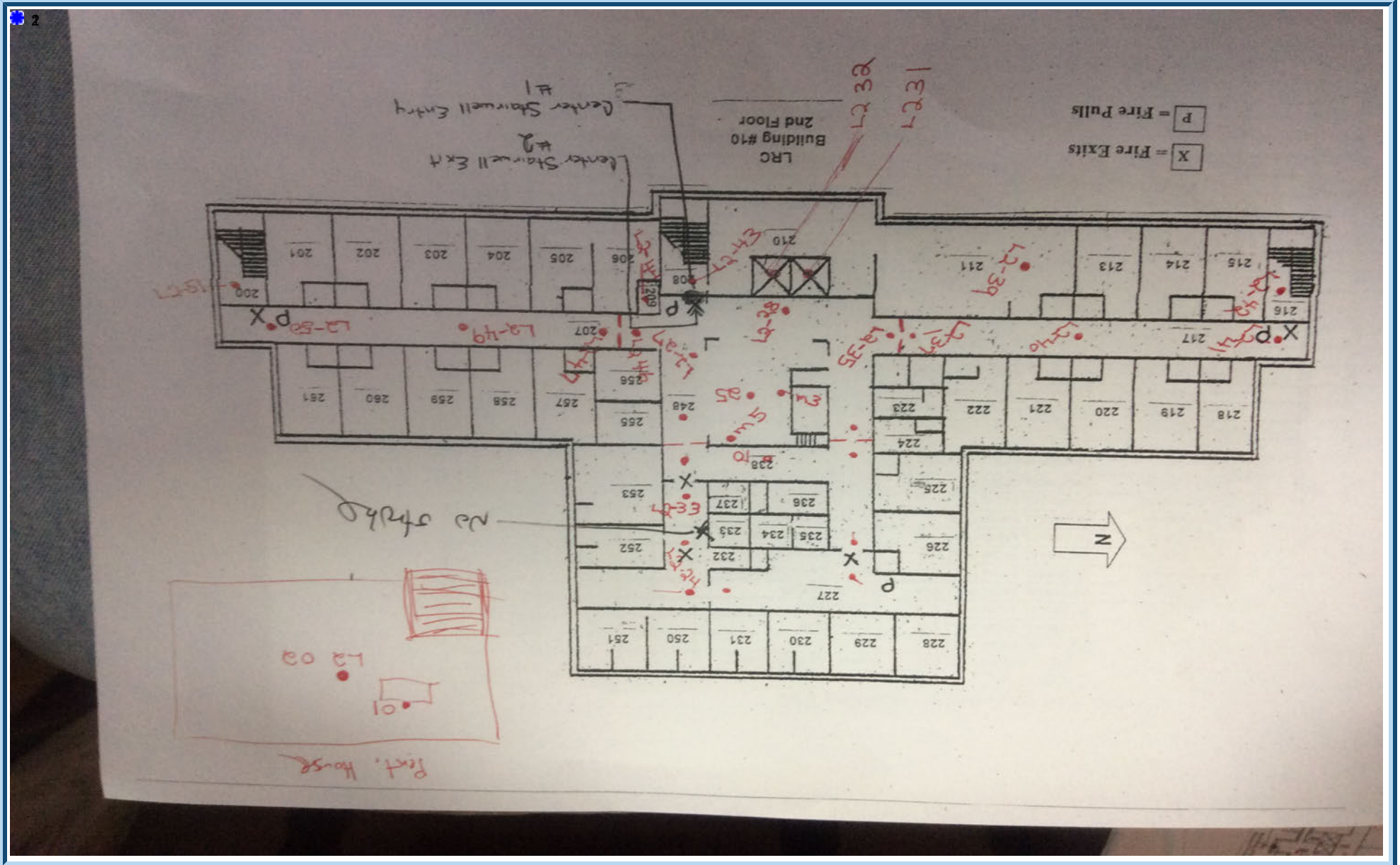
2nd Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Power Supply	Notifier	FCPS-24	L2M06	Maint. rm 209	Not Inspected		8/3/2021 9:29 AM
2	Annuciator	Notifier			tech station	Not Inspected		8/3/2021 9:29 AM



Annunciator	FACP	Power Supply
Passed = Green	Mitigated = Green	Failed = Red
		Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd Floor
TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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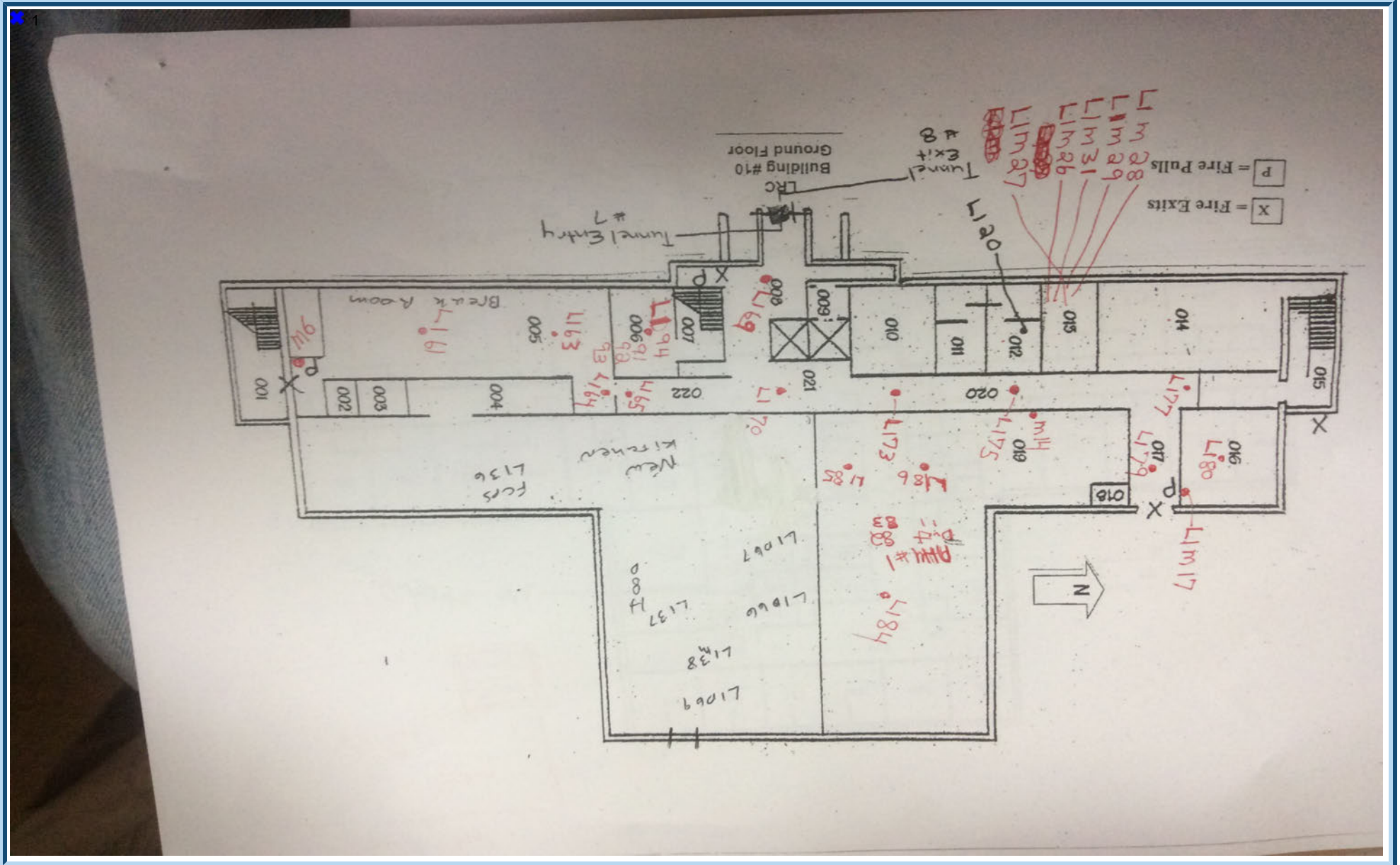
Omaha, NE
Scottsbluff, NE
800-274-0888

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	Not Inspected		8/3/2021 9:29 AM



Annuciator	FACP	Power Supply
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

LOWER LEVEL
TJC EP5 FA Equipment Signals

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SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Omaha, NE
Scottsbluff, NE
800-274-0888

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V8AH			2-21-19	1st Floor Maint 108	Passed	
1	12V8AH			2-21-19	1st Floor Maint 108	Passed	
3	12V26AH	Notifier	AFP-1010	2-21-19	1st Floor Front Entrance	Passed	Left
3	12V26AH	Notifier	AFP-1010	2-21-2019	1st Floor Front Entrance	Passed	Right
1	12V8AH			2-21-2019	2nd Floor Maint. rm 209	Not Inspected	
1	12V8AH			2-21-2019	2nd Floor Maint. rm 209	Not Inspected	
1	12V8AH			2-21-2019	LOWER LEVEL AHU Rm	Not Inspected	
1	12V8AH			2-21-2019	LOWER LEVEL AHU Rm	Not Inspected	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1	02	Power Supply	Notifier	FCPS-24	120	Maint 108	1st Floor	Passed	24-5	
2		Annuciator	Notifier			Front lobby	1st Floor	Passed		
3		FACP	Notifier	AFP-1010	120VAC	Front Entrance	1st Floor	Passed		
1	L2M06	Power Supply	Notifier	FCPS-24	120	Maint. rm 209	2nd Floor	Not Inspected		
2		Annuciator	Notifier			tech station	2nd Floor	Not Inspected		
1	M12	Power Supply	Notifier	FCPS-24	120	AHU Rm	LOWER LEVEL	Not Inspected		

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

Account: LRC Bldg. # 10 - Lincoln Regional Center
Address: 801 West Prospector PL., Lincoln, NE 68522

TJC EP19 Shutdown 2nd Semi-Annual Inspection Summary

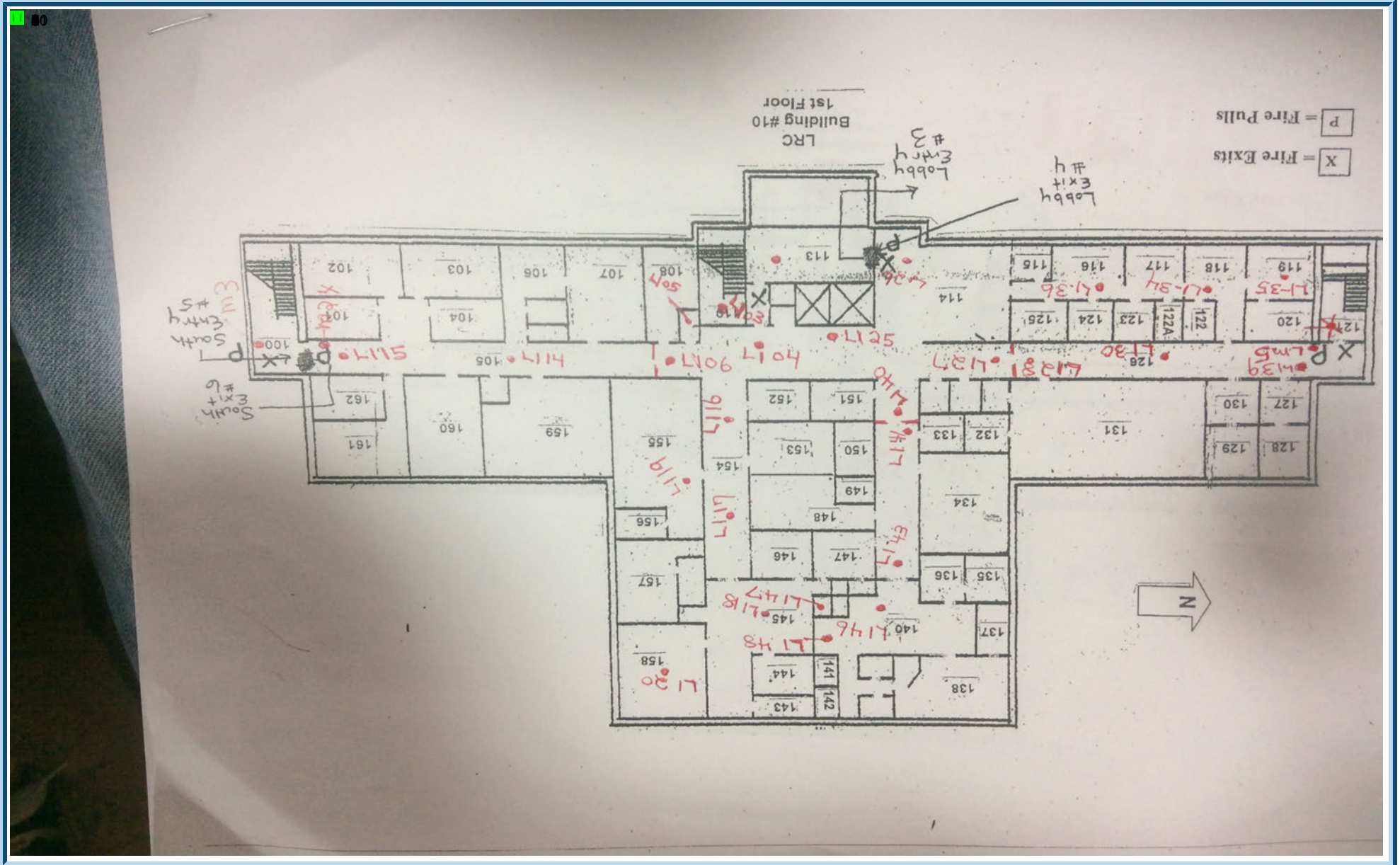
Result Totals

Devices	Fan	Relays
Passed	5	24
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	5	24

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 126 E.	Passed		8/9/2021 12:41 PM
2	Relays				Door Holder 126 W.	Passed		8/9/2021 12:41 PM
3	Relays				Door Holder 105 E.	Passed		8/9/2021 12:40 PM
4	Relays				Door Holder 105 W.	Passed		8/9/2021 12:40 PM
5	Relays				Door Holder 148 N.	Passed		8/9/2021 12:38 PM
6	Relays				Door Holder 148 S.	Passed		8/9/2021 12:37 PM
7	Relays				Door Holder 154 N.	Passed		8/9/2021 12:37 PM
8	Relays				Door Holder 154 S.	Passed		8/9/2021 12:37 PM
9	Relays				Door Holder Chapel RM 140	Passed		8/9/2021 12:37 PM
10	Relays	L1M11			Door Holder module	Passed		8/9/2021 12:37 PM
11	Relays	L1M09			Smoke relay 1st damper	Passed		8/9/2021 12:37 PM



✖ Fan

Passed = Green

Mitigated = Green

Failed = Red

Relays

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

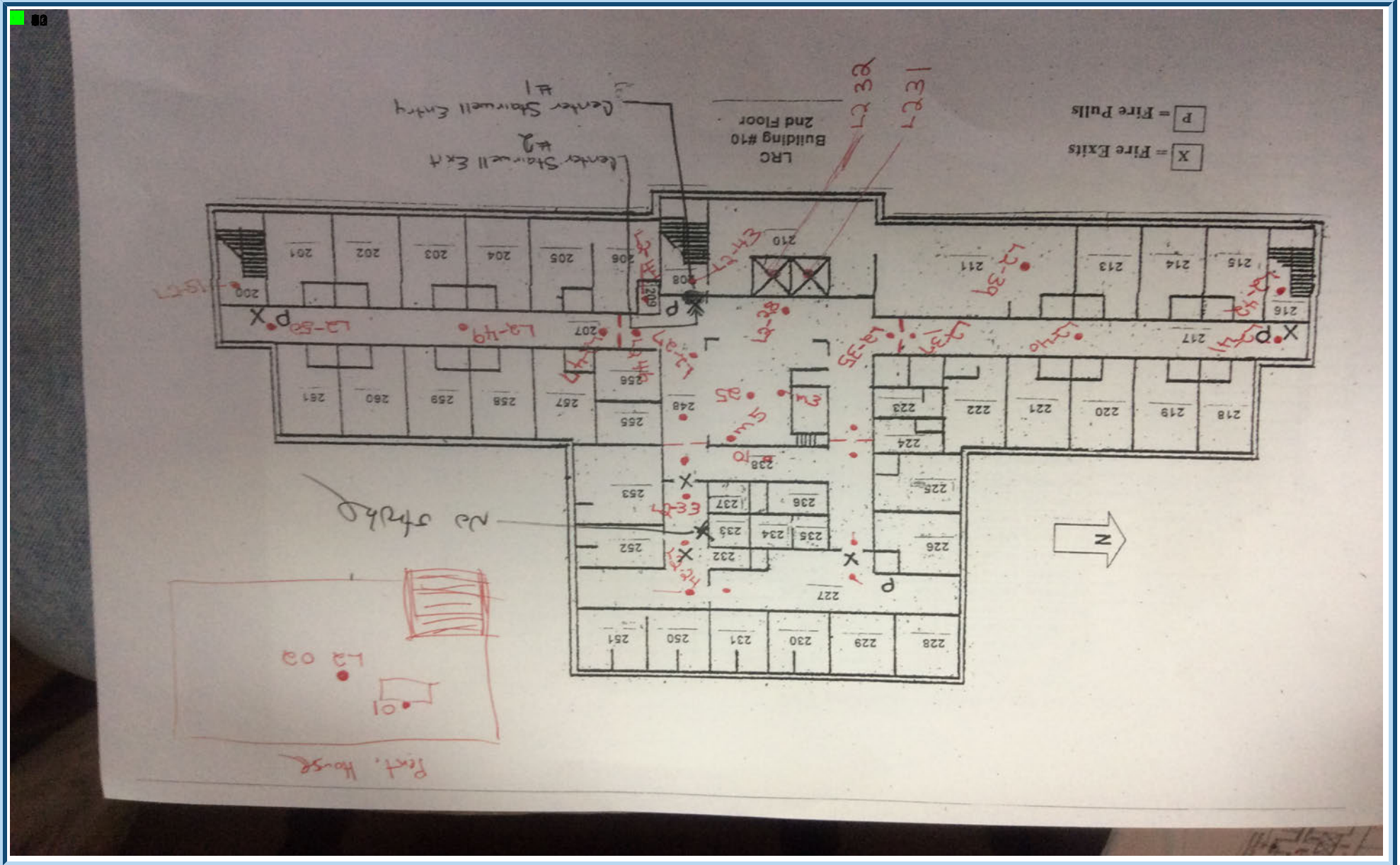
TJC EP19 Shutdown

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd Floor TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder Dining RM 212	Passed		8/9/2021 12:47 PM
2	Relays				Door Holder 217 N.	Passed		8/9/2021 12:46 PM
3	Relays				Door Holder 217 S.	Passed		8/9/2021 12:46 PM
4	Relays				Door Holder 207 N.	Passed		8/9/2021 12:45 PM
5	Relays				Door Holder 207 S.	Passed		8/9/2021 12:45 PM
6	Relays				Door Holder 238 E.	Passed		8/9/2021 12:45 PM
7	Relays				Door Holder 238 W.	Passed		8/9/2021 12:44 PM
8	Relays				Door Holder 239 E.	Passed		8/9/2021 12:44 PM
9	Relays				Door Holder 239 W.	Passed		8/9/2021 12:43 PM
10	Relays				Door Holder 227 Corridor	Passed		8/9/2021 12:42 PM
11	Relays				Door Holder 249 Corridor	Passed		8/9/2021 12:42 PM
12	Fan	L2M01			penthouse fan	Passed		8/13/2021 4:25 PM
13	Relays	L2M01			Smoke relay 2nd damper	Passed		8/9/2021 12:42 PM



✖ Fan

Passed = Green

Mitigated = Green

Failed = Red

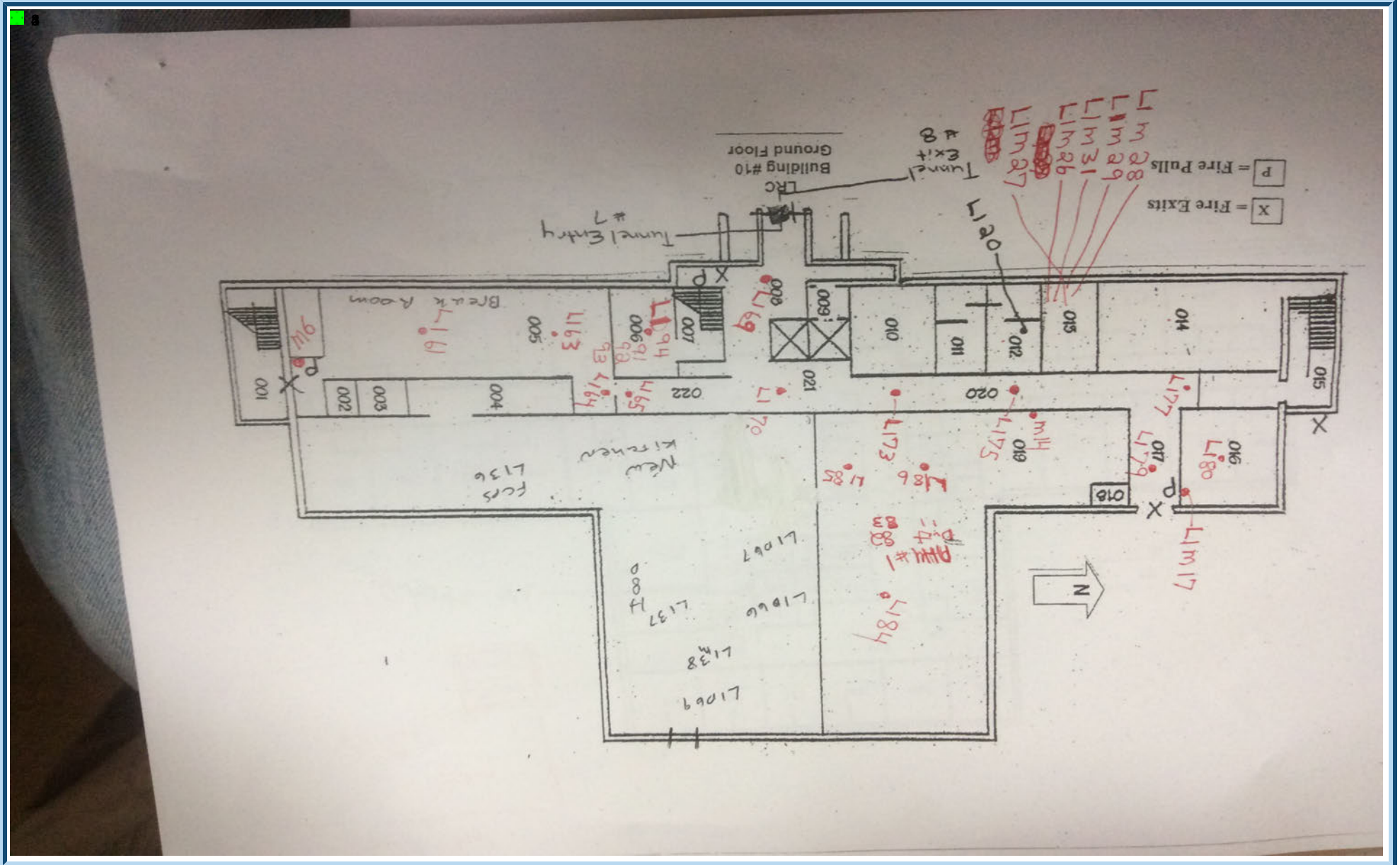
Not Tested = Blue

Relays

Not Tested = Blue

LOWER LEVEL TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays				Door Holder 005	Passed		8/9/2021 12:42 PM
2	Fan	L1M07			Canteen fan	Passed		8/13/2021 4:23 PM
3	Fan	L1M15			AHU 1	Passed		8/13/2021 4:24 PM
4	Fan	L1M16			AHU 2	Passed		8/13/2021 4:24 PM
5	Fan	L1M22			AHU	Passed		8/13/2021 4:24 PM



✖ Fan

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

▮▮ Relays

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

LOWER LEVEL

TJC EP19 Shutdown

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Supercomponent Results

Number	Type	Zone/address	Make	Model	Location	Layout	Result	Comments
12	Fan	L2M01			penthouse fan	2nd Floor	Passed	
2	Fan	L1M07			Canteen fan	LOWER LEVEL	Passed	
3	Fan	L1M15			AHU 1	LOWER LEVEL	Passed	
4	Fan	L1M16			AHU 2	LOWER LEVEL	Passed	
5	Fan	L1M22			AHU	LOWER LEVEL	Passed	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 10 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

- building currently under construction inspected what we could

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property: LRC Bldg. # 10 - Lincoln Regional Center

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

Inspection Date: //

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 10 - Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	(402) 479-5453
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	402-471-2027
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	2900 S 70th st #330
Monitoring Org Phone	(402) 474-3737
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied
Phone Line one or IP	Customer supplied

Phone Line two or IP	Customer supplied
Means Of Transmission	POTS

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	
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	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		
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.	

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	
Title:	
Phone:	
Date:	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

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

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

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

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2nd Semi-Annual Inspection Summary

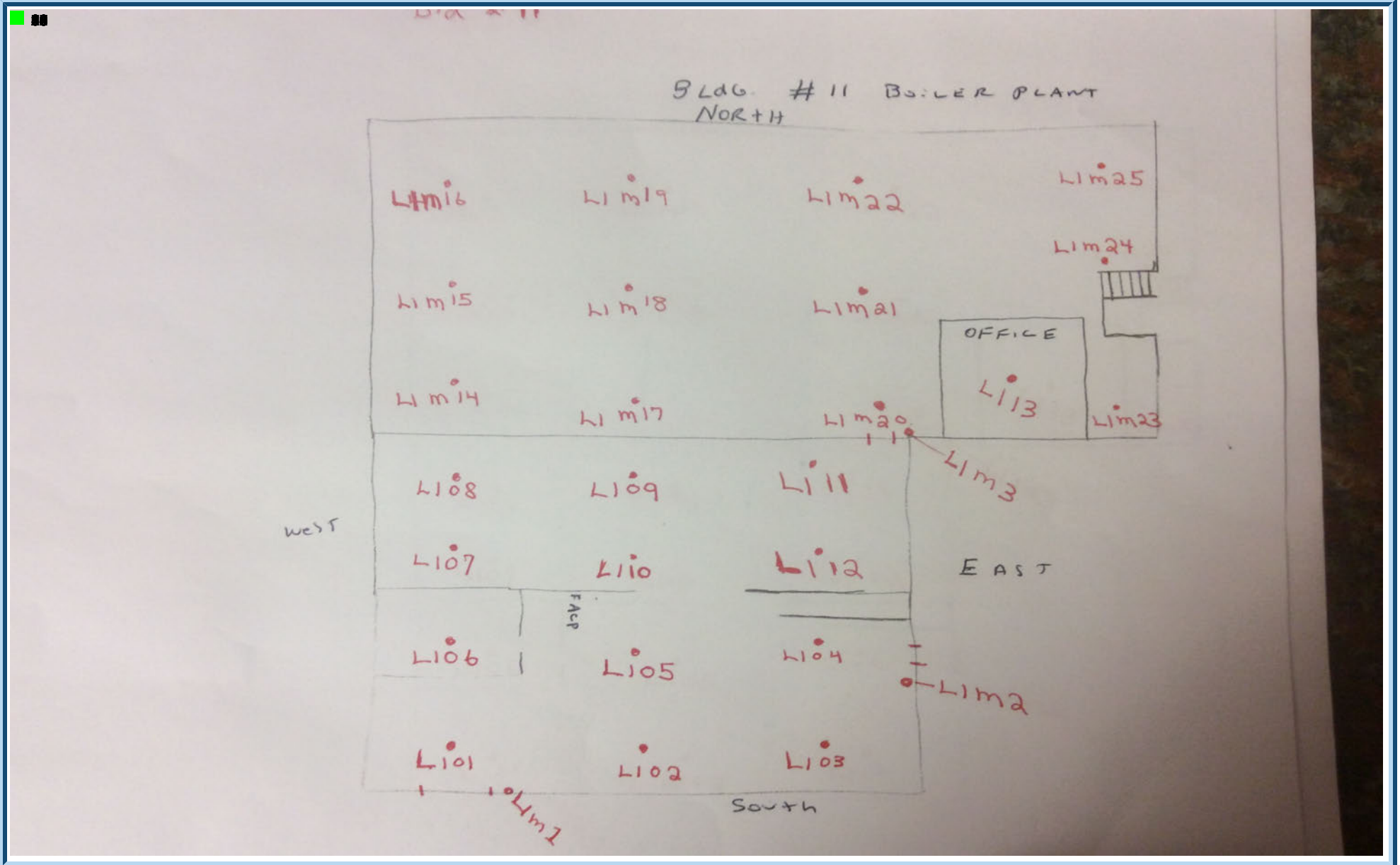
Result Totals

Devices	Heat Detector	Manual Pull Station
Passed	25	3
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	-	-
Total	25	3

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

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		8/3/2021 1:59 PM
2	Manual Pull Station	L1M03	Notifier	BGX-101L	South Exit	Passed		8/3/2021 2:00 PM
3	Heat Detector	L1D01	Notifier	FDX-511	Southwest Heat Det.	Passed		8/3/2021 2:00 PM
4	Heat Detector	L1D02	Notifier	FDX-511	SouthCenter Heat Det.	Passed		8/3/2021 2:00 PM
5	Heat Detector	L1D02	Notifier	FDX-511	SouthCenter Heat Det.	Passed		8/3/2021 2:00 PM
6	Heat Detector	L1D03	Notifier	FDX-511	Southeast Heat Det.	Passed		8/3/2021 2:01 PM
7	Heat Detector	L1D04	Notifier	FDX-511	Northeast Heat Det.	Passed		8/3/2021 2:02 PM
8	Heat Detector	L1D06	Notifier	FDX-511	Northwest Heat Det.	Passed		8/3/2021 2:02 PM
9	Heat Detector	L1D07	Notifier	FDX-511	Southwest Heat Det.	Passed		8/3/2021 2:02 PM
10	Heat Detector	L1D08	Notifier	FDX-511	Northwest Heat Det.	Passed		8/3/2021 2:03 PM
11	Heat Detector	L1D09	Notifier	FDX-511	North Center Heat Det.	Passed		8/3/2021 2:03 PM
12	Heat Detector	L1D10	Notifier	FDX-511	South Center Heat Det.	Passed		8/3/2021 2:04 PM
13	Heat Detector	L1D11	Notifier	FDX-511	NorthEast Heat Det.	Passed		8/3/2021 2:04 PM
14	Heat Detector	L1D12	Notifier	FDX-511	SouthEast Heat Det.	Passed		8/3/2021 2:05 PM
15	Heat Detector	L1D13	Notifier	FDX-511	Boiler room office	Passed		8/3/2021 2:05 PM
16	Heat Detector	L1M25	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:05 PM
17	Manual Pull Station	L1M01	Notifier	BGX-101L	South Exit	Passed		8/3/2021 2:05 PM
18	Heat Detector	L1M14	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:10 PM
19	Heat Detector	L1M15	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:10 PM
20	Heat Detector	L1M16	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:10 PM
21	Heat Detector	L1M17	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:12 PM
22	Heat Detector	L1M18	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:11 PM
23	Heat Detector	L1M19	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:11 PM
24	Heat Detector	L1M20	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:13 PM
25	Heat Detector	L1M21	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:12 PM
26	Heat Detector	L1M22	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:13 PM
27	Heat Detector	L1M23	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:12 PM
28	Heat Detector	L1M24	Notifier		Boiler Area	Passed	Thermo tech	8/3/2021 2:11 PM



Heat Detector

Manual Pull Station

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

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

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

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

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP4 Notification 2nd Semi-Annual Inspection Summary

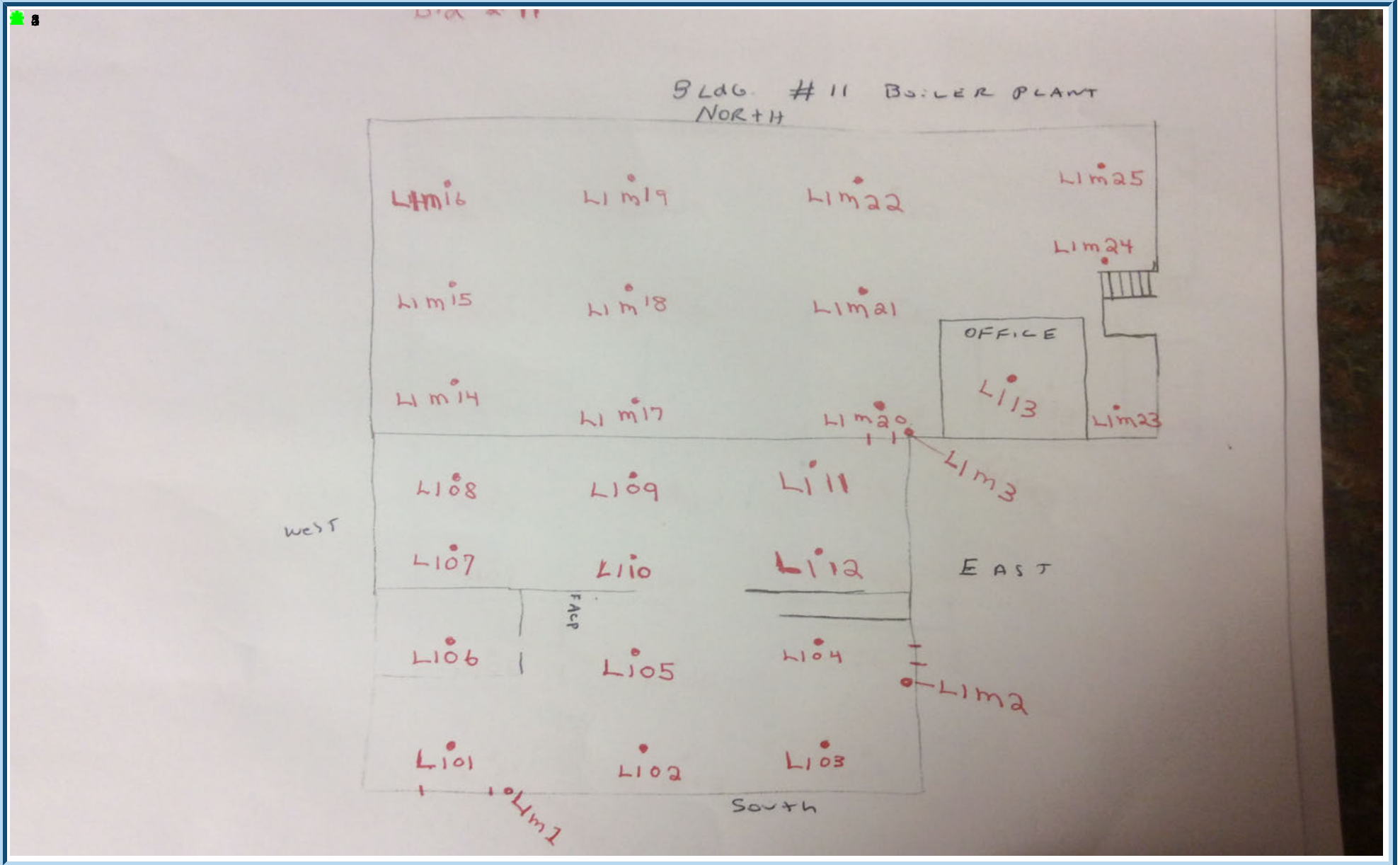
Result Totals

Devices	Bell	Horn	Strobe
Passed	2	1	2
Mitigated	-	-	-
New - Passed	-	-	-
Failed	-	-	-
Removed	-	-	-
Not Inspected	-	-	-
Total	2	1	2

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	Across from pop machine	Passed		8/3/2021 2:17 PM
2	Strobe		SS24110ADA	Across from pop machine	Passed		8/3/2021 2:17 PM
3	Strobe		SS24110ADA	Boiler Room Left of panel	Passed		8/3/2021 2:17 PM
4	Bell		KMS-8-24VDC/P	Left of main panel	Passed		8/3/2021 2:17 PM
5	Horn			Above FACP	Passed		8/3/2021 2:16 PM



Bell	Horn	Strobe
Passed = Green	Mitigated = Green	Failed = Red	Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

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

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Account: LRC Bldg. # 11 - Lincoln Regional Center

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

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP5 FA Equipment Signals 2nd Semi-Annual Inspection Summary

Result Totals

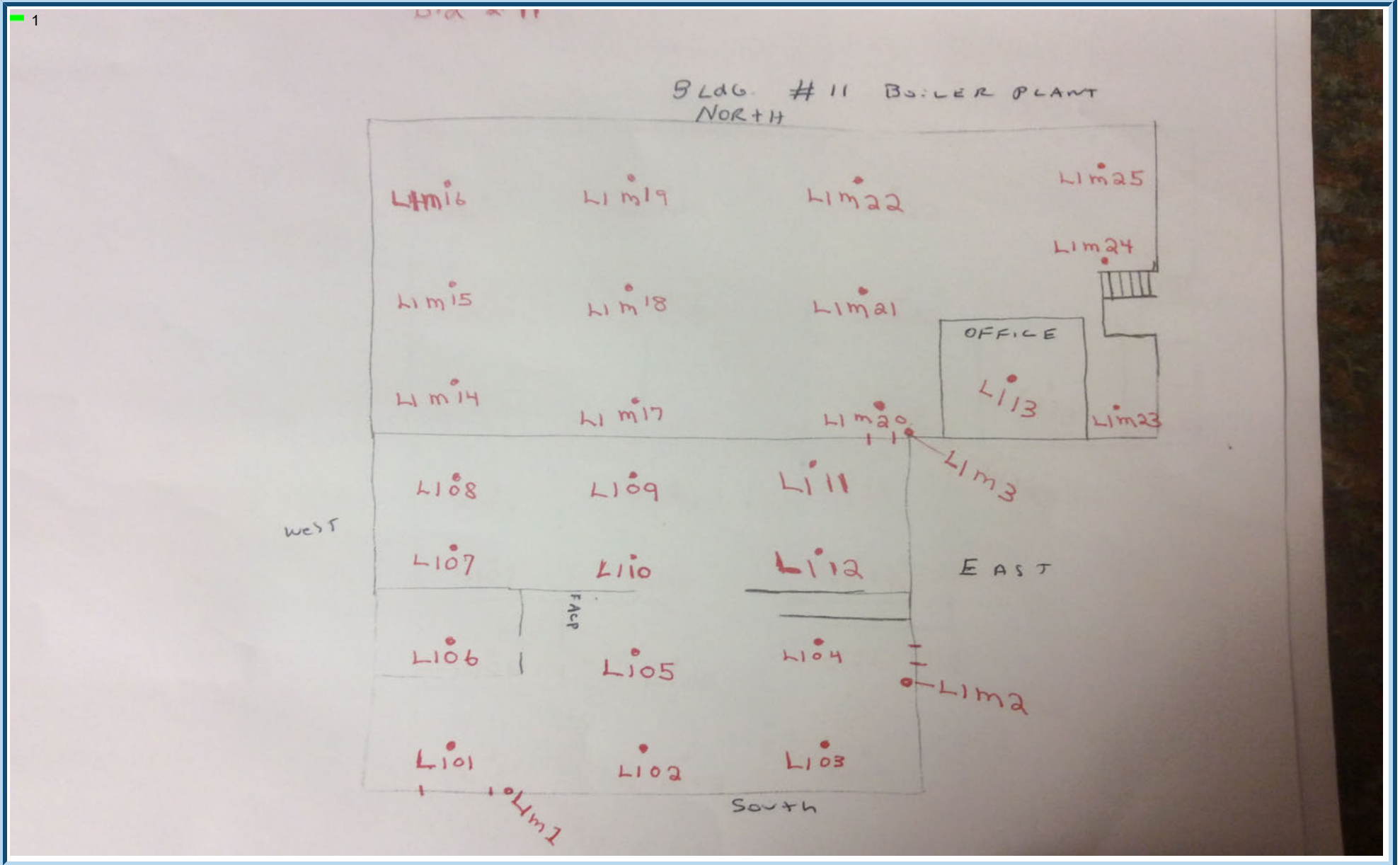
Devices	
Passed	
Mitigated	
New - Passed	
Failed	
Removed	
Not Inspected	
Total	

Supercomponent Information	
Type	1 - FACP
Location	1st Floor Boiler Room
Model	nfs2 640
Voltage/Current	120
s/Communication	Yes Passed

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

1st Floor TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	nfs2 640		Boiler Room	Passed		8/3/2021 2:19 PM



FACP

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st Floor

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH	Notifier	AFP1010	4-16-2019	1st Floor Boiler Room	Passed	
1	12V26AH	Notifier	AFP1010	4-16-2019	1st Floor Boiler Room	Passed	Right

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	nfs2 640	120	Boiler Room	1st Floor	Passed	24 HRs	

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 11 - Lincoln Regional Center

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

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property:	LRC Bldg. # 11 - Lincoln Regional Center	Inspection Date: 8/3/2021	
Property Address:	801 West Prospector PL. Power Plant Lincoln, NE 68522		

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 11 - Lincoln Regional Center
Shipping Street	801 West Prospector PL. Power Plant
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	(402) 479-5453
Main Account Email	
Authority Having Juristiction	Nebraska State Fire Marshalls
AHJ Phone Number	402-471-2027
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	2900 S 70th st #330
Monitoring Org Phone	(402) 474-3737
Monitoring Org Email	
Monitoring Acct Number	Customer Supplied

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

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Bevan Flynn

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		
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.	8-3-2021 1:00pm

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Bevan Flynn
Title:	
Phone:	
Date:	8-3-21

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 14 - Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP2 Tampers Waterflows 2nd Semi-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 8/3/2021 in accordance with applicable requirements.

GROUND FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L1M23	042	Passed			8/6/2021 1:21 PM
2	Control Valve Switch	L1M22	Center Hall by 039	Passed			8/6/2021 1:21 PM
3	PIV	L1M21	Outside	Passed			8/6/2021 1:21 PM
4	Control Valve Switch	L1M22	Center Hall by 039	Passed			8/6/2021 1:22 PM
5	Control Valve Switch	L1M23	042	Passed			8/6/2021 1:22 PM
6	Control Valve Switch	L1M23	042	Passed			8/6/2021 1:23 PM
7	Control Valve Switch	L1M23	042	Passed			8/6/2021 1:23 PM
8	Control Valve Switch	L1M23	042	Passed			8/6/2021 1:23 PM

Control Valve Switch | PIV | Standpipe Water Flow

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

GROUND FLOOR

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L2M11	1st Water Flow	Passed			8/6/2021 1:23 PM
2	Control Valve Switch		1st flr hall	Passed			8/6/2021 1:23 PM

Control Valve Switch | PIV | Standpipe Water Flow

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP2 Tampers Waterflows Results

Number	Type	Zone/address	Location	Result	Trip Time	Comments	Date
1	Standpipe Water Flow	L3M07	2nd Water Flow	Passed			8/6/2021 1:24 PM
2	Control Valve Switch		2nd flr tamper	Passed			8/6/2021 1:24 PM

Control Valve Switch | PIV | Standpipe Water Flow

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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			8/6/2021 1:24 PM
2	Standpipe Water Flow	L4M10	3rd Flr	Passed			8/6/2021 1:25 PM
3	Control Valve Switch	L4M11	Penthouse supervisory tamper	Passed			8/6/2021 1:25 PM
4	Control Valve Switch		3rd flr store room	Passed			8/6/2021 1:25 PM
5	Control Valve Switch		3rd flr store room	Passed			8/6/2021 1:25 PM

Control Valve Switch

Passed = Green

PIV

Mitigated = Green

Failed = Red

Standpipe Water Flow

Not Tested = Blue

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3rd FLOOR

TJC EP2 Tampers Waterflows

PROTEX CENTRAL
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Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 14 - Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP3 Initiating Devices 2nd Semi-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 8/3/2021 in accordance with applicable requirements.

GROUND FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L1D71	Notifier	SDX-551	Lobby Maintenance	Passed		8/6/2021 10:54 AM
2	Heat Detector	L1D40	Notifier	FDX-551	Asbestos Room	Passed		8/6/2021 10:54 AM
3	Heat Detector	L1D42	Notifier	FDX-551	Housekeeping Office	Passed		8/6/2021 10:54 AM
4	Heat Detector	L1D43	Notifier	FDX-551	Housekeeping Office	Passed		8/6/2021 10:54 AM
5	Smoke Detector	L1D44	Notifier	SDX-551	Hall By O.T. Stairs	Passed		8/6/2021 10:55 AM
6	Smoke Detector	L1D45	Notifier	SDX-551	Hall By House Keeping	Passed		8/6/2021 10:55 AM
7	Smoke Detector	L1D47	Notifier	SDX-551	Hall By O.T.	Passed		8/6/2021 10:55 AM
8	Smoke Detector	L1D48	Notifier	SDX-551	Hall By O.T.	Passed		8/6/2021 10:55 AM
9	Smoke Detector	L1D49	Notifier	SDX-551	Hall By O.T.	Passed		8/6/2021 10:56 AM
10	Heat Detector	L1D50	Notifier	FDX-551	O.T. Room	Passed		8/6/2021 10:56 AM
11	Heat Detector	L1D51	Notifier	FDX-551	O.T. Room	Passed		8/6/2021 10:56 AM
12	Heat Detector	L1D52	Notifier	FDX-551	O.T. Small Storage	Passed		8/6/2021 10:57 AM
13	Heat Detector	L1D53	Notifier	FDX-551	O.T. Storage	Passed		8/6/2021 10:57 AM
14	Smoke Detector	L1D55	Notifier	SDX-551	West Hall	Passed		8/6/2021 10:57 AM
15	Heat Detector	L1D57	Notifier	FDX-551	O.T. RR Storage	Passed		8/6/2021 10:58 AM
16	Smoke Detector	L1D58	Notifier	SDX-551	West Hall	Passed		8/6/2021 10:58 AM
17	Heat Detector	L1D59	Notifier	FDX-551	Patient Storage	Passed		8/6/2021 10:58 AM
18	Smoke Detector	L1D60	Notifier	SDX-551	Hall By Engineer Files	Passed		8/6/2021 10:58 AM
19	Heat Detector	L1D61	Notifier	FDX-551	RM 022	Passed		8/6/2021 10:59 AM
20	Heat Detector	L1D62	Notifier	FDX-551	Engineering Copy Room	Passed		8/6/2021 10:59 AM
21	Smoke Detector	L1D63	Notifier	SDX-551	Hall By Architecture	Passed		8/6/2021 10:59 AM
22	Smoke Detector	L1D64	Notifier	SDX-551	Hall By Engineer	Passed		8/6/2021 10:59 AM
23	Heat Detector	L1D65	Notifier	FDX-551	Pipe Chase	Passed		8/6/2021 11:00 AM
24	Smoke Detector	L1D66	Notifier	SDX-551	Engineering Sec. Office	Passed		8/6/2021 11:00 AM
25	Smoke Detector	L1D67	Notifier	SDX-551	Hall By Women's RR	Passed		8/6/2021 11:00 AM
26	Heat Detector	L1D69	Notifier	FDX-551	Mech Equipment Room	Passed		8/6/2021 11:00 AM
27	Smoke Detector	L1D72	Notifier	SDX-551	Maintenance Break Room	Passed		8/6/2021 11:01 AM
28	Duct Detector	L1D80	Innovair/Notifier	SDX-551	Mech Rm 15	Passed		8/6/2021 11:01 AM
29	Manual Pull Station	L1M10	Notifier	BGX-101L	O.T. Stairs	Passed		8/6/2021 11:01 AM
30	Manual Pull Station	L1M12	Notifier	BGX-101L	Exit By Women's RR	Passed		8/6/2021 11:02 AM
31	Manual Pull Station	L1M14	Notifier	BGX-101L	North Exit	Passed		8/6/2021 11:02 AM
32	Heat Detector	L1D39	Notifier	FDX-551	Main Electrical RM	Passed		8/6/2021 11:02 AM
33	Smoke Detector	L1D46	Notifier	SDX-551	Hall By House Keeping	Passed		8/6/2021 11:02 AM
34	Manual Pull Station	L1M05	Notifier	BGX-101L	Center Stairs Exit	Passed		8/6/2021 11:03 AM
35	Heat Detector	L1D41	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/6/2021 11:03 AM
36	Heat Detector	L1D01	Notifier	FDX-551	Exercise RM	Passed		8/6/2021 11:03 AM
37	Heat Detector	L1D02	Notifier	FDX-551	Exercise RM	Passed		8/6/2021 11:04 AM
38	Smoke Detector	L1D03	Notifier	SDX-551	North Hall	Passed		8/6/2021 11:04 AM
39	Heat Detector	L1D05	Notifier	FDX-551	Women's Shower	Passed		8/6/2021 11:04 AM
40	Heat Detector	L1D06	Notifier	FDX-551	Dressing Room	Passed		8/6/2021 11:05 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L1D07	Notifier	FDX-551	Maintenance Storage	Passed		8/6/2021 11:05 AM
42	Heat Detector	L1D08	Notifier	FDX-551	Contractor Storage	Passed		8/6/2021 11:05 AM
43	Smoke Detector	L1D09	Notifier	SDX-551	Mini Gym	Passed		8/6/2021 11:05 AM
44	Smoke Detector	L1D10	Notifier	SDX-551	Mini Gym	Passed		8/6/2021 11:06 AM
45	Smoke Detector	L1D11	Notifier	SDX-551	Mini Gym	Passed		8/6/2021 11:06 AM
46	Smoke Detector	L1D12	Notifier	SDX-551	East Hall	Passed		8/6/2021 11:06 AM
47	Heat Detector	L1D14	Notifier	FDX-551	Staff Restroom	Passed		8/6/2021 11:07 AM
48	Heat Detector	L1D15	Notifier	FDX-551	East Game Room	Passed		8/6/2021 11:07 AM
49	Heat Detector	L1D17	Notifier	FDX-551	East Game Room	Passed		8/6/2021 11:07 AM
50	Smoke Detector	L1D18	Notifier	SDX-551	East Hall	Passed		8/6/2021 11:07 AM
51	Heat Detector	L1D19	Notifier	FDX-551	East Hall	Passed		8/6/2021 11:08 AM
52	Heat Detector	L1D20	Notifier	FDX-551	East Game Room	Passed		8/6/2021 11:08 AM
53	Heat Detector	L1D21	Notifier	FDX-551	East Hall	Passed		8/6/2021 11:08 AM
54	Heat Detector	L1D22	Notifier	FDX-551	Student Office	Passed		8/6/2021 11:08 AM
55	Heat Detector	L1D23	Notifier	FDX-551	East Group RM	Passed		8/6/2021 11:09 AM
56	Heat Detector	L1D24	Notifier	FDX-551	West Group RM	Passed		8/6/2021 11:09 AM
57	Heat Detector	L1D25	Notifier	FDX-551	Maintenance Office	Passed		8/6/2021 11:09 AM
58	Heat Detector	L1D26	Notifier	FDX-551	Laundry Dryer RM	Passed		8/6/2021 11:10 AM
59	Smoke Detector	L1D27	Notifier	SDX-551	Hall by sewing	Passed		8/6/2021 11:10 AM
60	Heat Detector	L1D28	Notifier	FDX-551	Sewing Room	Passed		8/6/2021 11:10 AM
61	Smoke Detector	L1D29	Notifier	SDX-551	North Tunnel	Passed		8/6/2021 11:11 AM
62	Smoke Detector	L1D31	Notifier	SDX-551	Hall by Converter Rm	Passed		8/6/2021 11:13 AM
63	Heat Detector	L1D32	Notifier	FDX-551	Chiller Room	Passed		8/6/2021 11:13 AM
64	Smoke Detector	L1D33	Notifier	SDX-551	Hall by Laundry	Passed		8/6/2021 11:13 AM
65	Heat Detector	L1D34	Notifier	FDX-551	Laundry Wash Room	Passed		8/6/2021 11:14 AM
66	Heat Detector	L1D35	Notifier	FDX-551	Center Hall	Passed		8/6/2021 11:14 AM
67	Smoke Detector	L1D36	Notifier	SDX-551	Hall by telephone Rm	Passed		8/6/2021 11:14 AM
68	Smoke Detector	L1D37	Notifier	SDX-551	Hall by telephone Rm	Passed		8/6/2021 11:14 AM
69	Heat Detector	L1D41	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/6/2021 11:15 AM
70	Heat Detector	L1D76	Notifier	FDX-551	E Storage by S Tunnel	Passed		8/6/2021 11:15 AM
71	Heat Detector	L1D77	Notifier	FDX-551	W Storage by S Tunnel	Passed		8/6/2021 11:15 AM
72	Smoke Detector	L1D78	Notifier	SDX-551	South Tunnel Doors	Passed		8/6/2021 11:16 AM
73	Smoke Detector	L1D79	Notifier	SDX-551	South Tunnel Doors	Passed		8/6/2021 11:16 AM
74	Duct Detector	L1D81	Innovair		Mech Rm 65	Passed		8/6/2021 11:16 AM
75	Manual Pull Station	L1M01	Notifier	BGX-101L	North East Exit	Passed		8/6/2021 11:17 AM
76	Manual Pull Station	L1M02	Notifier	BGX-101L	North Hall Exit	Passed		8/6/2021 11:17 AM
77	Manual Pull Station	L1M03	Notifier	BGX-101L	East Exit	Passed		8/6/2021 11:17 AM
78	Smoke Detector	L1D16	Notifier	SDX-551	East Game room	Passed		8/6/2021 11:18 AM
79	Manual Pull Station	L1M06	Notifier	BGX-101L	North Main Exit	Passed		8/6/2021 11:18 AM
80	Monitor Module	L1M04	Notifier		Restroom 061	Passed	Probe Style Heat	8/6/2021 11:18 AM
81	Monitor Module	L1M20	Notifier		Water heater Rm 042	Passed	Probe Style Heat Detector	8/6/2021 11:19 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
82	Monitor Module	L1M19	Notifier		Return Tank Rm 045	Passed	Probe Style Heat Detector	8/6/2021 11:19 AM
83	Monitor Module	L1M18	Notifier		Converter Room 049	Passed	Probe Style Heat Detector	8/6/2021 11:20 AM
84	Smoke Detector	L1D82	Notifier	FSP-851	Elevator Equipment Rm	Passed		8/6/2021 11:19 AM
85	Heat Detector	L1D83	Notifier	FDX-551	Elevator Equip Rm	Passed		8/6/2021 11:19 AM
86	Smoke Detector	L1D38	Notifier	SDX-551	Elevator Lobby	Passed		8/6/2021 11:20 AM
87	Smoke Detector	L1D73	Notifier	SDX-551	Elevator Lobby street lvl	Passed		8/6/2021 11:20 AM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module | Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

GROUND FLOOR

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Heat Detector	L2D60	Notifier	FDX-551	Room 108	Passed		8/6/2021 11:20 AM
2	Heat Detector	L2D45	Notifier	FDX-551	Room 148	Passed		8/6/2021 11:21 AM
3	Heat Detector	L2D46	Notifier	FDX-551	Room 147A	Passed		8/6/2021 11:22 AM
4	Heat Detector	L2D47	Notifier	FDX-551	Room 147B	Passed		8/6/2021 11:22 AM
5	Smoke Detector	L2D48	Notifier	SDX-551	Hall By West Tech St	Passed		8/6/2021 11:22 AM
6	Smoke Detector	L2D49	Notifier	SDX-551	Hall By Room124	Passed		8/6/2021 11:22 AM
7	Smoke Detector	L2D50	Notifier	SDX-551	Hall By West Tech St	Passed		8/6/2021 11:23 AM
8	Smoke Detector	L2D51	Notifier	SDX-551	Hall By Rm 123	Passed		8/6/2021 11:23 AM
9	Smoke Detector	L2D52	Notifier	SDX-551	Hall By Rm 113	Passed		8/6/2021 11:24 AM
10	Heat Detector	L2D53	Notifier	FDX-551	Room 113	Passed		8/6/2021 11:24 AM
11	Smoke Detector	L2D55	Notifier	SDX-551	Hall By Rm 119	Passed		8/6/2021 11:24 AM
12	Smoke Detector	L2D56	Notifier	SDX-551	Hall By Rm 117	Passed		8/6/2021 11:25 AM
13	Heat Detector	L2D57	Notifier	FDX-551	Room 109	Passed		8/6/2021 11:25 AM
14	Heat Detector	L2D58	Notifier	FDX-551	Room 102	Passed		8/6/2021 11:25 AM
15	Smoke Detector	L2D59	Notifier	SDX-551	Hall By Rm 106	Passed		8/6/2021 11:26 AM
16	Heat Detector	L2D60	Notifier	FDX-551	Room 108	Passed		8/6/2021 11:26 AM
17	Heat Detector	L2D61	Notifier	FDX-551	Room 104	Passed		8/6/2021 11:26 AM
18	Smoke Detector	L2D62	Notifier	SDX-551	Rm 122	Passed		8/6/2021 11:26 AM
19	Smoke Detector	L2D63	Notifier	SDX-551	Rm 123	Passed		8/6/2021 11:27 AM
20	Smoke Detector	L2D64	Notifier	SDX-551	Rm 125	Passed		8/6/2021 11:27 AM
21	Heat Detector	L2D88	Notifier	FDX-551	Room 112	Passed		8/6/2021 11:28 AM
22	Manual Pull Station	L2M06	Notifier	nag-12lx	West tech st	Passed		8/6/2021 11:28 AM
23	Heat Detector	L2D44	Notifier	FDX-551	Room 126	Passed		8/6/2021 11:28 AM
24	Heat Detector	L2D41	Notifier	FDX-551	Room 151	Passed		8/6/2021 11:29 AM
25	Heat Detector	L2D42	Notifier	FDX-551	Room 149	Passed		8/6/2021 11:29 AM
26	Heat Detector	L2D40	Notifier	FDX-551	Room 127	Passed		8/6/2021 11:29 AM
27	Smoke Detector	L2D39	Notifier	SDX-551	Hall by rm 127	Passed		8/6/2021 11:29 AM
28	Smoke Detector	L2D34	Notifier	SDX-551	Hall by rm 157	Passed		8/6/2021 11:30 AM
29	Smoke Detector	L2D38	Notifier	SDX-551	top of O.T. Stairs	Passed		8/6/2021 11:30 AM
30	Smoke Detector	L2D36	Notifier	SDX-551	Hall by Rm 154	Passed		8/6/2021 11:30 AM
31	Heat Detector	L2D35	Notifier	FDX-551	Hall by rm 131	Passed		8/6/2021 11:30 AM
32	Heat Detector	L2D37	Notifier	FDX-551	Room 128	Passed		8/6/2021 11:31 AM
33	Smoke Detector	L2D33	Notifier	SDX-551	Hall by south Exit	Passed		8/6/2021 11:31 AM
34	Smoke Detector	L2D30	Notifier	SDX-551	Rm 133	Passed		8/6/2021 11:31 AM
35	Smoke Detector	L2D26	Notifier	SDX-551	Hall by Rm 153	Passed		8/6/2021 11:32 AM
36	Heat Detector	L2D27	Notifier	FDX-551	Room 163	Passed		8/6/2021 11:32 AM
37	Smoke Detector	L2D28	Notifier	SDX-551	Rm 162	Passed		8/6/2021 11:32 AM
38	Heat Detector	L2D29	Notifier	FDX-551	Room 134	Passed		8/6/2021 11:32 AM
39	Smoke Detector	L2D25	Notifier	SDX-551	Hall by Rm 137	Passed		8/6/2021 11:33 AM
40	Smoke Detector	L2D24	Notifier	SDX-551	Hall by Rm 138	Passed		8/6/2021 11:33 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Heat Detector	L2D22	Notifier	FDX-551	Room 167	Passed		8/6/2021 11:33 AM
42	Heat Detector	L2D23	Notifier	FDX-551	kitchen ice machine	Passed		8/6/2021 11:33 AM
43	Heat Detector	L2D20	Notifier	FDX-551	Room 166	Passed		8/6/2021 11:34 AM
44	Heat Detector	L2D21	Notifier	FDX-551	Elec Equip Rm kitchen	Passed		8/6/2021 11:34 AM
45	Heat Detector	L2D19	Notifier	FDX-551	Dining Room 168	Passed		8/6/2021 11:34 AM
46	Heat Detector	L2D18	Notifier	FDX-551	Room 169	Passed		8/6/2021 11:35 AM
47	Heat Detector	L2D17	Notifier	FDX-551	Room 170	Passed		8/6/2021 11:35 AM
48	Smoke Detector	L2D16	Notifier	SDX-551	Hall by Rm 139	Passed		8/6/2021 11:35 AM
49	Manual Pull Station	L2M03	Notifier	nag-12lx	east tech station	Passed		8/6/2021 11:35 AM
50	Smoke Detector	L2D11	Notifier	SDX-551	Hall by East Tech	Passed		8/6/2021 11:36 AM
51	Heat Detector	L2D14	Notifier	FDX-551	Room 173A	Passed		8/6/2021 11:36 AM
52	Smoke Detector	L2D12	Notifier	SDX-551	Hall by East Tech	Passed		8/6/2021 11:36 AM
53	Heat Detector	L2D15	Notifier	FDX-551	Room 173	Passed		8/6/2021 11:37 AM
54	Smoke Detector	L2D13	Notifier	SDX-551	Hall by Rm 141	Passed		8/6/2021 11:37 AM
55	Smoke Detector	L2D65	Notifier	FSP-851	Rm 175	Passed		8/6/2021 11:37 AM
56	Smoke Detector	L2D66	Notifier	FSP-851	Rm 138 Closet	Passed		8/6/2021 11:38 AM
57	Smoke Detector	L2D09	Notifier	SDX-551	Hall by Showers	Passed		8/6/2021 11:38 AM
58	Heat Detector	L2D10	Notifier	FDX-551	Room 177	Passed		8/6/2021 11:38 AM
59	Heat Detector	L2D87	Notifier	FDX-551	Room 178	Passed		8/6/2021 11:38 AM
60	Heat Detector	L2D07	Notifier	FDX-551	Room 179	Passed		8/6/2021 11:39 AM
61	Smoke Detector	L2D06	Notifier	SDX-551	Hall by Rm 189	Passed		8/6/2021 11:39 AM
62	Smoke Detector	L2D05	Notifier	SDX-551	Rm 182	Passed		8/6/2021 11:39 AM
63	Heat Detector	L2D04	Notifier	FDX-551	Room 183	Passed		8/6/2021 11:40 AM
64	Smoke Detector	L2D03	Notifier	SDX-551	Hall by North Stairs	Passed		8/6/2021 11:40 AM
65	Smoke Detector	L2D02	Notifier	SDX-551	Hall by Rm 192	Passed		8/6/2021 11:40 AM
66	Smoke Detector	L2D01	Notifier	SDX-551	Rm 192	Passed		8/6/2021 11:41 AM
67	Smoke Detector	L2D32	Notifier	SDX-551	Elevator Lobby	Passed		8/6/2021 11:41 AM
68	Smoke Detector	L2D31	Notifier	SDX-551	Elevator Lobby Hall	Passed		8/6/2021 11:44 AM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module | Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L3D57	Notifier	FSP-851	Hall outside Day Room	Passed		8/6/2021 11:44 AM
2	Heat Detector	L3D58	Notifier	FST-852	West Storage	Passed		8/6/2021 11:44 AM
3	Smoke Detector	L3D56	Notifier	FSP-851	Hall outside rm 293A	Passed		8/6/2021 11:44 AM
4	Smoke Detector	L3D54	Notifier	FSP-851	Hall outside rm 294	Passed		8/6/2021 11:45 AM
5	Heat Detector	L3D55	Notifier	FST-852	Rm 294	Passed		8/6/2021 11:45 AM
6	Smoke Detector	L3D53	Notifier	FSP-851	Hall outside rm 288A	Passed		8/6/2021 11:45 AM
7	Smoke Detector	L3D52	Notifier	FSP-851	Hall outside rm 282A	Passed		8/6/2021 11:45 AM
8	Smoke Detector	L3D50	Notifier	FSP-851	Nurse Station	Passed		8/6/2021 11:46 AM
9	Manual Pull Station	L3M22	Notifier	NBG-12LX	2 West tech station	Passed		8/6/2021 11:46 AM
10	Smoke Detector	L3D51	Notifier	FSP-851	Hall outside rm 274	Passed		8/6/2021 11:46 AM
11	Smoke Detector	L3D46	Notifier	FSP-851	Hall outside rm 268A	Passed		8/6/2021 11:47 AM
12	Smoke Detector	L3D47	Notifier	FSP-851	Hall outside Laundry	Passed		8/6/2021 11:47 AM
13	Heat Detector	L3D48	Notifier	FST-852	Laundry Rm	Passed		8/6/2021 11:47 AM
14	Heat Detector	L3D49	Notifier	FST-852	Kitchen	Passed		8/6/2021 11:48 AM
15	Smoke Detector	L3D44	Notifier	FSP-851	Hall outside rm 265	Passed		8/6/2021 11:48 AM
16	Heat Detector	L3D45	Notifier	FDX-551	Rm 265	Passed		8/6/2021 11:49 AM
17	Smoke Detector	L3D43	Notifier	FSP-851	Hall outside rm 262	Passed		8/6/2021 11:49 AM
18	Smoke Detector	L3D42	Notifier	FSP-851	Hall outside rm 241	Passed		8/6/2021 11:49 AM
19	Smoke Detector	L3D40	Notifier	FSP-851	Hall outside rm 257	Passed		8/6/2021 11:49 AM
20	Smoke Detector	L3D41	Notifier	FSP-851	Elevator Lobby	Passed		8/6/2021 11:50 AM
21	Manual Pull Station	L3M18	Notifier	NBG-12LX	Outside Elevator Lobby	Passed		8/6/2021 11:50 AM
22	Smoke Detector	L3D36	Notifier	FSP-851	Hall outside rm 256	Passed		8/6/2021 11:50 AM
23	Manual Pull Station	L3M19	Notifier	NBG-12LX	2nd Flr South Exit	Passed		8/6/2021 11:51 AM
24	Heat Detector	L3D35	Notifier	FST-852	Rm 257	Passed		8/6/2021 11:52 AM
25	Heat Detector	L3D37	Notifier	FST-852	Rm 256	Passed		8/6/2021 11:52 AM
26	Heat Detector	L3D38	Notifier	FST-852	Rm 255	Passed		8/6/2021 11:52 AM
27	Heat Detector	L3D39	Notifier	FST-852	Rm 254	Passed		8/6/2021 11:53 AM
28	Smoke Detector	L3D32	Notifier	FSP-851	Hall outside rm 252	Passed		8/6/2021 11:53 AM
29	Smoke Detector	L3D33	Notifier	FSP-851	Corridor 241B	Passed		8/6/2021 11:53 AM
30	Smoke Detector	L3D34	Notifier	FSP-851	rm 249	Passed		8/6/2021 11:53 AM
31	Kitchen Hood Monitor	L3M50	Notifier		West Range Hood	Passed		8/6/2021 11:54 AM
32	Smoke Detector	L3D31	Notifier	FSP-851	Hall by Room 247	Passed		8/6/2021 11:54 AM
33	Smoke Detector	L3D25	Notifier	FSP-851	Hall By Rm 243	Passed		8/6/2021 11:54 AM
34	Heat Detector	L3D26	Notifier	FST-852	Electrical Rm 243	Passed		8/6/2021 11:55 AM
35	Smoke Detector	L3D01	Notifier	SDX-551	Outside Conf RM 240	Passed		8/6/2021 11:55 AM
36	Smoke Detector	L3D03	Notifier	SDX-551	Staff wing Hall	Passed		8/6/2021 11:55 AM
37	Smoke Detector	L3D02	Notifier	SDX-551	outside Observ W 230	Passed		8/6/2021 11:56 AM
38	Manual Pull Station	L3M02	Notifier	NBG-12LX	East Stairs	Passed		8/6/2021 11:56 AM
39	Smoke Detector	L3D10	Notifier	SDX-551	Outside Observ N 230	Passed		8/6/2021 11:56 AM
40	Heat Detector	L3D09	Notifier	FDX-551	Electrical Closet	Passed		8/6/2021 11:56 AM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L3D08	Notifier	SDX-551	Women’s Wing Living Rm	Passed		8/6/2021 11:57 AM
42	Heat Detector	L3D06	Notifier	FDX-551	Closet 225	Passed		8/6/2021 11:57 AM
43	Smoke Detector	L3D07	Notifier	SDX-551	Women’s Wing Hall	Passed		8/6/2021 11:57 AM
44	Heat Detector	L3D05	Notifier	FDX-551	Shower Room 228	Passed		8/6/2021 11:57 AM
45	Heat Detector	L3D04	Notifier	FDX-551	Laundry Room 227	Passed		8/6/2021 11:58 AM
46	Smoke Detector	L3D11	Notifier	SDX-551	Multi Purpose Rm 200	Passed		8/6/2021 11:58 AM
47	Smoke Detector	L3D12	Notifier	SDX-551	Multi Purpose Rm 200	Passed		8/6/2021 11:58 AM
48	Heat Detector	L3D18	Notifier	FDX-551	Pantry 218	Passed		8/6/2021 11:59 AM
49	Heat Detector	L3D19	Notifier	FDX-551	Kitchen 217	Passed		8/6/2021 11:59 AM
50	Smoke Detector	L3D13	Notifier	SDX-551	Men’s Wing Hall S 201	Passed		8/6/2021 11:59 AM
51	Smoke Detector	L3D14	Notifier	FSP-751	Men’s Wing Cntr 201	Passed		8/6/2021 12:00 PM
52	Heat Detector	L3D22	Notifier	FDX-551	Closet 204	Passed		8/6/2021 12:00 PM
53	Heat Detector	L3D20	Notifier	FDX-551	Electrical Room 214	Passed		8/6/2021 12:00 PM
54	Smoke Detector	L3D15	Notifier	SDX-551	Men’s Wing N 201	Passed		8/6/2021 12:01 PM
55	Heat Detector	L3D21	Notifier	FDX-551	Closet 206	Passed		8/6/2021 12:01 PM
56	Smoke Detector	L3D16	Notifier	FSP-751	Hall 202	Passed		8/6/2021 12:02 PM
57	Smoke Detector	L3D17	Notifier	FSP-751	Living Room 207	Passed		8/6/2021 12:02 PM
58	Smoke Detector	L3D59	Notifier	FSP-851	RM 242 Closet	Passed		8/6/2021 12:02 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module | Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

3rd FLOOR TJC EP3 Initiating Devices Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Smoke Detector	L4D05	Notifier	SDX-551	Top of N Stairs	Passed		8/6/2021 12:02 PM
2	Heat Detector	L4D01	Notifier	FDX-551	Office Equipment Room	Passed		8/6/2021 12:03 PM
3	Heat Detector	L4D02	Notifier	FDX-551	Office Equipment Storage	Passed		8/6/2021 12:03 PM
4	Heat Detector	L4D03	Notifier	FDX-551	Office Equipment Storage	Passed		8/6/2021 12:03 PM
5	Heat Detector	L4D04	Notifier	FDX-551	Office Equipment Storage	Passed		8/6/2021 12:04 PM
6	Heat Detector	L4D06	Notifier	FDX-551	Maintenance Storage	Passed		8/6/2021 12:04 PM
7	Smoke Detector	L4D07	Notifier	SDX-551	Hall by N Stairs	Passed		8/6/2021 12:04 PM
8	Heat Detector	L4D08	Notifier	FDX-551	Custodial Storage	Passed		8/6/2021 12:04 PM
9	Heat Detector	L4D09	Notifier	FDX-551	Custodial Storage	Passed		8/6/2021 12:05 PM
10	Heat Detector	L4D11	Notifier	FDX-551	Old Equipment Rm	Passed		8/6/2021 12:05 PM
11	Smoke Detector	L4D12	Notifier	SDX-551	Hall by old equipment room	Passed		8/6/2021 12:05 PM
12	Heat Detector	L4D14	Notifier	FDX-551	Medical Records	Passed		8/6/2021 12:05 PM
13	Heat Detector	L4D15	Notifier	FDX-551	Medical Records	Passed		8/6/2021 12:06 PM
14	Heat Detector	L4D16	Notifier	FDX-551	Medical Records	Passed		8/6/2021 12:07 PM
15	Smoke Detector	L4D17	Notifier	SDX-551	Hall by medical records	Passed		8/6/2021 12:08 PM
16	Heat Detector	L4D18	Notifier	FDX-551	Medical Records	Passed		8/6/2021 12:08 PM
17	Heat Detector	L4D19	Notifier	FDX-551	Office Equipment Storage	Passed		8/6/2021 12:09 PM
18	Smoke Detector	L4D20	Notifier	SDX-551	Hall by Pipe Chase	Passed		8/6/2021 12:09 PM
19	Heat Detector	L4D21	Notifier	FDX-551	S Office Equipment Storage	Passed		8/6/2021 12:09 PM
20	Heat Detector	L4D23	Notifier	FDX-551	Junk Storage	Passed		8/6/2021 12:09 PM
21	Heat Detector	L4D25	Notifier	FDX-551	Paper Recycle Room	Passed		8/6/2021 12:10 PM
22	Smoke Detector	L4D24	Notifier	SDX-551	Hall by Paper Recycling	Passed		8/6/2021 12:10 PM
23	Heat Detector	L4D26	Notifier	FDX-551	General Storage	Passed		8/6/2021 12:11 PM
24	Smoke Detector	L4D27	Notifier	SDX-551	General Storage	Passed		8/6/2021 12:11 PM
25	Heat Detector	L4D28	Notifier	FDX-551	General Storage	Passed		8/6/2021 12:12 PM
26	Smoke Detector	L4D29	Notifier	SDX-551	Top of East Stairs	Passed		8/6/2021 12:12 PM
27	Heat Detector	L4D30	Notifier	FDX-551	IMS E. Storage	Passed		8/6/2021 12:13 PM
28	Heat Detector	L4D31	Notifier	FDX-551	General File Storage	Passed		8/6/2021 12:18 PM
29	Heat Detector	L4D32	Notifier	FDX-551	General File Storage	Passed		8/6/2021 12:19 PM
30	Smoke Detector	L4D33	Notifier	SDX-551	File Storage	Passed		8/6/2021 12:19 PM
31	Heat Detector	L4D34	Notifier	FDX-551	East Bathroom	Passed		8/6/2021 12:20 PM
32	Smoke Detector	L4D35	Notifier	SDX-551	Hall by Legal Files	Passed		8/6/2021 12:20 PM
33	Heat Detector	L4D36	Notifier	FDX-551	Legal File Storage	Passed		8/6/2021 12:20 PM
34	Heat Detector	L4D37	Notifier	FDX-551	IMS Supply Storage	Passed		8/6/2021 12:21 PM
35	Heat Detector	L4D38	Notifier	FDX-551	Custodian Storage	Passed		8/6/2021 12:22 PM
36	Heat Detector	L4D39	Notifier	FDX-551	Personnel Records	Passed		8/6/2021 12:22 PM
37	Smoke Detector	L4D40	Notifier	SDX-551	Hall by Cust. Office	Passed		8/6/2021 12:22 PM
38	Heat Detector	L4D41	Notifier	FDX-551	Custodial Office	Passed		8/6/2021 12:23 PM
39	Heat Detector	L4D42	Notifier	FDX-551	Conference Rm	Passed		8/6/2021 12:23 PM
40	Smoke Detector	L4D43	Notifier	SDX-551	Hall by Conference Rm	Passed		8/6/2021 12:23 PM

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
41	Smoke Detector	L4D44	Notifier	SDX-551	Center Stairs	Passed		8/6/2021 12:24 PM
42	Smoke Detector	L4D45	Notifier	SDX-551	Hall by Center Stairs	Passed		8/6/2021 12:25 PM
43	Smoke Detector	L4D46	Notifier	SDX-551	D.D.D	Passed		8/6/2021 12:25 PM
44	Smoke Detector	L4D47	Notifier	SDX-551	Elevator Lobby	Passed		8/6/2021 12:25 PM
45	Smoke Detector	L4D48	Notifier	SDX-551	D.D.D Sec.	Passed		8/6/2021 12:26 PM
46	Smoke Detector	L4D49	Notifier	SDX-551	Outside Rm 307	Passed		8/6/2021 12:28 PM
47	Heat Detector	L4D50	Notifier	FDX-551	D.D.D. Conference Rm	Passed		8/6/2021 12:29 PM
48	Heat Detector	L4D51	Notifier	FDX-551	D.D.D.	Passed		8/6/2021 12:29 PM
49	Heat Detector	L4D52	Notifier	FDX-551	Telephone Equipment Rm	Passed		8/6/2021 12:29 PM
50	Smoke Detector	L4D53	Notifier	SDX-551	Outside Telephone Eq.Rm	Passed		8/6/2021 12:30 PM
51	Smoke Detector	L4D54	Notifier	SDX-551	Outside Computer Rm	Passed		8/6/2021 12:30 PM
52	Smoke Detector	L4D55	Notifier	SDX-551	IMS Offices	Passed		8/6/2021 12:30 PM
53	Smoke Detector	L4D56	Notifier	SDX-551	IMS Offices	Passed		8/6/2021 12:30 PM
54	Smoke Detector	L4D57	Notifier	SDX-551	Computer Rm	Passed		8/6/2021 12:31 PM
55	Smoke Detector	L4D58	Notifier	SDX-551	Hall by west stairs	Passed		8/6/2021 12:31 PM
56	Smoke Detector	L4D59	Notifier	SDX-551	Rm 318	Passed		8/6/2021 12:31 PM
57	Smoke Detector	L4D60	Notifier	SDX-551	Hall by copier	Passed		8/6/2021 12:32 PM
58	Heat Detector	L4D61	Notifier	FDX-551	Pipe Chase	Passed		8/6/2021 12:32 PM
59	Smoke Detector	L4D62	Notifier	SDX-551	Hall by OBRA	Passed		8/6/2021 12:32 PM
60	Smoke Detector	L4D64	Notifier	SDX-551	Hall by OBRA	Passed		8/6/2021 12:32 PM
61	Heat Detector	L4D65	Notifier	FDX-551	DADA confer. rm	Passed		8/6/2021 12:33 PM
62	Smoke Detector	L4D66	Notifier	SDX-551	Hall by Restrooms	Passed		8/6/2021 12:33 PM
63	Smoke Detector	L4D67	Notifier	SDX-551	Hall by N Stairs	Passed		8/6/2021 12:33 PM
64	Smoke Detector	L4D68	Notifier	SDX-551	Top of N stairs	Passed		8/6/2021 12:33 PM
65	Smoke Detector	L4D69	Notifier	SDX-551	DADA	Passed		8/6/2021 12:34 PM
66	Smoke Detector	L4D70	Notifier	SDX-551	DADA	Passed		8/6/2021 12:34 PM
67	Smoke Detector	L4D71	Notifier	SDX-551	Hall by Stairs	Passed		8/6/2021 12:34 PM
68	Heat Detector	L4D72	Notifier	FDX-551	Restroom	Passed		8/6/2021 12:35 PM
69	Heat Detector	L4D73	Notifier	FDX-551	SE DET.	Passed		8/6/2021 12:35 PM
70	Heat Detector	L4D74	Notifier	FDX-551	SW DET.	Passed		8/6/2021 12:35 PM
71	Heat Detector	L4D75	Notifier	FDX-551	NW DET.	Passed		8/6/2021 12:36 PM
72	Heat Detector	L4D76	Notifier	FDX-551	Storage RM	Passed		8/6/2021 12:36 PM
73	Smoke Detector	L4D77	Notifier	SDX-551	Top of Elevator Shaft	Passed		8/6/2021 12:36 PM
74	Smoke Detector	L4D78	Notifier	SDX-551	Top of Stairs	Passed		8/6/2021 12:37 PM
75	Heat Detector	L4D79	Notifier	FDX-551	Elevator Penthouse	Passed		8/6/2021 12:37 PM
76	Heat Detector	L4D89	Notifier	FDX-551	open Storage	Passed		8/6/2021 12:37 PM
77	Manual Pull Station	L4M01	Notifier	BGX-101L	N Stairs	Passed		8/6/2021 12:37 PM
78	Manual Pull Station	L4M03	Notifier	BGX-101L	E Stairs	Passed		8/6/2021 12:38 PM
79	Manual Pull Station	L4M04	Notifier	BGX-101L	Center Stairs	Passed		8/6/2021 12:38 PM
80	Manual Pull Station	L4M06	Notifier	BGX-101L	N Stairs	Passed		8/6/2021 12:38 PM
81	Manual Pull Station	L4M08	Notifier	BGX-101L	Stairs Exit	Passed		8/6/2021 12:39 PM

Duct Detector | Heat Detector | Kitchen Hood Monitor | Manual Pull Station | Monitor Module | Smoke Detector

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

3rd FLOOR

TJC EP3 Initiating Devices

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

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

TJC EP4 Notification 2nd Semi-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 8/3/2021 in accordance with applicable requirements.

GROUND FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe			Men’s 010	Passed		8/6/2021 1:26 PM
2	Strobe			Women’s 011	Passed		8/6/2021 1:27 PM
3	Strobe			Hall Outside Restrooms	Passed		8/6/2021 1:27 PM
4	Bell		KMS-8-24VDC/P	Hall outside Restrooms	Passed		8/6/2021 1:27 PM
5	Bell		KMS-8-24VDC/P	Outside Room 033E	Passed		8/6/2021 1:30 PM
6	Strobe			Outside 033E	Passed		8/6/2021 1:28 PM
7	Strobe			Hallway 033	Passed		8/6/2021 1:28 PM
8	Bell		KMS-8-24VDC/P	Hallway 033	Passed		8/6/2021 1:28 PM
9	Strobe			029	Passed		8/6/2021 1:28 PM
10	Strobe		SS24110ADA	029	Passed		8/6/2021 1:29 PM
11	Strobe		SS24110ADA	Center 040	Passed		8/6/2021 1:29 PM
12	Bell		KMS-8-24VDC/P	Center 040	Passed		8/6/2021 1:29 PM
13	Horn Strobe			East Game Room	Passed		8/6/2021 1:29 PM
14	Strobe		SS24110ADA	East Game Room	Passed		8/6/2021 1:30 PM
15	Strobe		SS24110ADA	Near AHU RM 056B	Passed		8/6/2021 1:32 PM
16	Bell		KMS-8-24VDC/P	Near AHU RM 056 B	Passed		8/6/2021 1:31 PM
17	Bell		KMS-8-24VDC/P	063	Passed		8/6/2021 1:32 PM
18	Strobe		SS24110ADA	063	Passed		8/6/2021 1:31 PM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

GROUND FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SS24110ADA	Outside RM 111	Passed		8/6/2021 1:32 PM
2	Bell		KMS-8-24VDC/P	Outside 111	Passed		8/6/2021 1:32 PM
3	Strobe		SS24110ADA	RM 114	Passed		8/6/2021 1:33 PM
4	Strobe		SS24110ADA	RM 115	Passed		8/6/2021 1:33 PM
5	Bell		KMS-8-24VDC/P	Outside 147	Passed		8/6/2021 1:33 PM
6	Bell		KMS-8-24VDC/P	Room 149	Passed		8/6/2021 1:33 PM
7	Strobe		SS24110ADA	inside Room 149	Passed		8/6/2021 1:34 PM
8	Strobe		SS24110ADA	inside Room 152	Passed		8/6/2021 1:34 PM
9	Strobe		SS24110ADA	inside Room 153	Passed		8/6/2021 1:34 PM
10	Strobe		SS24110ADA	outsideRoom 161	Passed		8/6/2021 1:35 PM
11	Bell		KMS-8-24VDC/P	outside Room 161	Passed		8/6/2021 1:35 PM
12	Strobe		SS24110ADA	inside room 158	Passed		8/6/2021 1:35 PM
13	Strobe		SS24110ADA	inside room 159	Passed		8/6/2021 1:35 PM
14	Strobe		SS24110ADA	dinning Room 168	Passed		8/6/2021 1:36 PM
15	Bell		KMS-8-24VDC/P	dinning Room 168	Passed		8/6/2021 1:36 PM
16	Bell		KMS-8-24VDC/P	east tech station	Passed		8/6/2021 1:36 PM
17	Strobe		SS24110ADA	bathroom 172	Passed		8/6/2021 1:37 PM
18	Strobe		SS24110ADA	bathroom 171	Passed		8/6/2021 1:37 PM
19	Strobe		SS24110ADA	Across Room 179	Passed		8/6/2021 1:37 PM
20	Bell		KMS-8-24VDC/P	Across Room 179	Passed		8/6/2021 1:38 PM
21	Bell		KMS-8-24VDC/P	outside Room 194	Passed		8/6/2021 1:40 PM
22	Strobe		SS24110ADA	Outside Room 194	Passed		8/6/2021 1:40 PM
23	Strobe		SS24110ADA	east tech station	Passed		8/6/2021 1:41 PM
24	Strobe		SS24110ADA	Outside RM 147	Passed		8/6/2021 1:41 PM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Strobe		SR	RM 298	Passed		8/6/2021 1:42 PM
2	Strobe		SR	RM 299	Passed		8/6/2021 1:42 PM
3	Strobe		SR	Hall outside RM 299	Passed		8/6/2021 1:42 PM
4	Strobe		SR	Hall outside RM 295	Passed		8/6/2021 1:43 PM
5	Bell		SSM24-8	Hall outside rm 295	Passed		8/6/2021 1:42 PM
6	Strobe		SR	Hall outside Rm 290	Passed		8/6/2021 1:43 PM
7	Strobe		SR	Hall outside Rm 281	Passed		8/6/2021 1:43 PM
8	Bell		SSM24-8	Hall outside rm 281	Passed		8/6/2021 1:44 PM
9	Strobe		SR	Hall outside Rm 278	Passed		8/6/2021 1:44 PM
10	Bell		SSM24-8	Hall outside rm 278	Passed		8/6/2021 1:44 PM
11	Strobe		SPR	Rm 274	Passed		8/6/2021 1:45 PM
12	Strobe		SR	Rm 273	Passed		8/6/2021 1:45 PM
13	Strobe		SPR	Rm 272	Passed		8/6/2021 1:45 PM
14	Strobe		SR	outside Rm 269	Passed		8/6/2021 1:46 PM
15	Strobe		FSF204-st	RM 269	Passed		8/6/2021 1:46 PM
16	Strobe		SR	outside Rm 270	Passed		8/6/2021 1:46 PM
17	Strobe		SR	Rm 270	Passed		8/6/2021 1:47 PM
18	Strobe		FSF204-st	RM 266	Passed		8/6/2021 1:47 PM
19	Strobe		SR	outside Rm 259	Passed		8/6/2021 1:47 PM
20	Bell		SSM24-8	Hall outside rm 259	Passed		8/6/2021 1:47 PM
21	Strobe		SR	Elevator lobby	Passed		8/6/2021 1:48 PM
22	Strobe		SR	Outside Elevator lobby	Passed		8/6/2021 1:57 PM
23	Strobe		SR	Outside 254	Passed		8/6/2021 1:48 PM
24	Strobe		SR	Outside 241 B1	Passed		8/6/2021 1:48 PM
25	Strobe		SR	251	Passed		8/6/2021 1:49 PM
26	Strobe		SR	250	Passed		8/6/2021 1:49 PM
27	Strobe		SPR	Rm 252	Passed		8/6/2021 1:49 PM
28	Strobe		SPR	Rm 247	Passed		8/6/2021 1:49 PM
29	Strobe		SPR	Rm 242	Passed		8/6/2021 1:50 PM
30	Strobe		SR	Outside Rm 243	Passed		8/6/2021 1:50 PM
31	Bell		SSM24-8	Hall outside rm 243	Passed		8/6/2021 1:51 PM
32	Strobe		SPR	Center Above pop machines	Passed		8/6/2021 1:51 PM
33	Strobe		SPR	244	Passed		8/6/2021 1:51 PM
34	Strobe		SS24110ADA	Outside Rm 240	Passed		8/6/2021 1:58 PM
35	Bell		SSM24-8	Hall outside rm 240	Passed		8/6/2021 1:52 PM
36	Strobe		SS24110ADA	Rm 240	Passed		8/6/2021 1:52 PM
37	Strobe		SS24110ADA	Outside Rm 230	Passed		8/6/2021 1:53 PM
38	Bell		SSM24-8	Hall outside rm 230	Passed		8/6/2021 1:53 PM
39	Strobe		SS24110ADA	Rm 232	Passed		8/6/2021 1:54 PM
40	Strobe		SS24110ADA	Rm 231	Passed		8/6/2021 1:54 PM

Number	Type	Zone/address	Model	Location	Result	Comments	Date
41	Strobe		SS24110ADA	Outside Rm 225	Passed		8/6/2021 1:54 PM
42	Bell		SSM24-8	Hall outside rm 225	Passed		8/6/2021 1:55 PM
43	Bell		SSM24-8	Hall outside rm 217	Passed		8/6/2021 1:55 PM
44	Strobe		SS24110ADA	Outside Rm 217	Passed		8/6/2021 1:55 PM
45	Strobe		SS24110ADA	Outside Rm 215	Passed		8/6/2021 1:56 PM
46	Bell		SSM24-8	Hall outside rm 215	Passed		8/6/2021 1:56 PM
47	Bell		SSM24-8	Hall outside rm 208	Passed		8/6/2021 1:56 PM
48	Strobe		SS24110ADA	Outside Rm 208	Passed		8/6/2021 1:56 PM
49	Strobe		SS24110ADA	Outside Rm 208 around corner	Passed		8/6/2021 1:57 PM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

3rd FLOOR TJC EP4 Notification Results

Number	Type	Zone/address	Model	Location	Result	Comments	Date
1	Bell		KMS-8-24VDC/P	NE stairwell	Passed		8/6/2021 1:58 PM
2	Strobe		SS24110ADA	NE Stairwell	Passed		8/6/2021 1:59 PM
3	Strobe		SS24110ADA	Hallway 343	Passed		8/6/2021 1:59 PM
4	Bell		KMS-8-24VDC/P	Hallway 343	Passed		8/6/2021 2:06 PM
5	Bell		KMS-8-24VDC/P	Hallway 333	Passed		8/6/2021 2:07 PM
6	Strobe		SS24110ADA	Hallway 333	Passed		8/6/2021 2:07 PM
7	Bell		KMS-8-24VDC/P	Hallway 309	Passed		8/6/2021 2:07 PM
8	Strobe		SS24110ADA	Hallway 309	Passed		8/6/2021 2:08 PM
9	Strobe		SS24110ADA	335	Passed		8/6/2021 2:08 PM
10	Strobe		SS24110ADA	334	Passed		8/6/2021 2:09 PM
11	Strobe		SS24110ADA	337	Passed		8/6/2021 2:09 PM
12	Strobe		SS24110ADA	332	Passed		8/6/2021 2:10 PM
13	Bell		KMS-8-24VDC/P	3rd floor northwest by exit door	Passed		8/6/2021 2:09 PM
14	Strobe		SS24110ADA	3rd floor northwest next to exit	Passed		8/6/2021 2:09 PM
15	Strobe		SS24110ADA	Old Conference	Passed		8/6/2021 2:08 PM

Bell | Horn Strobe | Strobe

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

3rd FLOOR

TJC EP4 Notification

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Assistant Inspector:
Scope: Full
Frequency: 1st Semi-Annual
Account Manager: (800) 274-0888

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

TJC EP5 FA Equipment Signals 1st Semi-Annual Inspection Summary

Result Totals

Devices	Annuciator	Power Supply
Passed	-	6
Mitigated	-	-
New - Passed	-	-
Failed	-	-
Removed	-	-
Not Inspected	8	-
Total	8	6

Supercomponent Information	
Type	1 - FACP
Location	GROUND FLOOR 038A
Model	nfs23030
Voltage/Current	120
s/Communication	-

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

GROUND FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	FACP	Notifier	nfs23030		038A	Passed		8/6/2021 2:11 PM
2	Power Supply	Notifier	FCPS-24		038A	Passed	NAC 4 not going into trouble when resistor removed. Unused circuit not being used	8/6/2021 2:11 PM
3	Annuciator	Notifier			Front Entrance	Not Inspected		

Annuciator | FACP | Power Supply

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

GROUND FLOOR

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
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800-274-0888

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	Not Inspected		
2	Annuciator	Notifier			1 West tech station	Not Inspected		
3	Annuciator	Notifier			east tech station	Not Inspected		
4	Power Supply	Notifier	FCPS-24	L2M10	Closet 138	Passed		8/6/2021 2:12 PM
5	Power Supply	Notifier	FCPS-24	L2M09	Closet 138	Passed		8/6/2021 2:14 PM

Annuciator | FACP | Power Supply

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR

TJC EP5 FA Equipment Signals

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SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Scottsbluff, NE
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2nd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			2 West Tech Station	Not Inspected		
2	Annuciator	Notifier			2 Outside Elevator Lobby	Not Inspected		
3	Annuciator	Notifier			tech 230	Not Inspected		
4	Power Supply	Notifier	FCPS-24S8	L3M16	242 Closet	Passed	NAC 2 and 4 not going into trouble when wires taken off NAC 4 might be controlling door holders	8/6/2021 2:15 PM
5	Power Supply	Notifier	FCPS-24	L3M06	242 Closet	Passed		8/6/2021 2:16 PM

Annuciator | FACP | Power Supply

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2nd FLOOR

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
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3rd FLOOR TJC EP5 FA Equipment Signals Results

Number	Type	Make	Model	Zone/address	Location	Result	Comments	Date
1	Annuciator	Notifier			Elevator Lobby	Not Inspected		
2	Power Supply	Notifier	FCPS-24		Near 335 Closet	Passed		8/6/2021 2:17 PM

Annuciator

FACP

Power Supply

Passed = Green

Mitigated = Green

Failed = Red

Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

3rd FLOOR

TJC EP5 FA Equipment Signals

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
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Scottsbluff, NE
800-274-0888

Subcomponent Results

Supercomponent Number	Type	Make	Model	DATES	Parent Location	Result	Comments
1	12V26AH			2-12-2019	GROUND FLOOR 038A	Passed	
1	12V26AH			2-12-2019	GROUND FLOOR 038A	Passed	
2	12V8AH	Notifier	FCPS-24	2-19-19	GROUND FLOOR 038A	Passed	
2	12V8AH	Notifier	FCPS-24	2-19-19	GROUND FLOOR 038A	Passed	
4	12V8AH	Notifier	FCPS-24	2-12-18	1st FLOOR Closet 138	Passed	
4	12V8AH	Notifier	FCPS-24	2-12-18	1st FLOOR Closet 138	Passed	
5	12V8AH	Notifier	FCPS-24	2-19	1st FLOOR Closet 138	Passed	
5	12V8AH	Notifier	FCPS-24	2-19	1st FLOOR Closet 138	Passed	
4	12V8AH	Notifier	FCPS-24S8	2-19-19	2nd FLOOR 242 Closet	Passed	
4	12V8AH	Notifier	FCPS-24S8	2-19-19	2nd FLOOR 242 Closet	Passed	
5	12V8AH	Notifier	FCPS-24	2-19-19	2nd FLOOR 242 Closet	Passed	
5	12V8AH	Notifier	FCPS-24	2-19-19	2nd FLOOR 242 Closet	Passed	
2	12V8AH			2-19-19	3rd FLOOR Near 335 Closet	Passed	
2	12V8AH			2-19-19	3rd FLOOR Near 335 Closet	Passed	

Supercomponent Results

Number	Zone/address	Type	Make	Model	Voltage/Current	Location	Layout	Result	Standby/Alarm capacity	Comments
1		FACP	Notifier	nfs23030	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	Not Inspected		
1		Annuciator	Notifier			1st Flr S Exit	1st FLOOR	Not Inspected		
2		Annuciator	Notifier			1 West tech station	1st FLOOR	Not Inspected		
3		Annuciator	Notifier			east tech station	1st FLOOR	Not Inspected		
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	Not Inspected		
2		Annuciator	Notifier			2 Outside Elevator Lobby	2nd FLOOR	Not Inspected		
3		Annuciator	Notifier			tech 230	2nd FLOOR	Not Inspected		
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	Not Inspected		
2		Power Supply	Notifier	FCPS-24	120	Near 335 Closet	3rd FLOOR	Passed		

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

Inspection Provider: Protex Central
Lead Inspector: Conner Holsclaw
Account: LRC Bldg. # 14 - Lincoln Regional Center
Assistant Inspector:
Address: 801 West Prospector PL., Lincoln, NE 68522
Scope: Full
Frequency: 2nd Semi-Annual
Account Manager: (800) 274-0888

TJC EP19 Shutdown 2nd Semi-Annual Inspection Summary

Result Totals

Devices	Relays
Passed	60
Mitigated	-
New - Passed	-
Failed	-
Removed	-
Not Inspected	-
Total	60

This inspection was performed on 8/3/2021 in accordance with applicable requirements.

GROUND FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays	L1M07	Notifier		Door Release 038A	Passed		8/6/2021 2:18 PM
2	Relays	L1M95	Notifier		Door Release RM041	Passed		8/6/2021 2:18 PM
3	Relays	L1M30	Notifier		Elevator Mech Rm 039	Passed	Primary Recall	8/6/2021 2:19 PM
4	Relays	L1M31	Notifier		Elevator Mech Rm 039	Passed	Alternate Recall	8/6/2021 2:20 PM
5	Relays	L1M32	Notifier		Elevator Mech Rm 039	Passed	Flash Hat	8/6/2021 2:20 PM
6	Relays	L1M33	Notifier		Elevator Mech Rm 039	Passed	Shunt	8/6/2021 2:21 PM
7	Relays	L1M24	Notifier	FRM-1	Mech Rm 014	Passed	AHU-1	8/6/2021 2:21 PM
8	Relays	L1M25	Notifier	FRM-1	Mech Rm 056B	Passed	AHU-2	8/6/2021 2:22 PM
9	Relays	L1M26	Smoke	Damper	SD-001 by 052	Passed		8/6/2021 2:22 PM
10	Relays		Smoke	Damper	SD-002 045	Passed		8/9/2021 11:24 AM
11	Relays	L1M28	Smoke	Damper	SD-003 033e	Passed		8/6/2021 2:23 PM
12	Relays	L1M28	Smoke	Damper	SD-004	Passed		8/6/2021 2:30 PM
13	Relays				Door Holder Hallway 028	Passed	Door Holder	8/6/2021 2:23 PM
14	Relays		Smoke	Damper	1 SD-014	Passed		8/6/2021 2:22 PM

Relays

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

1st FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays	L2M95			Door Release 1st flr	Passed		8/9/2021 11:24 AM
2	Relays		Smoke	Damper	1SD-013	Passed		8/9/2021 11:24 AM
3	Relays		Smoke	Damper	1SD-011 144	Passed		8/9/2021 11:18 AM
4	Relays		Smoke	Damper	1SD-012 127	Passed		8/9/2021 11:18 AM
5	Relays				163 Door Holder	Passed		8/9/2021 11:17 AM
6	Relays				163 Door Holder	Passed		8/9/2021 11:15 AM
7	Relays		Smoke	Damper	1SD-010 163	Passed		8/9/2021 11:15 AM
8	Relays		Smoke	Damper	1SD-009 163	Passed		8/9/2021 11:14 AM
9	Relays		Smoke	Damper	1SD-007 Hall by 157	Passed		8/9/2021 11:13 AM
10	Relays		Smoke	Damper	1SD-008 Hall by 157	Passed		8/9/2021 11:13 AM
11	Relays				174 Door Holder	Passed		8/9/2021 11:13 AM
12	Relays				174 Door Holder	Passed		8/9/2021 11:11 AM
13	Relays		Smoke	Damper	1SD-006 Hall by 174	Passed		8/9/2021 11:11 AM
14	Relays		Smoke	Damper	1SD-005 138 Closet	Passed		8/9/2021 11:11 AM
15	Relays		Smoke	Damper	1SD-003 Patient Telephone	Passed		8/9/2021 11:10 AM
16	Relays		Smoke	Damper	1SD-004 Patient Telephone	Passed		8/9/2021 11:09 AM
17	Relays		Smoke	Damper	1SD-002 178	Passed		8/9/2021 11:09 AM
18	Relays		Smoke	Damper	1SD-001 183	Passed		8/9/2021 11:09 AM

Relays

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

1st FLOOR
TJC EP19 Shutdown

PROTEX CENTRAL
SPECIALIZED PROTECTION SOLUTIONS INTEGRATOR
Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

2nd FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays		Smoke	Damper	2-SD001 213	Passed		8/9/2021 11:01 AM
2	Relays		Smoke	Damper	2-SD002 217	Passed		8/9/2021 11:01 AM
3	Relays		Smoke	Damper	2-SD003 218	Passed		8/9/2021 11:00 AM
4	Relays				Door Holder 201	Passed		8/9/2021 11:00 AM
5	Relays				Door Holder 201	Passed		8/9/2021 10:56 AM
6	Relays				Door Holder 200	Passed		8/9/2021 10:56 AM
7	Relays				Door Holder 200	Passed		8/9/2021 10:55 AM
8	Relays		Smoke	Damper	2-SD004 239	Passed		8/9/2021 10:55 AM
9	Relays		Smoke	Damper	2-SD005 239	Passed		8/9/2021 10:55 AM
10	Relays		Smoke	Damper	2-SD006 242 Closet	Passed		8/9/2021 10:54 AM
11	Relays				Door Holder by 241C	Passed		8/9/2021 10:54 AM
12	Relays				Door Holder by 241C	Passed		8/9/2021 10:54 AM
13	Relays		Smoke	Damper	2-SD007 by 258	Passed		8/9/2021 10:53 AM
14	Relays		Smoke	Damper	2-SD008 265	Passed		8/9/2021 10:46 AM
15	Relays		Smoke	Damper	2-SD009 241 M2	Passed		8/9/2021 10:46 AM
16	Relays				Door Holder by 294	Passed		8/9/2021 10:45 AM
17	Relays				Door Holder by 294	Passed		8/9/2021 10:44 AM
18	Relays		Smoke	Damper	2-SD010 by 294	Passed		8/9/2021 10:44 AM
19	Relays		Smoke	Damper	2-SD011 by 294	Passed		8/9/2021 10:43 AM
20	Relays		Smoke	Damper	2-SD012 Stairwell	Passed		8/9/2021 10:43 AM

Relays

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

3rd FLOOR TJC EP19 Shutdown Results

Number	Type	Zone/address	Make	Model	Location	Result	Comments	Date
1	Relays		Smoke	Damper	3-SD06 314	Passed		8/9/2021 10:43 AM
2	Relays		Smoke	Damper	3-SD05 338	Passed		8/9/2021 10:42 AM
3	Relays		Smoke	Damper	3-SD004 326	Passed		8/9/2021 10:42 AM
4	Relays				Door Holder by 333	Passed		8/9/2021 10:36 AM
5	Relays		Smoke	Damper	3-SD003	Passed		8/9/2021 10:36 AM
6	Relays		Smoke	Damper	3-SD002 351	Passed		8/9/2021 10:35 AM
7	Relays		Smoke	Damper	3-SD001 354	Passed		8/9/2021 10:35 AM
8	Relays				Door Holder Elevator Lobby	Passed		8/9/2021 10:34 AM

Relays

Passed = Green | Mitigated = Green | Failed = Red | Not Tested = Blue

TOTALREPORT®
INSPECTION AND CONDITION ASSESMENT REPORTING

2021 INSPECTION

LRC Bldg. # 14 - Lincoln Regional Center

801 West Prospector PL., Lincoln, NE 68522

DISCLAIMER: This TOTALREPORT inspection and systems layout documentation has been assembled and prepared based on information furnished to Protex Central by the customer and its representatives up to and including the inspection date. The information in this report has been obtained from sources believed to be reliable and accurate. While we do not doubt its accuracy, we cannot completely and firmly verify it and thus make no guarantee, warranty, or representation about it other than what we have been able to verify. Additionally, this report, and enclosed graphic layouts do not reflect any changes to the premises subsequent to the date listed on the report, or any changes to the documents furnished to Protex Central subsequent to this date.

Des Moines, IA
Hastings, NE
North Platte, NE
Omaha, NE
Scottsbluff, NE
800-274-0888

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

NFPA72 2016 Testing and Inspection Form

Property: LRC Bldg. # 14 - Lincoln Regional Center

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

Inspection Date: 8/13/2021

1. PROPERTY INFORMATION

Account Name or Property Name	LRC Bldg. # 14 - Lincoln Regional Center
Shipping Street	801 West Prospector PL.
Shipping City	Lincoln
Shipping State/Province	NE
Shipping Zip/Postal Code	68522
Account Phone	(402) 479-5453
Main Account Email	gordon.tebo@nebraska.gov
Authority Having Juristiction	Nebraska State Fire Marshal
AHJ Phone Number	
Description of property	Hospital
Scope of this instance of inspection	Full

2. TESTING AND MONITORING INFORMATION

Testing Organization	Protex Central
Address	1239 N Minnesota Ave, Hastings, NE, 68901
Phone	(800) 274-0888
Monitoring Organization	NECO
Address	Customer supplied
Monitoring Org Phone	Customer supplied
Monitoring Org Email	
Monitoring Acct Number	Customer supplied
Phone Line one or IP	Customer supplied

Phone Line two or IP	Customer supplied
Means Of Transmission	Pots

3. DOCUMENTATION

Onsite location of the required record documents and site specific software

Is the location of documents and software indicated on the Component list and or layouts?	No
If the location is not indicated as YES above give description of location here	Maint. Depart

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		
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.	8-3-21

9. CERTIFICATION

This system as specified herein has been inspected and tested according to NFPA 72, 2016 edition, Chapter 14.

Inspector Name	Conner Holsclaw
Date/Time	
Inspector Qualifications	NE Fire Inspector #030
Phone	(800) 274-0888
Company Name	Protex Central

10 .DEFECTS OR MALFUNCTIONS NOT CORRECTED ARE LISTED ON THE DEFICIENCIES PAGE OF THIS REPORT

10.1 ACCEPTANCE BY OWNER OR OWNER'S REPRESENTATIVE:

The listed name below accepted the test report as specified herein:

Property Rep Auto Field	Kurt Anderson
If the Auto Field is not correct who is the responsible party who is accepting the Test report?	Bevan flynn
Title:	
Phone:	
Date:	8-3-21

Fire Sprinkler

Sprinkler Inspection, Testing and/or Maintenance 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
Sep 14, 2021

Building: Lincoln regional center B 3
Contact: Kurt Anderson
Title: Na

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 3	**Contact:** Kurt Anderson
Address: 801 west prospector	**Phone:** Na
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Sep 14, 2021

Building: Lincoln regional center B 3

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	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 (2021)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Supervisory Signal	5	5	0	5	5

LS 02.01.35 EP 14 All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Control Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 17

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 3
Inspector: Jerad Baxter	Contact: Kurt Anderson
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Tamper Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Tamper Switch	Basement Center room 008	30561921	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 008	30561922	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 008	59342398	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 008	59342401	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	1st Center rom 116	59342404	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Waterflow Switch	Basement Center room 008	59342402	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	Basement Center room 008	30561918	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Center rom 116	59342405	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd Center rom 216	59342406	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement Center room 008	59342396	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Supervisory Signal	5	5	0	5	5

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Supervisory Signal	Basement Center room 008	30561920	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center room 008	30561923	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center room 008	59342400	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	1st Center rom 116	59342403	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd Center rom 216	59342408	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Control Valve	2nd Center rom 216	59342407	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Garden Center outside Sw side	59342397	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Annual	1
Drain	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	4
Total		**17**
Grand Total		**17**

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 3

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Supervisory Signal	Alarm	29.41%	5
Control Valve	Valve	5.88%	1
Waterflow Switch	Alarm	23.53%	4
Tamper Switch	Alarm	29.41%	5
Post Indicator Valve	Valve	5.88%	1
Drain	Device	5.88%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Drain	1		Main		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	5				03/02/2020
Tamper Switch	1				03/02/2020
Tamper Switch	4		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020

Sprinkler Inspection, Testing and/or Maintenance 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
Sep 14, 2021

Building: Lincoln regional center B 5
Contact: tiffany na
Title: administrative assistant

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 5	**Contact:** tiffany na
Address: 801 west prospector pl	**Phone:** (402) 471-4444
Address:	**Fax:**
City/State/Zip: lincoln, ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Sep 14, 2021

Building: Lincoln regional center B 5

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Tamper Switch	7	7	0	7	7
Waterflow Switch	7	7	0	7	7

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Supervisory Signal	7	7	0	7	7

LS 02.01.35 EP 14 All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Control Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 24

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 5
Inspector: Jerad Baxter	Contact: tiffany na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Tamper Switch	Basement Boiler	59342377	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Boiler	59342378	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	1st Closet closet by reception center	59342382	1-s-2	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	1st Closet room 133a	59342386	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342390	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342388	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	2nd Closet s5 west stairwell	59342395	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Waterflow Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Waterflow Switch	Basement Boiler	59342380	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Closet room 133a	59342384	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Closet room 133a S2	68605364	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement Boiler	59342375	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Supervisory Signal	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Supervisory Signal	Basement Boiler	59342376	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Boiler	59342379	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	1st Closet closet by reception center	59342381	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	09/08/20 -P		03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Control Valve	1st Closet room 133a S2	68605365	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Garden outside ne of entrance	59342356	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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	7
Tamper Switch	Annual	7
Waterflow Switch	Annual	7
Total		**24**
Grand Total		**24**

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Inventory & Warranty Report lists each of the devices and items that are included in your Inspection Report. A complete inventory count by device type and category is provided. Items installed within the last 90 days, within the last year, and devices installed for two years or more are grouped together for easy reference.

Device or Type	Category	% of Inventory	Quantity
Tamper Switch	Alarm	29.17%	7
Supervisory Signal	Alarm	29.17%	7
Waterflow Switch	Alarm	29.17%	7
Control Valve	Valve	4.17%	1
Drain	Device	4.17%	1
Post Indicator Valve	Valve	4.17%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Drain	1		Main		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	7				03/02/2020
Tamper Switch	7		Control Valve	Supervisory	03/02/2020
Waterflow Switch	7		Vane	Alarm	03/02/2020

Zone Address Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 5

The Zone Address Report lists all of the devices and items that have an individual address, or are grouped together under a common zone. The device type, location and description are included for your reference. For more information on the device, use the link provided under ScanID.

Address	Device Type	Location	Type	ScanID
Control Panel 1				
Zone/Address: s-2				
	Tamper Switch	1st Closet closet by reception center	Control Valve	59342382
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

Sprinkler Inspection, Testing and/or Maintenance 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
Sep 14, 2021

Building: Lincoln regional center B 10
Contact: Kurt Na
Title: Maintance manager

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 10	**Contact:** Kurt Na
Address: 800 west prospector	**Phone:** Na
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Sep 14, 2021

Building: Lincoln regional center B 10

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Tamper Switch	7	7	0	7	7
Waterflow Switch	3	3	0	3	3

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

LS 02.01.34 EP 10 All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	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 (2021)	Total Quantity
Inspector's Test	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 19

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 10
Inspector: Jerad Baxter	Contact: Kurt Na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 10

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Tamper Switch	Basement Center room 013	59342343	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 013	59342344	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 013	59342345	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 013	59342349	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center room 013	59342350	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Tamper Switch	1st Center room 147	59342409	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	2nd East room 234	59342340	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Waterflow Switch	Basement Center room 013	59342347	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Center room 147	59342411	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd East room 234	59342339	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement Center room 013	59342353	0	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Supervisory Signal	Basement Center room 013	59342342	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center room 013	59342346	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center room 013	59342348	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center room 013	59342351	1	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -P
Supervisory Signal	1st Center room 147	59342410	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd East room 234	59342341	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P

Device Total: 6

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Testing the waterflow alarms on wet pipe systems shall be accomplished by opening the inspector's test connection. (2011 ed.) (NFPA 25 5.3.3.3)	

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Inspector's Test	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Inspector's Test	2nd East room 234	Y89971	0			03/01/21 -P	06/07/21 -P	09/14/21 -P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Basement Center room 013	59342352	0	09/08/20 -P	12/07/20 -P		06/07/21 -P	09/14/21 -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
Inspector's Test	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	6
Tamper Switch	Annual	7
Waterflow Switch	Annual	3
Total		**19**
Grand Total		**19**

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
Tamper Switch	Alarm	36.84%	7
Supervisory Signal	Alarm	31.58%	6
Waterflow Switch	Alarm	15.79%	3
Inspector's Test	Valve	5.26%	1
Post Indicator Valve	Valve	5.26%	1
Drain	Device	5.26%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Drain	1		Main		03/02/2020
Inspector's Test	1				03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	5				03/02/2020
Supervisory Signal	1		Pressure		03/02/2020
Tamper Switch	1				03/02/2020
Tamper Switch	1			Supervisory	03/02/2020
Tamper Switch	4		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, Testing and/or Maintenance 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
Sep 14, 2021

Building: Lincoln regional center B 14
Contact: Kurt Na
Title: Maintance manager

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln regional center B 14	**Contact:** Kurt Na
Address: 801 west prospector	**Phone:** 479-5452
Address:	**Fax:**
City/State/Zip: Lincoln, Ne 68522	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Sep 14, 2021

Building: Lincoln regional center B 14

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Tamper Switch	9	9	0	9	9
Waterflow Switch	5	5	0	5	5

EC 02.03.05 EP 09

Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

EC 02.03.05 EP 10

Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.34 EP 10

All other Life Safety Code fire alarm requirements related to NFPA 101-2012 18/19.3.4

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Supervisory Signal	11	11	0	11	11

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Backflow Prevention	0	0	0	0	1
Check Valve	1	1	0	1	1
Control Valve	2	2	0	2	2
Post Indicator Valve	1	1	0	1	1

Total Device Count: 32

Certification

Company: NIFCO Mechanical Systems	Building: Lincoln regional center B 14
Inspector: Jerad Baxter	Contact: Kurt Na
Signed:	Signed:

Jerad Baxter Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8699
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Inspection & Testing section lists all of the items inspected in your building, which are then categorized by the applicable code reference. The most recent inspection is listed in the far right column and is based on the Finish Date of that inspection. The latest inspection uploaded in each previous quarter appears in the four columns to the left. Passed=P, Failed=F, Replaced=R

EC 02.03.05 EP 02 Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Tamper Switch	9	9	0	9	9

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Tamper Switch	Basement Room 42	59342430	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Room 42	59342432	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Room 42	59342437	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Room 42	59342438	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center Room 039	59342338	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	Basement Center Room 039	59342335	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	1st Center Room 135 above ceiling	59342412	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	3rd Center Room 340	59342419	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Tamper Switch	3rd Center Room 340	59342421	1-3rd floor	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Waterflow Switch	Basement Room 42	59342427	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Waterflow Switch	3rd Center Room 340	59342423	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement Room 42	59342426	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Fire Dep't Connection	Basement Room 42	59342433	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Supervisory Signal	11	11	0	11	11

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Supervisory Signal	Basement Room 42	59342429	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Room 42	59342431	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Room 42	59342439	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Room 42	59342436	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center Room 039	59342337	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Basement Center Room 039	59342336	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	3rd Center Room 340	59342418	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Supervisory Signal	Penthouse Elevator room	59342424	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P

Device Total: 11

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

All backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. (2011 ed.) (NFPA 25 13.6.2.1)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Backflow Prevention	0	0	0	0	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Backflow Prevention	Basement Room 42	59342428	0					
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)	

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Check Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Check Valve	Basement Room 42	59342434	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Control Valve	2nd Center Room 247 above ceiling	59342416	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Control Valve	Penthouse Elevator room	59342425	1	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P

Device Total: 2

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Garden South In yard south of building	59342435	0	09/08/20 -P	12/07/20 -P	03/01/21 -P	06/07/21 -P	09/14/21 -P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Check Valve	Annual	1
Control Valve	Annual	2
Drain	Annual	1
Fire Dep't Connection	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	11
Tamper Switch	Annual	9
Waterflow Switch	Annual	5
Total		**31**
	Untested	
Backflow Prevention		1
Total		**1**
Grand Total		**32**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

This section lists out all the devices and components that have been associated with a Wet Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane				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
Tamper Switch	Alarm	28.12%	9
Supervisory Signal	Alarm	34.38%	11
Fire Dep't Connection	Hose	3.12%	1
Post Indicator Valve	Valve	3.12%	1
Check Valve	Valve	3.12%	1
Drain	Device	3.12%	1
Control Valve	Valve	6.25%	2
Waterflow Switch	Alarm	15.62%	5

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Backflow Prevention	1				03/02/2020
Check Valve	1		Grooved		03/02/2020
Control Valve	2		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Fire Dep't Connection	1		Wall		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	9				03/02/2020
Supervisory Signal	2		Pressure		03/02/2020
Tamper Switch	9		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Waterflow Switch	1		Vane	Alarm	03/02/2020

Zone Address Report

Generated by: BuildingReports.com

Building: Lincoln regional center B 14

The Zone Address Report lists all of the devices and items that have an individual address, or are grouped together under a common zone. The device type, location and description are included for your reference. For more information on the device, use the link provided under ScanID.

Address	Device Type	Location	Type	ScanID
Control Panel 1				
Zone/Address: 3rd floor				
	Tamper Switch	3rd Center Room 340	Control Valve	59342421
	Waterflow Switch	3rd Center Room 340	Vane	59342422

State Fire Marshall

Occupancy Permits

Attachment L9

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11969

Name of Facility:	**Lincoln Regional Center Bldg #14**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Lincoln**
Maximum Occupancy:	**85 Beds**
Date Issued:	**6/23/2021**

Inspected By: **Monica Ellis**
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: 12016

Name of Facility:	**Lincoln Regional Center Bldg #3 Psych Admissions**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Lincoln**
Maximum Occupancy:	**46 Beds**
Date Issued:	**6/23/2021**

Inspected By: **Monica Ellis**
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: 12017

Name of Facility:	**Lincoln Regional Center Bldg #5 Forensic**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Lincoln**
Maximum Occupancy:	**109 Beds**
Date Issued:	**6/23/2021**

Inspected By: **Monica Ellis**
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.

Major Projects

Attachment N1

Subject: Projects in 2021

Wragge, Kevin <Kevin.Wragge@nebraska.gov> Thu, Nov 4, 8:41 AM
to Lewis, Matthew, Wragge, Kevin

The only thing I could find for 2021 is 3 offices on 1 east were remodeled ,clean linen room on 3 floor remodeled,clean out in court yard done, gate in court yard started ,moved control panel in the tunnel for stem controller,and remodeled the rooms on 3th floor offices all completed except gate Work orders come in emails right now but we are working on getting corrigo here I would say 2 to 3 work orders a day is a good number that could be around 400 hundred Major project right now we don't track but we will have to start

DHHS Public Health, Licensure Unit Surveys

Attachment N2

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	R 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 000}	Initial Comments On 3/16/21-3/17/21, DHHS Public Health representatives conducted a revisit on the licensure survey to determine compliance with 175 NAC 9, Licensure Regulations for Hospitals. The facility was recited for being out of compliance with the regulations identified below at the time of survey: 9-006.09 G5 Pharmacy.	{I 000}		
{I 560}	9-006.09G Pharmacy Services Pharmacy services must be provided to meet the needs of patients directly or through written agreement, and must be under the supervision of a pharmacist licensed in Nebraska. The storage, control, handling, compounding and dispensing of drugs, devices and biologicals must be in accordance with Neb. Rev. Stat. §§ 71-1,142 to 71-1,147.59 and the regulations promulgated thereunder. 9-006.09G1 Emergency drugs, devices and biologicals as determined by the medical staff must be readily available for use at designated locations when an emergency occurs. 9-006.09G2 Current and accurate records must be kept on the receipt and disposition of all controlled substances. 9-006.09G3 The supply of drugs, devices and biologicals and controlled substances must be protected and restricted to use for legally authorized purposes. 9-006.09G4 Abuses and losses of controlled substances must be reported in accordance with Neb. Rev. Stat. §§ 28-401 to 28-445, the Uniform Controlled Substances Act, and the regulations promulgated thereunder. 9-006.09G5 Drugs, devices and biologicals must be stored in locked areas in accordance with the manufacturer ' s instructions for temperature, light, humidity or other storage	{I 560}		

Licensure Unit

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

Interim Hospital Administrator 4/9/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	R 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 560}	Continued From page 1 instructions. 9-006.09G6 Drugs, devices and biologicals must be removed from the pharmacy or storage area only by personnel designated in hospital policies and in accordance with state and federal law. 9-006.09G7 The supply of drugs, devices and biologicals must be checked on a regular basis to ensure expired, mislabeled, unlabeled or unusable products are not available for patient use and are disposed of in accordance with hospital policies and state and federal law. 9-006.09G8 Information relating to interactions, contraindications, side effects, toxicology, dosage, indications for use, and routes of administration for drugs, devices and biologicals must be available to staff. This Standard is not met as evidenced by: 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 7 of 7 medication refrigerators in the facility. Findings are: A. A tour of the medication refrigerator in the pharmacy, on the 5 patient units and in the MCM (Medication Cabinet Machine) room were identified as containing medications the pharmacist identified as needing a temperature range of 32-40 degrees Fahrenheit revealed the following: -The Pharmacy medication refrigerator lacked a temperature check 9 days in February 2021 and 1 days in March 2021 on the temperature log. -Unit 1 West medication refrigerator lacked a	{I 560}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	R 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 560}	Continued From page 2 temperature check 4 days in February 2021 and 3 days in March 2021 on the temperature log. The thermometer currently read 50 degrees F, staff stated that "we filled the refridgerator and must of bumped the temperature dial", "we will recheck in a little bit.". There was 6 days in February and 5 days in March that the thermometer registered below 32 degrees, no rechecks were noted; there were 2 days that the thermometer registered over 40 degrees. -Unit 2 West medication refrigerator log lacked a temperature check 4 days in February 2021 and 3 days in March 2021. There were 23 days in February and 11 days in March that the thermometer registered below 32 degrees, no rechecks were noted. Unit 2 East medication refrigerator log lacked a temperature check 3 days in February 2021 and 1 day in March 2021. There were 5 days in February and 4 days in March that the thermometer registered above 40 degrees, no rechecks were noted. -Unit 3 West medication refrigerator log lacked a temperature check 9 days in February 2021 and 2 days in March 2021. There were 10 days in February and 4 days in March that the thermometer registered below 32 degrees, no rechecks were noted. -Unit 3 East medication refrigerator log lacked a temperature check 7 days in February 2021 and 0 days in March 2021. There were 18 days in February and 8 days in March that the thermometer registered below 32 degrees, no rechecks were noted. -MCM cabinet refrigerator log lacked a temperature check 26 days in February 2021 and 15 days in March 2021 The medications stored in these refrigerators included but are not limited to vaccines, Injectable Ativan and insulin. Those medications	{I 560}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	R 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 560}	Continued From page 3 are to be stored in a range of 32-40 degrees F. B. An interview with the Registered Pharmacist (RP A) on 3/16/21 at 9:15 AM revealed that, "I checked the medications in those refridgerators and they are all stable and I will not need to replace them."	{I 560}		

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

March 31, 2021

Don Whitmire
Administrator
Norfolk Regional Center
P O Box 1209, 1700 North Victory Rd
Norfolk, NE 68701-1209

Dear Mr. Whitmire:

On March 17, 2021, DHHS representatives conducted an onsite revisit to verify that your facility had achieved and maintained compliance with the deficiencies cited during a survey conducted March 16 & 17, 2021. During the revisit survey, the original cited deficiencies Tags I 470 and I 570 were found to be in compliance, however, Tag I 560 was not corrected as you will see on the enclosed State Form.

STATEMENT OF COMPLIANCE (SOC)

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

An acceptable SOC 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 **May 1, 2021.**

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

SIGNATURE ON FIRST PAGE OF THE State Form: The first page must be signed by the facility Administrator or representative and faxed to 402-742-8319.

We will notify you whether your statement of compliance 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,

Jean Ellis, RN, BSN - Program Manager II
DHHS Public Health - Licensure Unit
Office of Acute Care Facilities
PO Box 94986, Lincoln, NE 68509-4986

JE/lc

Enclosures: State Form

FACILITY STATEMENT OF COMPLIANCE

PROVIDER NAME:	Norfolk Regional Center	Survey Date
STREET ADDRESS, CITY, ZIP:	1700 North Victory Rd, Norfolk, NE 68701	3/17/2021
	Provider License Number:	520003
	PROVIDER'S STATEMENT OF COMPLIANCE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)	**COMPLETION DATE(S)**
CITED TAG #	I 560: 9-006.09G Pharmacy Services- Pharmacy services must be provided to meet the needs of patients directly or through written agreement, and must be under the supervision of a pharmacist licensed in Nebraska. The storage, control, handling, compounding and dispensing of drugs, devices and biologicals must be in accordance with Neb. Rev. Stat. §§ 71-1,142 to 71-1,147.59 and the regulations promulgated thereunder.	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all medication refridgerators and freezers are monitored per policy.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-560	QA will update the Fridge/Freezer Temp sheet to be monthly and include a comment section to capture steps taken when temps are out of range.	4/1/2021
I-560	Overnight assignment sheets will be updated to include task of documenting Fridge/Freezer temps.	4/1/2021
I-560	DON sent email to all nursing staff outlining expectations associated to monitoring fridge temps.	4/7/2021
I-560	NRC Supervisor Long Sheets will be updated to include Fridge/Freezer temps.	4/9/2021
I-560	QA Audit form will be updated to include name of staff member who is assigned to check temp log to allow for follow-up by leadership. QA will send audit results to Nursing Leadership.	4/9/2021
I-560	NRC House Supervisor/Administrative Nurse/Team Leader will conduct daily rounds to ensure Fridge/Freezer temps are completed.	4/9/2021
I-560	NRC Pharmacy-Medication Storage policy will be updated.	4/16/2021
I-560	DON will send out email outlining changes in NRC Pharmacy-Medication Storage Policy. Nursing Administrative Nurses will post email in medication rooms.	4/16/2021
I-560	All nursing personnel and pharmacy staff will complete electronic training on the updated NRC Pharmacy-Medication Storage policy.	4/30/2021
I-560	NRC began project to implement automated temp monitoring system.	3/22/2021
	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:	
I-560	NRC QA Department will complete an audit to ensure the refrigerator monitoring forms are completed. The audit will continue until 100% compliance has occurred for 90 days. The results will be reported and discussed in Administrative Council, PIRM and all staff meetings.	5/1/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (<u>By JOB TITLE, not by NAME</u>) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	Director of Nursing	

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	520003	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK REGIONAL CENTER	P O BOX 1209, 1700 NORTH VICTORY RD NORFOLK, NE 68701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments On 3/29/21 and 4/6/21, DHHS Public Health representatives conducted a licensure complaint investigation to determine complieance with 175 NAC9, Licensure Regulations for Hospitals. The faiclity was out of compliance with the regulation of Patient Rights 9-006.04 at the time of survey.	I 000		
I 180	9-006.04 Patient Rights Each hospital must protect and promote each patient ' s rights. This includes the establishment and implementation of written policies and procedures, which include, but are not limited to, the following rights. Each patient or designee, when appropriate, must have the right to: 1. Respectful and safe care given by competent personnel; 2. Be informed of patient rights during the admission process; 3. Be informed in advance about care and treatment and of any change; 4. Participate in the development and implementation of a plan of care and any changes; 5. Make informed decisions regarding care and to receive information necessary to make decisions; 6. Refuse treatment and to be informed of the medical consequences of refusing treatment; 7. Formulate advance directives and to have the hospital comply with the directives unless the hospital notifies the patient of the inability to do so; 8. Personal privacy and confidentiality of medical records; 9. Be free from abuse, neglect, and exploitation; 10. Access information contained in his/her medical record within a reasonable time frame	I 180		

Licensure Unit

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

Interim Hospital Administrator | 4/15/21

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

April 14, 2021

Don Whitmire, Interim Administrator
Norfolk Regional Center
P O Box 1209, 1700 North Victory Rd
Norfolk, NE 68701-1209

Dear Mr. Whitmire:

An unannounced visit was made to Norfolk Regional Center on March 29 through April 6, 2021, by representatives of this Department. The purpose of the visit was to investigate complaints on non-compliance with regulatory requirements received by our office.

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

ALLEGATIONS:
The facility failed to implement policies and procedures to protect patients from abuse.
The facility failed to ensure the patient's rights were protected.

FINDINGS:

1. Based on observations, staff interviews with administrative and patient care staff, record reviews of patient records, review of facility internal investigations and review of policies and procedures, and security video, the facility implements policies and procedures to protect patients from abuse. Incidents of staff to patient allegations are investigated, reeducation was reviewed. This allegation was unsubstantiated.

2. Based on observations, staff interviews with administrative and patient care staff, patient record reviews that included patients that were restrained, facility internal investigations, review of several patient grievances and the steps provided to the patients was completed per the grievance policy (No deficient practice was identified for patient rights related to grievances and following their policy for resolution of grievances). Review of policies and procedures revealed the facility implements policies and procedures to protect patients from abuse and to protect patient's rights. Staff monitor and intervene immediately to protect patients. One patient that was restrained was not released timely after meeting release criteria. Deficient practice was identified.

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,

Jean Ellis, RN, BSN - Program Manager II
DHHS Public Health - Licensure Unit
Office of Acute Care Facilities
PO Box 94986, Lincoln, NE 68509-4986

JE/lc

FACILITY STATEMENT OF COMPLIANCE

PROVIDER NAME:	Norfolk Regional Center	Survey Date
STREET ADDRESS, CITY, ZIP:	1700 North Victory Rd, Norfolk, NE 68701	4/6/2021
	Provider License Number:	520003
	PROVIDER'S STATEMENT OF COMPLIANCE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE VIOLATION)	**COMPLETION DATE(S)**
CITED TAG #	I-180: 9-006.04 Patient Rights: This Standard is not met as evidenced by: Based on record review, staff interview, administrative investigation report review, and review of policies and procedures, available security video, the facility failed to ensure 1 of 8 (Patient 5) patients were released from a restraint timely after meeting the release criteria. This has the potential to effect all patients	
	A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY: NRC will ensure all patients are release from a restraint timely after meeting the release criteria.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
I-180	NRC will update the NRC Behavioral Interventions - Seclusion/Restraints policy to clarify the frequency of RN assessments of release criteria.	4/23/2021
I-180	NRC will update the NRC Behavioral Interventions - Seclusion/Restraints policy to clarify the location in which ongoing assessments of release criteria are documented.	4/23/2021
I-180	NRC will update the NRC Behavioral Interventions - Seclusion/Restraints policy to reflect the minimal frequency of staff observation notes when monitoring a patient in Restraint/Seclusion.	4/23/2021
I-180	NRC will update the Restraints Flow Sheet Suggested Descpitors Menu form to reflect updates in the NRC Behavioral Interventions - Seclusion/Restraints policy.	4/23/2021
I-180	NRC will update the Restraint Behavioral Intervention Flow Sheet to reflect updates in the NRC Behavioral Interventions - Seclusion/Restraints policy.	4/23/2021
I-180	NRC will update the Quality Assurance Department R/S Retrospective Review form to include audit of ongoing assessments of release criteria by RN.	4/23/2021
I-180	NRC will update the Restraint and Seclusion-Nursing Guidance form to reflect updates in the NRC Behavioral Interventions - Seclusion/Restraints policy.	4/23/2021
I-180	NRC Medical Director will meet with NRC medical providers to educate on the updates in the NRC Behavioral Interventions - Seclusion/Restraints policy.	4/23/2021
I-180	All nursing personnel and QA Department staff will complete an on-line education training of updates in NRC Behavioral Interventions - Seclusion/Restraints policy.	5/3/2021
	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:	
I-180	NRC QA Department will complete an audit of all Restraint and Seclusion incidents to ensure ongoing assessments of release criteria are completed and documented.	5/3/2021
I-180	NRC QA department will complete an audit of staff training records to ensure completion of on-line education training of updates in the NRC Behavioral Interventions - Seclusion/Restraints policy.	5/4/2021
	D. IDENTIFICATION OF THE PERSON RESPONSIBLE (<u>By JOB TITLE, not by NAME</u>) FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY:	
	NRC Hospital Administrator	

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

April 14, 2021

Don Whitmire, Interim Administrator
Norfolk Regional Center
P O Box 1209, 1700 North Victory Rd
Norfolk, NE 68701-1209

RE: Norfolk Regional Center,

Dear Mr. Whitmire:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On March 29 through April 6, 2021, DHHS representatives conducted an investigative survey to determine whether your facility was in compliance with State Licensure regulations for Psychiatric Hospitals. Enclosed you will find the State Form documenting the results of that survey. All references to regulatory requirements contained in this letter are found in Title 17 NAC 9 Regulations Governing Licensure of Hospitals.

STATEMENT OF COMPLIANCE (SOC)

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

An acceptable SOC 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 **May 21, 2021**.

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

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

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

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

Sincerely,

Jean Ellis, RN, BSN - Program Manager II
DHHS Public Health - Licensure Unit
Office of Acute Care Facilities
PO Box 94986, Lincoln, NE 68509-4986

JE/lc

Enclosures: State Form
Health –ePOC

Facility Staffing Information

Attachment N3

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data
12/1/2020 - 11/30/2021

Facility: NRC Norfolk Regional Center

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		188	57	245	192	51	54	2%	22%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
I77012	ACTIVITY ASSISTANT	0	0	0	9	0	1	1%	11%
H77023	ACTIVITY SPECIALIST	9	0	9	0	0	0		
V77024	ACTIVITY SUPERVISOR	1	0	1	1	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	5	0	5	4	0	0	0%	0%
K01014	ADMINISTRATIVE SPECIALIST (NEW)	1	0	1	0	0	0		
S01013	ADMINISTRATIVE TECHNICIAN (NEW)	2	0	2	0	1	0	0%	0%
V75016	ASSOCIATE DIRECTOR OF NURSING (NEW)	1	0	1	0	1	0	0%	0%
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	1	0	1	0	0	1		
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	1	2	3	0	0	0		
H72554	BEHAVIORAL HEALTH PRACTITIONER IV (NEW)	2	0	2	0	0	0		
V72556	BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II (NEW)	1	0	1	0	0	0		
C72342	CERTIFIED MASTER SOCIAL WORKER	4	0	4	4	0	0	0%	0%
V72343	CERTIFIED MASTER SOCIAL WORKER SUPERVISOR	0	1	1	0	0	0		
H75321	CLINICAL NURSE TRAINER (NEW)	1	0	1	1	0	0	0%	0%
V72460	CLINICAL PROGRAM MANAGER	1	0	1	1	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	3	0	3	3	0	0	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	0	0	0	4	0	1	2%	25%
G73280	DHHS QUALITY ASSURANCE COORDINATOR	1	0	1	1	0	0	0%	0%
S09130	DHHS SCHEDULING COORDINATOR	0	0	0	1	0	0	0%	0%
G75017	DIRECTOR OF NURSING (NEW)	1	0	1	1	0	0	0%	0%
M84141	FACILITY MAINTENANCE TECHNICIAN I	0	0	0	1	0	0	0%	0%
N00750	FACILITY OPERATING OFFICER	1	0	1	1	0	1	8%	100%
M80122	FOOD SERVICE ASSISTANT	0	0	0	2	0	1	4%	50%
R80011	FOOD SERVICE ASSISTANT (NEW)	1	0	1	0	1	0	0%	0%
M80123	FOOD SERVICE COOK	0	0	0	4	1	2	3%	40%
V80230	FOOD SERVICE MANAGER	1	0	1	1	0	0	0%	0%
V80220	FOOD SERVICE SUPERVISOR	1	1	2	1	0	0	0%	0%
M80012	FOOD SERVICE WORKER (NEW)	4	7	11	0	1	0	0%	0%
V02202	HEALTH INFORMATION MANAGER	1	0	1	1	0	0	0%	0%
H76312	HUMAN SERVICES TREATMENT SPECIALIST II	4	0	4	4	0	0	0%	0%
I75013	LICENSED PRACTICAL NURSE (NEW)	2	3	5	4	0	2	4%	50%
R75013	LICENSED PRACTICAL NURSE (NEW)	3	4	7	4	2	3	4%	50%
M84011	MAINTENANCE TECHNICIAN (NEW)	5	0	5	0	1	0	0%	0%
C72341	MASTER SOCIAL WORKER	1	0	1	0	0	0		
S02111	MEDICAL RECORDS CLERK	0	0	0	1	0	1	8%	100%
H72431	MENTAL HEALTH PRACTITIONER I	0	0	0	2	0	0	0%	0%
H72432	MENTAL HEALTH PRACTITIONER II	0	0	0	3	0	1	3%	33%
V72433	MENTAL HLTH PRACTITIONER SUPERVISOR	0	0	0	1	0	0	0%	0%
P76142	MENTAL HLTH SECURITY SPECIALIST II	79	21	100	87	34	34	2%	28%
R76142	MENTAL HLTH SECURITY SPECIALIST II	12	9	21	12	4	3	2%	19%
V76154	MENTAL HLTH SECURITY UNIT SUPERVISOR	5	0	5	0	0	0		
D75350	NURSE PRACTITIONER	2	0	2	2	1	1	3%	33%
S01012	OFFICE SPECIALIST (NEW)	3	1	4	0	1	1	8%	100%
S01011	OFFICE TECHNICIAN (NEW)	2	0	2	0	0	0		
V17123	PERSONNEL MANAGER II	1	0	1	1	0	0	0%	0%
H74731	PHARMACIST	1	0	1	1	0	0	0%	0%
I74712	PHARMACY INVENTORY TECHNICIAN	1	0	1	1	0	0	0%	0%
G74732	PHARMACY MANAGER	1	0	1	1	0	0	0%	0%
D75410	PHYSICIAN ASSISTANT	1	0	1	1	0	0	0%	0%
N74213	PSYCHIATRIC DIRECTOR	0	1	1	0	0	0		
R74211	PSYCHIATRIST	2	1	3	3	0	1	3%	33%
V74823	PSYCHOLOGIST/LICENSED	0	1	1	0	0	0		
N74825	PSYCHOLOGY DIRECTOR	1	0	1	0	1	0	0%	0%
H75014	REGISTERED NURSE (NEW)	13	4	17	11	2	0	0%	0%
R75014	REGISTERED NURSE (NEW)	2	1	3	3	0	0	0%	0%
C79920	RELIGIOUS COORDINATOR	1	0	1	1	0	0	0%	0%
S01412	SECRETARY II	0	0	0	1	0	0	0%	0%
S01841	STAFF ASSISTANT I	0	0	0	3	0	0	0%	0%
K01842	STAFF ASSISTANT II	0	0	0	1	0	0	0%	0%
S05012	SUPPLY TECHNICIAN II (NEW)	1	0	1	0	0	0		
S05211	SUPPLY WORKER I	0	0	0	1	0	0	0%	0%
A11011	TRAINING SPECIALIST (NEW)	1	0	1	0	0	0		
A11122	TRAINING SPECIALIST I	0	0	0	1	0	0	0%	0%
S01313	WORD PROCESSING SPECIALIST III	0	0	0	1	0	0	0%	0%
		188	**57**	**245**	**192**	**51**	**54**	**2%**	**22%**

Nebraska Legislature

Jerall Moreland <jmoreland@leg.ne.gov>

Ombudsman's Contact

Skirry, Sarah <Sarah.Skirry@nebraska.gov> Thu, Dec 2, 2021 at 9:05 AM
To: "Moreland, Jerall" <jmoreland@leg.ne.gov>
Cc: "Whitmire, Don" <Don.Whitmire@nebraska.gov>

Hi Jerall,

Attached is the information you requested from NRC.

We had 11 staff assaults from 12/1/20-11/30/21. 8 assaults occurred during the implementation of Restraint or Seclusion.

Please don't hesitate to reach out if you have any questions.

Thanks and best,

Sarah

Sarah Skirry | *Legislative Coordinator*

COMMUNICATIONS & LEGISLATIVE SERVICES

Nebraska Department of Health and Human Services

OFFICE: 402-314-9172

DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: Jerall Moreland <jmoreland@leg.ne.gov>
Sent: Monday, November 1, 2021 12:51 PM
To: Whitmire, Don <Don.Whitmire@nebraska.gov>; Snyder, Peter <Peter.Snyder@nebraska.gov>; Harrison, Corina <Corina.Harrison@nebraska.gov>; Popple, Mitchell <Mitchell.Popple@nebraska.gov>
Cc: Kahl, Larry <Larry.Kahl@nebraska.gov>
Subject: Ombudsman's Contact

As you are aware, Neb. Rev. Stat. 83-104 requires that our office report annually on the condition of state institutions, which is due to the Legislature on December 15. The period we are to report covers December 2020 through November 2021. In order to complete the report by the statutory deadline, I am making the below request for information concerning your respective Institutions.

COVID -19 Impact

Leadership update

Families/Guardians and Visitors Letter

Emergency Planning Meeting

Testing

Attachment N4

Leadership update

Subject: RE: COVID Updates

Lewis, Matthew <Matthew.Lewis@nebraska.gov>
to

Hello NRC team,

We wanted to take the time to update everyone about our current standing with COVID and our precautions put in

✓ Wearing masks will continue to be in place for the time being

✓ The Advisory Council to the Food and Drug Administration (FDA) approved boosters for the Moderna and J&J/ the end of this week. People who received the J&J/Janssen vaccine may be able to get any of the three vaccines

✓ If a NRC staff member wishes to obtain a booster shot, they will have to obtain that on their own as it is easily a provide proof of your booster to Human Resources (HR)

✓ Break rooms and dining room tables will continue to be used by one person at a time

Everything continues to be assessed every day and every week.

Thank you to everyone for everything you have done during these times and keeping everyone safe.

Matthew Lewis | Quality Assurance Coordinator
Handle With Care Instructor
Nebraska Department of Health and Human Services
Nebraska Sex Offender Program at Norfolk Regional Center
CELL: 402-750-0286 **OFFICE:** 402-370-4333

From: Lewis, Matthew
Sent: Friday, October 15, 2021 2:29 PM
Subject: COVID Updates

Hello NRC team,

We wanted to take the time to update everyone about our current standing with COVID and our precautions put in

✓ Groups/activities have resumed back to normal

✓ 2 East unit will remain closed due to planned construction starting next week

NORFOLK REGIONAL CENTER
Norfolk, Nebraska

COVID-19 Emergency Planning Meeting
October 18, 2021

Present: Terri [redacted], Michelle [redacted], Dawn [redacted], Cat [redacted], Etta [redacted], Matthew [redacted], Brittany [redacted], Dr. David [redacted], Diane [redacted], Larry [redacted], Amy [redacted], Don [redacted]
,
Others Present: Marg [redacted] (Recorder)

Shared Topics/Thoughts/Ideas

- No further information is available regarding the federal vaccine mandate.
- Don forwards the Rural Region One Medica[redacted] System (RROMRS) information to this group when received. The RROMRS section reflects information for the Norfolk area. COVID-19 remains active in our area.
- Two [redacted] tested positive for COVID-19 last week a couple days apart from each other.

Next Steps

- Patient activities have resumed normal operations, except 2-East remains closed for a construction project to update cameras and a monitoring system that starts today on the unit. Any patients who are not level 2 will return to 2-East after the construction is completed.
- [redacted] Parameters need to be set for deciding when masking can be discontinued. Those parameters should include both in-house staff and patient cases, as well as case counts in the community and data from the COVID dashboard. A low number of cases was what the previous decision to discontinue masking was based on. Madison County's trend continues to be high, even though surrounding counties are lower. Testing is not as accessible as it was before.
- The Advisory Council to the Food and Drug Administration (FDA) approved boosters of the Moderna and J&J/Janssen vaccines last Thursday, and full approval by the FDA and CDC is expected by the end of this week. People who received the J&J/Janssen vaccine may be able to get any of the three vaccines as a booster.
- When the vaccines first became available, all NRC patients were considered to be high risk. Dr. Che has advised all patients to inform someone if they want to receive the booster. Diane will order the vaccine for boosters when it is fully approved and patients are due to receive it.
- NRC staff members will need to obtain their booster shot on their own, as it is easily accessible from many providers. Staff are to provide proof of their booster to Denise Uhing in HR when obtained.

mh

Families/Guardian and Visitors Letter

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 7, 2021

Dear Family/Guardians/Visitors,

We appreciate your patience and understanding during these difficult times. We believe that we are prepared to resume in-person visitation, with limits that are expected to help continue our efforts to keep our facility safe for patients, employees and visitors. In-person visits will resume June 19, 2021, with the following caveats, some of which differ from previous visitation rules.

- Visitation areas will be set up to accommodate social distancing
- Outside courtyard areas may be utilized if weather permits
- A staggered visitation schedule will allow small groups of patients to have in-person visitation by unit
- In person visits will be scheduled at least 24 hours in advance to accommodate social distancing
- Health screenings for visitors entering the facility
- Availability of face masks for all visitors if they are not able to provide their own
- All visitors and patients who are not fully vaccinated are encouraged to wear face masks during visit
- You may use the facility vending machines - no food or drink may be brought in from outside the facility
- Visitors need to arrive at least 15 minutes prior to the starting visit time
- Anyone arriving after the visit start time will not be allowed to visit
- Each patient is limited to three approved visitors, children under the age of 14 are not allowed
- Any property left for the patient must be pre-approved

Beginning June 19, 2021, in-person visitation will be available on Wednesdays 1pm-2pm and Saturdays 10:30am—11:30am and 1pm—2pm. Please schedule your visit at least 24 hours in advance within the week in which you request to visit by calling Jessie Gullicksen at 402.370.3311.

We will continue to offer virtual visits in addition to in-person visitation as outlined above. We hope to return to our normal visitation schedule in the near future. When we do, we will continue to schedule all in person visits and plan to continue some virtual visitation options as long as we can safely do so. Should there be an increase in exposure and positive testing, we may need to re-evaluate our visitation practices with little to no prior notice.

Thank you for your understanding, continued support and assistance during this difficult time. Please let us know if you have any questions. Stay safe and healthy.

Sincerely,

Don Whitmire, MPA
NRC Interim Hospital Administrator
Division of Behavioral Health
Health and Human Services

Emergency Planning Meeting

NORFOLK REGIONAL CENTER
Norfolk, Nebraska

COVID-19 Emergency Planning Meeting
October 25, 2021

Present: Cathy [redacted], Kris [redacted], Terri [redacted], Diane [redacted], Michelle [redacted], Dawn [redacted], Cat [redacted], Etta [redacted], Bette [redacted], Dr. David [redacted], Diane [redacted], Larry [redacted], Amy [redacted], Don [redacted]
,
Others Present: Marg [redacted] (Recorder)

Shared Topics/Thoughts/Ideas

- No further information is available regarding the federal vaccine mandate.
- Data from Rural Region One Medical Response System (RROMRS) continues to show a plateau in cases in the Norfolk area.
- Two [redacted] who tested positive completed the isolation period on 10/22/21, but one remains on leave. No additional [redacted] tested positive.

Next Steps

- The construction project (cameras and workstations) on 2-East continues.
- The DHHS dashboard is now updated weekly instead of daily. What will NRC base a decision to discontinue the masking requirement on (e.g., new case numbers, directions for nursing homes, etc.)? [redacted]
- It is now 13 days since the last [redacted] tested positive. It was agreed to allow two people per table in the cafeteria and in break rooms to see how it goes. [redacted] discontinue extra wiping/disinfecting of high-touch areas.
- All three vaccine makers' booster shots now have FDA and CDC approval. Diane S. will try to order Moderna doses for NRC patients; patients who received the Pfizer vaccine downtown will need to get boosters downtown as well when they come due six months after their second dose. Staff members will need to get their boosters at a community provider. Staff are to provide proof of their booster to Human Resources.
- The Pfizer and Moderna boosters are half-doses. Boosters do not need to be from the same maker as the first and second doses, individuals can mix and match.
- Individuals who tested positive for COVID-19 do not need to wait 90 days to get the vaccine. There is also no waiting period required between getting the vaccine/booster and a flu shot, but get them in opposite arms.

mh

Testing

2021- Fall COVID Testing

Covid testing is coordinated through Darlene Porter [redacted], if she is out, HIM will coordinate testing.

*If a staff member is running a fever, they may be asked to see their medical provider prior to entering the facility.

*Mask wearing requires the staff to wear a face covering (cloth, surgical masks, KN95, N95).

*If someone tests positive they are out 10 days from symptom onset or positive test.

*If a staff member begins to display symptoms during the increased monitoring period they should work with their supervisor (House Supervisor after hours) on the next steps. Additional screening may be scheduled.

If a staff member is placed on precautions they are removed from working on 1-West/2-West until all precautions are lifted.

Vaccinated-Exposed at work

- Immediate screening
- Placed on increased monitoring (tested M/W/F).
- Wear mask until tested negative day 5 or after (testing days are M/W/F) from date of last exposure. If your fifth day falls on a non-testing day you wait until a M/W/F.
- Expected duration of mask wearing is minimum of 5 days

Unvaccinated- Exposed at work

- Immediate screening
- Placed on increased monitoring (tested M/W/F).
- Wear mask until tested negative day 14 or after (testing days are M/W/F) from date of last exposure. If your 14th day falls on a non-testing day you wait until a M/W/F.
- Expected duration of mask wearing is minimum of 14 days

Vaccinated- Exposed at home (repeated exposure)

- Immediate screening
- Placed on increased monitoring (tested M/W/F).
- Wear mask until tested negative day 5 or after (testing days are M/W/F) from date of last exposure (which is 10 days from family members symptom onset or + test). If your fifth day (from last exposure) falls on a non-testing day you wait until a M/W/F.
- Expected duration of mask wearing is minimum of 15 days

Unvaccinated- Exposed at Home (repeated exposure)

- Immediate screening
- Placed on increased monitoring (tested M/W/F).
- Wear mask until tested negative day 14 or after (testing days are M/W/F) from date of last exposure (which is 10 days from family members symptom onset or + test). If your 14th day (from last exposure) falls on a non-testing day you wait until a M/W/F.
- Expected duration of mask wearing is minimum of 24 days

Inspection Documentation

Fire Alarm

Fire Sprinkler

Environmental

Attachment N5

Fire Alarm

NEBRASKA STATE FIRE MARSHAL

FIRE ALARM TEST REPORT

Acceptance ☐
Re-acceptance ☐
Periodic 1 ☐ 2 ☐

Date: _____

ELECTRONIC SYSTEMS

P.O. Box 1260 • Hastings, Nebraska 68902-1260
Telephone (402) 463-0200

CUSTOMER: _____

Address: _____

PREMISES PROTECTED: _____

Address: _____

TYPE OF SYSTEM: _____ MODEL #: _____ STANDBY POWER TYPE _____

MANUFACTURER: _____ SERIAL #: _____ TROUBLE BATTERY TYPE _____

INSTALLED BY: _____ AND VOLTAGE _____

System remotely monitored by: _____ Date 100% smoke calibration performed: _____

Time of inspection: _____ Next scheduled: _____

Time inspection completed and system back in service: _____ Date 100% heat detection last performed: _____

Smoke Detection Calibration Test method used _____ Next scheduled: _____

SYSTEM COMPONENTS	TOTAL QUANTITY	# TESTED
Manual Stations		
Heat Detectors		
Fixed Temp. Non-Restorable Line Type		
Fixed Temp. Non-Restorable Spot Type		
Fixed Temp./Rate of Rise/Restorable		
Restorable Line Type, Pneumatic		
Smoke Detectors		
Functional		
Calibrated		
Duct Detectors		
Waterflow Devices (TIME to ACTIVATE)		
Supervisory Switches		
Audible Devices		
Visual Devices		
Annunciators		
Control Unit		
Lamps and LED's		
Fuses		
Primary Power Supply		
Secondary Supply		
Magnetic Hold-open Devices		
Fan Relays		
Voice Alarm and 2-way phone		
Trouble Signals		
Alarm Circuit		
Zone Initiating Circuit		
Supervisory Signals		
Ground Fault		
Elevator Controls		
Powered Fire and Smoke Dampers		

DISCONNECT A.C. POWER AND CHECK SYSTEM ON EMERGENCY POWER

Did Trouble Signal operate properly? Yes No Date: _____

Did Alarm Signal operate properly? Yes No Date: _____

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD

Emergency Power Battery Type _____ Test Volts _____

Main Operating Power Type _____ Test Volts _____

What code is system installed under? _____

Is system operating according to code? _____

Comments: (Note any known deficiencies here) _____

List Current Repairs to System and Date of Repairs _____

(use back if needed) _____

INSPECTOR: _____ LICENSE #: _____ WITNESS: (For acceptance test only)

Expiration Date: _____

SUBSCRIBER: _____ _____
State Fire Marshal

Report shall be submitted to SFM following each inspection test.

SFM 207

246 So. 14 St.
Lincoln, NE 68508-1804
(402) 471-2027

MAIN OFFICE ☐
DISTRICT A ☐
DISTRICT B ☐
DISTRICT C ☐

Fire Sprinkler

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 556-7080
Fax (402) 733-7810

1821-1823 Raccoon Street
Des Moines, Iowa 50317
(515) 262-9311
Fax (515) 265-0361

613 East 59th Street
Davenport, Iowa 52807
(563) 388-6647
Fax (563) 388-6648

Quarterly Report of Inspection, Testing and Maintenance of Fire Sprinkler Systems

Name of Inspected Property: Norfolk Regional Center Date: 4-28-21

Inspector Name: M. Sadler Owners Initials:

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
1.	System in service on inspection			
2.	Hydraulic nameplate attached and legible			
3.	Alarm device free from physical damage			
4.	FDC is visible			
5.	FDC is accessible			
6.	FDC swivels/couplings undamaged/rotate smoothly			
7.	FDC plugs/caps in place/undamaged			
8.	FDC gaskets in place and in good condition			
9.	FDC identification sign in place			
10.	FDC check valve not leaking			
11.	FDC automatic drain valve in place and operating properly			
12.	FDC clapper is in place and operating properly			
13.	FDC interior inspected where caps missing			
14.	FDC obstructions removed as neccessary			
15.	Pressure reducing control valves (PRV) indicate open			
16.	PRV not leaking			
17.	PRV maintaining downstream pressure per design			
18.	PRV in good condition			
19.	PRV handwheel installed and not broken			
20.	ALARM PANEL CLEAR			
21.	COMMENTS:			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
1.	System in service before testing				
2.	Pertinent parties notified before testing				
3.	Adequate drainage provided before flow testing				
4.	Water flow alarm (other tan vane type) tested and is operational				
5.	Test conducted with inspector's test connection				
6.	Test conducted with bypass connection (freezing weather)				
7.	Test conducted per manufacturer's instructions				
8.	Alarm device appear free of physical damage				
9.	Adequate drainage provided before flow testing				
10.	A main drain test conducted downstream from backflow preventer .				
11.	A main drain test conducted downstream from pressure reducing valve				
12.	Supply water gauge reading befor flow	90			psi
13.	Gauge reading during stable flow (residual)	80			psi
14.	Time for supply pressure to return to normal	Timed			sec
15.	Pertinent parties notified of test conclusion				
16.	ALARM PANEL CLEAR				
17.	SYSTEM RETURNED TO SERVICE				
21.	COMMENTS:				

Quarterly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N
1.	System in service inspection			
2.	Hydraulic nameplate attached and legible			
3.	Alarm device free from physical damage			
4.	FDC visible			
5.	FDC is accessible			
6.	FDC swivels/couplings undamaged/rotate smoothly			
7.	FDC plugs/caps in place/undamaged			
8.	FDC gaskets in place and in good condition			
9.	FDC identification sign in place			
10.	FDC check valve not leaking			
11.	FDC automatic drain valve in place and operating properly			
12.	FDC clapper is in place and operating properly			
13.	FDC interior inspected where caps are missing			
14.	FDC obstructions removed as necessary			
15.	Pressur reducing control valves (PRV) indicates open			
16.	PRV not leaking			
17.	PRV maintaining downstram pressure by design			
18.	PRV in good condition			
19.	PRV handwheel installed and not broken			
18.	**ALARM PANEL CLEAR**			
19.	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N	
1.	System in service before testing				
2.	Pertinent parties notified before testing				
3.	Adequate drainage provided before flow testing				
4.	Water flow alarm tested and is operational				
5.	Test conducted with inspectors test connection				
6.	Test concucted with bypass connection(freezing weather)				
7.	Test conducted per manufacturer's instructions				
8.	Alarm devices appear free of physical damage				
9.	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position (semi-annual)				
10.	Signal restored only when valve returned to normal position (semi-annual)				
11.	One main drain test conducted downstream from backflow preventer				
12.	One main drain test conducted downstream from pressure reducing valve				
13.	Supply water gauge reading before flow (static)				psi
14.	Gauge reading during stable flow (residual)				psi
15.	Time for supply pressure to return to normal				sec
16.	Priming water level				
17.	Quick opening device(s) (QOD) tested				
18.	Low Presure alarm tested				
19.	Pertinent parties notified of test conclusion				
20.	ALARM PANEL CLEAR				
21.	SYSTEM RETURNED TO SERVICE				
22.	COMMENTS				

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
Fax (402) 733-7810

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(515) 262-9311
Fax (515) 265-0361

613 East 59th Street
Davenport, Iowa 52807
(563) 388-6647
Fax (563) 388-6648

Quarterly Report of Inspection, Testing and Maintenance of Fire Sprinkler Systems

Name of Inspected Property: Norfolk Regional Center Date: 7-29-21

Inspector Name: M. Sade Owners Initials:

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
1.	System in service on inspection			
2.	Hydraulic nameplate attached and legible			
3.	Alarm device free from physical damage			
4.	FDC is visible			
5.	FDC is accessible			
6.	FDC swivels/couplings undamaged/rotate smoothly			
7.	FDC plugs/caps in place/undamaged			
8.	FDC gaskets in place and in good condition			
9.	FDC identification sign in place			
10.	FDC check valve not leaking			
11.	FDC automatic drain valve in place and operating properly			
12.	FDC clapper is in place and operating properly			
13.	FDC interior inspected where caps missing			
14.	FDC obstructions removed as neccessary			
15.	Pressure reducing control valves (PRV) indicate open			
16.	PRV not leaking			
17.	PRV maintaining downstream pressure per design			
18.	PRV in good condition			
19.	PRV handwheel installed and not broken			
20.	ALARM PANEL CLEAR			
21.	COMMENTS:			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
1.	System in service before testing				
2.	Pertinent parties notified before testing				
3.	Adequate drainage provided before flow testing				
4.	Water flow alarm (other tan vane type) tested and is operational				
5.	Test conducted with inspector's test connection				
6.	Test conducted with bypass connection (freezing weather)				
7.	Test conducted per manufacturer's instructions				
8.	Alarm device appear free of physical damage				
9.	Adequate drainage provided before flow testing				
10.	A main drain test conducted downstream from backflow preventer .				
11.	A main drain test conducted downstream from pressure reducing valve				
12.	Supply water gauge reading befor flow 90				psi
13.	Gauge reading during stable flow (residual) 80				psi
14.	Time for supply pressure to return to normal Zuec				sec
15.	Pertinent parties notified of test conclusion				
16.	ALARM PANEL CLEAR				
17.	SYSTEM RETURNED TO SERVICE				
21.	COMMENTS:				

Quarterly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N
1.	System in service inspection			
2.	Hydraulic nameplate attached and legible			
3.	Alarm device free from physical damage			
4.	FDC visible			
5.	FDC is accessible			
6.	FDC swivels/couplings undamaged/rotate smoothly			
7.	FDC plugs/caps in place/undamaged			
8.	FDC gaskets in place and in good condition			
9.	FDC identification sign in place			
10.	FDC check valve not leaking			
11.	FDC automatic drain valve in place and operating properly			
12.	FDC clapper is in place and operating properly			
13.	FDC interior inspected where caps are missing			
14.	FDC obstructions removed as necessary			
15.	Pressur reducing control valves (PRV) indicates open			
16.	PRV not leaking			
17.	PRV maintaining downstram pressure by design			
18.	PRV in good condition			
19.	PRV handwheel installed and not broken			
18.	**ALARM PANEL CLEAR**			
19.	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N	
1.	System in service before testing				
2.	Pertinent parties notified before testing				
3.	Adequate drainage provided before flow testing				
4.	Water flow alarm tested and is operational				
5.	Test conducted with inspectors test connection				
6.	Test conducted with bypass connection(freezing weather)				
7.	Test conducted per manufacturer's instructions				
8.	Alarm devices appear free of physical damage				
9.	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position (semi-annual)				
10.	Signal restored only when valve returned to normal position (semi-annual)				
11.	One main drain test conducted downstream from backflow preventer				
12.	One main drain test conducted downstream from pressure reducing valve				
13.	Supply water gauge reading before flow (static)				psi
14.	Gauge reading during stable flow (residual)				psi
15.	Time for supply pressure to return to normal				sec
16.	Priming water level				
17.	Quick opening device(s) (QOD) tested				
18.	Low Presure alarm tested				
19.	Pertinent parties notified of test conclusion				
20.	ALARM PANEL CLEAR				
21.	SYSTEM RETURNED TO SERVICE				
22.	COMMENTS				

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

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FAX (515) 265-0361

1216 East 37th Street
Davenport, Iowa 52807
(319) 323-0914
FAX (319) 323-0914

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

FOR OFFICE USE ONLY
[ ] DIST A.
[ ] DIST B.
[ ] DIST C.
[ ] MAIN OFC.
[ ] STATE BLDG.

LOCATION OF SYSTEM Norfolk Regional Ctr.
1700 N. Victory Lane
Norfolk Ne. 68701

NAME OF PERSON/COMPANY PERFORMING INSPECTION

MIDWEST AUTOMATIC FIRE SPRINKLER CO.
4910 F STREET SUITE 400
OMAHA NE 68117

MW0237

TYPE OF SYSTEM
[X] WET
[ ] DRY
[ ] OTHER

DATE OF INSPECTION 1.28.21

TYPE OF OCCUPANCY Office Rms

SIGNATURE OF OWNERS REPRESENTATIVE

SIGNATURE OF SPRINKLER INSPECTOR

LICENSE# 93007

FORMS INCLUDED WITH THIS COVER SHEET
CONTRACTORS TEST CERTFICATION
[ ] UNDERGROUND (FORM 85-AB)
[ ] ABOVEGROUND (FORM 85-AC)
[ ] REPORT OF INSPECTION (SHEET 1+SHEET 2)
[ ] DRY PIPE VALVE TRIP TEST

TYPE OF INSPECTION
[ ] INITIAL ACCEPTENCE OF SYSTEM
[ ] REINSPECTION DUE TO REMODEL, REPAIR ETC.
[X] PERIODIC, ANNUAL INSPECTION

MAJOR DEFICIENCES/COMMENTS

Spigot # 07927 BFP # 07928

SYSTEM IN COMPLIANCE[X] HAS MINOR DEFICENCIES[ ] HAS MAJOR DEFICENCIES[ ]

SEND TO: NEBRASKA STATE FIRE MARSHAL 246 SO.14 LINCOLN, NE. 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MIDWEST AUTOMATIC FIRE SPRINKLER CO.

REPORT OF INSPECTION

Inspection Report No. 237 — Inspection Contract No. _____
Conferred With _____ — Phone No. _____

REPORT TO Norfolk Rec Center — BUILDING OR LOCATION Same
STREET 1700 No. Victory Lane — INSPECTOR M. Speck
CITY & STATE Norfolk, Ne. — DATE 1-28-21

Owner's Section (To be answered by Owner or Occupant)

A. Explain any occupancy hazard changes since the previous inspection. None

B. Describe fire protection modifications made since last inspection. None

C. Describe any fires since last inspection. None

D. When was the system piping last checked for stoppage, corrosion or foreign material? 2017

E. When was the dry-piping system last checked for proper pitch? NA

F. Are dry valves adequately protected from freezing? _____

Signature _____ Title _____ Date 1-28-21

Inspector's Section (All responses reference current inspection) NA = NOT APPLICABLE

1. General
   a. Is the building occupied? ☑ Yes ☐ No — Is occupancy same as previous inspection? ☑ yes ☐ no ☐ NA
   b. Are all systems in service? ☐ Yes ☐ No
   c. Is there a minimum of 18 in. (457 mm) clearance between the top of the storage and the sprinkler deflectors? ☐ Yes ☐ No
   d. Does all electrical heat tape appear to be satisfactory? ☐ Yes ☐ No ☐ NA
   e. Does the hand hose on the sprinkler system(s) appear to be satisfactory? ☐ Yes ☐ No ☐ NA
2. Control Valves *(See Item 15.)*
   a. Are all sprinkler system control valves and all other valves in the appropriate open or closed position? ☐ Yes ☐ No
   b. Are all control valves in the open position locked, sealed or equipped with a tamper switch? ☐ Yes ☐ No
3. Water Supplies *(See Item 16.)*
   a. Was a water flow test of main drain made at the sprinkler riser(s)? ☑ Yes ☐ No
4. Tanks, Pumps, Fire Department Connections
   a. Are fire pumps, gravity tanks, reservoirs and pressure tanks in good condition and properly maintained? ☐ Yes ☐ No ☐ NA
   b. Are fire department connections in satisfactory condition, couplings free, caps in place, and check valves tight? ☑ Yes ☐ No ☐ NA
   Are they accessible and visible? ☐ Yes ☐ No ☐ NA
5. Wet Systems
   a. Are cold weather valves (O.S. & Y.) in the appropriate open or closed position? ☑ Yes ☐ No ☐ NA
   b. Have antifreeze system solutions been tested? ☐ Yes ☐ No ☑ NA
   c. Were the antifreeze test results satisfactory? ☐ Yes ☐ No ☑ NA
   d. In areas protected by wet system(s), does the building appear to be properly heated in all areas, including blind attics and perimeter areas where accessible? ☐ Yes ☐ No ☐ NA Do all exterior openings appear to be protected against freezing? ☐ Yes ☐ No ☐ NA
6. Dry Systems *(See Items 11 to 13.)*
   a. Are dry valve(s) in service? ☐ Yes ☐ No ☐ NA
   b. Are the air pressures and priming water levels in accordance with the manufacturer's instructions? ☐ Yes ☐ No ☐ NA
   c. Has the operation of the air or nitrogen supplies been tested? ☐ Yes ☐ No ☑ NA Are they in service? ☐ Yes ☐ No ☐ NA
   d. Were low points drained during this inspection? ☐ Yes ☐ No ☑ NA
   e. Did quick-opening devices operate satisfactorily? ☐ Yes ☐ No ☑ NA
   f. Did the dry valve(s) trip properly during the trip pressure test? ☐ Yes ☐ No ☑ NA
   g. Did the heating equipment in the dry-pipe valve room(s) operate at the time of inspection? ☐ Yes ☐ No ☑ NA
7. Special Systems *(See Item 14.)*
   a. Did the deluge or pre-action valves operate properly during testing? ☐ Yes ☐ No ☑ NA
   b. Did the heat-responsive devices operate properly during testing? ☐ Yes ☐ No ☑ NA
   c. Did the supervisory devices operate during testing? ☐ Yes ☐ No ☑ NA
8. Alarms
   a. Did water motor(s) and gong(s) test satisfactorily? ☐ Yes ☐ No ☐ NA
   b. Did electric alarm(s) test satisfactorily? ☐ Yes ☐ No ☐ NA
   c. Did supervisory alarm service test satisfactorily? ☐ Yes ☐ No ☐ NA

   "Flow Switch" Time: _____ min _____ sec.
9. Sprinklers
   a. Are all sprinklers free from corrosion, loading or obstruction to spray discharge? ☐ Yes ☐ No
   b. Are sprinklers less than 50 years old? (Older sprinklers require sample testing) ☑ Yes ☐ No
   c. Are quick response and residential sprinklers less than 20 years old? (Older sprinklers require sample testing) ☐ Yes ☐ No
   d. Is stock of spare sprinklers available? ☑ Yes ☐ No
   e. Does the exterior condition of sprinkler system appear to be satisfactory? ☑ Yes ☐ No
   f. Are sprinklers of proper temperature ratings for their locations? ☐ Yes ☐ No

Are all new additions and building changes property protected? ☐ yes ☐ no ☑ NA

Flow S 28 sec
K - 26 sec
HW - 56 sec
3E 41 sec
3W 42 sec
2W 52 sec
2E 45 sec
1E 53 sec
1W 47 sec

SHEET 2 OF 2 - Use separate sheet for each system inspection

System No. or Description if multiple systems _____ _____

Inspection Report No. 239

11. Date dry-pipe valve trip tested (control valve partially open) N/A *(See Trip Test Table which follows.)*
12. Date dry-pipe valve trip tested (control valve fully open) N/A *(See Trip Test Table which follows.)*
13. Date quick-opening device tested N/A *(See Trip Test Table which follows.)*

TRIP TEST TABLE

DRY PIPE OPERATING TEST

DRY VALVE MAKE	DRY VALVE MODEL	DRY VALVE SERIAL NO.	C.O.D. MAKE	C.O.D. MODEL	C.O.D. SERIAL NO.

	Time to Trip Thru Test Pipe MIN.	Time to Trip Thru Test Pipe SEC.	Water Pressure PSI	Air Pressure PSI	Trip Point Air Pressure PSI	Time Water Reached Test Outlet MIN.	Time Water Reached Test Outlet SEC.	Alarm Operated Properly YES	Alarm Operated Properly NO
Without Q.O.D.									
With Q.O.D.									

14. Date deluge or preaction valve tested N/A *(See Trip Test Table which follows.)*

TRIP TEST TABLE

DELUGE & PREACTION VALVES

Operation ☐ PNEUMATIC ☐ ELECTRIC ☐ HYDRAULIC							
Piping Supervised ☐ YES ☐ NO		Detecting media supervised ☐ YES ☐ NO					
Does valve operate from the manual trip and/or remote control stations ☐ YES ☐ NO							
Is there an accessible facility in each circuit for testing ☐ YES ☐ NO		Method of testing circuits					
MAKE	MODEL	Does each circuit operate supervision loss alarm YES	Does each circuit operate supervision loss alarm NO	Does each circuit operate valve release YES	Does each circuit operate valve release NO	Maximum time to operate release YES	Maximum time to operate release NO

15. See Control Valve Maintenance Table.

Control Valve Maintenance Table

Control Valves	Number	Type	Open	Secured	Closed	Signs	Explain Abnormal Condition
City Connection Control Valve	1	PIV	YS	YS	NO	YS	
Tank Control Valves							
Pump Control Valves							
Sectional Control Valves	18	BFLY	YS	YS	NO	YS	
System Control Valves	2	BFLY	YS	YS	NO	YES	
Other Control Valves							

16. Water Flow Test at Sprinkler Riser

Water Supply Source: City Tank Pump

	Date	Test Pipe Location	Size of Test Pipe	Static Pressure	Residual (Flow) Pressure
Last Water Flow Test	10.29.20	RISER	2"	80	55
This Water Flow Test	1.28.20	RISER	2"	82	70

17. Explain any "No" answers and comments: NONE

18. Adjustments or corrections made during this inspection:

19. Although these comments are not the result of an engineering review, the following desirable improvements are recommended:

Signature: _____ Date: 1.28.21

Environmental

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 2 West
Date: 6-30-21

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	2/4 , 0 lic radios
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 10 / 12	**Percentage:** 83 %	

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	
	Section Score: 3 / 3	**Percentage:** 100 %	

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

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication

		Score	Comment
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 /5	**Percentage:** 100 %	

Emergency Management/Utility Systems

		Score	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	0	See attached
	Section Score: 7 /8	**Percentage:** 87.5 %	

Medical Equipment Management Plan

		Score	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 /5	**Percentage:** 100 %	

S bathroom stall
1st stall - possible mildew
2nd stall - back to that
3rd stall - flushes by itself

S1 - Frame paint
S15 - odor
S-8 - odor

S dehill - ceiling tiles

W-5 peeling paint

W-4 peeling paint

W-6 - odor

W12 odor

Conference room - air fresher?

W-1 smells funny

Kitchen - Frame
- cheese mold

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 3 East

Date: 6-29-24

Surveyors Signatures: [signature]

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	3/4 Lodge #14 radios
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?		

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 3 / 3 **Percentage:** 100 %

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

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

	Hazardous Material Waste and Communication	**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

	Emergency Management/Utility Systems	**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 / 8	**Percentage:** 100 %	

	Medical Equipment Management Plan	**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

Supply room - clothes, coat hooks
office - fan dirty
Fridge: cheese mold dairy
- stock drink in fridge
N-7 - bubbling ceiling
N-9 paint bubbling, needs light bulb
N-5 needs light bulb
N-13 bubbling paint
N-6 dirty ceiling
N-2 ~~old vents~~ old heater cover
Scale?
S Above window needs paint
S shower vent - need paint
laundry room - heater coming up
outlet cracked on ceiling
S-2 needs cleaned
S-4 vent cleaned
S-10 light cover?
S-12 frame paint
S-15 needs cleaned
S-11 frame needs fixed
S-9 paint bubble, Frame
S-7 vent cleaned
S-1 paint bubble

N-Bathroom 1st sink - cold leaks
N-shower - Mildew?

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 3 west

Date: 6-25-21

Surveyors Signatures: MHSUS,

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

Section Score: 9 / 12 **Percentage:** 75 %

	Infection Control	Score	Comment
1	Gloves are readily available in ~~utility rooms~~ staff office	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 3 / 3 **Percentage:** 100 %

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

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8/ 8	**Percentage:** 100 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5/ 5	**Percentage:** 100 %	

2 recl chair needs fixed
N-2 heater cover needs replaced
N-4 walls need cleaned
N-5 need clean
Hand dryer loud
Soap Sodium 1st two sides show damage
- dirty vent
3rd stall - loose flusher
- mold

S-6 bubbling paint, Frame
S-5 - paint on window, bubbling ceiling
S-13- bubbling Frame
S-16 heater cover
S-14 bubbling paint
S-12 vent cleaned
S-10 Soap pump
S-4 walls seem cleaned, Frame
- light like dimmer
S-2 toilet heater cover
- door needs outlet
- unhygienic
Shower loose handle
- leaking
Door not shutting correctly
trash can lid

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: West

Date: 12-24-21

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	1	
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	0	See notes
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	0	Discussed with TL
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	
	Section Score: 10/12	**Percentage:** 83 %	

	Infection Control	Score	Comment
1	Gloves are readily available in ~~utility~~ rooms (the office)	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	
	Section Score: 3/3	**Percentage:** 100 %	

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

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	discussed location with TC
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 / 8	**Percentage:** 100 %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	0	Door open - shut clean
4	Code Green buttons easily accessible and not blocked.	0	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 4/5	**Percentage:** 80 %	

Supply Room - light out supply room
Fridge nurse station?
ceiling tile - water damage S hallway
S Alcove missing ceiling tile
loose ceiling tile S side hall + 3
S side hall air conditioner - needs cleaned
Male vent needs cleaned
W-8 vent
West fire door?
Chairs unlisted
Transition kitchen
Kitchen floor needs stripped
Conference room - needs paint
N-10 vent cleaned
N-8 vent clean
N-shower needs cleaned

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 2 East

Date: 6-23-21

Surveyors Signatures:

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

Section Score: 8 / 12 **Percentage:** 66 %

	Infection Control	Score	Comment
1	Gloves are readily available in ~~utility rooms~~ office	1	
2	Refrigerator longs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.	1	
3	Food is not present in medication refrigerator other then what is used in giving medication.	1	

Section Score: 3 / 3 **Percentage:** 100 %

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

8	Is fire/smoke doors free of being propped/held wedged open?	1	
9	Sprinkler heads have 18" clearance especially in storage areas.	1	
10	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.	1	
	Section Score: 10 /10	**Percentage:** 100 %	

Hazardous Material Waste and Communication		Score	Comment
1	Chemicals stored in appropriate cabinets (i.e. metal)	1	
2	EVS closet is locked when not in use.	1	
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)	1	
4	Product labels are not altered or defaced.	1	
5	Personal Protective Equipment is readily available (i.e. gloves)	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

Emergency Management/Utility Systems		Score	
1	Flash lights work---extra batteries available	1	
2	Two way radios charged and working properly?	1	
3	Weather radio plugged in and alerts when activated?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	Emergency blankets easily accessible.	1	
6	Red Emergency Management Manual is readily available and up to date?	1	
7	Panel box is not block and is locked?	1	
8	Toilets, faucets and drains working properly? No apparent leaks.	1	
	Section Score: 8 / 8	**Percentage:** 100 %	

Medical Equipment Management Plan		Score	
1	Medical Equipment have any frayed cords?	1	
2	Sharps container no more than ¾ full?	1	
3	Medication room is secure when not in use?	1	
4	Code Green buttons easily accessible and not blocked.	1	
5	No open medication containers lying on top of medication cart.	1	
	Section Score: 5 / 5	**Percentage:** 100 %	

Supply Room - cluttered
Staff bathroom - drain water?
Staff office - frame
Outside staff office needs paint - both sides
Bathroom vent needs clean - paint peeling - leak on seat?

S-1 - Wall - paint
vent clean

S-3 wall paint
S-5 paint
S-7 Frame
S-9 heater cover
S-11 clean
S-13 ceiling bubble
S-15 vent clean
S-14 Frame, paint, heater cover
S-12 swept
S-10 bare board
S-8 needs cleaned
S-6 Ceiling paint, paint
S-4 Frame, hole by window
S-2 vent piece missing
S Hall - hole wall
S Alcove - vent clean
E Dryer wall - paint
Could needs replaced on TV. Safety - needs
Sensor off.
Small with paint
W Inside alcove - hole in wall
W Shower - mildew needs
Soap dispenser cleaned?

1st washer - needs stud - next dryer
- fan not filling

Fridge cheese opened
V Bathroom - mirror
with toilet - bowl to flush
N-5 ceiling
N-7 frame
Conference room - dusty
N-10 peeling paint
Frame, paint
SSC office - paint, vent clean
- fridge needs removed

IW

G Sa Lw B

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive				✓	X	X	X	
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓					X
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 4 (F)

= 52 (G)

Divide (G) by (E) X 100 92.8 %

2W

T S BR BC T S

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓	✓	✓	✓				
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓					X	X
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 2 (F)

= 54 (G)

Divide (G) by (E) X 100 96.4 %

3E

IE C AA P6

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓	✓	✓				
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive			✓	✓	x	x		
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓					x
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 3 (F)

= 53 (G)

Divide (G) by (E) X 100 94.6 %

2E H T JA CL H

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓	✓	✓				
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓				
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish		✓	✓	✓	x			
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓				
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓			✓		x	x	
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216	✓	✓	✓	✓				
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 3 (F)

= 53 (G)

Divide (G) by (E) X 100 94.6 %

3W -

C ML JA AR

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
Who would receive a falling star logo?	Any patient that is at high risk for falls.	✓	✓		✓			✓	
Who is responsible for making fall reduction a priority?	All NRC staff.	✓	✓	✓	✓				
Identify one security sensitive area.	HIM, Security Server Room, Medication Room, Pharmacy, Human Resource (Areas where access is limited)	✓	✓	✓	✓				
NRC has a ____ tolerance for violence from staff and visitors.	ZERO	✓	✓	✓	✓				
How would you report a fire?	Page Code Red, Activate fire pull and call house supervisor.	✓	✓	✓	✓			✓	
What does R.A.C.E. stand for?	Rescue, Alarm, Confine, Evacuate and Extinguish	✓	✓		✓			✓	
Where are your fire exits? What does the red strobe light mean?	Have Staff identify where they are on the unit. FIRE DRILL.	✓	✓	✓	✓			✓	
What does SDS stand for? Where is it at?	Safety Data Sheet, located on "S" drive	✓	✓		✓			✓	
What types of medical equipment are you required to use as part of your normal job responsibility?	Some may not use any- other could use stethoscope, thermometer, O2 concentrator,	✓	✓	✓	✓				
Where is the hospital incident command center located?	Room 216		✓		✓	✓		✓	
Where is your red emergency manual located?	Should be in the nursing office/easily accessible.	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3387, on-call maintenance staff or the maintenance supervisor.	✓	✓	✓	✓				
What steps do you take to have something fixed on the unit by Maintenance?	Fill out Incident Report, Email Compliance and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A 0 (B)

= 14 (C)

X 4 number of employees questioned (D)

Subtotal = 56 (E)

Subtract total number of NO answers - 5 (F)

= 51 (G)

Divide (G) by (E) X 100 91 %

NRC Environmental Inspection Form

Date: 4-24-21 Area 1st Floor Lobby

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.			✓			
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.	✓					
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible			✓			
Other Security Deficiencies		✓				
Hazardous Mat.						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms operable and not obstructed	✓					
No "daisy-chaining" of electrical items.	✓					

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

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked			✓			
No objects blocking sprinklers	✓					
All seasonal combustible decorations have been treated with fire retardant and are tagged.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

9-24-21

Staff Signature/Date

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

NRC Environmental Inspection Form

Date: _____ **Area** _____

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.	✓					
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat.						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms	✓					

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

operable and not obstructed						
No "daisy-chaining" of electrical items.	✓					
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	✓					
Fire extinguisher pin in place	✓					
Magnetic doors (in patient area) are latching correctly	✓					
Electrical Panel in staff office is not blocked	✓					
No objects blocking sprinklers	✓					
All seasonal combustible decorations have been treated with fire retardant and are tagged.	✓					
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working	✓					

Additional Comments:

Staff Signature/Date

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

NRC Environmental Inspection Form

Date: _____ **Area** _____

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	✓					
Area well lit/no lights out	✓					
Area free of slip/trip hazards and excess staples	✓					
Unit Restraints accounted for.	✓					
Outlet covers are intact.	✓					
All employees are wearing ID badge in plain sight and carrying radios.	✓					
Electrical panel unobstructed	✓					
Security						
All doors secured	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Other Security Deficiencies		✓				
Hazardous Mat.						
EVS utility rooms locked.	✓					
All chemicals are stored properly with appropriate labeling.	✓					
Only hospital approved cleaning supplies in the patient areas.	✓					
Fire						
Fire door/Alarms	✓					

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

operable and not obstructed						
No "daisy-chaining" of electrical items.						
Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.						
Fire extinguisher pin in place						
Magnetic doors (in patient area) are latching correctly						
Electrical Panel in staff office is not blocked						
No objects blocking sprinklers						
All seasonal combustible decorations have been treated with fire retardant and are tagged.						
Facility Safety						
Gates are operable and no issues with perimeter fence.						
Exterior doors are locked and working properly						
Exterior lights are working						

Additional Comments:

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_____

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Staff Signature/Date

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

NRC Environmental Inspection Form

Date: 9-22-21 Area 3 EAST

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew		N		Three out of four a/c units in day hall have mold. A/C in RN office has mold. Multiple patient rooms have mold. Kitchen Unit has Mold.	Email sent to housekeeping for cleaning to be done on A/C units.	9-22-21
Area well lit/no lights out	Y					
Area free of slip/trip hazards and excess staples	Y					
Unit Restraints accounted for.	Y					
Outlet covers are intact.	Y					
All employees are wearing ID badge in plain sight and carrying radios.	Y					
Electrical panel unobstructed	Y					
Security						
All doors secured	Y					
Window Integrity checked	Y					
Badge Readers are working properly	Y					
Sensitive areas are maintained secure/No unusual activity	Y					
Code Green Buttons Accessible	Y					
Other Security Deficiencies			N/A	.		
Hazardous Mat.						
EVS utility rooms locked.	Y					
All chemicals are stored properly with appropriate labeling.	Y					
Only hospital approved cleaning supplies in the patient areas.	Y					
Fire						
Fire door/Alarms	Y					

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

operable and not obstructed						
No "daisy-chaining" of electrical items.	**Y**					
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.	**Y**					
Fire extinguisher pin in place	**Y**					
Magnetic doors (in patient area) are latching correctly	**Y**					
Electrical Panel in staff office is not blocked	**Y**					
No objects blocking sprinklers	**Y**					
All seasonal combustible decorations have been treated with fire retardant and are tagged.			**N/A**			
Facility Safety						
Gates are operable and no issues with perimeter fence.			**N/A**			
Exterior doors are locked and working properly			**N/A**			
Exterior lights are working			**N/A**			

Additional Comments:

Adam D Anderson /9-22-21

Staff Signature/Date

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

NRC Environmental Inspection Form

Date: 9-7-21 **Area** 2 EAST

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew		N		**South bathroom paint is coming off the ceiling.**		
Area well lit/no lights out	Y					
Area free of slip/trip hazards and excess staples	Y					
Unit Restraints accounted for.	Y					
Outlet covers are intact.	Y					
All employees are wearing ID badge in plain sight and carrying radios.	Y					
Electrical panel unobstructed	Y					
Security						
All doors secured	Y					
Window Integrity checked	Y					
Badge Readers are working properly	Y					
Sensitive areas are maintained secure/No unusual activity	Y					
Code Green Buttons Accessible	Y					
Other Security Deficiencies		N				
Hazardous Mat.						
EVS utility rooms locked.	Y					
All chemicals are stored properly with appropriate labeling.	Y					
Only hospital approved cleaning supplies in the patient areas.	Y					
Fire						
Fire door/Alarms	Y					

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

operable and not obstructed						
No "daisy-chaining" of electrical items.	Y					
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.	Y					
Fire extinguisher pin in place	Y					
Magnetic doors (in patient area) are latching correctly	Y					
Electrical Panel in staff office is not blocked	Y					
No objects blocking sprinklers	Y					
All seasonal combustible decorations have been treated with fire retardant and are tagged.	Y					
Facility Safety						
Gates are operable and no issues with perimeter fence.	Y					
Exterior doors are locked and working properly	Y					
Exterior lights are working	Y					

Additional Comments:

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__JBeaver___RT_____

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

NRC Environmental Inspection Form

Date: 9-7-21 **Area** SSC

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew		N		**E5 has paint coming off the ceiling and onto the floor. E-4 has paint coming off the north wall.**		
Area well lit/no lights out	Y					
Area free of slip/trip hazards and excess staples	Y					
Unit Restraints accounted for.	Y					
Outlet covers are intact.	Y					
All employees are wearing ID badge in plain sight and carrying radios.	Y					
Electrical panel unobstructed	**Y**					
Security						
All doors secured	Y					
Window Integrity checked	Y					
Badge Readers are working properly	Y					
Sensitive areas are maintained secure/No unusual activity	Y					
Code Green Buttons Accessible	Y					
Other Security Deficiencies		N				
Hazardous Mat.						
EVS utility rooms locked.	Y					
All chemicals are stored properly with appropriate labeling.	Y					
Only hospital approved cleaning supplies in the patient areas.	Y					
Fire						
Fire door/Alarms	Y					

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

operable and not obstructed						
No "daisy-chaining" of electrical items.	Y					
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.	Y					
Fire extinguisher pin in place	Y					
Magnetic doors (in patient area) are latching correctly	Y					
Electrical Panel in staff office is not blocked	Y					
No objects blocking sprinklers	Y					
All seasonal combustible decorations have been treated with fire retardant and are tagged.	Y					
Facility Safety						
Gates are operable and no issues with perimeter fence.	Y					
Exterior doors are locked and working properly	Y					
Exterior lights are working	Y					

Additional Comments:

_____ _____

_____

_____

_____

__JBeaver___RT_____

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

NRC Environmental Inspection Form

Date 9/11/2022 **Area** LW

Indicator	Yes	No	NA	Comments	Corrective Action	Date Corrected
Safety						
Area clean, including Pt rooms. Showers/ bathrooms free of mold/mildew	X					
Area well lit/no lights out	X					
Area free of slip/trip hazards and excess staples	X					
Unit Restraints accounted for.	X					
Outlet covers are intact.	X					
All employees are wearing ID badge in plain sight and carrying radios.	X					
Electrical panel unobstructed	X					
Security						
All doors secured	X					
Window Integrity checked	X					
Badge Readers are working properly	X					
Sensitive areas are maintained secure/No unusual activity	X					
Code Green Buttons Accessible	X					
Other Security Deficiencies		X				
Hazardous Mat.						
EVS utility rooms locked.	X					
All chemicals are stored properly with appropriate labeling.	X					
Only hospital approved cleaning supplies in the patient areas.	X					
Fire						
Fire door/Alarms operable and not obstructed	X					
No "daisy-chaining" of electrical items.	X					

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

Corridors and exits are clear and unobstructed. No items are hung from ceiling or impacting 8' clearance in hallways. Exit signs functioning and pointed in correct direction.	X					
Fire extinguisher pin in place	X					
Magnetic doors (in patient area) are latching correctly	X					
Electrical Panel in staff office is not blocked	X					
No objects blocking sprinklers	X					
All seasonal combustible decorations have been treated with fire retardant and are tagged.	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:

_____

_____

_____

_____

9/11/2021

Staff Signature/Date

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

State Fire Marshall

Occupancy Permit

Attachment N6

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 12376

Name of Facility:	**Norfolk Regional Center Hospital**
Type of Facility:	**Hospital**
Location:	**1700 N Victory Rd Norfolk**
Maximum Occupancy:	**150 Beds**
Date Issued:	**5/26/2021**

Inspected By: **Robert Folck**
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.

STATE OF NEBRASKA*STATE FIRE MARSHAL
246 SOUTH 14TH STREET
LINCOLN, NE 68508-1804

	Fee Sheet Number: 4626
Facility Name Norfolk Regional Center Hospital	Occupant Street Address 1700 N Victory Rd
Operator & Phone number	City / Town Norfolk
Owner / Address / Phone number/Email Tom Barr 402-370-3400 dhhs.nrclicensure@nebraska.gov 1700 N Victory Rd Norfolk, NE 68701-0000	County Madison
	How Occupied Existing Healthcare
Occupant load 150 beds	Date of Inspection 11-30-2020
	Fee Card ☐YES ☒NO ☐N/A

ORDER

Contact person/number :
Initial inspection : 10-6-2020
Revisit inspection : 11-30-2020
Hours of operation :
Plan review numbers :

This is a Revisit of the inspection conducted on 10-06-2020. All deficiencies have been corrected and upon payment of all required inspection fees will be APPROVED at that time.

All items must be corrected to comply with the laws of the State of Nebraska and with rules and regulations adopted by the State Fire Marshal as mandated by section 81-502 to 81-541.01

It is the duty of the owner or person in charge of the above-named facility to immediately take measures to bring the facility into compliance with state regulations. **ALL CORRECTIONS SHALL BE MADE AND ALL ITEMS CORRECTED ON OR BEFORE.** _____

If you have questions on this Order, contact Deputy, by phone **District A:** 402-471-2590 or **District B:** 402-395-2164 or by Email at sfm.inspections@nebraska.gov

Witness my signature at Winnetoon Nebraska this 30th day of November, 2020

By: Robert Folck
Robert Folck , Deputy State Fire Marshal

License Verification

Attachment W1

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

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

LRC Whitehall Psychiatric Residential Treatment Facility

MEETS STATUTORY REQUIREMENTS AS
MENTAL HEALTH SUBSTANCE USE TREATMENT CENTER
Lic # MHSU031

Gary J. Anthone, MD

SEAL

EXPIRES
9/30/2022

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.

State of Nebraska

Department of Health and Human Services
Division of Public Health

Nebraska Department of Health and Human Services, State of Nebraska
Is hereby authorized in compliance with laws of the State of Nebraska to establish and conduct a
Residential Child-Caring Agency
located at: **5845 Huntington Ave. Lincoln NE 68509**

A maximum of **24** children in ages **13 YRS** to **19 YRS** may be in attendance at any one time.

Lincoln Regional Center Whitehall Program is hereby issued License No. **RCCA022** which is effective from **01/12/2018** and will expire on **03/31/2022**

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 **April 8, 2021.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATE OF NEBRASKA SEAL EST. JULY 1, 2007

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

Child Care Licensing Upcoming Audit

Site visit

Oliver, Joni <Joni.Oliver@nebraska.gov>

Mon 11/8/2021 11:26 AM

To: 'Kristine Tevis' [redacted] 'Alexandria Kosiski' <alex.kosiski[redacted]>; 'Janece Ferris' <janece@[redacted]>; 'Garrett Swanberg' <garrett@[redacted]>; trisha <trisha@[redacted]>; Renee Ambrose <rambrose@[redacted]>; 'Katherine Spoon (kspoon@[redacted])' <kspoon@[redacted]>; Rudder, Lacy <LRudder@[redacted]>; 'Clark, Dawn' <DClark@[redacted]>; Lana Verbrigghe <lverbrigghe@[redacted]>; nguerrier@[redacted] <nguerrier@[redacted]>; Popple, Mitchell <Mitchell.Popple@[redacted]>; Kristina Lesley <kristina.lesley@[redacted]>; Liz MacDonald <lmacdonald@[redacted]>; Mandee Walter <mwalter@[redacted]>; fsbservices01@[redacted] <fsbservices01@[redacted]>

Hello – It is my intent to get to all of my agencies yet prior to the end of the 2021 calendar year. Although my visits are to be unannounced, I recognize we are entering a very busy time of year and availability will be challenging.

Please respond ASAP with a list of specific dates between November 29th and December 30th **that no one is available** at your facility to access personnel and client records such that a review could not be conducted. If there are persons I have not usually met with that would be available, please share those names/titles so I may ask for them in your absence. Please also send an updated staff list if it has changed since your last submission, and an approximate count of all youth currently supported in out-of-home placement so that I can schedule review time accordingly.

If you have questions, please call or email at your earliest convenience so we can determine how to proceed.

Thank you so much for your assistance and patience during what has been a rather complicated and chaotic licensing year! I do look forward to seeing all of you before the ball drops to ring in the new year!

Joni Oliver | *Children's Licensing Inspection Specialist*

DIVISION OF PUBLIC HEALTH, LICENSURE UNIT

Nebraska Department of Health and Human Services

E-MAIL: joni.oliver@nebraska.gov

ADDRESS: **P.O. Box 186; Crete, NE 68333**

PHONE: (402) 416-4807

DHHS.ne.gov | Facebook | Twitter | LinkedIn

Major Projects

Attachment W2

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. [redacted]

   a. [redacted]

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

   a. No new construction projects have been identified for the reporting period, December 2020 through November 2021.

2. Please provide a summary of completed major projects as of today.

   a. DHHS and DAS partnered to replace flooring and lighting in cottages 1, 2, 5, and 6. This work was completed by February 2021. It was conducted while patient numbers were low so there was no impact to patient population.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

   a. Yes, the Whitehall facility utilizes Corrigo, a web based work order system.

4. Please provide the number of work orders submitted since December 2020.

   a. The number of work orders completed to include preventative maintenance work orders was 1,542 completed.

5. What kind of system do you use to track non-major repair projects?

a. Maintenance has in depth documentation kept on the facility's share drive on any non-major projects that are done at Whitehall.

C. **COVID-19 Impact.**

1. [redacted]

   a. [redacted]

2. [redacted]

   a. [redacted] D-19 Protocols (These are what Whitehall adopted as

3. [redacted]

   a. [redacted]

4. [redacted]

DHHS Public Health, Licensure Unit Surveys

Attachment W3

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

November 2, 2021

Mitchell Popple, Interim Administrator
Lrc Whitehall Psychiatric Residential Treatment Facility
5845 Huntington Avenue
Lincoln, NE 68507

Dear Mr. Popple:

An unannounced visit was made to Lrc Whitehall Psychiatric Residential Treatment Facility on October 26, -November 1, 2021, by a representative of this Department. The purpose of the visit was to investigate a complaint on non-compliance with regulatory requirements received by our office.

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

ALLEGATION:
The facility fails to follow their policy and procedures for reporting allegations of abuse.
The facility fails to protect clients from abuse.

FINDINGS:
Based on record review and interview the allegation was not substantiated as the client had made a report five months after the client had been discharged from the program.

Based on record review, observation and interview there was no evidence of the incident to have occured at the school, no identified private conversation between the client and the staff person about what had allegedly happened at the school. Interviews with staff and clients that were there at the time of the incident when the client was there, reported not having witnessed or hearing any type of inappropriate touching or sexual incident between the client and the staff person, nor had there been any sexual touching or sexual contact at the school when the client was at the facility.

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

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREAT	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	Initial Comments This facility is governed by Title 175 NAC Chapter 18, Regulations Governing Licensure of Mental Health Centers. A representative of the DHHS, Division of Public Health, conducted a complaint investigation to determine compliance with these regulations. The facility census at the time of the complaint investigation was 17. The facility was found to be in compliance with these regulations.	X 000		

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

Facility Staffing Information

Attachment W4

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data
12/1/2020 - 11/30/2021

Facility: WH Whitehall

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		46	13	59	50	24	19	2%	26%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
H77023	ACTIVITY SPECIALIST	1	0	1	2	2	3	6%	75%
V77024	ACTIVITY SUPERVISOR	1	0	1	1	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	1	2	1	0	0	0%	0%
A01014	ADMINISTRATIVE SPECIALIST (NEW)	2	0	2	0	0	0		
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	2	0	2	0	0	0		
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	1	0	1	0	0	0		
H72553	BEHAVIORAL HEALTH PRACTITIONER III (NEW)	1	0	1	0	0	0		
C72342	CERTIFIED MASTER SOCIAL WORKER	1	1	2	0	0	0		
C72792	CHEMICAL DEPENDENCY COUNSELOR	0	0	0	1	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	1	0	1	0	1	0	0%	0%
V78791	DHHS PROGRAM MANAGER I	0	1	1	0	0	0		
N00750	FACILITY OPERATING OFFICER	1	0	1	1	0	1	8%	100%
S02201	HEALTH INFORMATION TECHNICIAN	0	0	0	1	0	0	0%	0%
H76311	HUMAN SERVICES TREATMENT SPECIALIST I	1	0	1	1	0	0	0%	0%
C72341	MASTER SOCIAL WORKER	0	0	0	1	0	0	0%	0%
H72431	MENTAL HEALTH PRACTITIONER I	0	0	0	2	0	0	0%	0%
S01012	OFFICE SPECIALIST (NEW)	1	0	1	0	0	0		
G11900	PRINCIPAL	0	0	0	1	0	0	0%	0%
N74823	PSYCHOLOGIST/LICENSED	0	0	0	1	1	0	0%	0%
N74822	PSYCHOLOGIST/PROV LICENSED	0	0	0	1	0	1	8%	100%
H75014	REGISTERED NURSE (NEW)	0	0	0	1	1	2	8%	100%
S01842	STAFF ASSISTANT II	0	0	0	2	0	0	0%	0%
T11360	TEACHER (SCATA CONTRACT)	4	0	4	3	0	0	0%	0%
R11380	TEACHER/TEMPORARY	0	0	0	0	1	1	8%	100%
C72481	YOUTH COUNSELOR I	2	0	2	2	0	0	0%	0%
V72483	YOUTH COUNSELOR SUPERVISOR	0	2	2	0	0	0		
P76752	YOUTH SECURITY SPECIALIST II	22	4	26	19	13	6	2%	19%
R76752	YOUTH SECURITY SPECIALIST II	0	4	4	0	1	1	8%	100%
V76753	YOUTH SECURITY SUPERVISOR	4	0	4	9	4	4	3%	31%
		46	**13**	**59**	**50**	**24**	**19**	**2%**	**26%**

Whitehall Facility Staffing & Assault Data
Reporting Period: December 1, 2020 through November 30, 2021
Neb. Rev. Stat. 83-104

A. **Facility Staffing Levels:**

a. The number of positions filled as of November 30, 2021.

i. 46 positions

b. The number of positions vacant as of November 30, 2021.

i. 13 vacant positions

c. The number of positions needed in your HR staffing plan for FY22 as of November 30, 2021.

i. 59 positions needed in the staffing plan for FY22

d. The number of position filled in your HR staffing plan for FY22 as of November 30, 2021.

i. 46 positions

e. The monthly turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 2%

f. The aggregate turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 26%

B. Staff Assaults:

a. The number of assaults on staff for the period of 12/01/2020 through 11/30/2021.

i. 0 total youth on staff assaults

b. Number of assaults as a result of a use of force event.

i. 0 youth on staff assaults during physical interventions

COVID -19 Impact

Impact

Leadership Update

Family Member Letter

Pandemic plan

Attachment W5

Impact

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

[redacted]

[redacted]

a. [redacted]

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

    a. COVID-19 presented some major challenges for all facilities but one of the biggest perceived challenges that the Whitehall facility faced during the first shut down was the facility's ability to meet with stakeholders and families about treatment updates on the children. Administration had to redesign the entire process so that Whitehall could meet health department standards for the amount of people that could be in a room at one time. The use of WebEx has revolutionized how facilities conduct team meetings each week with the youth, their families, and other interested parties. The onset of the COVID-19 pandemic has resulted in the facility having the ability to get more outside people involved remotely with youth on campus than even was possible before. In a sense the pandemic forced the facility to grow and think of new ways to do things so that quality treatment could still be provided even in the midst of a global pandemic. Even now that families are starting to come back onto the campus and have the youth back into the community we continue to have great participation from outside parties in the treatment of the youth.

2. Please provide a copy of your most recent COVID protocols.

    a. Attached as LRC-Pandemic COVID-19 Protocols (These are what Whitehall adopted as well) in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. The Whitehall visitation letter that was sent to families via USPS and pronation via email is attached and can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

a. Currently, the campus is open to visitation and the youth are allowed to visit with their families off grounds. When Whitehall gains a new youth, they are tested for COVID-19 and are placed temporarily into quarantine until that test result comes back. If the test result comes back positive the Medical department at Whitehall will call the health department and quarantine the youth for 10 days. Currently there is one youth on quarantine due to arriving to the facility COVID positive and will be off quarantine on November 10th, 2021. When visitors come to campus they are required to check their temperature when signing in to our administration building. Whitehall currently does not require masks on campus unless the health department has suggested otherwise in response to a positive case on campus which has been very far and few between. If a staff member believes they have been exposed they are directed to call the health department and go with their recommendation on whether the staff member should quarantine or be tested.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. Whitehall does not have any COVID-19 planning meeting minutes, but rather follows the direction of LRC and DHHS administration for any updates regarding COVID-19 protocols.

Leadership Update

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Date: Friday, May 21, 2021

To: All DHHS 24/7 facilities

From: Larry Kahl, COO

RE: Mask Wearing related to COVID-19

Team,

With the recent community changes related to the softening of requirements for wearing masks to address COVID-19, it is timely for us to update our approach as well. Upon consultation with our state epidemiologist, we will proceed with the recommendation below.

Effective Monday, May 24, staff may wear the masks of their choice (surgical, cloth or N-95) during work hours. We will require N-95 masks if caring for a known COVID-19 positive patient. Otherwise the option of mask type is at the discretion of the wearer.

We will continue to evaluate the need for mask wearing on a regular basis as we continue to trend downward in the number of new COVID-19 cases.

I have also heard from families and loved ones regarding our visitation policy relative to COVID-19 case reduction. The revised process is currently under review and is planned to be released in the near future.

Thank you for your continued dedication and everything you do for our patients!

Mask Requirement Memo

Popple, Mitchell <Mitchell.Popple@nebraska.gov>

Fri 5/21/2021 2:58 PM

To: Augustine, Kristin <Kristin.Augustine@nebraska.gov>; Baldridge, Ann <Ann.Baldridge@nebraska.gov>; Barry, Jerome <Jerome.Barry@nebraska.gov>; Belcher, Jarrod <Jarrod.Belcher@nebraska.gov>; Billups, Waleska <Waleska.Billups@nebraska.gov>; Bletscher, Morgan <Morgan.Bletscher@nebraska.gov>; Bloom, Everett <Everett.Bloom@nebraska.gov>; Borosko, Jeremy <Jeremy.Borosko@nebraska.gov>; Brahm, Allison <Allison.Brahm@nebraska.gov>; Casper, Scott <Scott.Casper@nebraska.gov>; Coufal, Samantha <Samantha.Coufal@nebraska.gov>; Dale, Jordan <Jordan.Dale@nebraska.gov>; Eisbach, Karl <Karl.Eisbach@nebraska.gov>; Frost, Amanda <Amanda.Frost@nebraska.gov>; Hansen, Cindy <Cindy.Hansen@nebraska.gov>; Jenkins, Charles <Charles.Jenkins@nebraska.gov>; Johnson, Joanna <Joanna.Johnson@nebraska.gov>; Kero, Randa <Randa.Kero@nebraska.gov>; Kinney-Brown, Carleen <Carleen.Kinney-Brown@nebraska.gov>; Knaub, Michel <Michel.Knaub@nebraska.gov>

1 attachments (85 KB)

Memo to 24 7 facilities.pdf;

Please see the attached memo for information regarding masks in DHHS facilities. Thank you.

Mitch

Mitchell Popple | *Interim Facility Administrator*

BEHAVIORAL HEALTH

Nebraska Department of Health and Human Services

OFFICE: 402-471-6969

DHHS.ne.gov | Facebook | Twitter | LinkedIn

Whitehall Vision Statement: Whitehall Vision Statement: *We change communities by changing the youth we serve. We change the lives of the youth we serve using passionate care and individualized treatment. We make futures brighter. We make lives better. We are Whitehall, and we make a difference.*

Family Member Letter

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 2, 2021

Dear Family Members,

The Whitehall PRTF understands the importance of our youth being able to have visitation with their family members. The facility is working towards resuming visitation between the youth in our program and their families. We are being cautious as we take this first step in reopening visitation, therefore we will be implementing very slow steps as we return to visitation on campus.

Starting on June 4, 2021,

Whitehall will allow only immediate family and legal parties to visit at this time.

To ensure the safety of our youth, family members, and staff, Whitehall has implemented the following visitation protocols.

EXPECTATIONS:

- Visitors will be limited to 2 immediate family members per youth.
- No children under age 13 will be allowed to visit.
- All visits will take place on the campus of Whitehall, either outside weather permitting or in the TAB building atrium.
- No off-campus visits are allowed at this time.
- If you leave campus for any reason we will not be able to allow you back onto campus.
- All visitors and youth will be required to wear a mask for the duration of the visit. If you do not have a mask, there will be masks available at our facility.
- As an extra precaution to keeping everyone safe, items for the youth will not be allowed to be brought into the facility.

PROCESS FOR VISITATION:

- Visitation Hours.
    - Weekday visitation will be Friday between the hours of 1515 and 1900, Saturday and Sunday between the hours of 0900 and 1900. Only one family will be allowed to visit at a time. Families must call the front office to request a day and time to be approved by treatment team, 402-471-6969.
    - A continuation of virtual visitation with family and other approved contacts can continue as requested by the family and youth. We want all parties to be comfortable during visitation.

SCREENING PROCESS:

- A screening will be completed for all scheduled visitors.
- After providing a photo ID, each visitor will be required to answer screening questions and have a temperature taken and recorded. We will not be able to allow visitors into the facility if there are concerns about the responses to the screening questions or a temperature over 100.4 degrees.
- Hand sanitizer will be provided in the small foyer prior to entering the building for your use.

As a program, we are very hopeful that this gradual relaxation of restrictions will be successful and as a result we will be able to relax other restrictions as we all do our part follow the current visitation guidelines.

Please remember the health and safety of your family members and our staff is important to us. If you or anyone who is planning to visit the facility does not feel well or is running a temperature, please stay home. We will work with you to schedule another visit at a more appropriate time.

Should there be an increase in exposure and positive testing, we may have to reevaluate our visitation practices. This could include the cease of visitations without advanced notice should the current situation change and warrant such action.

Thank you for assisting us in maintaining a safe environment for the youth in our care.

Mitchell Popple Interim FA 6/2/21

Mitchell Popple, Interim Facility Administrator

Pandemic Plan

Lincoln Regional Center (LRC)

SUBJECT: COVID-19 PANDEMIC PLAN

Effective Date: February 28, 2020 Page No. 1 of 11
Revision Date: April 23, 2021
Infection Prevention & Control Committee Review: February 28, 2020

STANDARD: Center for Disease Control (CDC), American Practitioners of Infection Control (APIC)

POLICY: The Lincoln Regional Center will ensure a sustainable healthcare response to Pandemic COVID-19 in accordance with the Lincoln Regional Center Policy IC-01.

PURPOSE: To provide early detection and containment of Pandemic COVID-19 while maintaining the overall operation of LRC and meet basic needs of the facility.

RESPONSIBILITY: All staff

EQUIPMENT: Personal Protective Equipment (PPE), N-95 filter masks, Surgical Masks, Clean Isolation Gown, Eye Protection, Emergency Operations Manual, Infection Control Manual, Contingency Staffing Plan

PROCEDURE:

I. INITIAL IMPLEMENTATION

A. LRC will work with State, Lancaster County Health Department and other local Health Departments.
B. Contingency Staffing Plan for Managing Widespread Outbreaks / Disaster, as detailed in the Emergency Operations Manual, will go into effect.
C. Designated LRC leadership will meet daily via Huddle and as needed to address essential needs and emergent situations as they arise.
D. Identification of Essential Personnel can be reassessed daily by designated LRC leadership and are as follows:
    1. All employees will be considered essential for anti-viral therapy when available and these staff will be identified daily, based on availability, potential for exposure, and the need to meet minimal departmental staffing requirements, as per contingency staffing plan. This includes allowing for rotation of specific departmental staff in order to meet the essential services of the facility and care of the Patients.
    2. Ancillary staff will be rotated to areas of need.
    3. Once a vaccine is available, staff designated to receive the vaccine will be identified at time of availability of vaccine, based on employees who have had the Pandemic COVID-19 and available staff.
E. LRC will follow all directed health measures, and progressions, related to COVID-19 as outlined by the local health department.

II. CONTAINMENT

A. Signs and Symptoms associated with COVID-19. Severity ranges from little to no symptoms to being severely ill and dying. Symptoms may appear 2-14 days after exposure to the virus:
    1. Fever or Chills
    2. Dry Cough

3. Shortness of Breath or difficulty breathing
4. Fatigue
5. Sore Throat
6. Body Aches
7. Headache
8. New loss of taste or smell
9. Congestion or Runny Nose
10. Nausea or vomiting
11. Diarrhea

All staff will be screened prior to their shift and all patients will be screened 3 times daily for COVID-19 symptoms and temperatures greater than 100°F so possible infections can be identified in their earliest stages. If identified Dr. Connolly is notified immediately for further consultation. All staff are required to wear a cloth/surgical mask at all times when around others to control the spread.

B. If above signs and symptoms are identified, they have recently traveled outside of the United States, or had close contact (within 6 feet) with a person who is under investigation/has laboratory confirmed COVID-19 place patient in Airborne/Droplet precaution IMMEDIATELY until Lab Test can confirm a diagnosis. Follow directions within the Infection Control Manual related to Airborne/Droplet precautions.
1. Signs will be placed at each entrance notifying visitors, to each building, that if they have symptoms of respiratory illness they will need to reschedule their visit until a time they are not symptomatic. All Visitors will be screened for fever, other related symptoms, and travel history before being allowed in the building. Once a Local Outbreak has been confirmed, all visitation may be restricted until further notice.
2. Staff returning to work from any illness will be cleared by Infection Control Nurse and will need to pass the staff screening prior to being allowed in the building. If no staff screenings are taking place they will complete an employee assessment form while being assessed by an on duty nurse before being allowed back on the unit.
3. Staff returning from vacation time where they have traveled outside of the United States, were possibly exposed, or have been having symptoms of COVID-19 will consult with the Infection Control Manager or Nurse in their building for an assessment before entering their respective building.
    a. Staff may be asked to wear PPE appropriate to the situation while working
    b. Staff may be asked to visit their doctor and obtain a return to work note
    c. Staff may be asked to return home for up to 14 days for safety
    d. Staff may be asked to provide a doctor's note clearing them to return to work

C. If Signs and Symptoms indicate an infectious agent in our patient population:
1. Call Dr. Connolly immediately for consultation and orders
2. Notify Infection Control Nurse, if not available call Director of Nursing
3. Quarantine patient pending lab results
4. Confirmed positive test results require isolation

D. If a confirmed positive test result within our patient population occurs:

1. Call Dr. Connolly for orders to transfer patient to isolation for safety
2. The Unit of residence will be quarantined for 14 days due to the likelihood of peer to peer exposure.
3. Quarantined Units will require all staff working that respective unit to wear Face Shields, N-95 Masks, and Gloves at all times while utilizing an appropriate Donning and doffing procedure.
   a. If no further positive tests are obtained and there are no further patients exhibiting sign or symptoms, the quarantine status expires after 14 days.

4. Isolation Units will require all staff working that respective unit to wear Face Shield, N-95 Mask, Gown, Shoe Covers, and Gloves at all times while utilizing an appropriate donning and doffing procedure.
   b. After 10 days post symptoms or 10 days post positive test for asymptomatics, the patient(s) can be tested to assess whether discontinuation of isolation is appropriate. The patient(s) will need 2 negative tests results a minimum of 24 hours apart to be deemed recovered, at which time they can rejoin the general population.

E. Appropriate lab procedures will be used to perform diagnostic testing.
   1. Testing is available through the Nebraska Public Health Lab (NPHL) and Physician's Lab
   2. BINAX Rapid Testing is available on site
   3. Test Nebraska can be utilized during times of mass testing
   4. Results will be obtained within in 1-7 days.

F. Director of the Division of Behavioral Health, Medical Director, Infection Control Doctor, Director of Nursing, Hospital Operating Officer, Infection Control Nurse, and, as needed, the Safety Coordinator, and Risk Administrator will be involved in decision to cohort all ill patients together away from non-ill Patients, if needed. During outbreaks, confine patients with confirmed illness to the isolation area for their building/campus Patients with suspected Covid-19 should be placed in the quarantine area of their building until lab test confirms a diagnosis. This may be expanded to all patients being served meals in their rooms and closing down communal areas to dining and other gatherings. Due to medical limitations of LRC, patients needing immediate rehydration or emergency medical attention may need to be transported to a Medical Hospital for treatment. If transfer of a patient is required, record and communicate the transfer to LRC Health Information Management staff for tracking purposes.

1. Quarantine Areas for each building are as follows, if the entire building is not under quarantine status. Note that beds will need to be added to these areas until the diagnosis is confirmed. Quarantine areas will only be utilized if testing can occur for patients that are suspected of being COVID-19 positive due to exposure or are showing symptoms. If testing is unavailable, utilization of isolation areas is necessary.

   a. Building 10 will Quarantine patients in either of the following areas.
      Canteen Area 1440 sq ft = 20 patient capacity
      Activity Room in Basement Area 720 sq ft = 10 patient capacity

b. Building 3 will Quarantine patients in the Garden Level or 2W.
2229 sq ft = 30 patient capacity

c. Building 5 will Quarantine patients in the Gymnasium or specific units
3840 sq ft = 51 patient capacity

d. Building 14 will Quarantine patients in the 2 West unit
24 single person rooms are available

e. Available areas on the 3rd floor of B-14 if needed
Wayne George Training Room: 1682 sq ft = 23 patient capacity
Conference Room 5: 928 sq ft = 13 patient capacity

f. Total patient Quarantine capacity in these areas is 171 patients

As Units become smaller due to patient movement, additional quarantine areas can be added in the wings of patient area and/or patients will be quarantined to their room if quarantine space is unavailable.

2. The following areas can be used for Isolation, if needed, due to the ability to circulate fresh air through the air handlers. These areas are to be utilized for COVID-19 positive patients or if testing is not adequate:

a. Building 5's S-3 Unit has a 35 bed capacity.

b. Building 10's East Hall can be closed off from the unit and has a 16 bed capacity.

c. Building 3's 2 West Unit has a 25 bed maximum capacity.

d. Isolation space of up to 100 patient capacity, given allowances offered in Executive Order 20-12

A patient's bed can be moved from their room to the Isolation area if needed. As unit census reduces, due to patient movement, Isolation areas can be added in the wings of patient areas..

G. **Personal Protective Equipment (PPE)**

1. **Caring for Patients with pandemic infections**

Healthcare personnel should be particularly vigilant to AVOID:

a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.

b. Contaminating environmental surfaces that are not directly related to Patient care (e.g., door knobs, light switches).
c. Encourage patients in isolation and quarantine to wear a surgical mask if deemed appropriate by the mask clinical assessment. AIIR's single patient rooms at negative pressure relative to the surrounding areas and with a minimum of 6 air changes per hour, are UNAVAILABLE on campus.

2. **Masks (N-95 if available or surgical/procedure or Cloth if needed):**
   - If N-95 is back ordered or out of stock, LRC will consult with the SEMRS coalition and Public Health Department to obtain emergency supplies through the SNS and Department of Public Health. If N-95 is not available surgical or cloth masks will then be utilized.

   a. Wear an N-95 mask when entering an isolation unit. If N-95 in unavailable a surgical mask should be worn once and then discarded. If pandemic COVID-19 patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask, gown, and eye protection for the duration of their shift while changing gloves in between patients/activities and performing hand hygiene.
   b. Change surgical masks when they become moist. N-95 can last for 8 hours or 1 shift.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.

3. **Gloves:**
   a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.
   e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids.
   f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. **Gowns:**

a. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most Patient interactions do not necessitate the use of gowns. A disposable gown made of synthetic fiber or a washable cloth gown may be used.

c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.

d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.

e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

5. **Goggles or Face Shield:**

a. In general, wearing goggles or a face shield for routine contact with patients with pandemic COVID-19 is necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet precaution.

6. **PPE for Special Circumstances**

a. **PPE for aerosol - generating procedures**
During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., nebulizer treatment), healthcare personnel should wear gloves, gown, face/eye protection, and an N-95 respirator if fit tested by the Infection Control Manager.

H. **Hand Hygiene**

1. Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based or non-alcohol based products (gels, rinses, foams) containing an emollient that do not require the use of water.
2. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
3. In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based or non-alcohol based products for hand disinfection are preferred.
4. Always perform hand hygiene between patient contacts and after removing PPE.
5. Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels)

and hand disinfection (i.e., alcohol-based or non-alcohol based products) are readily accessible in areas in which patient care is provided.

I. **Disposal of Solid Waste**

1. Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus:
2. Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste. Directions for disposing of medical waste found in Infection Control Manual.
3. Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
4. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

J. **Linen and Laundry**

1. Standard precautions are followed for linen and laundry that might be contaminated with respiratory secretions from Patients with pandemic COVID-19:
2. Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area. Please follow-direction per LRC Infection Control Manual.
3. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
4. Wear gloves for transporting bagged linen and laundry.
5. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
6. Wash and dry linen according to routine standards and procedures.

K. **Dishes and Eating Utensils**

Standard precautions are followed for handling dishes and eating utensils used by a patient with known or possible pandemic COVID-19:

1. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of Patients) should be discarded with other general waste per Emergency Disaster Manual.
2. Wear gloves when handling Patient trays, dishes, and utensils.

L. **Patient-care equipment**

Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

1. Wear gloves when handling and transporting used patient-care equipment.
2. Wipe heavily soiled equipment with an LRC approved surface disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection of reusable care equipment.

3. Wipe external surfaces of portable equipment for performing x-rays and other procedures in the area with an LRC approved surface disinfectant upon removal from the Patient's room.

M. **Environmental cleaning and disinfection**

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Multiguard and Sani Cloths (if unavailable due to supply shortages other assessable disinfectants indicated on the approved COVID-19 Disinfectant List will be procured) will be used for disinfection. Often touched areas will be disinfected at mid-shift and at the end of each shift.

N. **Cleaning and disinfection of Patient-occupied rooms**

1. Wear gloves in accordance with facility policies for environmental cleaning, an N-95 mask, Eye Protection, and Gowns are necessary for routine cleaning of an infection positive room.
2. Keep areas around the Patient room free of unnecessary supplies and equipment to facilitate daily cleaning.
3. Use any LRC approved hospital detergent-disinfectant
4. Follow facility procedures for regular cleaning of Patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.
5. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions and per LRC Small and Large Spill Cleanup Policy found in the Infection Control Manual.

O. **Cleaning and disinfection after Patient discharge or transfer**

1. Close off room for at least 3 hours prior to entry and follow standard facility cleaning policy for post-discharge cleaning of a room.
2. Clean and disinfect all surfaces that were in contact with the Patient or might have become contaminated during care.
3. Disinfectants utilized will be Multiguard Spray and Sani-Cloth wipes (if unavailable due to supply shortages other assessable disinfectants indicated on the approved COVID-19 Disinfectant List will be procured)

P. **Postmortem care**

1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.
2. The Health Department will provide body bags for deceased Patients who will then be placed in the Grounds building to await transport.

Q. **Laboratory specimens and practices**

1. Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

III. OUTBREAK NOTIFICATION

A. All doors will remain locked. Only employees with access cards will be allowed to enter. Vendors/suppliers will be screened by nursing staff prior to entering building to deliver or stock supplies. Vendors/suppliers may be instructed to drop off all supplies at the Dock if outbreak has decreased onsite work population and staff are unavailable to screen and assist them prior to entering the buildings.

B. Infection Control Manager will direct all means of media notification in connection with Public Information Officer if public announcements are needed.
   1. Visual alerts will be at entrances advising visitors that visitation is restricted.
   2. Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:
      a. Use elbow or sleeve to cover your cough or sneeze.
      b. Wear PPE deemed appropriate for situation by Infection Control Dept.
      c. Follow Social Distancing Guidelines
      d. Perform hand hygiene often.

C. Individual activities and Unit activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the Patients.

D. Clinical Director, Infection Control Doctor, Infection Control Manager, and Director of Nursing will decide what departments and activities continue during the duration of the outbreak.

E. Department Heads/Supervisors will contact the Infection Control Manager for any clarification of memos/orders/notifications/questions.

F. Remain vigilant for another outbreak of pandemic COVID-19.

G. All Admissions will be screened by Infection Control Manager or Infection Control Doctor before being admitted to LRC, unless admissions are suspended during active outbreak
   1. 14 days of Vitals and access to their medical record will be requested for screening prior to admission. Additionally, COVID testing pre-admission may also be requested.
   2. When admission arrives the Infection Control Doctor will assess patient for signs/symptoms of COVID-19 before being admitted. If admitted the admitting nurse under consultation of the Infection Control Doctor will complete a COVID-19 Screening Assessment in AVATAR.

H. All Transfers between LRC's programs will be screened by Infection Control Manager or Infection Control Doctor prior to transfer.
   1. 3 days of Vitals and access to their medical record will be required for screening prior to transfer.
   2. When transfer arrives to their respective program, the admitting nurse under the consultation of the Infection Control Doctor will assess the patient for signs/symptoms of COVID-19 before being admitted. The admitting nurse will complete a COVID-19 Screening Assessment in AVATAR.

IV. MONITORING OF HEALTH CARE PERSONNEL

A. Employees who report to work will be screened, in the lobby of their respective buildings, for signs and symptoms of the COVID-19 before reporting for duty. Staff may be given antiviral therapy if necessary and available especially with staff working in isolation and quarantine areas.

B. Screening of all employees will be done by Nursing Administration, RN Supervisor, Infection Control Manager, HCP, or trained designee before being allowed on the unit. Staff who are exhibiting signs/symptoms associated with COVID-19 or who have a temperature greater than 100°Fwill be sent home and required to consult with the Infection Control Nurse before being cleared to return to work. If a supply shortage restricts this practice, staff will be asked to self–monitor at home prior to coming to work. If staff do not have a thermometer at home they will check in with a nurse before reporting for duty.

C. Infection Control Manager will track all staff exhibiting symptoms of COVID-19 and will give clearance for them to return to work based on the following requirements
   1. It has been 10 days since the onset of symptoms with marked improvement in symptoms AND they have been fever free for 24 hours without the aid of a fever reducing medication (i.e. Acetaminophen, Motrin)
   2. Or they provide a doctor's note clearing them to return to work.

D. Staff at high risk for complications of pandemic COVID-19 (i.e. pregnant, immuno-compromised, and older in age) should be informed about this medical risk and offered an alternative work assignment away from COVID-19 patient care or considered for administrative leave, if available

E. Staff age will be assessed when staffing quarantine and isolation areas due to increased age increasing risk of Acute Respiratory Distress Syndrome.
   1. Staff under the age of 39 with no compromising issues will be asked to staff the quarantine and isolation areas first if possible.
   2. If more staff are needed, staff from the age of 40-49 with no compromising issues will then be asked to staff the quarantine and isolation areas if possible.

F. Non-essential staff may be able to work from home or work in a low risk area of the hospital. Essential staff will be needed to continue operations at LRC and are defined as:
   1. Nursing Staff
   2. Security Specialists including Team Leaders
   3. Licensed Independent Providers
   4. 1 Psychologist per Building
   5. Dietary Staff
   6. Environmental Services Staff
   7. Safety Personnel of each building
   8. Manager On-Call
   9. 1 Social Worker per Building
   10. Pharmacy Staff

V. **TREATMENT**

A. No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated. COVID-19 Vaccines are available on site for staff and patients on a voluntary bases.

VI. **Maintaining Operations/Programming**

A. The following Tools/Protocols offer further guidance with continuing operations during the COVID-19 Pandemic. The Tools/Protocols can be found using the following hyperlink: S:\LRC POLICY MANUAL\Infection Control\COVID-19 Tools and Protocols

1. Insulation Unit Guidelines
2. Quarantine Unit Guidelines
3. Isolation Unit Guidelines
4. Visitation Protocol
5. Café Protocol
6. Canteen Protocol
7. Computer Cleaning Protocol
8. Dental Services Protocol
9. GYM Protocol
10. Library Services Protocol
11. LRC Applicant Interview Protocol
12. Medical Clinic Protocol
13. Recreational Room Protocol
14. Salon Services Protocol
15. LRC's Phasing Document

Please note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

Corrigo Tracking

Attachment W6

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. Please provide a copy of the most recent inspections and/or audit reports as of today. To include, but not limited to applicable reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, permits, alarm system, sprinkler, etc.

    a. All inspection and audit information regarding the DHHS Whitehall Facility has been attached in Section A of this packet.

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

    a. No new construction projects have been identified for the reporting period, December 2020 through November 2021.

2. Please provide a summary of completed major projects as of today.

    a. DHHS and DAS partnered to replace flooring and lighting in cottages 1, 2, 5, and 6. This work was completed by February 2021. It was conducted while patient numbers were low so there was no impact to patient population.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

    a. Yes, the Whitehall facility utilizes Corrigo, a web based work order system.

4. Please provide the number of work orders submitted since December 2020.

    a. The number of work orders completed to include preventative maintenance work orders was 1,542 completed.

5. What kind of system do you use to track non-major repair projects?

a. Maintenance has in depth documentation kept on the facility's share drive on any non-major projects that are done at Whitehall.

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

    a. COVID-19 presented some major challenges for all facilities but one of the biggest perceived challenges that the Whitehall facility faced during the first shut down was the facility's ability to meet with stakeholders and families about treatment updates on the children. Administration had to redesign the entire process so that Whitehall could meet health department standards for the amount of people that could be in a room at one time. The use of WebEx has revolutionized how facilities conduct team meetings each week with the youth, their families, and other interested parties. The onset of the COVID-19 pandemic has resulted in the facility having the ability to get more outside people involved remotely with youth on campus than even was possible before. In a sense the pandemic forced the facility to grow and think of new ways to do things so that quality treatment could still be provided even in the midst of a global pandemic. Even now that families are starting to come back onto the campus and have the youth back into the community we continue to have great participation from outside parties in the treatment of the youth.

2. Please provide a copy of your most recent COVID protocols.

    a. Attached as LRC-Pandemic COVID-19 Protocols (These are what Whitehall adopted as well) in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. The Whitehall visitation letter that was sent to families via USPS and pronation via email is attached and can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

a. Currently, the campus is open to visitation and the youth are allowed to visit with their families off grounds. When Whitehall gains a new youth, they are tested for COVID-19 and are placed temporarily into quarantine until that test result comes back. If the test result comes back positive the Medical department at Whitehall will call the health department and quarantine the youth for 10 days. Currently there is one youth on quarantine due to arriving to the facility COVID positive and will be off quarantine on November 10th, 2021. When visitors come to campus they are required to check their temperature when signing in to our administration building. Whitehall currently does not require masks on campus unless the health department has suggested otherwise in response to a positive case on campus which has been very far and few between. If a staff member believes they have been exposed they are directed to call the health department and go with their recommendation on whether the staff member should quarantine or be tested.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. Whitehall does not have any COVID-19 planning meeting minutes, but rather follows the direction of LRC and DHHS administration for any updates regarding COVID-19 protocols.

Inspection Reports

Fire Alarm

Fire sprinkler

Attachment W7

Fire Alarm and Life Safety System Inspection Certificate

For

White Hall Bldg 2
5801 Walker Ave
Lincoln, NE 68507

Tested to NFPA 72 Standards

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.

Annual Inspection
Inspection Date
Sep 20, 2021

Building: White Hall Bldg 2
Contact: Bevan Flynn
Title: Maintenance

Company: Electronic Contracting Company
Contact: Corey Herrmann
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: White Hall Bldg 2	**Contact:** Bevan Flynn
Address: 5801 Walker Ave	**Phone:** 4024993596
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: Electronic Contracting Company	**Inspector:** Corey Herrmann
Address: 6501 N 70TH St	**Phone:** (402) 466-8274
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507-3248	**Mobile:**
Country: United States of America	**Email:** cherrmann@eccoinc.com

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Control	1	3.45%	1	100.00%	1	100.00%	0	0.00%
Initiating	24	82.76%	24	100.00%	24	100.00%	0	0.00%
Supervisory	4	13.79%	4	100.00%	4	100.00%	0	0.00%
Totals	**29**	**100%**	**29**	**100.00%**	**29**	**100.00%**	**0**	**0.00%**

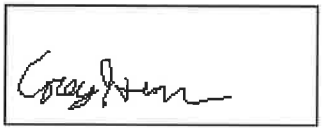
Certification

Company: Electronic Contracting Company

Building: White Hall Bldg 2

Inspector: Corey Herrmann

Contact: Bevan Flynn



Signed: Sep 20, 2021 1:57:32 PM

Signed:

Corey Herrmann Certifications

Certification Type	Number
Nebraska Fire Alarm Inspector	818

Inspection & Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 2 — Control Panel: 1

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	Service	Time	Date
	Passed			
Control				
Battery	FACP	Tested	1:55:49 PM	09/20/2021
Initiating				
Pull Station	Basement Exit	Tested	1:55:07 PM	09/20/2021
Pull Station	Dining Room	Tested	1:37:38 PM	09/20/2021
Pull Station	Door 8 Exit	Tested	1:46:57 PM	09/20/2021
Pull Station	FACP Exit	Tested	1:39:00 PM	09/20/2021
Smoke Detector	Dining Room	Tested/Cleaned	1:36:50 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	1:41:55 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	1:43:06 PM	09/20/2021
Smoke Detector	Janitors Closet	Tested/Cleaned	1:44:39 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	1:34:47 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	1:35:10 PM	09/20/2021
Smoke Detector	North Basement	Tested/Cleaned	1:53:43 PM	09/20/2021
Smoke Detector	Nurses Office	Tested/Cleaned	1:41:08 PM	09/20/2021
Smoke Detector	Room 1 Office	Tested/Cleaned	1:39:45 PM	09/20/2021
Smoke Detector	Room 10	Tested/Cleaned	1:45:56 PM	09/20/2021
Smoke Detector	Room 11	Tested/Cleaned	1:45:22 PM	09/20/2021
Smoke Detector	Room 14	Tested/Cleaned	1:44:04 PM	09/20/2021
Smoke Detector	Room 15	Tested/Cleaned	1:43:34 PM	09/20/2021
Smoke Detector	Room 16	Tested/Cleaned	1:42:32 PM	09/20/2021
Smoke Detector	Room 3 Office	Tested/Cleaned	1:40:43 PM	09/20/2021
Smoke Detector	Room 6	Tested/Cleaned	1:47:52 PM	09/20/2021
Smoke Detector	Room 7	Tested/Cleaned	1:47:29 PM	09/20/2021
Smoke Detector	Room 9	Tested/Cleaned	1:46:23 PM	09/20/2021
Smoke Detector	South Basement	Tested/Cleaned	1:54:18 PM	09/20/2021
Smoke Detector	Stairs	Tested/Cleaned	1:48:45 PM	09/20/2021
Supervisory				
Tamper Switch	Laundry Room	Tested	1:50:31 PM	09/20/2021
Tamper Switch	Laundry Room	Tested	1:50:35 PM	09/20/2021
Water Pressure Switch	Laundry Room	Tested	1:51:01 PM	09/20/2021
Water Pressure Switch	Laundry Room	Tested	1:51:50 PM	09/20/2021

Service Summary

Generated by: BuildingReports.com

Building: White Hall Bldg 2

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Battery	Tested	1
Pull Station	Tested	4
Smoke Detector	Tested/Cleaned	20
Tamper Switch	Tested	2
Water Pressure Switch	Tested	2
Total		**29**
Grand Total		**29**

Battery & Power Supply Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 2	Control Panel: 1

The Battery & Power Supply Testing section details the readings and measurements of batteries and power supplies used to provide power to the fire alarm and life safety systems. Items are grouped by Passed or Failed/Other.

Battery

Type	Location	Rated Ah	Rated Volts	Pre Test	Post Test	Min Ah	Tested Ah
Passed							
Sealed Lead Acid	FACP	5	12				

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: White Hall Bldg 2 — Control Panel: 1

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
Battery	Control	3.45%	1
Pull Station	Initiating	13.79%	4
Smoke Detector	Initiating	68.97%	20
Tamper Switch	Supervisory	6.90%	2
Water Pressure Switch	Supervisory	6.90%	2

Type	Qty	Model #	Description	Install Date
In Service - 3 Years to 5 Years				
Pull Station	4	NBG-12L		04/18/2018
Smoke Detector	20			04/18/2018
Interstate				
Battery	1	1055	Sealed Lead Acid	04/18/2018
Potter Electric				
Water Pressure Switch	1	PS40-2A	High	04/18/2018
Water Pressure Switch	1	PS40-2A	Low	04/18/2018
Victaulic				
Tamper Switch	2	702		04/18/2018

Fire Alarm and Life Safety System Inspection Certificate

For

White Hall Bldg 6
5819 Huntington Ave
Lincoln, NE 68507

Tested to NFPA 72 Standards

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.

Annual Inspection
Inspection Date
Sep 20, 2021

Building: White Hall Bldg 6
Contact: Bevan Flynn
Title: Maintenance

Company: Electronic Contracting Company
Contact: Corey Herrmann
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: White Hall Bldg 6	**Contact:** Bevan Flynn
Address: 5819 Huntington Ave	**Phone:** 4024993596
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: Electronic Contracting Company	**Inspector:** Corey Herrmann
Address: 6501 N 70TH St	**Phone:** (402) 466-8274
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507-3248	**Mobile:**
Country: United States of America	**Email:** cherrmann@eccoinc.com

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Control	1	3.23%	1	100.00%	1	100.00%	0	0.00%
Initiating	27	87.10%	27	100.00%	27	100.00%	0	0.00%
Supervisory	3	9.68%	3	100.00%	3	100.00%	0	0.00%
Totals	31	100%	31	100.00%	31	100.00%	0	0.00%

Certification

Company: Electronic Contracting Company

Building: White Hall Bldg 6

Inspector: Corey Herrmann

Contact: Bevan Flynn

Signed: Sep 20, 2021 12:44:59 PM

Signed:

Corey Herrmann Certifications

Certification Type	Number
Nebraska Fire Alarm Inspector	818

Inspection & Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 6 — Control Panel: 1

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	Service	Time	Date
	Passed			
Control				
Battery	FACP	Tested	12:13:40 PM	09/20/2021
Initiating				
Pull Station	Basement Exit	Tested	12:40:49 PM	09/20/2021
Pull Station	Dining Room	Tested	12:20:01 PM	09/20/2021
Pull Station	Door 8 Exit	Tested	12:31:13 PM	09/20/2021
Pull Station	FACP Exit	Tested	12:43:24 PM	09/20/2021
Smoke Detector	Dining Room	Tested/Cleaned	12:19:00 PM	09/20/2021
Smoke Detector	Door 4 Bathroom Hall	Tested/Cleaned	12:26:26 PM	09/20/2021
Smoke Detector	Door 5/Nurse Office	Tested/Cleaned	12:33:35 PM	09/20/2021
Smoke Detector	FACP	Tested/Cleaned	12:19:12 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	12:25:57 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	12:30:28 PM	09/20/2021
Smoke Detector	Janitors Closet	Tested/Cleaned	12:25:17 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	12:16:15 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	12:16:34 PM	09/20/2021
Smoke Detector	Main Hall	Tested/Cleaned	12:23:01 PM	09/20/2021
Smoke Detector	North Basement	Tested/Cleaned	12:38:57 PM	09/20/2021
Smoke Detector	Office	Tested/Cleaned	12:21:58 PM	09/20/2021
Smoke Detector	Room 10	Tested/Cleaned	12:32:14 PM	09/20/2021
Smoke Detector	Room 11	Tested/Cleaned	12:27:31 PM	09/20/2021
Smoke Detector	Room 14	Tested/Cleaned	12:24:54 PM	09/20/2021
Smoke Detector	Room 15	Tested/Cleaned	12:24:28 PM	09/20/2021
Smoke Detector	Room 16	Tested/Cleaned	12:23:51 PM	09/20/2021
Smoke Detector	Room 6	Tested/Cleaned	12:29:36 PM	09/20/2021
Smoke Detector	Room 7	Tested/Cleaned	12:30:08 PM	09/20/2021
Smoke Detector	Room 9	Tested/Cleaned	12:31:46 PM	09/20/2021
Smoke Detector	Security Office	Tested/Cleaned	12:22:33 PM	09/20/2021
Smoke Detector	South Basement	Tested/Cleaned	12:39:12 PM	09/20/2021
Waterflow Switch	Laundry Room	Tested	12:37:26 PM	09/20/2021
Supervisory				
Tamper Switch	Laundry Room	Tested	12:36:08 PM	09/20/2021
Tamper Switch	Laundry Room	Tested	12:36:15 PM	09/20/2021
Tamper Switch	Laundry Room	Tested	12:36:26 PM	09/20/2021

Service Summary

Generated by: BuildingReports.com

Building: White Hall Bldg 6

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Battery	Tested	1
Pull Station	Tested	4
Smoke Detector	Tested/Cleaned	22
Tamper Switch	Tested	3
Waterflow Switch	Tested	1
Total		31
Grand Total		31

Time, Temperature & Level Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 6				Control Panel: 1		
The Time, Temperature, & Level Testing section details the measurements taken from various devices that are designed to respond in a certain amount of time, respond at a certain temperature, or respond within the acceptable range of volume or level. Items are grouped by Passed or Failed/Other.						
Type	**Location**	**Comment**	**Sec**	**Deg**	**Lvl**	**ScanID**
Passed						
Waterflow Switch						
	Laundry Room	Passed	46	n/a	n/a	59341106

Battery & Power Supply Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 6	Control Panel: 1

The Battery & Power Supply Testing section details the readings and measurements of batteries and power supplies used to provide power to the fire alarm and life safety systems. Items are grouped by Passed or Failed/Other.

Battery

Type	Location	Rated Ah	Rated Volts	Pre Test	Post Test	Min Ah	Tested Ah
Passed							
Sealed Lead Acid	FACP	5	12				

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: White Hall Bldg 6	Control Panel: 1

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
Battery	Control	3.23%	1
Pull Station	Initiating	12.90%	4
Smoke Detector	Initiating	70.97%	22
Tamper Switch	Supervisory	9.68%	3
Waterflow Switch	Initiating	3.23%	1

Type	Qty	Model #	Description	Install Date
In Service - 3 Years to 5 Years				
Smoke Detector	22			08/18/2017
Interstate				
Battery	1	1055	Sealed Lead Acid	08/18/2017
Spectronics				
Pull Station	4	SG-32SK2		08/18/2017
System Sensor				
Waterflow Switch	1	WFD-20		08/18/2017
Victaulic				
Tamper Switch	2	702		08/18/2017
Tamper Switch	1	728		08/18/2017

Fire Alarm and Life Safety System Inspection Certificate

For

White Hall Bldg 5 Knight House
5845 Huntington Ave
Lincoln, NE 68507

Tested to NFPA 72 Standards

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.

Annual Inspection
Inspection Date
Sep 20, 2021

Building: White Hall Bldg 5 Knight House
Contact: Bevan Flynn
Title: Maintenance

Company: Electronic Contracting Company
Contact: Corey Herrmann
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: White Hall Bldg 5 Knight House	**Contact:** Bevan Flynn
Address: 5845 Huntington Ave	**Phone:** 4024993596
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: Electronic Contracting Company	**Inspector:** Corey Herrmann
Address: 6501 N 70TH St	**Phone:** (402) 466-8274
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507-3248	**Mobile:**
Country: United States of America	**Email:** cherrmann@eccoinc.com

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Control	1	8.33%	1	100.00%	1	100.00%	0	0.00%
Initiating	11	91.67%	11	100.00%	11	100.00%	0	0.00%
Totals	12	100%	12	100.00%	12	100.00%	0	0.00%

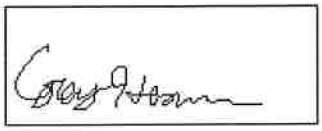
Certification

Company: Electronic Contracting Company

Building: White Hall Bldg 5 Knight House

Inspector: Corey Herrmann

Contact: Bevan Flynn



Signed: Sep 20, 2021 1:07:45 PM

Signed:

Corey Herrmann Certifications

Certification Type	Number
Nebraska Fire Alarm Inspector	818

Inspection & Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 5 Knight House Control Panel: 1

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	Service	Time	Date
	Passed			
Control				
Battery	FACP	Tested	12:47:50 PM	09/20/2021
Initiating				
Pull Station	Basement Exit	Tested	1:00:59 PM	09/20/2021
Pull Station	Dining Room	Tested	12:49:45 PM	09/20/2021
Pull Station	Hallway Exit	Tested	12:58:04 PM	09/20/2021
Smoke Detector	Dining Room	Tested/Cleaned	12:50:38 PM	09/20/2021
Smoke Detector	FACP	Tested/Cleaned	12:48:06 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	12:53:09 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	12:54:21 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	12:54:51 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	12:48:38 PM	09/20/2021
Smoke Detector	North Basement	Tested/Cleaned	1:00:03 PM	09/20/2021
Smoke Detector	South Basement	Tested/Cleaned	1:00:16 PM	09/20/2021

Service Summary

Generated by: BuildingReports.com

Building: White Hall Bldg 5 Knight House

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Battery	Tested	1
Pull Station	Tested	3
Smoke Detector	Tested/Cleaned	8
Total		12
Grand Total		12

Battery & Power Supply Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 5 Knight House Control Panel: 1

The Battery & Power Supply Testing section details the readings and measurements of batteries and power supplies used to provide power to the fire alarm and life safety systems. Items are grouped by Passed or Failed/Other.

Battery

Type	Location	Rated Ah	Rated Volts	Pre Test	Post Test	Min Ah	Tested Ah
		Passed					
Sealed Lead Acid	FACP	5	12				

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: White Hall Bldg 5 Knight House — Control Panel: 1

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
Battery	Control	8.33%	1
Pull Station	Initiating	25.00%	3
Smoke Detector	Initiating	66.67%	8

Type	Qty	Model #	Description	Install Date
In Service - 2 Years to 3 Years				
Smoke Detector	8			05/18/2019
EST				
Pull Station	1	CAV-1		05/18/2019
Interstate				
Battery	1	1055	Sealed Lead Acid	05/18/2019
Notifier				
Pull Station	2			05/18/2019

Fire Alarm and Life Safety System Inspection Certificate

For

White Hall Bldg 11 Admin
Training
5900 Walker Ave
Lincoln, NE 68507

Tested to NFPA 72 Standards

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.

Annual Inspection
Inspection Date
Sep 20, 2021

Building: White Hall Bldg 11 Admin Training
Contact: Bevan Flynn
Title: Maintenance

Company: Electronic Contracting Company
Contact: Corey Herrmann
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: White Hall Bldg 11 Admin Training	**Contact:** Bevan Flynn
Address: 5900 Walker Ave	**Phone:** 4024993596
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: Electronic Contracting Company	**Inspector:** Corey Herrmann
Address: 6501 N 70TH St	**Phone:** (402) 466-8274
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507-3248	**Mobile:**
Country: United States of America	**Email:** cherrmann@eccoinc.com

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Control	1	14.29%	1	100.00%	1	100.00%	0	0.00%
Initiating	6	85.71%	6	100.00%	6	100.00%	0	0.00%
Totals	7	100%	7	100.00%	7	100.00%	0	0.00%

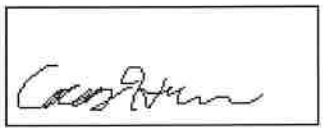
Certification

Company: Electronic Contracting Company

Building: White Hall Bldg 11 Admin Training

Inspector: Corey Herrmann

Contact: Bevan Flynn



Signed: Sep 20, 2021 9:02:45 AM

Signed:

Corey Herrmann Certifications

Certification Type	Number
Nebraska Fire Alarm Inspector	818

Inspection & Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 11 Admin Training Control Panel: 1

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	Service	Time	Date
	Passed			
Control				
Battery	FACP	Tested	8:46:59 AM	09/20/2021
Initiating				
Pull Station	East Courtyard Exit	Tested	8:56:28 AM	09/20/2021
Pull Station	East Exit	Tested	9:00:56 AM	09/20/2021
Pull Station	FACP	Tested	8:49:17 AM	09/20/2021
Pull Station	Green Room Exit	Tested	8:58:29 AM	09/20/2021
Pull Station	South Courtyard Exit	Tested	8:53:25 AM	09/20/2021
Pull Station	West Courtyard Exit	Tested	8:51:47 AM	09/20/2021

Service Summary

Generated by: BuildingReports.com

Building: White Hall Bldg 11 Admin Training

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Battery	Tested	1
Pull Station	Tested	6
Total		7
Grand Total		7

Battery & Power Supply Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 11 Admin Training Control Panel: 1

The Battery & Power Supply Testing section details the readings and measurements of batteries and power supplies used to provide power to the fire alarm and life safety systems. Items are grouped by Passed or Failed/Other.

Battery

Type	Location	Rated Ah	Rated Volts	Pre Test	Post Test	Min Ah	Tested Ah
		Passed					
Sealed Lead Acid	FACP	8	12				

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: White Hall Bldg 11 Admin Training	Control Panel: 1

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
Battery	Control	14.29%	1
Pull Station	Initiating	85.71%	6

Type	Qty	Model #	Description	Install Date
In Service - 1 Year to 2 Years				
Interstate				
Battery	1	1075	Sealed Lead Acid	02/27/2020
Notifier				
Pull Station	2	NBG-12L		02/27/2020
Pre-Lite				
Pull Station	4			02/27/2020

Fire Alarm and Life Safety System Inspection Certificate

For

White Hall Bldg 1
5800 Leighton Ave
Lincoln, NE 68507

Tested to NFPA 72 Standards

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.

Annual Inspection
Inspection Date
Sep 20, 2021

Building: White Hall Bldg 1
Contact: Bevan Flynn
Title: Maintenance

Company: Electronic Contracting Company
Contact: Corey Herrmann
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: White Hall Bldg 1	**Contact:** Bevan Flynn
Address: 5800 Leighton Ave	**Phone:** 402-499-3596
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: Electronic Contracting Company	**Inspector:** Corey Herrmann
Address: 6501 N 70TH St	**Phone:** (402) 466-8274
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68507-3248	**Mobile:**
Country: United States of America	**Email:** cherrmann@eccoinc.com

Inspection Summary

Category	Total Items		Serviced		Passed		Failed/Other	
	Qty	%	Qty	%	Qty	%	Qty	%
Control	1	3.33%	1	100.00%	1	100.00%	0	0.00%
Initiating	25	83.33%	25	100.00%	25	100.00%	0	0.00%
Supervisory	4	13.33%	4	100.00%	4	100.00%	0	0.00%
Totals	30	100%	30	100.00%	30	100.00%	0	0.00%

Certification

Company: Electronic Contracting Company

Building: White Hall Bldg 1

Inspector: Corey Herrmann

Contact: Bevan Flynn

Signed: Sep 20, 2021 2:18:44 PM

Signed:

Corey Herrmann Certifications

Certification Type	Number
Nebraska Fire Alarm Inspector	818

Inspection & Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 1	Control Panel: 1

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	Service	Time	Date
	Passed			
Control				
Battery	FACP	Tested	2:01:29 PM	09/20/2021
Initiating				
Pull Station	Basement Exit	Tested	2:17:07 PM	09/20/2021
Pull Station	Dining Room	Tested	2:04:12 PM	09/20/2021
Pull Station	Door 8 Exit	Tested	2:15:18 PM	09/20/2021
Pull Station	FACP	Tested	2:06:44 PM	09/20/2021
Smoke Detector	Basement North	Tested/Cleaned	2:16:15 PM	09/20/2021
Smoke Detector	Basement South	Tested/Cleaned	2:16:33 PM	09/20/2021
Smoke Detector	Dining Room	Tested/Cleaned	2:06:03 PM	09/20/2021
Smoke Detector	FACP	Tested/Cleaned	2:06:16 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	2:10:17 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	2:14:29 PM	09/20/2021
Smoke Detector	Hallway	Tested/Cleaned	2:14:49 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	2:03:06 PM	09/20/2021
Smoke Detector	Living Room	Tested/Cleaned	2:03:27 PM	09/20/2021
Smoke Detector	Nurses Office	Tested/Cleaned	2:09:48 PM	09/20/2021
Smoke Detector	Office	Tested/Cleaned	2:09:14 PM	09/20/2021
Smoke Detector	Room 1 Office	Tested/Cleaned	2:07:59 PM	09/20/2021
Smoke Detector	Room 10	Tested/Cleaned	2:12:39 PM	09/20/2021
Smoke Detector	Room 11	Tested/Cleaned	2:12:15 PM	09/20/2021
Smoke Detector	Room 13	Tested/Cleaned	2:11:35 PM	09/20/2021
Smoke Detector	Room 14	Tested/Cleaned	2:11:15 PM	09/20/2021
Smoke Detector	Room 15	Tested/Cleaned	2:10:47 PM	09/20/2021
Smoke Detector	Room 16	Tested/Cleaned	2:08:31 PM	09/20/2021
Smoke Detector	Room 6	Tested/Cleaned	2:14:04 PM	09/20/2021
Smoke Detector	Room 7	Tested/Cleaned	2:13:33 PM	09/20/2021
Smoke Detector	Room 9	Tested/Cleaned	2:13:05 PM	09/20/2021
Supervisory				
Tamper Switch	Laundry Room	Tested	2:17:50 PM	09/20/2021
Tamper Switch	Laundry Room	Tested	2:17:59 PM	09/20/2021
Water Pressure Switch	Laundry Room	Tested	2:18:12 PM	09/20/2021
Water Pressure Switch	Laundry Room	Tested	2:18:24 PM	09/20/2021

Service Summary

Generated by: BuildingReports.com

Building: White Hall Bldg 1

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Battery	Tested	1
Pull Station	Tested	4
Smoke Detector	Tested/Cleaned	21
Tamper Switch	Tested	2
Water Pressure Switch	Tested	2
Total		**30**
Grand Total		**30**

Battery & Power Supply Testing

Generated by: BuildingReports.com

Building: White Hall Bldg 1				Control Panel: 1			
The Battery & Power Supply Testing section details the readings and measurements of batteries and power supplies used to provide power to the fire alarm and life safety systems. Items are grouped by Passed or Failed/Other.							
Battery							
Type	Location	Rated Ah	Rated Volts	Pre Test	Post Test	Min Ah	Tested Ah
Passed							
Sealed Lead Acid	FACP	5	12				

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: White Hall Bldg 1 — Control Panel: 1

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
Battery	Control	3.33%	1
Pull Station	Initiating	13.33%	4
Smoke Detector	Initiating	70.00%	21
Tamper Switch	Supervisory	6.67%	2
Water Pressure Switch	Supervisory	6.67%	2

Type	Qty	Model #	Description	Install Date
In Service - 3 Years to 5 Years				
Smoke Detector	21			09/18/2018
Notifier				
Pull Station	4	NBG-12L		09/18/2018
Potter Electric				
Water Pressure Switch	1	PS10-2A	Low	09/18/2018
Water Pressure Switch	1	PS40-2A	High	09/18/2018
Power Patrol				
Battery	1	1055	Sealed Lead Acid	09/18/2018
Victaulic				
Tamper Switch	2	702		09/18/2018

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Community Life #2
5801 Walker Ave.
LINCOLN, NE 68507

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
Aug 16, 2021

Building: Community Life #2
Contact: Tiffany F
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Community Life #2	**Contact:** Tiffany F
Address: 5801 Walker Ave.	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/Zip: LINCOLN, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Travis Billesbach
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1687
Country: United States of America	**Email:** tbillesbach@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Aug 16, 2021

Building: Community Life #2

EC 02.03.05 EP 01

Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

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 (2021)	Total Quantity
Drain	1	1	0	1	1

EC 02.03.05 EP 10

Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 05

Annual - Sprinkler heads undamaged, free from corrosion, foreign materials, paint.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Dry Sprinkler	1	1	0	1	1

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 (2021)	Total Quantity
Control Valve	2	2	0	2	2
Dry Pipe Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 9

Certification

Company: NIFCO Mechanical Systems	Building: Community Life #2
Inspector: Travis Billesbach	Contact: Tiffany F
Signed:	Signed:

Travis Billesbach Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8466
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Community Life #2

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 01 Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Each initiating device circuit shall be tested for correct indication at the control unit. (2010 ed.) (NFPA 72 Table 14.4.2.2 (13.c))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Pressure Switch	Basement East Mechanical Laundry	59341110	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Pressure Switch	Basement East Mechanical Laundry	59341111	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 2								

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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement East Mechanical Laundry	59341113	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Fire Dep't Connection	Ground East Outside	59341115	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 1								

LS 02.01.35 EP 05	Annual - Sprinkler heads undamaged, free from corrosion, foreign materials, paint.

Sprinklers shall be inspected from the floor level annually. Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the correct orientation. (2011 ed.) (NFPA 25 5.2.1.1 through 5.2.1.4)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Dry Sprinkler	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Dry Sprinkler	Basement East Mechanical Laundry	59341116	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Control Valve	Basement East Mechanical Laundry	59341117	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/13/21 -P	08/16/21 -P
Control Valve	Basement East Mechanical Laundry	59341118	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P

Device Total: 2

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5							
Each dry pipe valve shall be trip tested annually during warm weather. (2011 ed.) (NFPA 25 13.4.4.2.2)								
Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity			
Dry Pipe Valve	1	1	0	1	1			
Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Dry Pipe Valve	Basement East Mechanical Laundry	59341112	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)	

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Ground East Outside	5Q114	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/13/21 -P	08/16/21 -P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Community Life #2

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Quarter 1 Test	2
Drain	Quarter 1 Test	1
Dry Pipe Valve	Quarter 1 Test	1
Dry Sprinkler	Quarter 1 Test	1
Fire Dep't Connection	Quarter 1 Test	1
Post Indicator Valve	Quarter 1 Test	1
Pressure Switch	Quarter 1 Test	2
Total		**9**
Grand Total		**9**

Dry Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Community Life #2 — Building-, Building-

This section lists out all the devices and components that have been associated with a Dry Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Pressure Switch

Type	Description	Manufacturer	Low	High	Zone/Address	OK	ScanID
High	Alarm				1	☑	59341110
Low	Supervisory				1	☑	59341111

Components

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"	Open	Supervised	☑	59341117

Description
Main Control

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"	Open	Supervised	☑	59341118

Description
Main Control

Dry Pipe Valve

Manufacturer	Model #	Location	Internal Date	OK	ScanID
Viking	F-2	Basement East Mechanical Laundry	02/20/2020	☑	59341112

Type	Status	Position	Size	Serial #
Grooved	Supervised	Trim Closed	3"	

Water psi	Air Pressure	Trip Air	Trip Time	Total Timing (sec)	Partial Trip Date	Full Trip Date
78	32				02/20/2020	02/20/2020

Post Indicator Valve

Manufacturer	Model	Location	OK	ScanID
		Ground East Outside	☑	5Q114

Type	Size	Position	Status	Number of Turns
Ground	6"	Open	Locked & Supervised	

Devices

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	78	80	59		☑	59341113

Previous Inspections

May 10, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	80	81	57	2	☑	59341113

February 16, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	79	75	59		☑	59341113

Dry Sprinkler

Qty	Type	Size	KFactor	Finish	Temperature	OK	ScanID
						☑	59341116

Location	Description
Basement East Mechanical Laundry	

Fire Dep't Connection

Location	Type	BallDrip	Rotating Swivels	Size	OK	ScanID
Ground East Outside	Freestanding	Yes	Yes	4"	☑	59341115

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Community Life #2

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
Pressure Switch	Alarm	22.22%	2
Post Indicator Valve	Valve	11.11%	1
Fire Dep't Connection	Hose	11.11%	1
Dry Sprinkler	Sprinkler	11.11%	1
Dry Pipe Valve	Valve	11.11%	1
Drain	Device	11.11%	1
Control Valve	Valve	22.22%	2

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Building- Dry Pipe, Building-					
Control Valve	2		Butterfly	Main Control	02/20/2020
Drain	1		Main		02/20/2020
Fire Dep't Connection	1		Freestanding		02/20/2020
Post Indicator Valve	1		Ground		02/20/2020
Pressure Switch	1		High	Alarm	02/20/2020
Pressure Switch	1		Low	Supervisory	02/20/2020
Dry Pipe Valve	1	F-2	Grooved		02/20/2020
In Service - 10 Years to 15 Years					
Building- Dry Pipe, Building-					
Dry Sprinkler	1				02/05/2008

Notes & Recommendations

Generated by: BuildingReports.com

Building: Community Life #2

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
		Building- Dry Pipe, Building-		
1	Post Indicator Valve	Ground East Outside	Passed	5Q114
	Retest after annual.			
	Device is in compliance.			

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Family Life
5819 Huntington
LINCOLN, NE 68507

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
Aug 16, 2021

Building: Family Life
Contact: Tiffany F
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Family Life	**Contact:** Tiffany F
Address: 5819 Huntington	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/Zip: LINCOLN, NE 68507	**Mobile:**
Country: United States of America	**Email:**

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Travis Billesbach
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/Zip: Lincoln, NE 68522-1701	**Mobile:** 531-220-1687
Country: United States of America	**Email:** tbillesbach@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Aug 16, 2021

Building: Family Life

EC 02.03.05 EP 01

Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

EC 02.03.05 EP 02

Six-month testing of tamper switches and vane-type and pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Waterflow Switch	1	1	0	1	1

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 (2021)	Total Quantity
Drain	0	0	0	1	1

EC 02.03.05 EP 10

Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

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 (2021)	Total Quantity
Control Valve	0	0	0	3	3
Dry Pipe Valve	0	0	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 10

Certification

Company: NIFCO Mechanical Systems	Building: Family Life
Inspector: Travis Billesbach	Contact: Tiffany F
Signed:	Signed:

Travis Billesbach Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8466
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Family Life

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 01 — Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Each initiating device circuit shall be tested for correct indication at the control unit. (2010 ed.) (NFPA 72 Table 14.4.2.2 (13.c))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Pressure Switch	Basement East Mechanical Laundry	59341102	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Pressure Switch	Basement East Mechanical Laundry	59341103	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P

Device Total: 2

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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Waterflow Switch	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Waterflow Switch	Basement East Mechanical Laundry	59341106	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 1								

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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement East Mechanical Laundry	59341101	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Fire Dep't Connection	Ground West	59341108	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Control Valve	0	0	0	3	3

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Control Valve	Basement East Mechanical Laundry	59341104	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	
Control Valve	Basement East Mechanical Laundry	59341105	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	
Control Valve	Basement East Mechanical Laundry	59341109	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	

Device Total: 3

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5							
Each dry pipe valve shall be trip tested annually during warm weather. (2011 ed.) (NFPA 25 13.4.4.2.2)								
Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity			
Dry Pipe Valve	0	0	0	1	1			
Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Dry Pipe Valve	Basement East Mechanical Laundry	59341100	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Ground Southeast	59341107	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P

Device Total: 1

Service Summary

Generated by: BuildingReports.com

Building: Family Life

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Fire Dep't Connection	Quarter 1 Test	1
Post Indicator Valve	Quarter 1 Test	1
Pressure Switch	Quarter 1 Test	2
Waterflow Switch	Quarter 1 Test	1
Total		5
	Untested	
Control Valve		3
Drain		1
Dry Pipe Valve		1
Total		5
Grand Total		10

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Family Life	Building-, Building-basement 1st

This section lists out all the devices and components that have been associated with a Wet Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane				2.0	1	☑	59341106

Dry Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Family Life — Building-, Area-Attic

This section lists out all the devices and components that have been associated with a Dry Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Pressure Switch

Type	Description	Manufacturer	Low	High	Zone/Address	OK	ScanID
High	Alarm				1	☑	59341102
Low	Supervisory				1	☑	59341103

Components

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	3"			☐	59341109

Description
Isolation

Dry Pipe Valve

Manufacturer	Model #	Location	Internal Date	OK	ScanID
Viking	F-2	Basement East Mechanical Laundry	02/20/2020	☐	59341100

Type	Status	Position	Size	Serial #
Grooved			3"	

Water psi	Air Pressure	Trip Air	Trip Time	Total Timing (sec)	Partial Trip Date	Full Trip Date
					02/20/2020	02/20/2020

Devices

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	80	79	55		☐	59341101

Previous Inspections

May 10, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	80	79	55	2	☑	59341101

February 16, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID

Main	Basement East Mechanical Laundry	1.25"	81	78	56		☑	59341101

Private Fire Service Mains

Generated by: BuildingReports.com

Building: Family Life — Building-, Building-

This section lists out all the devices and components that have been associated with a Private Fire Service Main 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.

Components

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"			☐	59341104

Description
Main Control

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"			☐	59341105

Description
Main Control

Post Indicator Valve

Manufacturer	Model	Location	OK	ScanID
		Ground Southeast	☑	59341107

Type	Size	Position	Status	Number of Turns
Ground	6"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	BallDrip	Rotating Swivels	Size	OK	ScanID
Ground West	Freestanding	Yes	Yes	4"	☑	59341108

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Family Life

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
Dry Pipe Valve	Valve	10.00%	1
Drain	Device	10.00%	1
Control Valve	Valve	30.00%	3
Waterflow Switch	Alarm	10.00%	1
Pressure Switch	Alarm	20.00%	2
Post Indicator Valve	Valve	10.00%	1
Fire Dep't Connection	Hose	10.00%	1

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Building- Dry Pipe, Area-Attic					
Control Valve	1		Butterfly	Isolation	02/20/2020
Drain	1		Main		02/20/2020
Pressure Switch	1		High	Alarm	02/20/2020
Pressure Switch	1		Low	Supervisory	02/20/2020
Dry Pipe Valve	1	F-2	Grooved		02/20/2020
Building- Service Main, Building-					
Control Valve	2		Butterfly	Main Control	02/20/2020
Fire Dep't Connection	1		Freestanding		02/20/2020
Post Indicator Valve	1		Ground		02/20/2020
Building- Wet Pipe, Building-basement 1st					
Waterflow Switch	1		Vane	Alarm	02/20/2020

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Warner House #1
5800 Leighton
LINCOLN, NE 68507

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
Aug 16, 2021

Building: Warner House #1
Contact: Tiffany F
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Travis Billesbach
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Warner House #1
Address: 5800 Leighton
Address:
City/State/Zip: LINCOLN, NE 68507
Country: United States of America

Contact: Tiffany F
Phone: 402-479-5452
Fax:
Mobile:
Email:

Inspection Performed By

Company: NIFCO Mechanical Systems
Address: 500 Blue Heron Dr
Address:
City/State/Zip: Lincoln, NE 68522-1701
Country: United States of America

Inspector: Travis Billesbach
Phone: 402-477-0666
Fax:
Mobile: 531-220-1687
Email: tbillesbach@nifcomechanical.com

Monitoring

Company:	**Phone:**	**Account #:**

Central Station Signal Verification

Type:	**Mfg:**	**Model #:**
Test Time/Date:	**Restore Time:**	**Note:**

Inspection Completion Date: Aug 16, 2021

Building: Warner House #1

EC 02.03.05 EP 01 — Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

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 (2021)	Total Quantity
Drain	1	1	0	1	1

EC 02.03.05 EP 10 — Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7; Table 13.1.1.2

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

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 (2021)	Total Quantity
Control Valve	2	2	0	2	2
Dry Pipe Valve	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 8

Certification

Company: NIFCO Mechanical Systems	Building: Warner House #1
Inspector: Travis Billesbach	Contact: Tiffany F
Signed:	Signed:

Travis Billesbach Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8466
NICET Inspection and Testing of Water-Based Systems Level I	

Inspection & Testing

Generated by: BuildingReports.com

Building: Warner House #1

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 01 Quarterly test of supervisory signal devices (except valve tamper switches). NFPA 72-2010 Table 14.4.5

Each initiating device circuit shall be tested for correct indication at the control unit. (2010 ed.) (NFPA 72 Table 14.4.2.2 (13.c))

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Pressure Switch	2	2	0	2	2

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Pressure Switch	Basement East Mechanical Laundry	59341119	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Pressure Switch	Basement East Mechanical Laundry	59341120	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P

Device Total: 2

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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Drain	Basement East Mechanical Laundry	59341122	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -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 Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Fire Dep't Connection	Ground East Outside	59341126	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -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 Q3/21**	**Pass Q3/21**	**Fail Q3/21**	**Tested YTD (2021)**	**Total Quantity**			
Control Valve	2	2	0	2	2			
Device Type	**Location**	**ScanID**	**Address**	**Q3/20**	**Q4/20**	**Q1/21**	**Q2/21**	**Q3/21**
Control Valve	Basement East Mechanical Laundry	59341123	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Control Valve	Basement East Mechanical Laundry	59341124	1	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 2								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5							
Each dry pipe valve shall be trip tested annually during warm weather. (2011 ed.) (NFPA 25 13.4.4.2.2)								
Devices	**Tested Q3/21**	**Pass Q3/21**	**Fail Q3/21**	**Tested YTD (2021)**	**Total Quantity**			
Dry Pipe Valve	1	1	0	1	1			
Device Type	**Location**	**ScanID**	**Address**	**Q3/20**	**Q4/20**	**Q1/21**	**Q2/21**	**Q3/21**
Dry Pipe Valve	Basement East Mechanical Laundry	59341121	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/21	Pass Q3/21	Fail Q3/21	Tested YTD (2021)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/20	Q4/20	Q1/21	Q2/21	Q3/21
Post Indicator Valve	Ground East Outside	59341125	0	08/20/20 -P	11/19/20 -P	02/16/21 -P	05/10/21 -P	08/16/21 -P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Warner House #1

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Quarter 1 Test	2
Drain	Quarter 1 Test	1
Dry Pipe Valve	Quarter 1 Test	1
Fire Dep't Connection	Quarter 1 Test	1
Post Indicator Valve	Quarter 1 Test	1
Pressure Switch	Quarter 1 Test	2
Total		**8**
Grand Total		**8**

Dry Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Warner House #1 — Building-, Building-

This section lists out all the devices and components that have been associated with a Dry Pipe System and provides details as to type of component, pressure readings, response time, etc. If a component has an OK checkbox that is checked, then that component was actually tested. However, for Pass/Fail test results, see the Inspection and Testing section.

Alarms

Pressure Switch

Type	Description	Manufacturer	Low	High	Zone/Address	OK	ScanID
Low	Supervisory				1	☑	59341119
High	Alarm				1	☑	59341120

Components

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"	Open	Supervised	☑	59341123

Description
Main Control

Control Valve

Type	Manufacturer	Model	Location	Size	Position	Status	OK	ScanID
Butterfly			Basement East Mechanical Laundry	4"	Open	Supervised	☑	59341124

Description
Main Control

Dry Pipe Valve

Manufacturer	Model #	Location	Internal Date	OK	ScanID
Viking	f-2	Basement East Mechanical Laundry	02/20/2020	☑	59341121

Type	Status	Position	Size	Serial #
Grooved	Supervised	Trim Closed	3"	

Water psi	Air Pressure	Trip Air	Trip Time	Total Timing (sec)	Partial Trip Date	Full Trip Date
72	36				02/20/2020	02/20/2020

Post Indicator Valve

Manufacturer	Model	Location	OK	ScanID
		Ground East Outside	☑	59341125

Type	Size	Position	Status	Number of Turns
Ground		Open	Locked & Supervised	

Devices

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	79	878	72		☑	59341122

Previous Inspections

May 10, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	77	80	70	2	☑	59341122

February 16, 2021

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	80	80	72		☑	59341122

Fire Dep't Connection

Location	Type	BallDrip	Rotating Swivels	Size	OK	ScanID
Ground East Outside	Freestanding	Yes	Yes		☑	59341126

Inventory & Warranty Report

Generated by: BuildingReports.com

Building: Warner House #1

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
Pressure Switch	Alarm	25.00%	2
Post Indicator Valve	Valve	12.50%	1
Fire Dep't Connection	Hose	12.50%	1
Dry Pipe Valve	Valve	12.50%	1
Drain	Device	12.50%	1
Control Valve	Valve	25.00%	2

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 1 Year to 2 Years					
Building- Dry Pipe, Building-					
Control Valve	2		Butterfly	Main Control	02/20/2020
Drain	1		Main		02/20/2020
Fire Dep't Connection	1		Freestanding		02/20/2020
Post Indicator Valve	1		Ground		02/20/2020
Pressure Switch	1		High	Alarm	02/20/2020
Pressure Switch	1		Low	Supervisory	02/20/2020
Dry Pipe Valve	1	f-2	Grooved		02/20/2020

State Fire Marshall

Occupancy Permits

Attachment W8

State Fire Marshal Agency

246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4631

Facility Type: Mental Health Center

Facility Name: Whitehall-Community Life
Street Address: 5801 Walker Ave
Mailing Address:
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee: /
Total Due: 50.00/NV

10-Co-2020
Inspection Date

8227

Signature of Inspecting official: Clint Rossman

1st Inspection: Clinton Rossman
Contact:
2nd Inspection:
Contact:
3rd Inspection:
Contact:
4th Inspection:
Contact:

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

If paying by check or money order, send payment along with this fee sheet to the State Fire Marshal, 246 S. 14th Street Lincoln, NE 68508.

Certificate of Occupancy: Upon receipt of payment of inspection fees and issuance of an Order of Approval, a Certificate of Occupancy will be sent to the email address provided on this form or as listed on the online payment request. If no e-mail address is provided, the certificate will be mailed to the facility address noted above.

If fees have not been received within 30 days of approval, an order of disapproval may be issued. If an order of disapproval is issued, another inspection will be required and an additional fee will be assessed.

State Fire Marshal Agency
246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4629

Facility Type: Mental Health Center

Facility Name: Whitehall-Office, Cafeteria, Clinic
Street Address: 5845 Huntington Ave
Mailing Address:
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee: /
Total Due: 50.00

10-6-2020
Inspection Date

827

Signature of Inspecting official: Clint Rossman
1st Inspection: Clinton Rossman
Contact:
2nd Inspection:
Contact:
3rd Inspection:
Contact:
4th Inspection:
Contact:

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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State Fire Marshal Agency

246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4630

Facility Type: Mental Health Center

Facility Name: Whitehall-Family Life
Street Address: 5819 Huntington Ave
Mailing Address: _____
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee: _____
Total Due: 50 00

10-6-2020
Inspection Date

Signature of Inspecting official: Clint Rossman

1st Inspection: _____
Contact: _____
2nd Inspection: _____
Contact: _____
3rd Inspection: _____
Contact: _____
4th Inspection: _____
Contact: _____

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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State Fire Marshal Agency

246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4635

Facility Type: Mental Health Center

Facility Name: Whitehall-Warner House
Street Address: 5800 Leighton Ave
Mailing Address:
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee: /
Total Due: 50 no /

8717

10-6-2020
Inspection Date

Signature of Inspecting official: Clint Rossman
1st Inspection: Clinton Rossman
Contact:
2nd Inspection:
Contact:
3rd Inspection:
Contact:
4th Inspection:
Contact:

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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If fees have not been received within 30 days of approval, an order of disapproval may be issued. If an order of disapproval is issued, another inspection will be required and an additional fee will be assessed.

State Fire Marshal Agency
246 South 14th Street
Lincoln, Ne 68508-1804

District: District A

Referral Number: 4630

Facility Type: Mental Health Center

Facility Name: Whitehall-Family Life

Street Address: 5819 Huntington Ave

Mailing Address: _____

Lincoln, NE 68509

Owner/Administrator

E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00

Revisit Fee: /

Total Due: 50

10-6-2020

Inspection Date

Signature of Inspecting official: Clint Rossman

1st Inspection: _____

Contact: _____

2nd Inspection: _____

Contact: _____

3rd Inspection: _____

Contact: _____

4th Inspection: _____

Contact: _____

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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If fees have not been received within 30 days of approval, an order of disapproval may be issued. If an order of disapproval is issued, another inspection will be required and an additional fee will be assessed.

State Fire Marshal Agency

246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4629

Facility Type: Mental Health Center

Facility Name: Whitehall-Office, Cafeteria, Clinic
Street Address: 5845 Huntington Ave
Mailing Address:
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee: /
Total Due: 50 00/100

10-6-2020
Inspection Date

Signature of Inspecting official: Clint Rossman

1st Inspection: Clinton Rossman
Contact:
2nd Inspection:
Contact:
3rd Inspection:
Contact:
4th Inspection:
Contact:

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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If fees have not been received within 30 days of approval, an order of disapproval may be issued. If an order of disapproval is issued, another inspection will be required and an additional fee will be assessed.

State Fire Marshal Agency

246 South 14th Street
Lincoln, Ne 68508-1804

District: District A
Referral Number: 4629

Facility Type: Mental Health Center

Facility Name: Whitehall-Office, Cafeteria, Clinic
Street Address: 5845 Huntington Ave
Mailing Address:
Lincoln, NE 68509
Owner/Administrator
E-Mail Address: jesse.foster@nebraska.gov

Inspection Fee: $ 50.00
Revisit Fee:
Total Due: 50.00

10-6-2020
Inspection Date

Signature of Inspecting official: Clint Rossman

1st Inspection: Clinton Rossman
Contact:
2nd Inspection:
Contact:
3rd Inspection:
Contact:
4th Inspection:
Contact:

Payment Options: Online remittance of fees is preferred. Online payments can be remitted via the website at https://sfm.nebraska.gov/fees. A convenience fee of $1.75 for e-checks and 2.49% for credit card payments will apply. For the transaction item, select **"Code Inspection Fees."**

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If fees have not been received within 30 days of approval, an order of disapproval may be issued. If an order of disapproval is issued, another inspection will be required and an additional fee will be assessed.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11303

Name of Facility:	**Whitehall-Warner House**
Type of Facility:	**Mental Health Center**
Location:	**5800 Leighton Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By: Chris B Gruell
State Fire Marshal

POST IN PROMINENT PLACE

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

FLC

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11301

Name of Facility:	**Whitehall-Family Life**
Type of Facility:	**Mental Health Center**
Location:	**5819 Huntington Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By: Chris B Gruell
State Fire Marshal

POST IN PROMINENT PLACE

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

Knight House

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11302

Name of Facility:	**Whitehall-Office, Cafeteria, Clinic**
Type of Facility:	**Mental Health Center**
Location:	**5845 Huntington Ave, Lincoln**
Maximum Occupancy:	**N/A**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11300

Name of Facility:	**Whitehall-Community Life**
Type of Facility:	**Mental Health Center**
Location:	**5801 Walker Ave, Lincoln**
Maximum Occupancy:	**8 Persons**
Date Issued:	**10/30/2020**

Inspected By: **Clint Rossman**
Deputy State Fire Marshal

Approved By:
State Fire Marshal

POST IN PROMINENT PLACE

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

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 103546

Name of Facility: **WHITEHALL-LINCOLN REGIONAL CENTER**

Type of Facility: **Child Day Care**

Location: **5845 Huntington Avenue , Lincoln**

Maximum Occupancy: **24 Persons**

Date Issued: **11/6/2018**

Inspected By: **8727 Clint Rossman**
Deputy State Fire Marshal

Approved By:

State Fire Marshal

POST IN PROMINENT PLACE

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

Major Projects

Attachment H1

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Youth Rehabilitation and Treatment Center – Hastings Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. [redacted]

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

    a. Locks for dorm doors – 12/2020 thru 3/2021
    b. Fire sprinkler head change along with bulkhead – 1/2021 thru 2/2021
    c. Reinforcement of walls via wallpaper install – 11/2020 thru 4/2021
    d. Glazing Security Film Installation – 9/2020 thru 11/2020
    e. Glazing Polycarbonate Installation – 8/2021 thru 11/2021

2. Please provide a summary of completed major projects as of today.

    a. All projects identified in number one of section B have been completed for the reporting period.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

    a. Yes, YRTC-Hastings utilizes Corrigo, a virtual based work order system.

4. Please provide the number of work orders submitted since December 2020.

    a. 310 preventative work orders
    b. 330 work order requests

5. What kind of system do you use to track non-major repair projects?

    a. The electronic tracking system, Corrigo tracks all non-major repair projects for YRTC-Hastings.

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

2. Please provide a copy of your <u>most recent</u> COVID protocols.

    a. All of YRTC-Hastings' most recent COIVD-19 protocols can be located in Section C of this packet.

3. Please provide a copy of your <u>most recent</u> letter to family/guardians/visitors on COVID updates

    a. All of YRTC-Hastings' most recent letter to family/guardians/visitors regarding COVID-19 updates can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

    a. All staff and visitors to YRTC-Hastings continue to undergo COVID-19 screening and temperature checks when entering the facility
    b. COVID-19 tests are administered to all staff and youth upon request, and required for all new incoming youth to the facility. New intakes are placed into a quarantine status until negative test results are received.
    c. YRTC-Hastings is currently allowing in person visitation as well as the option for WebEx while continuing to follow COVID-19 social distancing requirements and recommendations.

5. Please provide a copy of your <u>most recent</u> COVID-19 planning meeting minutes.

    a. YRTC-Hastings does not conduct COVID-19 planning meetings, but rather follows the direction of DHHS Administration for the COVID-19 protocols that are determined by DHHS and the South Heartland District Health Department in Hastings, Nebraska.

Facility Staffing Information

Attachment H2

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

Pete Ricketts, Governor

Youth Rehabilitation and Treatment Center – Hastings Staffing & Assault Data
Reporting Period: December 1, 2020 through November 30, 2021
Neb. Rev. Stat. 83-104

A. **Facility Staffing Levels:**

a. The number of positions filled as of November 30, 2021.

i. 72 positions

b. The number of positions vacant as of November 30, 2021.

i. 39 vacant positions

c. The number of positions needed in your HR staffing plan for FY22 as of November 30, 2021.

i. 39 positions needed for staffing plan for FY22

d. The number of position filled in your HR staffing plan for FY22 as of November 30, 2021.

i. 72 position filled for FY22

e. The monthly turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 3%

f. The aggregate turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 38%

B. Staff Assaults:

a. The number of assaults on staff for the period of 12/01/2020 through 11/30/2021.

i. 8 total youth on staff assaults

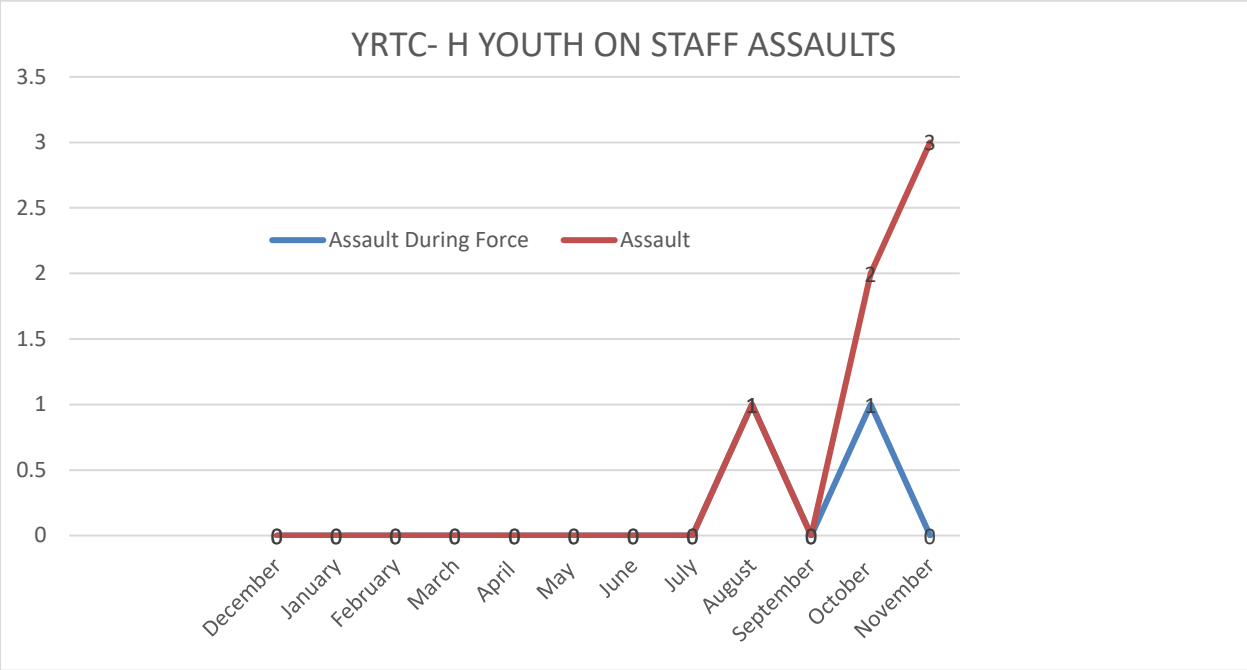
b. Number of assaults as a result of a use of force event.

i. 2 youth on staff assaults during physical interventions

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data
12/1/2020 - 11/30/2021

Facility: YRTC-H Beatrice State Developmental Center

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		77	39	116	68	41	40	3%	37%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
H77023	ACTIVITY SPECIALIST	0	1	1	1	0	0	0%	0%
V09121	ADMINISTRATIVE ASSISTANT I	0	0	0	1	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	1	1	1	4%	50%
A01014	ADMINISTRATIVE SPECIALIST (NEW)	1	0	1	0	1	0	0%	0%
V01013	ADMINISTRATIVE TECHNICIAN (NEW)	1	0	1	0	0	0		
I79510	BARBER/BEAUTICIAN	0	1	1	0	0	0		
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	1	0	1	0	1	3	25%	300%
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	0	5	5	0	0	0		
V72556	BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II (NEW)	0	1	1	0	0	1		
C72791	CHEMICAL DEPENDENCY TREATMENT SPECIALIST	0	0	0	2	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	0	1	1	0	0	0		
M82121	CUSTODIAN/HOUSEKEEPER	0	0	0	2	0	1	4%	50%
N78560	DHHS FACILITY ADMINISTRATOR	1	0	1	0	0	0		
V78792	DHHS PROGRAM MANAGER II	1	0	1	1	0	0	0%	0%
N00750	FACILITY OPERATING OFFICER	0	1	1	0	0	1		
M80123	FOOD SERVICE COOK	0	0	0	3	1	1	2%	25%
V80230	FOOD SERVICE MANAGER	1	0	1	1	0	0	0%	0%
M80012	FOOD SERVICE WORKER (NEW)	4	1	5	0	2	1	4%	50%
S02201	HEALTH INFORMATION TECHNICIAN	0	0	0	2	0	1	4%	50%
H76312	HUMAN SERVICES TREATMENT SPECIALIST II	0	0	0	1	0	1	8%	100%
M84011	MAINTENANCE TECHNICIAN (NEW)	1	1	2	0	0	0		
N75450	MEDICAL SERVICES DIRECTOR	0	1	1	0	0	0		
H72431	MENTAL HEALTH PRACTITIONER I	0	0	0	1	0	0	0%	0%
H72432	MENTAL HEALTH PRACTITIONER II	0	0	0	1	0	0	0%	0%
D75350	NURSE PRACTITIONER	1	1	2	0	1	0	0%	0%
S01012	OFFICE SPECIALIST (NEW)	2	1	3	0	1	1	8%	100%
S01011	OFFICE TECHNICIAN (NEW)	2	0	2	0	2	0	0%	0%
K17121	PERSONNEL OFFICER	1	0	1	1	0	0	0%	0%
V17121	PERSONNEL OFFICER	1	0	1	0	0	0		
N74823	PSYCHOLOGIST/LICENSED	1	0	1	1	0	0	0%	0%
V77045	RECREATION MANAGER	1	0	1	0	0	0		
H77043	RECREATION SPECIALIST	2	0	2	1	0	0	0%	0%
H75014	REGISTERED NURSE (NEW)	1	1	2	2	1	2	6%	67%
R75014	REGISTERED NURSE (NEW)	0	2	2	0	0	0		
C79920	RELIGIOUS COORDINATOR	1	0	1	0	1	0	0%	0%
V82330	SAFETY COORDINATOR	0	1	1	1	0	0	0%	0%
C72332	SOCIAL WORKER II	0	0	0	1	0	1	8%	100%
S01841	STAFF ASSISTANT I	0	0	0	1	0	0	0%	0%
S01842	STAFF ASSISTANT II	0	0	0	0	1	1	8%	100%
V05213	SUPPLY SUPERVISOR	1	0	1	1	0	0	0%	0%
S05012	SUPPLY TECHNICIAN II (NEW)	1	0	1	0	0	0		
S05212	SUPPLY WORKER II	0	0	0	1	0	0	0%	0%
S01511	SWITCHBOARD OPERATOR/RECEPTIONIST	0	0	0	0	1	1	8%	100%
T11360	TEACHER (SCATA CONTRACT)	9	1	10	5	2	0	0%	0%
A11012	TRAINING COORDINATOR (NEW)	1	0	1	0	0	0		
C72481	YOUTH COUNSELOR I	2	0	2	1	0	1	8%	100%
V72483	YOUTH COUNSELOR SUPERVISOR	2	0	2	0	0	0		
P76752	YOUTH SECURITY SPECIALIST II	25	11	36	26	21	20	4%	43%
R76752	YOUTH SECURITY SPECIALIST II	2	4	6	0	3	1	3%	33%
V76753	YOUTH SECURITY SUPERVISOR	9	4	13	9	1	1	1%	10%
		77	**39**	**116**	**68**	**41**	**40**	**3%**	**37%**



Average Count	Dec 2020 to Nov 2021
December	0
January	0
February	0
March	0
April	0
May	0
June	0
July	0
August	2
September	0
October	3
November	3

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Kearney		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	8	0	1	0	0	0	9
February	6	4	0	2	0	0	12
March	11	2	0	0	0	0	13
April	5	1	0	0	0	0	6
May	3	0	0	0	0	0	3
June	0	4	0	0	0	0	4
July	0	2	0	0	0	0	2
August	1	0	0	0	0	0	1
September	0	4	0	0	0	0	4
October	0	0	0	0	0	0	0
November	1	1	0	0	0	0	2
Total	**36**	18	1	2	0	0	57

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Lincoln		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	0	0	0	0	0	0	0
February	1	0	0	0	0	0	1
March	1	0	0	0	0	0	1
April	1	0	0	0	0	0	1
May	4	0	0	0	0	0	4
June	2	0	2	2	0	0	6
July	2	0	1	0	0	0	3
August	2	0	1	0	0	0	3
September	0	0	1	0	0	0	1
October	1	0	0	0	0	0	1
November							
Total	**15**	0	5	2	0	0	22

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Hastings		Injury Rating				Total
Month	1	2	3	4	5	6	
December	n/a	n/a	n/a	n/a	n/a	n/a	n/a
January	n/a	n/a	n/a	n/a	n/a	n/a	n/a

February	n/a	n/a	n/a	n/a	n/a	n/a	n/a
March	n/a	n/a	n/a	n/a	n/a	n/a	n/a
April	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0
August	2	0	0	0	0	0	2
September	0	0	0	0	0	0	0
October	3	0	0	0	0	0	3
November	3	0	0	0	0	0	3
Total	**8**	0	0	0	0	0	8

COVID -19 Impact

Impact

Leadership Update

Family Member Letter

Pandemic plan

Attachment H3

Impact

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

[redacted]

[redacted]

a. [redacted]

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

    a. COVID-19 presented some major challenges for all facilities but one of the biggest perceived challenges that the Whitehall facility faced during the first shut down was the facility's ability to meet with stakeholders and families about treatment updates on the children. Administration had to redesign the entire process so that Whitehall could meet health department standards for the amount of people that could be in a room at one time. The use of WebEx has revolutionized how facilities conduct team meetings each week with the youth, their families, and other interested parties. The onset of the COVID-19 pandemic has resulted in the facility having the ability to get more outside people involved remotely with youth on campus than even was possible before. In a sense the pandemic forced the facility to grow and think of new ways to do things so that quality treatment could still be provided even in the midst of a global pandemic. Even now that families are starting to come back onto the campus and have the youth back into the community we continue to have great participation from outside parties in the treatment of the youth.

2. Please provide a copy of your most recent COVID protocols.

    a. Attached as LRC-Pandemic COVID-19 Protocols (These are what Whitehall adopted as well) in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. The Whitehall visitation letter that was sent to families via USPS and pronation via email is attached and can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

a. Currently, the campus is open to visitation and the youth are allowed to visit with their families off grounds. When Whitehall gains a new youth, they are tested for COVID-19 and are placed temporarily into quarantine until that test result comes back. If the test result comes back positive the Medical department at Whitehall will call the health department and quarantine the youth for 10 days. Currently there is one youth on quarantine due to arriving to the facility COVID positive and will be off quarantine on November 10th, 2021. When visitors come to campus they are required to check their temperature when signing in to our administration building. Whitehall currently does not require masks on campus unless the health department has suggested otherwise in response to a positive case on campus which has been very far and few between. If a staff member believes they have been exposed they are directed to call the health department and go with their recommendation on whether the staff member should quarantine or be tested.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. Whitehall does not have any COVID-19 planning meeting minutes, but rather follows the direction of LRC and DHHS administration for any updates regarding COVID-19 protocols.

Leadership Update

Jacobe, Camella

From: Jensen, Corinne
Sent: Friday, October 15, 2021 11:00 AM
To: DHHS HYRTC YS Supervisors
Subject: FW: COVID update for Supervisors

Corinne Jensen | *Administrative Assistant I*
BEHAVIORAL HEALTH
Nebraska Department of Health and Human Services
OFFICE: 402-460-3127 | FAX: 402-460-3144
DHHS.ne.gov | Facebook | Twitter | LinkedIn

From: MyHR, DHHS <DHHS.MyHR@nebraska.gov>
Sent: Thursday, August 26, 2021 11:33 AM
Subject: COVID update for Supervisors

Department of Health and Human Services

COVID Update For Supervisors

NEBRASK
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Correction - If cleaning supplies are needed, contact the DHHS Procurement Team at dhhs.procurement@nebraska.gov

As the number of COVID cases is growing among our communities and with our teammates, we want to remind you of steps to be taken should you have an employee test positive.

- Notify your Human Resources Business Partner (HRBP) and your Division Leadership immediately!
- After confirmation of a positive case, you will work with your HRBP to send a letter/email out to all employees who work in the same physical area as the positive case. Because this is personal health information you are NOT to mention or discuss who the employee is who tested positive.
- Fully vaccinated employees who are exposed to COVID-19 do not need to stay home if they are not showing symptoms or if you have had COVID-19 in the last 3 months. However, fully vaccinated employees should get tested 3-5 days after exposure and it is recommended that they wear a mask indoors for 14 days following exposure or until you receive a negative test result.
- Employees who are not fully vaccinated and exposed, should quarantine for 10 days if they do not get tested; or 7 days after receiving a negative test result (which must occur on day 5 or later) and not experiencing symptoms.

- Cleaning of the work space will need to be done by on-site staff within 24 hours; we will not be contracting to have offices cleaned by outside vendors. Contact Procurement (DHHS.Procurement@nebraska.gov) if you need cleaning supplies.
- While most of our locations do not require wearing masks, we continue to encourage employees to wear them. Please follow your location requirements regarding masks.
- This week the Lincoln-Lancaster County Health Department (LLCHD) issued a local public health directive mandating face coverings. This memo is to provide clarification that the LLCHD public health directive does not apply to State government operations, our customers seeking services, or our teammates carrying out their duties.

Please contact your HR Business Partner if you have further questions.

My HR

Nebraska Department of Health and Human Services
OFFICE: 402-471-9439 | FAX: 402-742-2384
DHHS.ne.gov | Facebook | Twitter | LinkedIn

DHHS 24 HOUR FACILITY EMPLOYEE/VISITOR SCREENING

Staff/Visitor information

Name: _____

Supervisor Name: _____

Your Temperature Today: _____ Today's Date: _____

Staff/Visitor Signature_____

1. Do you have a fever of 100.4°F or above? ☐ Yes ☐ No

2. Have you had close contact with someone that has COVID-19? ☐ Yes ☐ No

   If Yes (date) _____.

3. **Do you have any of the following symptoms? Mark all that apply:**
   (If you check 2 or more of these symptoms, please notify YSS to call a nurse for further instruction)

   ☐ Fever (measured or subjective)
   ☐ Chills
   ☐ Shaking chills
   ☐ Muscle aches
   ☐ Headache
   ☐ Sore throat
   ☐ Nausea or vomiting
   ☐ Diarrhea
   ☐ Fatigue
   ☐ Congestion
   ☐ Runny nose

4. Do you have new symptoms? **If yes**, when did these new symptoms start?

   Date: _____
   (If you have checked 1 or more of these symptom, please notify YSS to call a nurse for further instruction)

   ☐ **New** Cough
   ☐ **New** Shortness of Breath
   ☐ **New** Difficulty Breathing
   ☐ **New** Loss of Taste and or Smell

If you answered yes to any of the above questions or have marked any of the check boxes according to instructions given, you must give this form to your supervisor BEFORE YOU START YOUR SHIFT.

Reviewed by: _____ Date: _____

Retain for 45 days
Updated 11/09/2020
Created in collaboration with Dr. Donahue

Family Member Letter

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 2, 2021

Dear Family Members,

The Youth Rehabilitation and Treatment Center in Hastings (YRTC-H) understands the importance of our youth being able to have visitation with their family members. The facility is working towards resuming visitation between the youth in our program and their families. We are being cautious as we take this first step in re-opening visitation, therefore we will be implementing very slow steps as we return to visitation on campus.

Starting on June 5, 2021:

YRTC-H will allow only immediate family to visit at this time.

To ensure the safety of our youth, family members, and staff, YRTC-H has implemented the following visitation protocols.

EXPECTATIONS:

- Visitors will be limited to 2 immediate family members per youth.
- No children under age 16 will be allowed to visit.
- All visits will take place on the campus of YRTC-H, in the visitation area (Administration Building).
- No off-campus visits are allowed at this time.
- If you leave campus for any reason we will not be able to allow you back onto campus.
- All visitors and youth will be required to wear a mask for the duration of the visit. If you do not have a mask, there will be masks available at our facility.
- As an extra precaution to keeping everyone safe, items for the youth will not be allowed to be brought into the facility.

PROCESS FOR VISITATION:

- Visitation Hours.
    - Weekday visitation will be Saturday and Sunday between the hours of 0900 and 1600. Only one family will be allowed to visit at a time. Families must call the front office before 3:00pm each Friday to schedule a day and time. Please call 402-462-1971, Option 6.
    - ~~A continuation of virtual~~ visitation with family and other approved contacts ~~can continue~~ as requested by the family and youth. We want all parties to be comfortable during visitation.

SCREENING PROCESS:

- A screening will be completed for all scheduled visitors.
- After providing a photo ID, each visitor will be required to answer screening questions and have a temperature taken and recorded. We will not be able to allow visitors into the facility if there are concerns about the responses to the screening questions or a temperature over 100.4 degrees.
- Hand sanitizer will be provided in the small foyer prior to entering the building for your use.

As a program, we are very hopeful that this gradual relaxation of restrictions will be successful and as a result we will be able to relax other restrictions as we all do our part follow the current visitation guidelines.

Please remember the health and safety of your family members and our staff is important to us. If you or anyone who is planning to visit the facility does not feel well or is running a temperature, please stay home. We will work with you to schedule another visit at a more appropriate time.

Should there be an increase in exposure and positive testing, we may have to re-evaluate our visitation practices. This could include the cease of visitations without advanced notice should the current situation change and warrant such action.

Thank you for assisting us in maintaining a safe environment for the youth in our care.

Sincerely,

Camella Jacobe, Facility Administrator

Pandemic Plan

Hastings Regional Center (HRC)

SUBJECT: COVID-19 PANDEMIC PLAN

Effective Date: February 28, 2020 Page No. 1 of 8
Revision Date: February 25, 2020
Infection Prevention & Control Committee Review: February 28, 2020

STANDARD: Center for Disease Control (CDC), American Practitioners of Infection Control (APIC)

POLICY: The Hastings Regional Center will ensure a sustainable healthcare response to Pandemic COVID-19 in accordance with the Hastings Regional Center Policy IC-01.

PURPOSE: To provide early detection and containment of Pandemic COVID-19 while maintaining the overall operation of HRC and meet basic needs of the facility.

RESPONSIBILITY: All staff

EQUIPMENT: Personal Protective Equipment (PPE), N-95 filter masks, Surgical Masks, Clean Isolation Gown, Eye Protection, Emergency Operations Manual, Infection Control Manual, Contingency Staffing Plan

PROCEDURE:

I. INITIAL IMPLEMENTATION

A. HRC will work with State, Adams County Health Department and other local Health Departments.
B. Contingency Staffing Plan for Managing Widespread Outbreaks / Disaster, as detailed in the Emergency Operations Manual, will go into effect.
C. Designated HRC leadership will meet daily and as needed to address essential needs and emergent situations as they arise.
D. Identification of Essential Personnel will be reassessed daily by designated HRC leadership and are as follows:
    1. All employees will be considered essential for anti-viral therapy when available and these staff will be identified daily, based on availability, potential for exposure, and the need to meet minimal departmental staffing requirements, as per contingency staffing plan. This includes allowing for rotation of specific departmental staff in order to meet the essential services of the facility and care of the Patients.
    2. Ancillary staff will be rotated to areas of need.
    3. Once a vaccine is available, staff designated to receive the vaccine will be identified at time of availability of vaccine based on employees who have had the Pandemic COVID-19 and available staff.

II. CONTAINMENT

A. Signs and Symptoms associated with an infectious agent. Severity ranges from little to no symptoms to being severely ill and dying:
    1. Fever
    2. Cough
    3. Shortness of breath
    4. Sore Throat
    5. Fatigue

B. If above signs and symptoms are identified, they have recently traveled to China, Iran, South Korea, Italy, or Japan, Hong Kong, or had close contact (within 6 feet) with a person who is under investigation/has laboratory confirmed COVID-19 place Patient in Airborne/Droplet precaution IMMEDIATELY until Lab Test can confirm a diagnosis. And follow directions within the Infection Control Manual related to Airborne/Droplet precautions.
   1. Signs will be placed at each entrance notifying visitors, to each building, that if they have symptoms of respiratory illness they will need to reschedule their visit until a time they are not symptomatic
   2. Staff returning to work from being ill will complete an employee assessment form and be assessed by a Nurse before being allowed back on the unit.
   3. Staff returning from vacation time where they have traveled outside of the country will consult with Infection Control Manager.
      a. Staff may be asked to wear a mask while working for up to 14 days
      b. Staff may be asked to visit their doctor and obtain a return to work note
      c. Staff may be asked to return home for up to 14 days for safety

C. If Signs and Symptoms indicate an infectious agent in our patient population:
   1. Notify Infection Control Nurse
   2. Isolate patient pending lab results
   3. Confirmed positive test results require quarantine
   4. Call Dr. Rodgers for consult and for transfer orders if possible

D. Appropriate lab procedures will be used to perform diagnostic testing.
   1. Testing is available through the Nebraska Public Health Lab (NPLH)
   2. NPLH will send test to CDC who will confirm the positive test results
   3. Results will be obtained within in 24 hours.

E. Director of Behavioral Health, Medical Director, Director of Nursing, Facilities Administrator, Administration staff, Infection Control Nurse, Safety Coordinator, and Risk Management will be involved in decision to cohort all ill Patients together away from non-ill Patients, if needed. During outbreaks, confine Patients with Confirmed Illness to the quarantine area for their building. Patients with suspected Covid-19 should be placed in the isolation area of their building until lab test confirms a diagnosis (Approximately 24 hours). This may be expanded to all Patients being served meals in their rooms and closing down communal areas to dining and other gatherings. Due to medical limitations of HRC, Patients needing immediate rehydration or emergency medical attention may need to be transported to a Medical Hospital for treatment. If transfer of a patient is required, record and communicate the transfer to HRC Health Information Management staff for tracking purposes.

   a. Building 3 will isolate patients on Unit 81.

As Units become smaller due to patient movement, areas can be added in the wings of patient areas.

A patient's bed can be moved from their room to the quarantine area if needed. As unit census reduces due to patient movement quarantine areas can be added.

HRC currently has 24 new mattresses that can be used in added isolation or quarantine areas where beds are not already available.

F. **Personal Protective Equipment (PPE)**

1. **Caring for Patients with pandemic infections**
   Healthcare personnel should be particularly vigilant to AVOID:
   a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
   b. Contaminating environmental surfaces that are not directly related to Patient care (e.g., door knobs, light switches).
   c. Encourage patients in isolation and quarantine to wear a surgical mask since no AIIR's, single rooms at negative pressure relative to the surrounding areas and with a minimum of 6 air changes per hour, are available on campus.

2. **Masks (N-95 if available or surgical/procedure): 1 box of surgical masks in stock. Procurement is currently trying to order additional masks.**
   - If N-95 is back ordered or out of stock HRC will consult with the SEMRS coalition to obtain emergency supplies through the SNS. If N-95 is not available surgical masks will then be utilized.
   a. Wear a mask when entering a patient room. A mask should be worn once and then discarded. If pandemic COVID-19 patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask and eye protection for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
   b. Change masks when they become moist.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.

3. **Gloves: Current stock, XL- 0 boxes, L- 34 boxes, M- 20 boxes, S- 0 boxes**
   a. A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.

b. Gloves should fit comfortably on the wearer's hands.
c. Remove and dispose of gloves after use on a Patient; do not wash gloves for subsequent reuse.
d. Perform hand hygiene after glove removal.
e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive Patient or environmental contact with blood or body fluids.
f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. **Gowns: Currently have 100 ordered.**
   a. Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most Patient interactions do not necessitate the use of gowns. A disposable gown made of synthetic fiber or a washable cloth gown may be used.
   c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.
   d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
   e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings could be used. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

5. **Goggles or Face Shield: Currently have 100 face shields on order.**
   a. In general, wearing goggles or a face shield for routine contact with patients with pandemic COVID-19 is necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet precaution.

6. **PPE for Special Circumstances**
   a. **PPE for aerosol - generating procedures**
   During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., nebulizer treatment), healthcare personnel should wear gloves, gown, face/eye protection, and an N-95 respirator if fit tested by the Infection Control Manager.

G. **Hand Hygiene**

1. Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based or non-alcohol based products (gels, rinses, foams) containing an emollient that do not require the use of water.
2. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
3. In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based or non-alcohol based products for hand disinfection are preferred.
4. Always perform hand hygiene between contacts and after removing PPE.
5. Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based or non-alcohol based products) are readily accessible in areas in which care is provided.

H. **Disposal of Solid Waste**

1. Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus:
2. Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste. Directions for disposing of medical waste found in Infection Control Manual.
3. Discard as routine waste used supplies that are not likely to be contaminated (e.g., paper wrappers).
4. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

I. **Linen and Laundry**

1. Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from Patients with pandemic COVID-19:
2. Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area. Please follow-direction per HRC Infection Control Manual.
3. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
4. Wear gloves for transporting bagged linen and laundry.
5. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
6. Wash and dry linen according to routine standards and procedures.

J. **Dishes and Eating Utensils**

Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic COVID-19:

1. Wash reusable dishes and utensils in a dishwasher with recommended water temperature per HRC policy.
2. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of Patients) should be discarded with other general waste per Emergency Disaster Manual.
3. Wear gloves when handling trays, dishes, and utensils.

K. **Patient-care equipment**

Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

1. Wear gloves when handling and transporting used patient-care equipment.
2. Wipe heavily soiled equipment with an HRC approved surface disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection of reusable care equipment.
3. Wipe external surfaces of portable equipment for performing x-rays and other procedures in the area with an HRC approved surface disinfectant upon removal from the Patient's room.

L. **Environmental cleaning and disinfection**

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Multiguard and Sani Cloths will be used for disinfection.

HRC currently has 38 tubs (160 count each) of Sanicloths. Procurement has ordered more in preparation.

M. **Cleaning and disinfection of Patient-occupied rooms**

1. Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are necessary for routine cleaning of an infection positive room when patient is present.
2. Keep areas around the Patient room free of unnecessary supplies and equipment to facilitate daily cleaning.
3. Use any HRC approved hospital detergent-disinfectant
4. Follow facility procedures for regular cleaning of Patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.

5. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions and per HRC Small and Large Spill Cleanup Policy found in the Infection Control Manual.

N. **Cleaning and disinfection after Patient discharge or transfer**
1. Follow standard facility cleaning policy for post-discharge cleaning of a room.
2. Clean and disinfect all surfaces that were in contact with the Patient or might have become contaminated during care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
3. Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.
4. Disinfectants utilized will be Multiguard Spray and Sani-Cloth wipes.

O. **Postmortem care**
1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.
2. The Health Department will provide body bags for deceased Patients who will then be placed in the Grounds building to await transport.

P. **Laboratory specimens and practices**
1. Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

III. OUTBREAK NOTIFICATION

A. All doors will remain locked. Only employees with access cards will be allowed to enter. Vendors or suppliers will be instructed to drop off all supplies at the Dock.

B. Infection Control Manager will direct all means of media notification in connection with Public Information Officer if public announcements are needed.
1. Visual alerts will be at entrances advising visitors that visitation is restricted.
2. Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:
   a. cover the nose/mouth when coughing or sneezing.
   b. use tissues to contain respiratory secretions.
   c. dispose of tissues in the nearest waste receptacle after use.
   d. perform hand hygiene after contact with respiratory secretions.

C. Facility Group activities and new admissions will be cancelled until the outbreak is over. Individual activities and Unit activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the Patients.

D. Clinical Director and Director of Nursing will decide what departments and activities continue during the duration of the outbreak.

E. Department Heads/Supervisors will contact the Infection Control Coordinator for any clarification of memos/orders/notifications/questions.

F. Infection Control Coordinator in collaboration with the Physician will contact the State Health and Human Services division of Infectious Disease and the Adams Health Department.

G. Remain vigilant for another outbreak of pandemic COVID-19.

IV. MONITORING OF HEALTH CARE PERSONNEL

A. Employees who report to work may be asked to come to be screened for signs and symptoms of the COVID-19 before reporting for duty and/or to be given antiviral therapy if necessary and available. Especially with staff working in isolation and quarantine areas.

B. Screening of all employees will be done by Nursing Administration, RN Supervisor, Infection Control Manager, and/or HCP. All symptomatic staff will be sent home for self-isolation and asked to contact health care provider before returning.

C. Any healthcare staff who have recovered from the pandemic COVID-19 will be prioritized for care of Patients with active pandemic COVID-19 and its complications.

D. Staff at high risk for complications of pandemic COVID-19 (i.e. pregnant, immuno-compromised, and older in age) should be informed about this medical risk and offered an alternative work assignment away from COVID-19 Patient care or considered for administrative leave.

E. Staff age will be assessed when staffing quarantine and isolation areas due to increased age increasing risk of Acute Respiratory Distress Syndrome.

1. Staff under the age of 39 with no compromising issues will be staffed in quarantine and isolation areas first if possible.

V. TREATMENT

A. No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated.

Please note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

INFECTION CONTROL MEETING
March 24, 2020 Revised

Present: Carrie Kort, Coordinator; Marj Colburn, Lisa Stramel, Vickie Lemburg, Pat Adrian, Grant Johnson, Terry Blum, Sandra Warford and Corinne Jensen as recorder.

Carrie requested this meeting to prepare and make sure we are all on the same page and determine what additional measures we need to add to our plan.

Supplies on Hand

We currently have the bare necessities on hand and if we want or need, Terry and Sandra can contact their Supervisor. A supply of items are in Lincoln and they will issue it out as needed.

- 5 each N95 masks;
- 20 each dust style masks;
- 100 disposable gloves;
- 10 short sleeve gowns;
- 7 pair reusable safety glasses;
- 3 each eye shields;
- 30 boxes of each size of gloves;
- 12 each of HDQ 2 liter bottles+;
- 29 tubs of sanitary wipes; We will need more ordered.
- Plenty of hand soap;
- Plenty of non-alcohol hand sanitizer++;
- 4 bottles of alcohol based hand sanitizer;
- Plenty of Kleenex;

+HDQ Disinfectant: Looking at the spray bottles of disinfectant in the breakrooms, it appears staff are not using it on a regular basis. Staff need to be reminded of this. Housekeeping will be checking all the HDQ spray bottles and will refill them each Wednesday. HDQ is not available to order, but our supply should last a long time.

++Non-alcohol hand sanitizer will be used by the youth since it is used in all of the youth facilities.

Medications

Crosier Park Pharmacy is not taking anything back. Drive-thru services only. Bubble packs will be used and staff will receive training on them Wednesday, 3/25/20. Ibuprofen will be stock even though acetaminophen is recommended. The ibuprofen bottle will have a label but no individual youth's name.

Cleaning

We need to be vigilant with hand washing, cleaning hard surfaces, door knobs, handrails, light switches, elevator buttons, table tops and phones. It is crucial to share information with staff face to face to ensure they get all the information that is being communicated by email. Carrie will provide education at the weekly Staff Meetings. We can't make them adhere to the guidelines, but we can make them aware. We are following the guidelines for everybody.

Staff are being told to role model the use of hand sanitizer and to clean up after themselves in the breakrooms.

Entry to the building will be limited to the following doors:

- Southeast and Southwest entrances;
- West Human Resources door – deliveries only;

Doors to be locked:

- Front entrance;
- Ambulance entry;
- Housekeeping wing;
- Human Resources

- ➢ Grant will run a report to identify staff who are not following the door rules. Grant will distribute an email regarding the doors to all staff.
- ➢ Lisa will email Ted to install a hand sanitizer dispenser outside the South cafeteria for staff to use when entering the building.
- ➢ Terry and Sandra will get additional small spray bottles.

Offices:

- Staff will be asked to spray down their surfaces and empty their trash. This will allow the Housekeepers to focus on other areas.
- The Med Room will be cleaned by staff, but housekeepers are asked to clean the floor and sinks once a week.

- ➢ Lisa will ask the Housekeepers where the office trash should be dumped.
- ➢ Terry and Sandra will order large trash cans on wheels.

PVC:

- Grant will have Bryce and Heather to clean real well including the keyboards.

Weight Room:

- Staff and youth do a good job of spraying this down after use.

School:

- The School may possible be shut down and provided remotely. There will be no teachers.
- The keyboards, desks and chairs will need to be wiped down.

- ➢ Marj will ask Craig if they could consolidate rooms.
- ➢ Privacy rooms will not be used if there is no school.

Units:

- ➢ Lisa will find out what the cleaning procedure is for the unit on a daily basis.
- ➢ Night shift will be asked to continue cleaning the keyboards, counters and phones in the dayhalls and nurses station area.
- ➢ Staff will be asked to use HDQ spray to do detail cleaning.
- ➢ Dirty linen receptacles will be purchased or found for outside the units. Large biohazard plastic bags will be used inside the linen bag so CSI Laundry knows that the bags contains linen from isolation and special precaution needs to be taken.

Positive Case of COVID-19:

- In the event we have a youth who tests positive, we will set up one unit for quarantine. If the youth becomes critical, we will transfer youth to the hospital.
- We will avoid using staff at risk to supervise quarantined youth.

- ➢ A log book will be maintained on each unit for taking the youth's temperature daily and answering the health screening questions.
- ➢ The temperature will be taken when they first wake up in the morning.

Positive Case of COVID-19

- A note will be placed on the binder that reads: Youth recording a temperature over 100.4 and if they answer yes to questions, they should remain on the unit until seen by a nurse.
- Large red bio-hazard bags will be ordered by Terry and Sandra.

Staff:

- We need to emphasize with staff to stay home if they are sick.
- Carrie has noticed that the majority of the staff's temperatures over the weekend were 97.2. We may need to consider using the ear type thermometer instead of the scanning type.
- There are lots of other health illnesses floating around now and can be confused with the symptoms of COVID-19. Stay home if you are sick!

Return to Work Criteria:

- Afebrile for 72 hours after testing positive for COVID-19 and a doctor's note;
- No fever for 24 hours if diagnosed with Influenza A
- Monday through Friday, the doctor's note should be submitted to Cheri with leave request. On the weekends, the note and leave request should be given to the Supervisor on duty.

Vehicles:

- Vehicles used by staff need to be wiped down with HDQ after traveling.

- Terry and Sandra will purchase six sack type bags with handles to hold the HDQ and rag;
- The bags will be stored at the Switchboard along with a pile of rags and a small trash cans lined with plastic bag for the dirty rag;

Cafeteria:

- Lisa will check the supply of plastic to-go containers and let Terry and Sandra know if more are needed.

If you determine you need additional items, contact Terry and Sandra. A special fund has been established for the costs of medical supplies for protection and treatment during the COVID-19 preparedness for the safety of the staff and youth.

HASTINGS REGIONAL CENTER
Hastings, Nebraska

Coronavirus Protocol

4/11/20

UNIT: _____

DATE	Symptoms			No Isolation Youth remains on unit
	( ) **Temperature 100.4 or above**			( ) Encourage youth to stay away from other youth as much as possible
	( ) **A new cough that started within the past 7 days**			( ) Encourage youth to practice good hand hygiene
	( ) **Shortness of breath or a new sore throat that started within the past 7 days**			( ) Monitor vitals as directed by nurse
	Interventions- Initial/Ongoing			**Isolation** *Youth is transferred to 81 or 82 West *
	( ) Notify the Nurse for direction			( ) Move youth to Isolation Unit
	( ) Coughing-offer the youth a mask to wear			( ) Staff wear PPE (gloves, gown, N95 face mask and eye wear) when on unit ( )Encourage youth to wear mask
	( ) Temperature-offer the youth PRN fever reducing medication			( ) Post signs on the door to indicate Isolation is inside and that PPE must be worn to enter the Isolation area
	( ) Shortness of breath-encourage the youth to sit up in a chair and lean forward while resting arms on a table ( ) Obtain O2 sat and report to nurse as directed			( ) Offer supportive interventions to the youth (PRN fever reducing/pain medication, rest, fluids and food as tolerated)
	( ) Document the vitals and symptoms in the youth's progress note-document interventions			( ) Encourage youth to practice good hand hygiene
	( ) Monitor vitals as directed by the Nurse			( ) Monitor Vitals as directed by Nurse (record on the youth's daily temperature log-include symptoms on this form
	( ) Offer fluids-Supervisor may get Gatorade from PVC			( ) PPE equipment must be thrown away after each use (with the exception of eye wear, it may be sanitized for re-use)
	( ) Encourage youth to rest in his room until further directive from Nurse			**Limit the number of staff entering the Isolation Unit**
	( ) Encourage youth to practice good hand hygiene			
	***Nursing Staff**-responsible for communicating with the Infection Control Coordinator, Physician, Youth's Family/Guardian and the Facility Administrator	***Infection Control Coordinator**-responsible for communicating with the Health Department		***Only the physician may stop the Isolation status***

Infection Control Coordinator: [signature] 4-12-20

Physician: [signature] 4-12-20

Corrigo Tracking

Attachment H4

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Youth Rehabilitation and Treatment Center – Hastings Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. Inspection and Audits.

1. Please provide a copy of the most recent inspections and/or audit reports as of today. To include, but not limited to applicable reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, permits, alarm system, sprinkler, etc.

    a. All inspection and audit information regarding the YRTC-Hastings has been attached in Section A of this packet.
    b. YRTC-Hastings did recently undergo a Fire Marshall Inspection, however have not yet received the final report.
    c. YRTC-Hastings also underwent a recent PREA audit as well and has not yet received the final report.

B. Construction Projects:

1. Please provide a list of the most recent major construction projects identified.

    a. Locks for dorm doors – 12/2020 thru 3/2021
    b. Fire sprinkler head change along with bulkhead – 1/2021 thru 2/2021
    c. Reinforcement of walls via wallpaper install – 11/2020 thru 4/2021
    d. Glazing Security Film Installation – 9/2020 thru 11/2020
    e. Glazing Polycarbonate Installation – 8/2021 thru 11/2021

2. Please provide a summary of completed major projects as of today.

    a. All projects identified in number one of section B have been completed for the reporting period.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

    a. Yes, YRTC-Hastings utilizes Corrigo, a virtual based work order system.

4. Please provide the number of work orders submitted since December 2020.

    a. 310 preventative work orders
    b. 330 work order requests

5. What kind of system do you use to track non-major repair projects?

    a. The electronic tracking system, Corrigo tracks all non-major repair projects for YRTC-Hastings.

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

2. Please provide a copy of your <u>most recent</u> COVID protocols.

    a. All of YRTC-Hastings' most recent COIVD-19 protocols can be located in Section C of this packet.

3. Please provide a copy of your <u>most recent</u> letter to family/guardians/visitors on COVID updates

    a. All of YRTC-Hastings' most recent letter to family/guardians/visitors regarding COVID-19 updates can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

    a. All staff and visitors to YRTC-Hastings continue to undergo COVID-19 screening and temperature checks when entering the facility
    b. COVID-19 tests are administered to all staff and youth upon request, and required for all new incoming youth to the facility. New intakes are placed into a quarantine status until negative test results are received.
    c. YRTC-Hastings is currently allowing in person visitation as well as the option for WebEx while continuing to follow COVID-19 social distancing requirements and recommendations.

5. Please provide a copy of your <u>most recent</u> COVID-19 planning meeting minutes.

    a. YRTC-Hastings does not conduct COVID-19 planning meetings, but rather follows the direction of DHHS Administration for the COVID-19 protocols that are determined by DHHS and the South Heartland District Health Department in Hastings, Nebraska.

Inspection Reports

Fire Alarm

Fire sprinkler

Attachment H5

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Site Address: Hastings Youth Treatment Facility - Admin Bldg
4200 W 2nd St
Hastings, NE 68901

INVOICE

Account Number	1001896
Invoice Number	348732
Invoice Date	4/30/2021
Terms	**Net 30 Days**
Amount Due	**$65.25**
Amount Enclosed:	**$**

Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

To ensure prompt credit, return this remittance and check payable to:

Midwest Alarm Services
PO Box 4511
Davenport, IA 52808

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Account Information

Customer Number	1001896
Invoice Number	348732
Invoice Date	4/30/2021
P.O.	addendum

Summary of Charges

Description	*Amount*
Fire Alarm Monitoring (31032103610)	
Hastings Youth Treatment Facility - Admin Bldg 4200 W 2nd St	
Fire Alarm 3/31/2021 - 5/31/2021	$60.99
Subtotal	**$60.99**
Sales Tax	**$4.26**
Current Charges:	**$65.25**
Credits:	**$0.00**
Payments - Thank You	**$0.00**
Total Amount Due:	**$65.25**

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Site Address: Hastings Youth Treatment Facility - Dorm North
4200 W 2nd St
Hastings, NE 68901

INVOICE

Account Number	1001896
Invoice Number	348734
Invoice Date	4/30/2021
Terms	**Net 30 Days**
Amount Due	**$70.62**
Amount Enclosed:	**$**

Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

To ensure prompt credit, return this remittance and check payable to:

Midwest Alarm Services
PO Box 4511
Davenport, IA 52808

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Account Information

Customer Number	1001896
Invoice Number	348734
Invoice Date	4/30/2021
P.O.	addendum

Summary of Charges

Description	*Amount*
Fire Alarm Monitoring (31032103612)	
Hastings Youth Treatment Facility - Dorm North 4200 W 2nd St	
Fire Alarm 3/26/2021 - 5/31/2021	$66.00
Subtotal	**$66.00**
Sales Tax	**$4.62**
Current Charges:	**$70.62**
Credits:	**$0.00**
Payments - Thank You	**$0.00**
Total Amount Due:	**$70.62**

WHO SHOULD WE BE CALLING?

STAY CURRENT. STAY SAFE.

To assure the quickest response to your emergency, we want to make sure that your call lists are always current.

To update your information, contact our Customer Care Team at

(800) 383-8781

customercare@mw-as.com

We look forward to hearing from you and thank you for your business.

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Site Address: Hastings Youth Treatment Facility - Dorm South
4200 W 2nd St
Hastings, NE 68901

INVOICE

Account Number	1001896
Invoice Number	348735
Invoice Date	4/30/2021
Terms	**Net 30 Days**
Amount Due	**$73.84**
Amount Enclosed:	**$**

Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

To ensure prompt credit, return this remittance and check payable to:

Midwest Alarm Services
PO Box 4511
Davenport, IA 52808

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Account Information

Customer Number	**1001896**
Invoice Number	**348735**
Invoice Date	**4/30/2021**
P.O.	**addendum**

Summary of Charges

Description	*Amount*
Fire Alarm Monitoring (31032103613)	
Hastings Youth Treatment Facility - Dorm South 4200 W 2nd St	
Fire Alarm 3/23/2021 - 5/31/2021	$69.00
Subtotal	**$69.00**
Sales Tax	**$4.84**
Current Charges:	**$73.84**
Credits:	**$0.00**
Payments - Thank You	**$0.00**
Total Amount Due:	**$73.84**

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Site Address: Hastings Youth Treatment Facility - Program Bldg
4200 W 2nd St
Hastings, NE 68901

INVOICE

Account Number	1001896
Invoice Number	348733
Invoice Date	4/30/2021
Terms	**Net 30 Days**
Amount Due	**$74.89**
Amount Enclosed:	**$**

Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

To ensure prompt credit, return this remittance and check payable to:

Midwest Alarm Services
PO Box 4511
Davenport, IA 52808

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Account Information

Customer Number	**1001896**
Invoice Number	**348733**
Invoice Date	**4/30/2021**
P.O.	**addendum**

Summary of Charges

Description	*Amount*
Fire Alarm Monitoring (31032103611)	
Hastings Youth Treatment Facility - Program Bldg 4200 W 2nd St	
Fire Alarm 3/22/2021 - 5/31/2021	$69.99
Subtotal	**$69.99**
Sales Tax	**$4.90**
Current Charges:	**$74.89**
Credits:	**$0.00**
Payments - Thank You	**$0.00**
Total Amount Due:	**$74.89**

WHO SHOULD WE BE CALLING?

STAY CURRENT. STAY SAFE.

To assure the quickest response to your emergency, we want to make sure that your call lists are always current.

To update your information, contact our Customer Care Team at

(800) 383-8781

customercare@mw-as.com

We look forward to hearing from you and thank you for your business.

Midwest Alarm Services Basic Agreement

Midwest Alarm Services

Grand Island 3630 W Old Hwy 30, Grand Island, NE 68803 (308)389.3981 midwestalarmservices.com

CUSTOMER Billing Name:	Contact Name:
State of Nebraska	Ted Buck
CUSTOMER Billing Address:	**Phone Number:**
4200 W. 2nd	402-469-8189
CUSTOMER Billing City, State, Zip:	**Email Address:**
Hastings, NE 68901	ted.buck@nebraska.gov

EQUIPMENT AND/OR SERVICES PROVIDED

This Agreement relates to the following Equipment to be MIDWEST Owned or CUSTOMER Owned:

Burglary	Not Provided
Fire	CUSTOMER Owned
Access	Not Provided
Elevator	Not Provided
CCTV	Not Provided
Radio	Not Provided
Area of Refuge	Not Provided
Videofied	Not Provided
Medical	Not Provided
Other	Not Provided

This Agreement relates to the following Services to be provided (P) or not provided (NP):

Monitoring	P	Total Connect	NP
Area of Refuge	NP	Supervisory	P
Activity Reports	NP	Carbon Monoxide	NP
CCTV Service Agreement	NP	Fire Alarm Inspection	NP
Access Control Service Agreement	NP	Extinguisher Inspection	NP
Burglar Alarm Service Agreement	NP	Sensitivity Inspection	NP
Fire Alarm Service Agreement	NP	Range Hood Inspection	NP
Nurse Call Service Agreement	NP	Automatic Sprinkler Inspection	NP
Alarm Response Officer	NP	Drop Door/Fire Curtain Inspection	NP
Central Station Online	P	Cellular Futureproof	NP
Detector Cleaning	NP	Other	NP

SPECIAL INSTRUCTIONS:
New Monitoring accounts - 120.00 per Month ($30.00 per Building) annual cost $1440.00

This Agreement made this 15 day of March, 2021 between MIDWEST ALARM SERVICES INC., referred to as "MIDWEST", and State of Nebraska - Hastings Youth Treatment, referred to as "CUSTOMER," provides as follows:

1. MIDWEST agrees to furnish and install the above defined Equipment and/or Services at the premises of CUSTOMER at
—See Addendum—
Equipment and/or Services are also referred to herein individually or collectively as "System."

2. For the consideration mentioned, CUSTOMER shall pay $ N/A, payable N/A upon acceptance of this Agreement, and the balance payable upon completion of the installation/purchase of the System. MIDWEST reserves the right to progressively bill based on a percentage of completion method computation for any installations that take longer than ninety (90) days. In addition, CUSTOMER shall also be subject to the terms in paragraph 6, if applicable.

3. CUSTOMER agrees to pay $ 120.00 Monthly for the provided Services, payable in advance during the term of this Agreement.

4. Except as otherwise herein provided, the term of this Agreement shall be 12 Months from the date Service is operative under this Agreement ("initial term"). After the initial term, this Agreement shall automatically renew for successive one-month terms, unless terminated by either party with thirty (30) days written notice. MIDWEST may terminate this Agreement for any reason upon ten (10) days' notice to CUSTOMER.

5. The CUSTOMER hereby agrees that MIDWEST shall have the right to modify the charges at any time or times after the expiration of twelve (12) months from the date of Agreement. If the CUSTOMER is unwilling to pay any such modified charges and notifies MIDWEST in writing within thirty (30) days after the effective date of such modified charges, MIDWEST may, at its sole option, terminate this Agreement as if the term had expired or, in the alternative, will continue the prior charges and will allow this Agreement to remain in full force and effect without further notice. Failure to notify MIDWEST in writing within thirty (30) days after the effective date of the modified charges will constitute CUSTOMER's acceptance of such modified charges.
6. CUSTOMER shall be responsible for and pay to MIDWEST any sales, excise, use, value added or other taxes which may be imposed upon MIDWEST or the CUSTOMER because of the existence of this Agreement and/or the carrying out of any of the provisions hereof. In addition, CUSTOMER shall pay any village or municipal permit or license fees, as well as any false alarm assessments, imposed by any governmental body.
7. When this Agreement refers to Inspection/Testing, listed Equipment will be inspected/tested/cleaned during normal business hours only (8am – 5pm Monday - Friday) unless specifically stated otherwise under Services provided area.
8. When this Agreement includes a Service package for normal wear and tear, (including all parts, with associated labor, except batteries), Services will be performed without charge. An additional charge shall be made for any Services necessitated by causes other than normal wear and tear in accordance with the standard charges of MIDWEST.
9. When this Agreement includes cellular communicator futureproof protection, MIDWEST will replace the cellular communicator as technology changes at no costs to CUSTOMER.
10. CUSTOMER authorizes MIDWEST to perform installation during regular work hours with CUSTOMER furnishing any necessary electric power at CUSTOMER'S cost. The charges referenced in paragraph 2 above are based on MIDWEST performing installation with its own personnel or contractors of its choosing. If, for any reason, installation must be performed by other contractors, charges shall be revised accordingly. If any inspection bureau, any other agency having jurisdiction, or the CUSTOMER shall require or make necessary any changes in the System installation, such changes must be requested in writing by CUSTOMER and shall be paid for by CUSTOMER. MIDWEST is authorized to make any preparation appropriate for installation of the System, including but not limited to, drilling holes or making attachments.
11. When this Agreement includes the use of a "digital communicator" for transmitting signals to a monitoring center, the CUSTOMER understands that a digital communicator uses standard telephone lines for sending signals, and further that the monitoring center will not receive signals when the transmission mode is cut, interfered with, or becomes otherwise damaged or non-operational. All charges made by any company for installation, line charges, telephone calls and service charges for telephone lines and/or accessories to transmit signals between CUSTOMER'S premises and any monitoring facility shall be paid by CUSTOMER. MIDWEST shall not be obligated to perform monitoring Services hereunder during any time when telephone lines or telephone equipment are not properly operating. Voice over Internet Protocol (VoIP) technology will affect the connection via the telephone line at CUSTOMER's premises to the monitoring center. If CUSTOMER chooses VoIP technology, CUSTOMER must notify MIDWEST of this choice to assure connectivity to the monitoring center. This may require an upgrade of the System that is not covered under any MIDWEST Service Agreement. MIDWEST recommends an alternate method of communication such as radio backup be added to the System.
12. If CUSTOMER fails to pay any amount under this Agreement by the date which such amount is due, then MIDWEST shall be entitled to retain all prepayments received and CUSTOMER shall immediately pay to MIDWEST (a) all payments then due and payable, (b) all charges of labor, material and equipment incurred by MIDWEST due to such failure to pay based on a time and material basis at MIDWEST'S then prevailing charges, and (c) ninety percent (90%) of all payments which would be due hereunder for the unexpired term as liquidated damages and not as a penalty. MIDWEST shall have no further obligation to perform under this Agreement if CUSTOMER fails to pay any amount under this Agreement by the date which such amount is due, it being understood and agreed that: 1) the parties intended to agree in advance to the settlement of damages that might arise from the breach; 2) the amount of liquidated damages is reasonable at the time of contracting, bearing some relation to the damages which might sustained; and 3) actual damages would be uncertain in amount and difficult to prove. In addition, if any suit or alternative dispute resolution proceeding is instituted and MIDWEST is the substantially prevailing party by judgment, award, finding or settlement, CUSTOMER shall pay directly or reimburse MIDWEST for all of MIDWEST's costs and expenses including, without limitation, consultants' and professionals' fees and costs including, without limitation, reasonable attorneys' fees and costs. Upon nonpayment of any sums due MIDWEST under this Agreement, MIDWEST reserves the right to remove or abandon all or any part of the System, wiring and apparatus from CUSTOMER'S premises upon written notice to CUSTOMER. In the event MIDWEST exercises its right of removal under this paragraph, it shall not be liable for any damages resulting from the removal. In all Systems, MIDWEST

retains ownership of the communications chip and accordingly may remove said chip when Service is terminated. For panels not containing chips, MIDWEST reserves the right to reprogram the panel not to call MIDWEST'S monitoring center if Service is terminated.

13. MIDWEST hereby warrants to CUSTOMER that the System is installed in a good and workmanlike manner. In the event that any part of the System, except for batteries, shall become defective within one (1) year from the date of the original installation, or for a term equal to that provided by the original Equipment manufacturer, whichever is less, MIDWEST shall replace or repair the defective part without charge. This warranty is not assignable. Neither MIDWEST nor its directors, officers, shareholders, partners or employees (collectively "representatives") make any express warranties as to any matter whatsoever including, without limitation, the condition of the Equipment, its merchantability, or its fitness for any particular purpose; all other warranties are specifically excluded. This warranty does not cover any damage to the System and/or Equipment caused by accident, vandalism, fire, water, lightning, act of God, repair service, modification or improper installation by anyone other than MIDWEST, or any other cause other than normal wear and tear. MIDWEST shall not be liable for any general, direct, special, exemplary, punitive, statutory, multiple, incidental or consequential damages. CUSTOMER acknowledges: that any affirmation of fact or promise made by MIDWEST shall not be deemed to create an express warranty; that MIDWEST does not make any representation or warranty, including any implied warranty of merchantability or fitness that the System may not be comprised, circumvented, or that the System will in all cases provide the signaling, monitoring and response for which it was intended; that there are no express warranties which extend beyond those contained in this Agreement, and that all implied warranties, if any, coincide with the duration of this warranty.

14. CUSTOMER understands and agrees as follows: (i) MIDWEST, its representatives, successors, assigns, suppliers and/or the manufacturers of the products used by MIDWEST (collectively "MIDWEST/SUPPLIERS") are not insurers; (ii) it is the specific intent of CUSTOMER and MIDWEST/SUPPLIERS that insurance covering all loss, damage and expense arising out of or from, in connection with, related to, as a consequence of or resulting from this Agreement, shall be obtained and continuously maintained by the CUSTOMER; (iii) it is the specific intent of CUSTOMER and MIDWEST/SUPPLIERS that recovery for all such loss, damage and expense shall be limited to any such insurance coverage only; (iv) it is the specific intent of CUSTOMER and MIDWEST/SUPPLIERS that MIDWEST/SUPPLIERS are released from any and all liability for all such loss, damage and expense; (v) MIDWEST/SUPPLIERS, EXCEPT AS SET FORTH HEREIN, MAKE NO GUARANTEE, REPRESENTATION OR WARRANTY INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE; (vi) MIDWEST/SUPPLIERS are released from all loss, damage or expense which may occur prior to, contemporaneously with, or subsequent to the execution of this Agreement due to the improper operation or non-operation of the System (including, without limitation, the communications Equipment or Service necessary to transmit to or receive any data at the monitoring center) or the response time of third party emergency personnel; and (vii) should there arise any liability on the part of MIDWEST/SUPPLIERS for economic losses, personal injury, including death, or property damage (real or personal) which is in connection with, arises out of or from, results from, is related to or is a consequence of the active or passive sole, joint or several negligence of any kind or degree of MIDWEST/SUPPLIERS, including, without limitation, acts, errors or omissions which occur prior to, contemporaneously with or subsequent to the execution of this Agreement, or breach of this Agreement, or any claim brought in product or strict liability, subrogation, contribution or indemnification, whether in contract, tort or equity, including, without limitation, any general, direct, special, incidental, exemplary, punitive, statutory or consequential damages, irrespective of cause, such liability shall be limited to the maximum sum of three hundred fifty dollars ($350.00) collectively for MIDWEST/SUPPLIERS, and this liability shall be exclusive.

15. CUSTOMER agrees to indemnify, defend and hold harmless MIDWEST/SUPPLIERS, from any loss, cost or expense, including attorneys' fees and court costs, on account of any claim for economic losses, personal injury, including death, or property damage (real or personal) by any person not a party to this Agreement arising out of or in connection with the operation or nonoperation of the System whether these claims be based upon alleged intentional conduct, negligence, or product liability on the part of MIDWEST/SUPPLIERS. The obligation to indemnify under this Agreement shall survive the termination of this Agreement.

16. CUSTOMER hereby releases MIDWEST/SUPPLIERS for all losses, damages and expenses (i) covered by CUSTOMER'S insurance policies, (ii) policy deductibles, co-pay percentage, or retained limits, (iii) in excess of amounts paid by CUSTOMER'S insurance, and (iv) due to under-insurance. As an inducement to MIDWEST to enter into this Agreement, CUSTOMER represents, warrants and covenants that CUSTOMER'S insurance companies shall not have (a) any rights created by a loan agreement, loan receipt, or other like document or procedure, or (b) any right to subrogation against MIDWEST/SUPPLIERS.

17. This Agreement is made under and will be construed and enforced in accordance with the laws of the State of Iowa without giving effect to any other state's choice of law rules. Each party hereby irrevocably agrees that any suit, action or other legal proceeding ("Suit") arising out of or from, in connection with or as a result of this Agreement shall be brought exclusively in the State Courts or the Courts of the United States located in Davenport, Iowa. Each party hereby waives any right to trial by jury in any Suit brought by either party. All claims, actions, or proceedings, legal or equitable, against MIDWEST/SUPPLIERS must be commenced within one (1) year after the cause of action has accrued, without judicial extension of time, or said claim, action, or proceeding is barred. In any suit, arbitration, or action commenced by MIDWEST against CUSTOMER, CUSTOMER shall not be permitted to interpose any counterclaim. CUSTOMER waives the right to bring any class action against MIDWEST/SUPPLIERS.
18. MIDWEST's invoices are payable by the CUSTOMER to MIDWEST upon presentation to the CUSTOMER, without deduction or offset of any kind or nature whatsoever. CUSTOMER agrees to pay MIDWEST interest at one and one-half percent per month, or such maximum amount as permitted by law, whichever is less, on any invoice not paid within thirty (30) days of invoice date.
19. This instrument contains the entire Agreement between CUSTOMER and MIDWEST with respect to the transactions described herein and supersedes all previous and contemporaneous negotiations, commitments, contracts, express or implied, warranties, express or implied, statements and representations, whether written or oral, pertaining thereto, all of which shall be deemed merged into this Agreement.
20. This Agreement is not assignable by CUSTOMER except upon the written consent of MIDWEST, which shall be in MIDWEST'S sole and absolute discretion. This Agreement or any portion thereof is assignable by MIDWEST in its sole and absolute discretion.
21. Should any provision hereof (or portion thereof), or its application to any circumstances, be held illegal, invalid or unenforceable to any extent, the validity and enforceability of the remainder of the provision and this instrument, or of such provisions as applied to any other circumstances, shall not be affected thereby, and shall continue in full force and effect as valid, binding and subsisting. All changes or amendments to this Agreement must be in writing and signed by all parties to be binding on the parties.
22. Additional charges shall apply if an alarm response officer discovers an authorized individual present who did not call to cancel the alarm properly.
23. Any electronic manipulation of this Agreement without written consent of MIDWEST voids this Agreement.
24. Calls with MIDWEST representatives may be recorded for quality assurance.

CUSTOMER ACCEPTANCE

In signing this Agreement, CUSTOMER agrees to the terms and conditions contained herein and specifically acknowledges and accepts the disclaimer/limitation of liability and indemnity paragraphs hereof and the other terms and conditions which are an integral part of this Agreement.

READ ALL PAGES OF THIS AGREEMENT BEFORE SIGNING

Signed: Steve Fahrenz (SIGNATURE) Regional Manager (TITLE) 3-15-21 (DATE)

By Stacy Helma, MIDWEST Agent
Digitally signed by: Hope Newton
Date: 2021.03.19 06:49:15 -05'00'

Approved _____, Authorized Representative of MIDWEST

System installed and operative this 31st day of March, 20 21.

Midwest Alarm Services

www.midwestalarmservices.com

O BASIC AI

ADDENDUM TO BASIC AGREEMENT DATED 12/10/2020

Site Name	Site Address	Monitoring	Device Monitoring	[illegible]							
Admin Building	4200 W. 2nd Hastings, NE 68901	$360.00									$360.00
Program Building	4200 W. 2nd Hastings, NE 68901	$360.00									$360.00
Dorm - North	4200 W. 2nd Hastings, NE 68901	$360.00									$360.00
Dorm - South	4200 W. 2nd Hastings, NE 68901	$360.00									$360.00
											$0.00
											$0.00
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											$0.00
								Annual	Cost	Total	$1,440.00

Customer Signature [signature] *Date* 3-15-21

Authorized Representative of MIDWEST Digitally signed by: Hope Newton Date: 2021.03.19 06:49:27 -05'00' *Date* 3/19/21

NEBRASKA STATE FIRE MARSHAL

DATE: 11-2-21

FIRE ALARM TEST REPORT

ACCEPTANCE ☐
RE-ACCEPTANCE ☐
PERIODIC 1 ☐ 2 ☐

ELECTRONIC SYSTEMS, INC

P.O BOX 1260 HASTINGS, NEBRASKA 68902-1260
TELEPHONE (402) 463-0200

CUSTOMER: Hastings Regional Center		
ADDRESS:		
PREMISES PROTECTED: Building 5 Admin		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	MODEL#: FC-901	STANDBYE POWER TYPE: GEL
MANUFACTURER: SIEMENS	SERIAL#:	TROUBLE BATTERY TYPE: SLA

SYSTEM REMOTELY MONITORED BY: Mutual Alarm	DATE 100% SMOKE CALIBRATION
TIME OF INSPECTION:	NEXT SCHEDULED
TIME INSPECTION COMPLETED	DATE 100% HEAT DETECTION TESTED
SMOKE DETECTION CALIBRATION TEST METHOD USED	NEXT SCHEDULED

SYSTEM COMPONENTS	TOTAL	TESTED
MANUAL STATIONS	1	1
HEAT DETECTORS		
FIXED TEMP.NON RESTORABLE LINE		
FIXED TEMP.NON RESTORABLE SPOT		
FIXED TEMP.RATE OF RISE/RESTORE		
RESTORABLE LINE TYPE		
SMOKE DETECTORS		
FUNCTIONAL	1	1
CALIBRATED		
DUCT DETECTORS	1	1
WATERFLOW DEVICES (TIME TO ACTIVATE)	3	3
SUPERVISORY SWITCHES	12	12
AUDIBLE DEVICES	18	18
VISUAL DEVICES		
ANNUNCIATORS		
CONTROL UNIT		
LAMPS AND LED'S		
FUSES		
PRIMARY POWER SUPPLY		
SECONDARY POWER SUPPLY		
MAGNETIC HOLD-OPEN DEVICES		
FAN RELAYS		
VOICE ALARM AND 2-WAY PHONE		
TROUBLE SIGNALS		
ALARM CIRCUIT	2	2
ZONE INITIATING CIRCUIT	1	1
SUPERVISORY SIGNALS	3	3
GROUND FAULT	√	√
ELEVATOR CONTROLS		
POWERED FIRE AND SMOKE DAMPERS		

DISCONNECT A.C. POWER AND CHECK SYSTEM ON EMERGENCY POWER
DID TROUBLE SIGNAL OPERATE? (YES) NO DATE: 11-2-21
DID ALARM SIGNAL OPERATE? (YES) NO DATE: 11-2-21

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD
EMERGENCY POWER BATTERY TYPE SLA TEST VOLTS 26.8
MAIN OPERATING POWER TYPE 0.5 TEST VOLTS 120VAC

WHAT CODE IS SYSTEM INSTALLED UNDER? NFPA 72
IS SYSTEM OPERATING TO CODE? Yes
COMMENTS: (NOTE ANY DEFICIANCIES)

LIST CURRENT REPAIRS TO SYSTEM AND DATE OF REPAIRS

INSPECTOR: Cody Wagner	LICENSE#: H32
Cad Nickel	EXPIRATION DATE: 3-23
SUBSCRIBER:	

REPORT SHALL BE REPORTED TO SFM FOLLOWING EACH INSPECTION TEST
246 SO. 14TH STREET LINCOLN, NE 68508-1804 (402) 471-2027
MAIN OFFICE:_____ DISTRICT A:_____ DISTRICT B:_____ DISTRICT C:_____

STATE FIRE MARSHAL

PO Box 85535
Lincoln, NE 68501

Invoice

Date	Invoice #
10/7/2021	IN 21260

Bill To

Hastings Youth Treatment Center
4200 W. 2nd Street
Hastings, NE 68901

P.O. No.	Terms	Project
	net 10 days	

Description	Qty	Rate	Amount
Performed Annual Fire Sprinkler Inspection at the Program Building and 2 Residential Buildings	1	350.00	350.00

Fire Sprinkler Inspections are considered a security service by the State of Nebraska and therefore taxable. If you are tax exempt, please send a Form 13 in with your payment.
Thank you, we appreciate your business.

Subtotal	$350.00
Sales Tax (0.0%)	$0.00
Total	$350.00
Payments/Credits	$0.00
Balance Due	$350.00

We now accept credit card payments with a 3% fee.

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment Center 4200 W. 2nd St. Hastings, NE	10-5-21 INSPECTION DATE Educational TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☒	DRY PIPE VALVE TEST	☒	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
48361	5	
48362	1	
48363	2	
48364	7	
48365	7	
		Owner to verify all heads in rooms are not painted, damaged or obstructed in any ways

STATUS OF SYSTEM – CHECK ONE

☑ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION: Meininger Fire Protection, Inc	INSPECTOR SIGNATURE
ADDRESS: 2521 West "L" Street, Suite 5	
CITY: Lincoln STATE: NE	NE LICENSE #: 05046
ZIP CODE: 68522	TESTER BFP LICENSE #: 7932
PHONE: 402-466-2616	OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP
Inspection Contract# 4200
Name of Inspected Property: Hastings Youth Treatment Center
Inspector Name: NN
Date: 10-5-21
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.2.0	Supply pressure gauge	60			psi
A.2.1	System pressure gauge	65			psi
A.2.2	Gauges appear to be in good condition	✓			
A.3.0	Control valves in normal open or closed position	✓			
A.3.1	Control valves properly locked or supervised	✓			
A.3.2	Control valves accessible	✓			
A.3.3	Control valves provided with appropriate wrenches	✓	✓		
A.3.4	Control valves free from external leaks	✓			
A.3.5	Control valve identification signs in place	✓			
A.3.6	System control valve sign indicates area served	✓			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓		
A.5.1	Alarm valve free of physical damage		✓		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓		
A.6.0	ALARM PANEL CLEAR	✓			
A.7.0	COMMENTS:				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center 4200

Inspector Name: Date:

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	✓		
B.3.10	FDC obstructions removed as necessary	✓		
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	ALARM PANEL CLEAR	✓		

B.6.0 COMMENTS:

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓			
C.2.1	Test conducted with inspector's test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Adequate drainage provided before flow testing	✓			
C.3.1	A main drain test conducted downstream from backflow preventer	✓			
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓		
C.3.3	Supply water gauge reading before flow (static)	65			psi
C.3.4	Gauge reading during stable flow (residual)	45			psi
C.3.5	Time for supply pressure to return to normal	—			sec
C.4.0	Pertinent parties notified of test conclusion	✓			
C.5.0	ALARM PANEL CLEAR	✓			
C.6.0	SYSTEM RETURNED TO SERVICE	✓			

C.7.0 COMMENTS:

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	✓			
D.1.1	Pertinent parties notified before testing	✓			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓			
D.2.1	Signal restored only when valve returned to normal position	✓			
D.3.0	Adequate drainage provided before flow testing	✓			
D.3.1	Main drain test conducted	✓			
D.3.2	Supply water gauge reading before flow (static)	65			psi
D.3.3	Gauge reading during stable flow (residual)	45			psi
D.3.4	Time for supply pressure to return to normal	—			sec
D.4.0	Pertinent parties notified of test conclusion	✓			
D.5.0	ALARM PANEL CLEAR	✓			
D.6.0	SYSTEM RETURNED TO SERVICE	✓			

D.7.0 COMMENTS:

INSPECTOR'S INITIAL NP (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center 4200

Inspector Name: NN Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓			
F.1.1	Pertinent parties notified before testing	✓			
F.1.2	Adequate drainage provided before flow testing	✓			
F.2.0	Main drain test conducted	✓			
F.2.1	Supply water gauge reading before flow (static)	65			psi
F.2.2	Gauge reading during stable flow (residual)	45			psi
F.2.3	Time for supply pressure to return to normal	—			sec
F.3.0	Antifreeze solution tested and freezing point determined			—	
F.3.1	Antifreeze solution freezing point	—			°F
F.3.2	Antifreeze solution freezing point after adjustment	—			°F
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓			
F.4.1	PIVs opened until spring or torsion felt in rod	—			
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	—			
F.4.3	Main drain test conducted (see F.2.0)	✓			
F.5.0	Backflow prevention assembly forward flow test conducted	—			
F.5.1	System demand flow was achieved through the device	—			
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓			
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓		
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓		
F.5.5	Forward flow test satisfied by annual fire pump flow test		✓		
F.5.6	Backflow preventer performance test conducted as required by the AHJ	✓			
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓		
F.7.0	Pertinent parties notified of test conclusion	✓			
F.8.0	**ALARM PANEL CLEAR**	✓			
F.9.0	**SYSTEM RETURNED TO SERVICE**	✓			
F.10.0	**COMMENTS:**				

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓			
G.2.0	Pertinent parties notified before conducting maintenance	✓			
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓			
G.3.1	Valve completely closed and reopened	✓			
G.4.0	Adequate drainage provided before flow testing	✓			
G.4.1	Main drain test conducted	✓			
G.4.2	Supply water gauge reading before flow (static)	65			psi
G.4.3	Gauge reading during stable flow (residual)	45			psi
G.4.4	Time for supply pressure to return to normal	—			sec
G.5.0	Pertinent parties notified after conclusion of maintenance	✓			
G.6.0	**ALARM PANEL CLEAR**	✓			
G.7.0	**SYSTEM RETURNED TO SERVICE**	✓			
G.8.0	**COMMENTS:**				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP
Inspection Contract# 4200
Name of Inspected Property: Hastings Youth Treatment Center
Inspector Name:
Date:
Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.1.1	Supply (water) gauge pressure	50			psi
A.1.2	System (air) gauge pressure	23			psi
A.1.3	Quick opening device gauge pressure	—			psi
A.1.4	Gauge near compressor	110			psi
A.1.5	Gauge pressures are normal	✓			
A.2.0	Control valves in normal open or closed position	✓			
A.2.1	Control valves properly locked or supervised	✓			
A.2.2	Control valves accessible	✓			
A.2.3	Control valves provided with appropriate wrenches	✓			
A.2.4	Control valves free from external leaks	✓			
A.2.5	Control valve identification signs in place	✓			
A.2.6	System control valve sign indicates area served	✓			
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.4.0	Dry pipe valve free of physical damage	✓			
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓			
A.4.2	Dry pipe valve intermediate chamber not leaking	✓			
A.5.0	ALARM PANEL CLEAR	✓			
A.6.0	COMMENTS:				

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	✓		
B.3.10	FDC obstructions removed as necessary	✓		
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	ALARM PANEL CLEAR	✓		
B.6.0	COMMENTS:			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm tested and is operational	✓			
C.2.1	Test conducted with inspectors test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position *(semi-annual)*	✓			
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	✓			
C.4.0	One main drain test conducted downstream from backflow preventer	✓			
C.4.1	One main drain test conducted downstream from pressure reducing valve		✓		
C.4.2	Supply water gauge reading before flow (static)	65			psi
C.4.3	Gauge reading during stable flow (residual)	45			psi
C.4.4	Time for supply pressure to return to normal	—			sec
C.5.0	Priming water level tested		✓		
C.6.0	Quick opening device(s) (QOD) tested		✓		
C.7.0	Low pressure alarm tested	✓			
C.8.0	Pertinent parties notified of test conclusion	✓			
C.9.0	ALARM PANEL CLEAR	✓			
C.10.0	SYSTEM RETURNED TO SERVICE	✓			
C.11.0	COMMENTS:				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center 4201

Inspector Name: Date:

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)	✓		
	PRIOR TO FREEZING WEATHER:	✓		
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	ALARM PANEL CLEAR	✓		

D.8.0 COMMENTS:

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.5.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static)	65 psi		
E.5.2	Gauge reading during stable flow (residual)	45 psi		
E.5.3	Time for supply pressure to return to normal	— sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		✓	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓		
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	ALARM PANEL CLEAR	✓		
E.11.0	SYSTEM RETURNED TO SERVICE	✓		

E.12.0 COMMENTS:

Partial TRIP TEST

Trip Test Table

Dry Valve Make	Size	Model	Serial No.	Year	Q.O.D. Make	Model	Serial No.	Year
Victaulic	4"	705N						

Dry Pipe Operating Test	Time to Trip Thru Test Pipe Min	Time to Trip Thru Test Pipe Sec	Water Pressure PSI	Air Pressure PSI	Time Water Trip Point Air Pressure PSI	Reached Test Outlet Min	Reached Test Outlet Sec	Alarm Operated Yes	Alarm Operated No
Without Q.O.D		10	50	23	7		1	✓	
With Q.O.D									

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hasting Youth Treatment Center 4200

Inspector Name: Date:

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer	✓		
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV		✓	
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	✓		
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	65 psi		
F.5.2	Gauge reading during stable flow (residual)	45 psi		
F.5.3	Time for supply pressure to return to normal	— sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓	
F.6.5	Forward flow test satisfied by annual fire pump flow test		✓	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		✓	
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	ALARM PANEL CLEAR	✓		
F.11.0	SYSTEM RETURNED TO SERVICE	✓		
F.12.0	COMMENTS			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks	✓		
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure	psi		
G.6.3	System side static pressure	psi		
G.6.4	Supply side residual pressure	psi		
G.6.5	System side residual pressure	psi		
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted (see AFSA Form 114A)			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	ALARM PANEL CLEAR			
G.11.0	SYSTEM RETURNED TO SERVICE			
G.12.0	COMMENTS:			

INSPECTOR'S INITIAL NAJ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION

Backflow Maintenance Form

Business/Building Hastings Youth Treatment Center

Service Address 4200 W. 2nd St.

Contact Person Chris Jacobe Phone Number 402-759-1140

☒ Annual Test ☒ DC	☐ RPP	4"	Colt	DC200	TC-1012
		Size	Manufacturer	Model No.	Serial #
☐ New Installation ☐ DC	☐ Replacement ☐ RPP				
		Size	Manufacturer	Model No.	Serial #

☐ Domestic Containment ☐ Irrigation ☒ Fire Service ☐ Boiler ☐ Carbonator ☐ Other (Desc.)

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker

Device Location Riser Room N/side of bldg.

Check Valve #1	Check Valve #2	Pressure Relief Valve	PVB/SVB
INITIAL TEST			
Held at 2.8 PSID	Held at 2.2 PSID	Opened at PSID	Air Inlet
Leaked ☐ Yes ☒ No	Closed Tight ☒ Yes ☐ No	Did not open	Opened at PSID
Cleaned	Leaked ☐ Yes ☒ No	Cleaned	Did not open
Replaced	Cleaned	Replaced	Check Valve
	#2 Shut Off Closed Tight ☒ Yes ☐ No		Held at PSID
			Leaked
			Cleaned
			Replaced
FINAL TEST			
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

I hereby certify the above backflow preventer has been tested in accordances with all rules and regulations of the State of Nebraska Health and Human Services, Department of Regulation and Licensure, Title 179, and the Lincoln Water System Title 17, and that all readings are true and accurate to the best of my ability.

Questions Call 402-466-2616
MEININGER FIRE PROTECTION
2521 West L Street, Suite 5
Lincoln, NE 68522

Nicole Nabity	MFP	7932	402 853-1578	
State Certified Technician (please print)	Company	Grade 6 Certificate No.	Cell/Phone No.	
[signature]	[signature]		10-5-21	
State Certified Technician (signature)	Customer Signature		Date of Test	
APOLLO	11050196		12/17/20	
Test Gauge Manufacturer	Test Gauge Serial No.		Date of Calibration	

Comments

Please Type or Print Legibly
White Copy (Water Department) Yellow Copy (MFP) Pink Copy (Business)

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment Center 1200 W. 2nd St. Hastings, NE Bldg B-North	10-5-21 INSPECTION DATE Residential TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☒	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
H8368	1	
H8369	2	
		Owner to verify all heads in rooms are not painted, damaged or obstructed in any way.

STATUS OF SYSTEM – CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION: Meininger Fire Protection, Inc	INSPECTOR SIGNATURE
ADDRESS: 2521 West "L" Street, Suite 5	
CITY: Lincoln STATE: NE	NE LICENSE #: 05046
ZIP CODE: 68522	TESTER BFP LICENSE #: 7932
PHONE: 402-466-2616	
	OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center Bldg B-North
Inspector Name: Date:
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.2.0	Supply pressure gauge	—			psi
A.2.1	System pressure gauge	50			psi
A.2.2	Gauges appear to be in good condition	✓			
A.3.0	Control valves in normal open or closed position	✓			
A.3.1	Control valves properly locked or supervised	✓			
A.3.2	Control valves accessible	✓			
A.3.3	Control valves provided with appropriate wrenches	✓			
A.3.4	Control valves free from external leaks	✓			
A.3.5	Control valve identification signs in place	✓			
A.3.6	System control valve sign indicates area served	✓			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position		✓		
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓		
A.5.1	Alarm valve free of physical damage		✓		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓		
A.6.0	ALARM PANEL CLEAR	✓			
A.7.0	COMMENTS:				

INSPECTOR'S INITIAL NW (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL ____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center Bldg B-North

Inspector Name: NM Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓			
C.2.1	Test conducted with inspector's test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Adequate drainage provided before flow testing	✓			
C.3.1	A main drain test conducted downstream from backflow preventer	✓			
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓		
C.3.3	Supply water gauge reading before flow (static)	65			psi
C.3.4	Gauge reading during stable flow (residual)	40			psi
C.3.5	Time for supply pressure to return to normal	—			sec
C.4.0	Pertinent parties notified of test conclusion	✓			
C.5.0	**ALARM PANEL CLEAR**	✓			
C.6.0	**SYSTEM RETURNED TO SERVICE**	✓			
C.7.0	**COMMENTS:**				

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	✓			
D.1.1	Pertinent parties notified before testing	✓			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓			
D.2.1	Signal restored only when valve returned to normal position	✓			
D.3.0	Adequate drainage provided before flow testing	✓			
D.3.1	Main drain test conducted	✓			
D.3.2	Supply water gauge reading before flow (static)	65			psi
D.3.3	Gauge reading during stable flow (residual)	40			psi
D.3.4	Time for supply pressure to return to normal	—			sec
D.4.0	Pertinent parties notified of test conclusion	✓			
D.5.0	**ALARM PANEL CLEAR**	✓			
D.6.0	**SYSTEM RETURNED TO SERVICE**	✓			
D.7.0	**COMMENTS:**				

INSPECTOR'S INITIAL NM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center Bldg B-North

Inspector Name: NN Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓			
F.1.1	Pertinent parties notified before testing	✓			
F.1.2	Adequate drainage provided before flow testing	✓			
F.2.0	Main drain test conducted	✓			
F.2.1	Supply water gauge reading before flow (static)	65			psi
F.2.2	Gauge reading during stable flow (residual)	40			psi
F.2.3	Time for supply pressure to return to normal	✓			sec
F.3.0	Antifreeze solution tested and freezing point determined		✓		
F.3.1	Antifreeze solution freezing point	✓			°F
F.3.2	Antifreeze solution freezing point after adjustment	✓			°F
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓			
F.4.1	PIVs opened until spring or torsion felt in rod	✓			
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓			
F.4.3	Main drain test conducted (see F.2.0)	✓			
F.5.0	Backflow prevention assembly forward flow test conducted	✓			
F.5.1	System demand flow was achieved through the device	✓			
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓			
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)			✓	
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)			✓	
F.5.5	Forward flow test satisfied by annual fire pump flow test			✓	
F.5.6	Backflow preventer performance test conducted as required by the AHJ	✓			
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve			✓	
F.7.0	Pertinent parties notified of test conclusion	✓			
F.8.0	**ALARM PANEL CLEAR**	✓			
F.9.0	**SYSTEM RETURNED TO SERVICE**	✓			
F.10.0	**COMMENTS:**				

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓			
G.2.0	Pertinent parties notified before conducting maintenance	✓			
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓			
G.3.1	Valve completely closed and reopened	✓			
G.4.0	Adequate drainage provided before flow testing	✓			
G.4.1	Main drain test conducted	✓			
G.4.2	Supply water gauge reading before flow (static)	65			psi
G.4.3	Gauge reading during stable flow (residual)	40			psi
G.4.4	Time for supply pressure to return to normal	✓			sec
G.5.0	Pertinent parties notified after conclusion of maintenance	✓			
G.6.0	**ALARM PANEL CLEAR**	✓			
G.7.0	**SYSTEM RETURNED TO SERVICE**	✓			
G.8.0	**COMMENTS:**				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL: DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center Bldg B-North
Inspector Name: NN Date: 10-5-21
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.1.1	Supply (water) gauge pressure				50 psi
A.1.2	System (air) gauge pressure				22 psi
A.1.3	Quick opening device gauge pressure				— psi
A.1.4	Gauge near compressor				120 psi
A.1.5	Gauge pressures are normal	✓			
A.2.0	Control valves in normal open or closed position	✓			
A.2.1	Control valves properly locked or supervised	✓			
A.2.2	Control valves accessible	✓			
A.2.3	Control valves provided with appropriate wrenches	✓			
A.2.4	Control valves free from external leaks	✓			
A.2.5	Control valve identification signs in place	✓			
A.2.6	System control valve sign indicates area served	✓			
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.4.0	Dry pipe valve free of physical damage	✓			
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓			
A.4.2	Dry pipe valve intermediate chamber not leaking	✓			
A.5.0	ALARM PANEL CLEAR	✓			
A.6.0	COMMENTS:				

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	n/a	✓	
B.3.10	FDC obstructions removed as necessary	n/a	✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	ALARM PANEL CLEAR	✓		
B.6.0	COMMENTS:			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm tested and is operational	✓			
C.2.1	Test conducted with inspectors test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position *(semi-annual)*	✓			
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	✓			
C.4.0	One main drain test conducted downstream from backflow preventer	✓			
C.4.1	One main drain test conducted downstream from pressure reducing valve	✓			
C.4.2	Supply water gauge reading before flow (static)				65 psi
C.4.3	Gauge reading during stable flow (residual)				40 psi
C.4.4	Time for supply pressure to return to normal				— sec
C.5.0	Priming water level tested	-	✓		
C.6.0	Quick opening device(s) (QOD) tested		✓		
C.7.0	Low pressure alarm tested	✓			
C.8.0	Pertinent parties notified of test conclusion	✓			
C.9.0	ALARM PANEL CLEAR	✓			
C.10.0	SYSTEM RETURNED TO SERVICE	✓			
C.11.0	COMMENTS:				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center Bldg B-North

Inspector Name: MM Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)	✓	—	
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	**ALARM PANEL CLEAR**			

D.8.0 **COMMENTS:**

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.6.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static)	65 psi		
E.5.2	Gauge reading during stable flow (residual)	40 psi		
E.5.3	Time for supply pressure to return to normal	— sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		—	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓		
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	**ALARM PANEL CLEAR**	✓		
E.11.0	**SYSTEM RETURNED TO SERVICE**	✓		

E.12.0 **COMMENTS:**

Partial Trip Test

Trip Test Table

	Dry Valve Make	Size	Year	Model	Serial No.	Q.O.D. Make	Model	Year Serial No.
	Viking	2½		768K				

Dry Pipe Operating Test	Time to Trip Thru Test Pipe Min	Sec	Water Pressure PSI	Air Pressure PSI	Time Water Trip Point Air Pressure PSI	Reached Test Outlet Min	Sec	Alarm Operated Yes	No
Without Q.O.D		112	50	22	7		1	X	
With Q.O.D									

INSPECTOR'S INITIAL MM (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
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Report of Inspection, Testing & Maintenance of Dry Pipe Sprinkler Systems...*continued*

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center Bldg B - North

Inspector Name: NN Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer	✓		
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV		✓	
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	✓		
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	65 psi		
F.5.2	Gauge reading during stable flow (residual)	40 psi		
F.5.3	Time for supply pressure to return to normal	— sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓	
F.6.5	Forward flow test satisfied by annual fire pump flow test	N/A	✓	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		✓	
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	ALARM PANEL CLEAR	✓		
F.11.0	SYSTEM RETURNED TO SERVICE	✓		
F.12.0	COMMENTS			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks			
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure psi			
G.6.3	System side static pressure psi			
G.6.4	Supply side residual pressure psi			
G.6.5	System side residual pressure psi			
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted (see AFSA Form 114A)			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	ALARM PANEL CLEAR			
G.11.0	SYSTEM RETURNED TO SERVICE			
G.12.0	COMMENTS:			

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-9-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

NEBRASKA STATE FIRE MARSHALL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Youth Treatment Center 1200 W. 2nd St. Hastings, NE South Bldg.	10-5-21 INSPECTION DATE Residential TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☒	REPORT OF INSPECTION	☒	PERIODIC ANNUAL INSPECTION
☒	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1 – WET RISER
2 – DRY RISER
3 – PREACTION RISER
5 – BACKFLOW PREVENTER
6 – STANDPIPE
7 – OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECITON AND ANY OTHER PERTINENT COMENTS ON SYSTEM

TAG #	ITEM #	MAJOR DEFICIENCIES / COMMENTS
48366	1	
48367	2	
		Owner to verify all heads in Rooms are not painted, damaged or obstructed in any way.

STATUS OF SYSTEM – CHECK ONE

☑ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION: Meininger Fire Protection, Inc	INSPECTOR SIGNATURE
ADDRESS: 2521 West "L" Street, Suite 5	
CITY: Lincoln STATE: NE	NE LICENSE #: 05046
ZIP CODE: 68522	TESTER BFP LICENSE #: 7932
PHONE: 402-466-2616	
	OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL – 246 SOUTH 14TH ST – LINCOLN, NE 68508-1804

A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

MEININGER FIRE PROTECTION INC.

White: AHJ Yellow: MFP Pink: Business

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP — Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center South Bldg.
Inspector Name: WW — Date: 10-5-21
Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Monthly Inspection for Wet Pipe Sprinkler System

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.2.0	Supply pressure gauge	—			psi
A.2.1	System pressure gauge	55			psi
A.2.2	Gauges appear to be in good condition	✓			
A.3.0	Control valves in normal open or closed position	✓			
A.3.1	Control valves properly locked or supervised	✓			
A.3.2	Control valves accessible	✓			
A.3.3	Control valves provided with appropriate wrenches	✓			
A.3.4	Control valves free from external leaks	✓			
A.3.5	Control valve identification signs in place	✓			
A.3.6	System control valve sign indicates area served	✓			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.5.0	Alarm valve gauges indicate normal supply water pressure		✓		
A.5.1	Alarm valve free of physical damage		✓		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		✓		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		✓		
A.6.0	ALARM PANEL CLEAR	✓			
A.7.0	COMMENTS:				

INSPECTOR'S INITIAL WW (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center South Bldg.

Inspector Name: JW Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	✓		
B.3.10	FDC obstructions removed as necessary	✓		
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	ALARM PANEL CLEAR	✓		

B.6.0 COMMENTS:

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓			
C.2.1	Test conducted with inspector's test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Adequate drainage provided before flow testing	✓			
C.3.1	A main drain test conducted downstream from backflow preventer	✓			
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓		
C.3.3	Supply water gauge reading before flow (static)	55			psi
C.3.4	Gauge reading during stable flow (residual)	40			psi
C.3.5	Time for supply pressure to return to normal	—			sec
C.4.0	Pertinent parties notified of test conclusion	✓			
C.5.0	ALARM PANEL CLEAR	✓			
C.6.0	SYSTEM RETURNED TO SERVICE	✓			

C.7.0 COMMENTS:

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	✓			
D.1.1	Pertinent parties notified before testing	✓			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓			
D.2.1	Signal restored only when valve returned to normal position	✓			
D.3.0	Adequate drainage provided before flow testing	✓			
D.3.1	Main drain test conducted	✓			
D.3.2	Supply water gauge reading before flow (static)	55			psi
D.3.3	Gauge reading during stable flow (residual)	40			psi
D.3.4	Time for supply pressure to return to normal	—			sec
D.4.0	Pertinent parties notified of test conclusion	✓			
D.5.0	ALARM PANEL CLEAR	✓			
D.6.0	SYSTEM RETURNED TO SERVICE	✓			

D.7.0 COMMENTS:

INSPECTOR'S INITIAL JW (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center South Bldg. Date: 10-5-21

Inspector Name: NN

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Annual Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service on inspection	✓		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
E.3.0	Piping appears free of mechanical damage	✓		
E.3.1	Piping appears free of leakage	✓		
E.3.2	Piping appears free of corrosion	✓		
E.3.3	Piping appears properly aligned	✓		
E.3.4	Piping appears free of external loading	✓		
E.4.0	Sprinklers appear free of leakage	✓		
E.4.1	Sprinklers appear free of corrosion	✓		
E.4.2	Sprinklers appear free of foreign materials	✓		
E.4.3	Sprinklers appear free of paint	✓		
E.4.4	Sprinklers appear free of physical damage	✓		
E.4.5	Sprinklers appear properly oriented	✓		
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
E.4.7	Glass bulbs appear full of liquid	✓		
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating	✓		
E.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
E.4.10	Wrench available for each type of sprinkler	✓		
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions	✓		
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
E.6.0	**ALARM PANEL CLEAR**	✓		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	✓			
F.1.1	Pertinent parties notified before testing	✓			
F.1.2	Adequate drainage provided before flow testing	✓			
F.2.0	Main drain test conducted	✓			
F.2.1	Supply water gauge reading before flow (static)	55			psi
F.2.2	Gauge reading during stable flow (residual)	40			psi
F.2.3	Time for supply pressure to return to normal	~			sec
F.3.0	Antifreeze solution tested and freezing point determined		✓		
F.3.1	Antifreeze solution freezing point	—			°F
F.3.2	Antifreeze solution freezing point after adjustment	—			°F
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position	✓			
F.4.1	PIVs opened until spring or torsion felt in rod	✓			
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓			
F.4.3	Main drain test conducted (see F.2.0)	✓			
F.5.0	Backflow prevention assembly forward flow test conducted	✓			
F.5.1	System demand flow was achieved through the device	✓			
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓			
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓		
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓		
F.5.5	Forward flow test satisfied by annual fire pump flow test		✓		
F.5.6	Backflow preventer performance test conducted as required by the AHJ	✓			
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓		
F.7.0	Pertinent parties notified of test conclusion	✓			
F.8.0	**ALARM PANEL CLEAR**	✓			
F.9.0	**SYSTEM RETURNED TO SERVICE**	✓			
F.10.0	**COMMENTS:**				

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	✓			
G.2.0	Pertinent parties notified before conducting maintenance	✓			
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated	✓			
G.3.1	Valve completely closed and reopened	✓			
G.4.0	Adequate drainage provided before flow testing	✓			
G.4.1	Main drain test conducted	✓			
G.4.2	Supply water gauge reading before flow (static)	55			psi
G.4.3	Gauge reading during stable flow (residual)	40			psi
G.4.4	Time for supply pressure to return to normal	~			sec
G.5.0	Pertinent parties notified after conclusion of maintenance	✓			
G.6.0	**ALARM PANEL CLEAR**	✓			
G.7.0	**SYSTEM RETURNED TO SERVICE**	✓			
G.8.0	**COMMENTS:**				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

AFSA American Fire Sprinkler Association

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

Inspecting Firm: MFP Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center South Bldg.
Inspector Name: NN Date: 10-5-21
Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Monthly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N	
A.1.0	System in service on inspection	✓			
A.1.1	Supply (water) gauge pressure	50			psi
A.1.2	System (air) gauge pressure	20			psi
A.1.3	Quick opening device gauge pressure	—			psi
A.1.4	Gauge near compressor	120			psi
A.1.5	Gauge pressures are normal	✓			
A.2.0	Control valves in normal open or closed position	✓			
A.2.1	Control valves properly locked or supervised	✓			
A.2.2	Control valves accessible	✓			
A.2.3	Control valves provided with appropriate wrenches	✓			
A.2.4	Control valves free from external leaks	✓			
A.2.5	Control valve identification signs in place	✓			
A.2.6	System control valve sign indicates area served	✓			
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	✓			
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		✓		
A.4.0	Dry pipe valve free of physical damage	✓			
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	✓			
A.4.2	Dry pipe valve intermediate chamber not leaking	✓			
A.5.0	**ALARM PANEL CLEAR**	✓			
A.6.0	**COMMENTS:**				

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing	✓	✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm tested and is operational	✓			
C.2.1	Test conducted with inspectors test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position *(semi-annual)*	✓			
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	✓			
C.4.0	One main drain test conducted downstream from backflow preventer	✓			
C.4.1	One main drain test conducted downstream from pressure reducing valve		✓		
C.4.2	Supply water gauge reading before flow (static)	55			psi
C.4.3	Gauge reading during stable flow (residual)	40			psi
C.4.4	Time for supply pressure to return to normal	—			sec
C.5.0	Priming water level tested		✓		
C.6.0	Quick opening device(s) (QOD) tested		✓		
C.7.0	Low pressure alarm tested	✓			
C.8.0	Pertinent parties notified of test conclusion	✓			
C.9.0	**ALARM PANEL CLEAR**	✓			
C.10.0	**SYSTEM RETURNED TO SERVICE**	✓			
C.11.0	**COMMENTS:**				

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP Inspection Contract#

Name of Inspected Property: Hastings Youth Treatment Center South Bldg.

Inspector Name: NN Date: 10-5-21

Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Inspection for Dry Pipe Sprinkler Systems

		Y	N/A	N
D.1.0	System in service on inspection	✓		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	✓		
D.3.0	Piping appears free of mechanical damage	✓		
D.3.1	Piping appears free of leakage	✓		
D.3.2	Piping appears free of corrosion	✓		
D.3.3	Piping appears properly aligned	✓		
D.3.4	Piping appears free of external loading	✓		
D.4.0	Sprinklers appear free of leakage	✓		
D.4.1	Sprinklers appear free of corrosion	✓		
D.4.2	Sprinklers appear free of foreign materials	✓		
D.4.3	Sprinklers appear free of paint	✓		
D.4.4	Sprinklers appear free of physical damage	✓		
D.4.5	Sprinklers appear properly oriented	✓		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	✓		
D.4.7	Glass bulbs appear full of liquid	✓		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	✓		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	✓		
D.4.10	Wrench available for each type of sprinkler	✓		
D.5.0	Dry pipe valve in good condition internally (check at trip test)	✓		
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	✓		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	✓		
D.7.0	ALARM PANEL CLEAR	✓		

D.8.0 COMMENTS:

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	✓		
E.2.0	Pertinent parties notified before conducting maintenance	✓		
E.3.0	Adequate drainage provided before flow testing or draining	✓		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated	✓		
E.4.1	Valve completely closed and reopened	✓		
E.5.0	Main drain test conducted	✓		
E.5.1	Supply water gauge reading before flow (static)	60 psi		
E.5.2	Gauge reading during stable flow (residual)	45 psi		
E.5.3	Time for supply pressure to return to normal	— sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		✓	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		✓	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve		✓	
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	✓		
E.9.0	Pertinent parties notified after conclusion of maintenance	✓		
E.10.0	ALARM PANEL CLEAR	✓		
E.11.0	SYSTEM RETURNED TO SERVICE	✓		

E.12.0 COMMENTS:

Partial TRIP TEST

Trip Test Table

	Dry Valve Make	Size	Model	Serial No.	Year	Q.O.D. Make	Model	Serial No.	Year
	Viking	2½	768N						

Dry Pipe Operating Test		Time to Trip Thru Test Pipe Min	Time to Trip Thru Test Pipe Sec	Water Pressure PSI	Air Pressure PSI	Time Water Trip Point Air Pressure PSI	Reached Test Outlet Min	Reached Test Outlet Sec	Alarm Operated Yes	Alarm Operated No
	Without Q.O.D		10	50	20	7		1	✓	
	With Q.O.D									

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION INC.
2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

Inspecting Firm: MFP
Inspection Contract#
Name of Inspected Property: Hastings Youth Treatment Center South Bldg.
Date:
Inspector Name:
Inspection Frequency: ☐ Monthly ☐ Quarterly ☑ Annually ☐ Other

Annual Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
F.1.0	System in service before testing	✓		
F.1.1	Pertinent parties notified before testing	✓		
F.1.2	Adequate drainage provided before flow testing	✓		
F.2.0	Dry pipe valve trip tested with control valve partially open *(required at full flow every 3 years)*	✓		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer	✓		
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV		✓	
F.2.3	Separate records of initial air and water pressure, tripping air pressure, and dry pipe valve operating conditions maintained on premises for comparison	✓		
F.2.4	Records of tripping time maintained for full flow trip tests	✓		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	✓		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	✓		
F.4.1	PIVs opened until spring or torsion felt in rod	✓		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	✓		
F.5.0	Main drain test conducted	✓		
F.5.1	Supply water gauge reading before flow (static)	55 psi		
F.5.2	Gauge reading during stable flow (residual)	40 psi		
F.5.3	Time for supply pressure to return to normal	— sec		
F.6.0	Backflow prevention assembly forward flow test conducted	✓		
F.6.1	System demand flow was achieved through the device	✓		
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)	✓		
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)		✓	
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		✓	
F.6.5	Forward flow test satisfied by annual fire pump flow test		✓	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	✓		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		✓	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		✓	
F.9.0	Pertinent parties notified of test conclusion	✓		
F.10.0	ALARM PANEL CLEAR	✓		
F.11.0	SYSTEM RETURNED TO SERVICE	✓		
F.12.0	COMMENTS			

Items of 5 Years or Greater Frequency

		Y	N/A	N
G.1.0	System in service before conducting tasks			
G.2.0	Pertinent parties notified before conducting tasks			
G.3.0	Dry pipe valve internally inspected			
G.3.1	Dry pipe valve strainers, filters, and restriction orifices internally inspected			
G.3.2	Dry pipe valve internal components cleaned/replaced as necessary			
G.3.3	Dry pipe valve internal components inspection/maintenance date:			
G.4.0	System gauges replaced as necessary			
G.4.1	System gauges tested by comparison with calibrated gauge			
G.4.2	System gauges accurate within 3% of full scale			
G.4.3	System gauges recalibrated as necessary			
G.4.4	System gauges test/replacement date:			
G.5.0	Check valves internally inspected			
G.5.1	Check valve internal components operate correctly			
G.5.2	Check valve internal components move freely			
G.5.3	Check valve internal components in good condition			
G.5.4	Check valve internal components cleaned/repaired/replaced as necessary			
G.5.5	Check valve internal inspection/maintenance date:			
G.6.0	Adequate drainage provided before flow testing			
G.6.1	PRV control valves full flow tested by opening sectional drain valve			
G.6.2	Supply side static pressure psi			
G.6.3	System side static pressure psi			
G.6.4	Supply side residual pressure psi			
G.6.5	System side residual pressure psi			
G.6.6	Results compared to previous full flow test			
G.6.7	Adjustments made as necessary			
G.7.0	Extra high temp solder type sprinklers tested/replaced – date:			
G.7.1	Sprinklers in harsh environment tested/replaced – date:			
G.7.2	Dry sprinklers tested/replaced (10 years) – date:			
G.7.3	Sprinklers with fast response elements tested/replaced (at 20 years, 10 thereafter) – date:			
G.7.4	All sprinklers tested/replaced (at 50 years, 10 thereafter) – date:			
G.7.5	All sprinklers tested/replaced (at 75 years, 5 thereafter) – date:			
G.7.6	All sprinklers manufactured before 1920 replaced – date:			
G.8.0	Obstruction investigation conducted (see AFSA Form 114A)			
G.9.0	Pertinent parties notified after conclusion of tasks			
G.10.0	ALARM PANEL CLEAR			
G.11.0	SYSTEM RETURNED TO SERVICE			
G.12.0	COMMENTS:			

INSPECTOR'S INITIAL NN (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE 10-5-21

WHITE - AHJ YELLOW - MFP PINK - OWNER

MIDWEST ALARM SERVICES

P.O. Box 4511
Davenport, IA 52808-4511

Site Address: Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

INVOICE

Account Number	1001896
Invoice Number	343239
Invoice Date	2/24/2021
Due Date	**3/26/2021**
Amount Due	**$240.76**
Amount Enclosed:	**$**

HASTINGS YOUTH TREATMENT FACILITY
4200 W 2ND ST
HASTINGS, NE 68901

-------APPROVED FOR PAYMENT-----
Initials TB Date 3-16-21
B/U 65047000 526100
P/O _____ /NONE

To ensure prompt credit, return this remittance and check payable to:
Midwest Alarm Services
PO Box 4511
Davenport, IA 52808

MIDWEST ALARM SERVICES
P.O. Box 4511
Davenport, IA 52808-4511

Account Information

Customer Number	**1001896**
Invoice Number	**343239**
Invoice Date	**2/24/2021**
P.O.	

Summary of Charges

Description	*Amount*
Service Call (137942)	
Hastings Youth Treatment Facility	
4200 W 2nd St	
Semi Annual Inspection - Program bldg	$75.00
Semi Annual Inspection - South Dorm	$75.00
Semi Annual Inspection - North Dorm	$75.00
Subtotal	**$225.00**
Sales Tax	**$15.76**
Current Charges:	**$240.76**
Credits:	**$0.00**
Payments - Thank You	**$0.00**
Total Amount Due:	**$240.76**

Notes

Semi Annual Fire Alarm Inspection Program Building, North Dorm and South Dorm - all system tested OK

001

NEBRASKA FIRE SPRINKLER
118 S APOLLO ST
ALDA NE 68810-9643
308-381-2033

Work Order

Order#: 7020

Order Date: 05/07/2021

Billed To: HASTINGS REGIONAL CENTER
DAS-STATE BLDG DIVISION
P. O. BOX 579
HASTINGS NE 68902

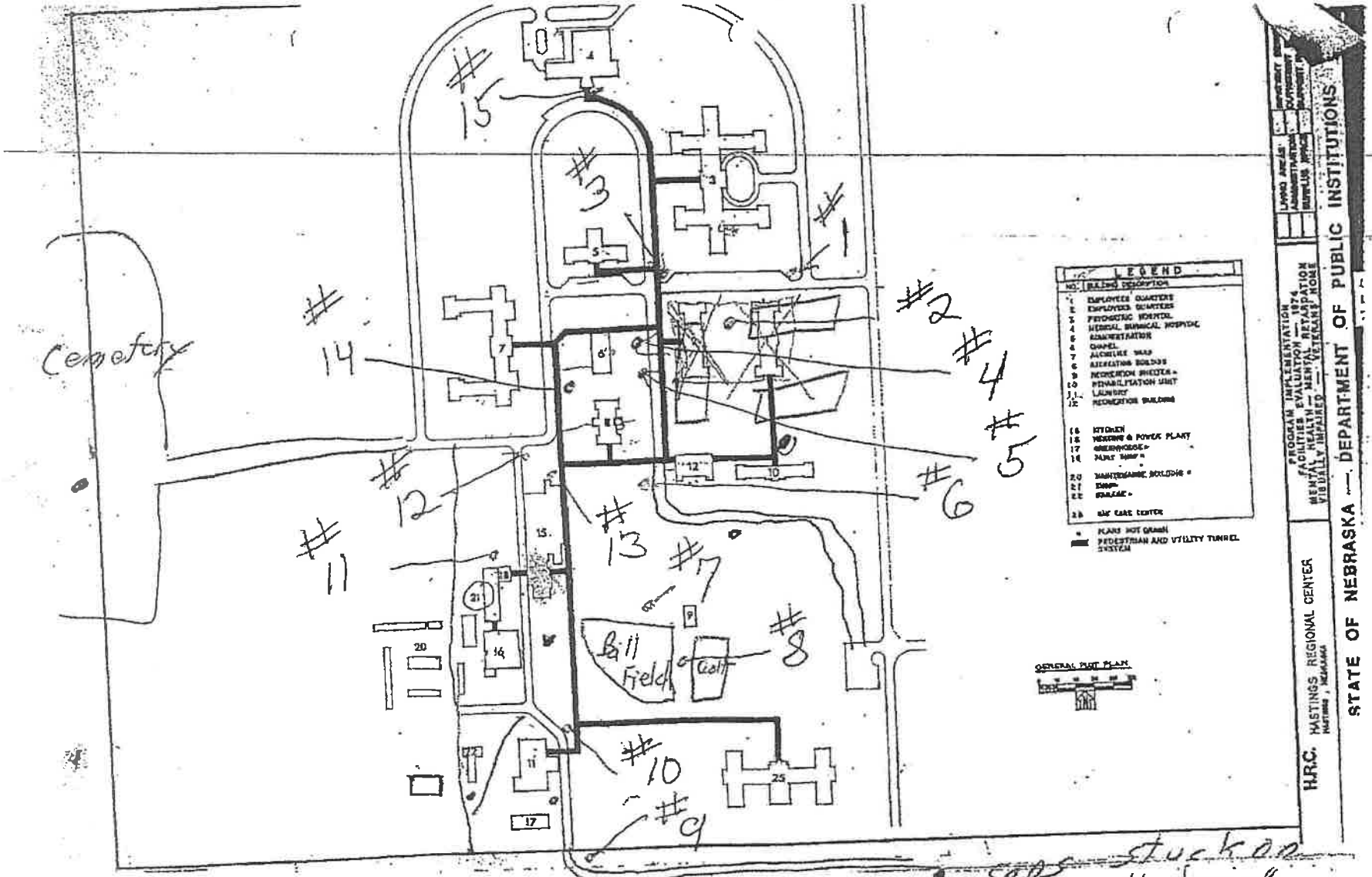
Location: HASTINGS REGIONAL CENTER
4200 WEST 2ND STREET
HASTINGS NE 68901

Scheduled: 05/07/2021 **Date Completed:** 5-11-21 **PO No:**

TEST 15 HYDRANTS
QUOTED
TED BUCK 402-469-8189

Part #	DESCRIPTION	QUANITY
	5-11-21 DC.	4.5

2020 Fire Hydrant Locations



- operational fire hydrant
- dead Fire Hydrant

caps stuckon broken Hydrant

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #1

Flow Hydrant Location: #2

Static pressure (residual hydrant): 43 psi (bar)

Residual pressure (residual hydrant): 35 psi (bar)

Pitot pressure (flow hydrant): 30 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 817 gpm (L/min) at 30 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #2

Flow Hydrant Location: #4

Static pressure (residual hydrant): 49 psi (bar)

Residual pressure (residual hydrant): 32 psi (bar)

Pitot pressure (flow hydrant): 30 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 817 gpm (L/min) at 30 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: _____

Conduct 2-In (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #3

Flow Hydrant Location: #2

Static pressure (residual hydrant): 50 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 30 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 817 gpm (L/min) at 20 psi (bar)

Notes/Comments Hydrant leaking underground at Static Pressure

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: # 4

Flow Hydrant Location: # 5

Static pressure (residual hydrant): 50 psi (bar)

Residual pressure (residual hydrant): 37 psi (bar)

Pitot pressure (flow hydrant): 30 psi (bar)

Nozzle Size (flow hydrant): 2 1/2 in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 817 gpm (L/min) at 30 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #5

Flow Hydrant Location: #4

Static pressure (residual hydrant): 53 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 33 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 857 gpm (L/min) at 33 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-21-21 **Inspector:** Duane Cook **System:** _____

Location: _____

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: # 6

Flow Hydrant Location: # 5

Static pressure (residual hydrant): 41 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 29 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 803 gpm (L/min) at 29 psi (bar)

Notes/Comments Hydrant leaking underground at static pressure

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: _____

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #7

Flow Hydrant Location: #8

Static pressure (residual hydrant): 54 psi (bar)

Residual pressure (residual hydrant): 30 psi (bar)

Pitot pressure (flow hydrant): 22 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 700 gpm (L/min) at 22 psi (bar)

Notes/Comments Hydrant leaking underground at Static Pressure

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 Inspector: Duane Cook System: _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #8

Flow Hydrant Location: #7

Static pressure (residual hydrant): 51 psi (bar)

Residual pressure (residual hydrant): 27 psi (bar)

Pitot pressure (flow hydrant): 25 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 746 gpm (L/min) at 25 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #9

Flow Hydrant Location: #10

Static pressure (residual hydrant): 57 psi (bar)

Residual pressure (residual hydrant): 24 psi (bar)

Pitot pressure (flow hydrant): 17 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): (.9) other .8

Available water flow: 692 / 615 gpm (L/min) at 17 / 17 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #10

Flow Hydrant Location: # 9

Static pressure (residual hydrant): 51 psi (bar)

Residual pressure (residual hydrant): 19 psi (bar)

Pitot pressure (flow hydrant): 16 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9); other _____

Available water flow: 621 gpm (L/min) at 16 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #11

Flow Hydrant Location: #12

Static pressure (residual hydrant): 53 psi (bar)

Residual pressure (residual hydrant): 25 psi (bar)

Pitot pressure (flow hydrant): 21 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 683 gpm (L/min) at 21 psi (bar)

Notes/Comments Hydrant leaking under ground at Static Pressure

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 Inspector: _____ System: _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #12

Flow Hydrant Location: #13

Static pressure (residual hydrant): 50 psi (bar)

Residual pressure (residual hydrant): 26 psi (bar)

Pitot pressure (flow hydrant): 18 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 633 gpm (L/min) at 18 psi (bar)

Notes/Comments Hydrant leaking underground at static pressure

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #13

Flow Hydrant Location: #14

Static pressure (residual hydrant): 49 psi (bar)

Residual pressure (residual hydrant): 26 psi (bar)

Pitot pressure (flow hydrant): 19 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 650 gpm (L/min) at 19. psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #14

Flow Hydrant Location: #13

Static pressure (residual hydrant): 55 psi (bar)

Residual pressure (residual hydrant): 29 psi (bar)

Pitot pressure (flow hydrant): 18 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 633 gpm (L/min) at 18 psi (bar)

Notes/Comments _____

Nebraska Fire Sprinkler
NEBRASKA FIRE SPRINKLER CORPORATION
P.O. Box 186 • Alda, NE 68810 • (308) 381-2033 • Fax (308) 381-2605

WATER SUPPLY SYSTEMS

ANNUAL FLOW TESTS

Date: 5-11-21 **Inspector:** Duane Cook **System:** _____

Location: Hastings Regional Center

Conduct 2-in (51-mm) main drain test for gravity tanks and pressure tanks.

Static pressure: _____ psi (bar)

Full flow pressure: _____ psi (bar)

Ground level tanks and underground tanks: Annual test is accomplished during fire pump full flow tests.

Water Distribution Systems

Annual test is accomplished during fire hydrant annual tests. For each test, record the following:

Residual Hydrant Location: #15

Flow Hydrant Location: # 14

Static pressure (residual hydrant): 53 psi (bar)

Residual pressure (residual hydrant): 34 psi (bar)

Pitot pressure (flow hydrant): 21 psi (bar)

Nozzle Size (flow hydrant): 2½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other .8

Available water flow: 683 gpm (L/min) at 21 psi (bar)

Notes/Comments _____

Invoice

K & G PLUMBING & HEATING, INC
918 EAST SECOND STREET
HASTINGS NE 68901
(402)-463-4470 FAX (402)-463-4632

Date	Invoice #
5/28/2021	21-0860

Project

Bill To
Hastings Regional Center 4200 W 2nd Street PO BOX 579 Hastings Ne 68901

SO#/Completion	P.O. No.
5/28/21	Ted 469 8189

Terms	Due Date
Net 15	6/12/2021

Thank you

Qty	Description	Rate	Amount
	Contact name: Ted Phone: 469 8189 Fax/e-mail: ted.buck@nebraska.gov Invoice scanned & e-mailed on: 5/28/21		
	Backflow Prevention Assembly Test Report attached for your records.		
1.5	Hours labor @ $140.00/hr - test 8" RPZ s in tunnel	140.00	210.00
	Our business continues to grow by referrals from our satisfied customers. MANY THANKS for your trust and confidence.		

Liable $5 minimum monthly service fee on past due accounts,as well as all legal & collection fees.

Total $210.00

BACKFLOW PREVENTION ASSEMBLY TEST REPORT

K&G PLUMBING & HEATING Inc

NAME OF PREMISE: Regional Center Commercial ☒ Residential ☐

SERVICE ADDRESS: 4200 W. 2nd. Street CITY: Hastings ZIP: 68901

CONTACT PERSON: Ted PHONE: 402-469-0189 FAX: _____

LOCATION OF ASSEMBLY: Tunnel Top Unit

TYPE: DCVA ☐ RPBA ☒ PVBA ☐ AIR GAP ☐ OTHER: _____

NEW INSTALLATION ☐ EXISTING ☒ REPLACEMENT ☐ OLD ASSEMBLY SERIAL NUMBER: _____

MAKE OF ASSEMBLY: Watts MODEL: 909 SERIAL NO.: 16522 SIZE: 8"

INITIAL TEST	DCVA/RPBA CHECK VALVE NO.1	DCVA/RPBA CHECK VALVE NO.2	RPBA	PVBA AIR INLET
PASSED ☒ FAILED ☐	LEAKED ☐ CLOSED TIGHT ☒ 7.6 PSID	LEAKED ☐ CLOSED TIGHT ☒ _____ PSID	OPENED AT 21 PSID #1 CHECK _____ PSID AIR GAP OK? _____	OPENED AT _____ PSID DID NOT OPEN ☐
NEW PARTS REPAIRS	CLEAN ☐ REPLACE ☐ PART	CLEAN ☐ REPLACE ☐ PART	CLEAN ☐ REPLACE ☐ PART	CHECK VALVE HELD AT _____ PSID LEAKED ☐ _____ CLEANED ☐ REPAIRED ☐
TEST AFTER REPAIRS	CLOSED TIGHT ☐ _____ PSID	CLOSED TIGHT ☐ _____ PSID	OPENED AT _____ PSID #1 CHECK _____ PSID	AIR INLET _____ PSID CHK VALVE _____ PSID

TEST AFTER REPAIRS: PASSED ☐ FAILED ☐ DATE: _____

AIR GAP INSPECTION: PASSED ☐ FAILED ☐ DATE: _____

REMARKS: _____

TESTER'S SIGNATURE _____ CERT. NO. 8690 DATE 5-28-21

PLUMBER'S SIGNATURE _____ CERT. NO. _____ DATE _____

ASSEMBLY MUST BE REPAIRED OR REPLACED WITHIN 30 DAYS OF THIS TEST DATE.

OWNER'S SIGNATURE _____ DATE _____

BACKFLOW PREVENTION ASSEMBLY TEST REPORT

9,1

K&G PLUMBING & HEATING INC

NAME OF PREMISE: Regional Center Commercial ☒ Residential ☐

SERVICE ADDRESS: 4200 W. 2nd. STREET CITY: Hastings ZIP: 68901

CONTACT PERSON: Ted PHONE: 402-469-8189 FAX: _____

LOCATION OF ASSEMBLY: Furnace Room Unit

TYPE: DCVA ☐ RPBA ☒ PVBA ☐ AIR GAP ☐ OTHER: _____

NEW INSTALLATION ☐ EXISTING ☒ REPLACEMENT ☐ OLD ASSEMBLY SERIAL NUMBER: _____

MAKE OF ASSEMBLY: Watts MODEL: 909 SERIAL NO.: E16513 SIZE: 8"

INITIAL TEST	DCVA/RPBA CHECK VALVE NO.1	DCVA/RPBA CHECK VALVE NO.2	RPBA	PVBA AIR INLET
PASSED ☒ FAILED ☐	LEAKED ☐ CLOSED TIGHT ☒ 8.1 PSID	LEAKED ☐ CLOSED TIGHT ☒ _____ PSID	OPENED AT 2.4 PSID #1 CHECK _____ PSID AIR GAP OK? _____	OPENED AT _____ PSID DID NOT OPEN ☐
NEW PARTS REPAIRS	CLEAN ☐ REPLACE ☐ PART	CLEAN ☐ REPLACE ☐ PART	CLEAN ☐ REPLACE ☐ PART	CHECK VALVE HELD AT _____ PSID LEAKED ☐ _____ CLEANED ☐ REPAIRED ☐
TEST AFTER REPAIRS	CLOSED TIGHT ☐ _____ PSID	CLOSED TIGHT ☐ _____ PSID	OPENED AT _____ PSID #1 CHECK _____ PSID	AIR INLET _____ PSID CHK VALVE _____ PSID

TEST AFTER REPAIRS: PASSED ☐ FAILED ☐ DATE: _____

AIR GAP INSPECTION: PASSED ☐ FAILED ☐ DATE: _____

REMARKS: _____

TESTER'S SIGNATURE [signature] CERT. NO. 8490 DATE 5-28-21

PLUMBER'S SIGNATURE _____ CERT. NO. _____ DATE _____

ASSEMBLY MUST BE REPAIRED OR REPLACED WITHIN 30 DAYS OF THIS TEST DATE.

OWNER'S SIGNATURE _____ DATE _____

Major Projects

Attachment YLF1

Youth Rehabilitation and Treatment Center - Lincoln Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. [redacted]

   a. [redacted]

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

   a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not identified any major construction projects of the facility.

2. Please provide a summary of completed major projects as of today.
   a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not completed any major construction projects in the facility.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

   a. All ongoing building maintenance and major construction projects for YRTC-Lincoln is contracted through Lancaster County. However, YRTC-Lincoln keeps track of all routine repair work completed for the facility by the maintenance department

4. Please provide the number of work orders submitted since December 2020.

   a. Approximately 73

5. What kind of system do you use to track non-major repair projects?

a. YRTC-Lincoln currently tracks non-major repair projects through electronic methods and through internal Maintenance Work Order forms.

Facility Staffing Information

Attachment YLF2

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

Pete Ricketts, Governor

Youth Rehabilitation and Treatment Center – Lincoln Staffing & Assault Data
Reporting Period: December 1, 2020 through November 30, 2021
Neb. Rev. Stat. 83-104

A. **Facility Staffing Levels:**

a. The number of positions filled as of November 30, 2021.

i. 50 positions

b. The number of positions vacant as of November 30, 2021.

i. 8 vacant positions

c. The number of positions needed in your HR staffing plan for FY22 as of November 30, 2021.

i. 56 positions needed in the staffing plan for FY22

d. The number of position filled in your HR staffing plan for FY22 as of November 30, 2021.

i. 50 positions

e. The monthly turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 4%

f. The aggregate turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 42%

B. Staff Assaults:

a. The number of assaults on staff for the period of 12/01/2020 through 11/30/2021.

i. 22 total youth on staff assaults

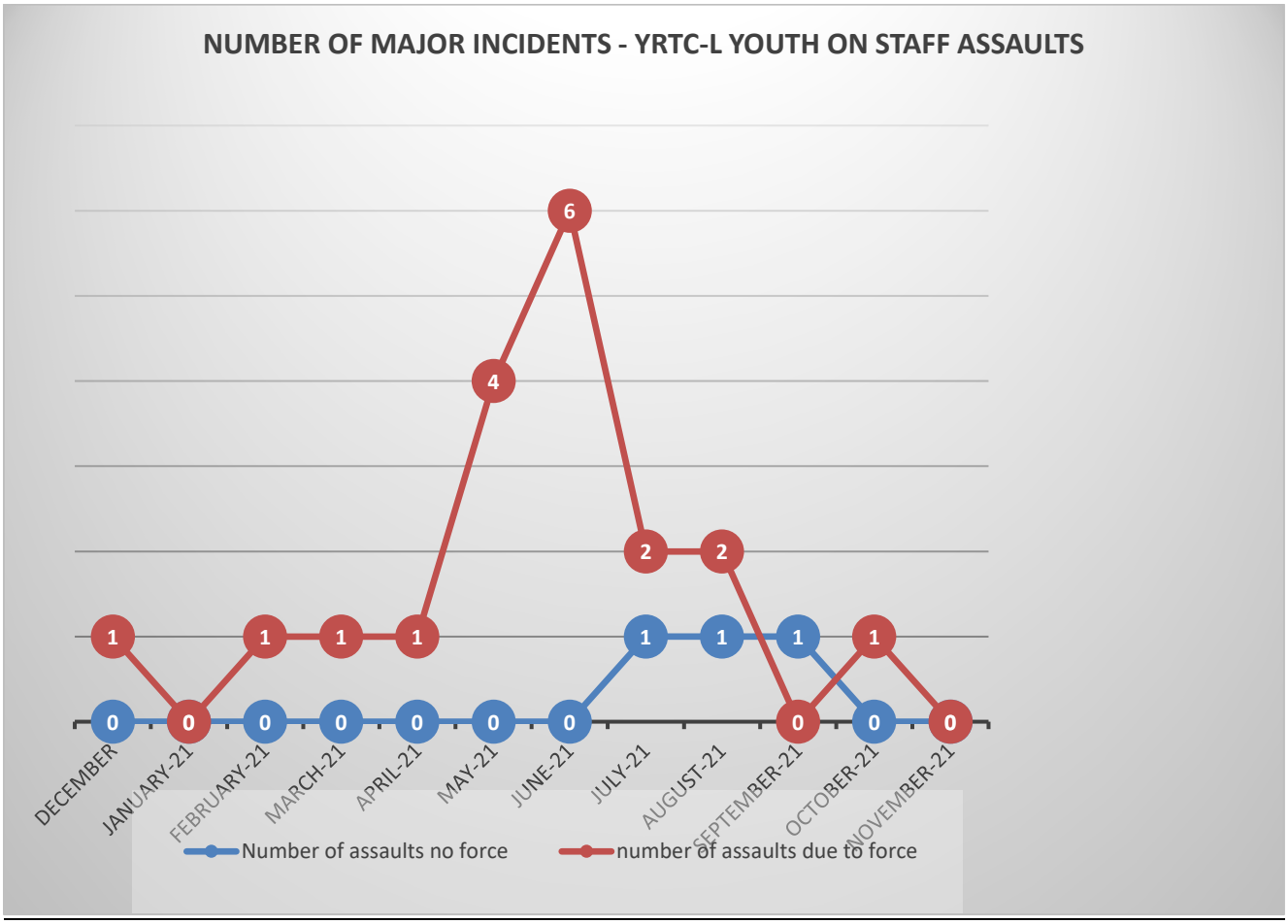
b. Number of assaults as a result of a use of force event.

i. 19 youth on staff assaults during physical interventions

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data
12/1/2020 - 11/30/2021

Facility: LYF Lincoln Youth Facility

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		45	56	101	56	32	37	4%	42%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
H77023	ACTIVITY SPECIALIST	1	2	3	2	0	1	4%	50%
A01014	ADMINISTRATIVE SPECIALIST (NEW)	1	0	1	0	0	0		
H76300	BEHAVIOR SUPPORT SPECIALIST	1	0	1	0	0	0		
P72011	BEHAVIOR TECHNICIAN	21	23	44	27	25	24	4%	46%
R72011	BEHAVIOR TECHNICIAN	0	20	20	4	1	4	7%	80%
V72013	BEHAVIOR TECHNICIAN LEAD	7	6	13	10	2	7	5%	58%
C72012	BEHAVIOR TECHNICIAN PROGRAMMING COORDINATOR	1	1	2	1	0	0	0%	0%
V72014	BEHAVIOR TECHNICIAN SUPERVISOR	2	0	2	2	1	1	3%	33%
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	2	0	2	0	1	0	0%	0%
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	1	0	1	0	0	0		
H72442	BOARD CERTIFIED BEHAVIOR ANALYST	0	2	2	0	0	0		
V72443	BOARD CERTIFIED BEHAVIOR ANALYST CLINICAL SUPERVISOR	1	0	1	1	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	1	0	1	1	0	0	0%	0%
N78560	DHHS FACILITY ADMINISTRATOR	1	0	1	1	0	0	0%	0%
G73280	DHHS QUALITY ASSURANCE COORDINATOR	0	0	0	1	0	0	0%	0%
H72432	MENTAL HEALTH PRACTITIONER II	0	0	0	1	0	0	0%	0%
G11900	PRINCIPAL	1	0	1	0	1	0	0%	0%
H77043	RECREATION SPECIALIST	0	1	1	0	0	0		
S01842	STAFF ASSISTANT II	0	0	0	1	0	0	0%	0%
T11360	TEACHER (SCATA CONTRACT)	4	0	4	4	1	0	0%	0%
P76752	YOUTH SECURITY SPECIALIST II	0	1	1	0	0	0		
		45	**56**	**101**	**56**	**32**	**37**	**4%**	**42%**



Total assault numbers by the month
December 2020- 1
January 2021- 0
February – 1
March – 1
April- 1
May- 4
June- 6
July -3
August – 3
September – 1
October – 1
November- 0

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Kearney		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	8	0	1	0	0	0	9
February	6	4	0	2	0	0	12
March	11	2	0	0	0	0	13
April	5	1	0	0	0	0	6
May	3	0	0	0	0	0	3
June	0	4	0	0	0	0	4
July	0	2	0	0	0	0	2
August	1	0	0	0	0	0	1
September	0	4	0	0	0	0	4
October	0	0	0	0	0	0	0
November	1	1	0	0	0	0	2
Total	**36**	18	1	2	0	0	57

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Lincoln		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	0	0	0	0	0	0	0
February	1	0	0	0	0	0	1
March	1	0	0	0	0	0	1
April	1	0	0	0	0	0	1
May	4	0	0	0	0	0	4
June	2	0	2	2	0	0	6
July	2	0	1	0	0	0	3
August	2	0	1	0	0	0	3
September	0	0	1	0	0	0	1
October	1	0	0	0	0	0	1
November							
Total	**15**	0	5	2	0	0	22

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Hastings		Injury Rating				Total
Month	1	2	3	4	5	6	
December	n/a	n/a	n/a	n/a	n/a	n/a	n/a
January	n/a	n/a	n/a	n/a	n/a	n/a	n/a

February	n/a	n/a	n/a	n/a	n/a	n/a	n/a
March	n/a	n/a	n/a	n/a	n/a	n/a	n/a
April	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0
August	2	0	0	0	0	0	2
September	0	0	0	0	0	0	0
October	3	0	0	0	0	0	3
November	3	0	0	0	0	0	3
Total	**8**	0	0	0	0	0	8

COVID -19 Impact

Impact

Leadership Update

Family Member Letter

Pandemic plan

Attachment YLF3

Impact

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

[redacted]

[redacted]

a. [redacted]

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

    a. COVID-19 presented some major challenges for all facilities but one of the biggest perceived challenges that the Whitehall facility faced during the first shut down was the facility's ability to meet with stakeholders and families about treatment updates on the children. Administration had to redesign the entire process so that Whitehall could meet health department standards for the amount of people that could be in a room at one time. The use of WebEx has revolutionized how facilities conduct team meetings each week with the youth, their families, and other interested parties. The onset of the COVID-19 pandemic has resulted in the facility having the ability to get more outside people involved remotely with youth on campus than even was possible before. In a sense the pandemic forced the facility to grow and think of new ways to do things so that quality treatment could still be provided even in the midst of a global pandemic. Even now that families are starting to come back onto the campus and have the youth back into the community we continue to have great participation from outside parties in the treatment of the youth.

2. Please provide a copy of your most recent COVID protocols.

    a. Attached as LRC-Pandemic COVID-19 Protocols (These are what Whitehall adopted as well) in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. The Whitehall visitation letter that was sent to families via USPS and pronation via email is attached and can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

a. Currently, the campus is open to visitation and the youth are allowed to visit with their families off grounds. When Whitehall gains a new youth, they are tested for COVID-19 and are placed temporarily into quarantine until that test result comes back. If the test result comes back positive the Medical department at Whitehall will call the health department and quarantine the youth for 10 days. Currently there is one youth on quarantine due to arriving to the facility COVID positive and will be off quarantine on November 10th, 2021. When visitors come to campus they are required to check their temperature when signing in to our administration building. Whitehall currently does not require masks on campus unless the health department has suggested otherwise in response to a positive case on campus which has been very far and few between. If a staff member believes they have been exposed they are directed to call the health department and go with their recommendation on whether the staff member should quarantine or be tested.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. Whitehall does not have any COVID-19 planning meeting minutes, but rather follows the direction of LRC and DHHS administration for any updates regarding COVID-19 protocols.

Leadership Update

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

TO: DHHS 24 hour care facility visitors

FROM: Sarah Brownell, DHHS, OJS, Lincoln Facility – Facility Administrator

DATE: March 10, 2020

SUBJECT: COVID-19 visitation screening

To ensure the health and safety of the youth and adults in our care, effective immediately and until further notice, DHHS 24 hour care facilities are implementing steps to prevent or mitigate community-based spread of COVID-19. These steps are based on guidance from the Centers for Disease Control and the experience from other states.

We understand how important it is to visit your respective family member or loved one and we ask that you also understand how crucial it is that we ensure the health and well-being of all the youth and adults in our care. If you are not able to see your loved one due to illness or health precautions, we may be able to offer alternative modes of communication.

We are also monitoring the health of residents of 24 hour facilities. Residents who exhibit symptoms of COVID-19 will be assessed and tested as appropriate. Should any resident of a DHHS 24 hour facility test positive for COVID-19, they will be isolated to prevent the spread of disease to other residents. Visitation for sick residents will be restricted during their illness.

Please understand that if and when this worldwide pandemic progresses, we may further restrict visitation out of an abundance of caution for our residents and community.

If you have any questions, please do not hesitate to contact the respective 24 hour care facility administration.

On-site screening

Please allow additional time when you arrive for your visit at one of the DHHS 24 hour care facilities. Out of an abundance of caution, we are **implementing screening measures for signs of exposure to COVID-19** (described below). Every visitor who enters a 24 hour care DHHS facility will be screened. The DHHS 24 hour care facilities:

- YRTC Kearney facility
- YRTC Geneva facility
- YRTC Lincoln facility
- Whitehall
- Hastings Regional Center
- Lincoln Regional Center
- Norfolk Regional Center
- Beatrice State Developmental Cente

Steps for safe visitation at DHHS 24 hour facilities

1. Visitor's self-assessment (prior to arriving at a facility)
    a. **Do you have symptoms associated with COVID-19?** If so, please reschedule your visit until your symptoms have passed. Symptoms include: fever (100.4°F or higher), cough, shortness of breath, sore throat, fatigue, or other flu-like symptoms.
    b. **Within the last 14 days, have you traveled to an area with widespread cases of COVID-19 or had contact with someone who tested positive for COVID-19?** If so, please reschedule your visit until 14 days after contact with that area or person.
2. On-site screening
    a. **Upon your arrival at the facility, you will be asked about your current health condition, recent travel history, and recent social contacts.** If your responses put you at higher risk of COVID-19, you may be asked to reschedule your visit.
    b. **Staff may take your temperature to ensure you are not running a fever over 100.4°F.** If you have a high fever, you will be asked to reschedule your visit.
3. Safe visiting
    a. **You are encouraged to limit touching during your visit.** This includes hugging, shaking hands and holding hands.
    b. Before and after your visit, please wash your hands with soap and water or use alcohol-based hand sanitizer.
4. Restrictions for sick residents/patients
    a. **Call ahead to ensure the person you want to visit is able to see visitors.** Visitation will be restricted for residents/patients who test positive for COVID-19.

About the virus

COVID-19 is a new virus that causes respiratory illness in humans, usually 2–14 days after exposure. Illnesses have ranged from mild symptoms to severe illness, including fever, cough, and shortness of breath. Reports show older adults and people with underlying health conditions are more likely to be severely impacted by COVID-19. The virus is thought to spread mainly from close contact with an infected person. It spreads in the air, like flu, through droplets from sneezes and coughs. The droplets can stay suspended in the air for some time and can land on surfaces that are touched by others.

Family Member Letter

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Dear Family/Guardians,

When the State began making preparations for the potential impact of the COVID-19 pandemic, YRTC recognized that it was crucial that we take extra precautions to maintain the health and safety of your loved ones who we support. As you know, these steps included temporarily prohibiting in-person visitation with youth. As Nebraska has worked to flatten the COVID-19 curve, we are now taking steps toward resuming visitation. Before we are able to open visitation, we need to make sure we are using the best practices available to help ensure a safe environment for your children and the staff that support them.
These are some of the steps we are taking as we move toward the resumption of visitation:

For our residents/patients and staff

- Providing COVID-19 testing to staff and youth
- Continued health screenings for staff at the beginning of their shift or work day
- Continued health screenings of the youth/residents in our programs on a daily basis
- Staff will wear face masks and face masks will be offered to youth/residents to wear as well
- Increased awareness and expectations for hand hygiene and cleaning within the facility
- Reminding staff to stay home if they are sick or showing any signs of illness
- Encouraging staff to self-quarantine if they believe they have been exposed to COVID-19

For family members

- A continuation of virtual visits with family and other approved contacts
- Begin visitation for immediate family members, as early as July 2020
- Visitation areas will be set up to accommodate social distancing requirements
- A staggered visitation schedule will allow small groups of youth to have face to face visitation
- Establishing an adequate supply of PPE for use in managing infection control concerns
- Availability of face masks for all visitors to the program if they are not able to provide their own
- Health screenings for visitors entering the facilities
  A focus on social distancing and limiting physical contact to emergency situations only

We understand that this is a difficult time for everyone. We will continue to offer and support alternative visitation options in our efforts to keep families safe. Please do not hesitate to contact your Program Coordinator, Aaron Smith, at 402-471-0499 if you would like help in setting up a call or video visit option.

As this pandemic evolves, we will keep you informed of any changes regarding visitation. Should there be an increase in exposure and positive testing, we may need to re-evaluate our visitation practices with little to no prior notice.

Thank you for your understanding and continued support and assistance during this difficult time.
Sincerely,

Facility Administrator

Pandemic Plan

DHHS, OJS, Lincoln Facility

SUBJECT: COVID-19 PANDEMIC PLAN

Effective Date: March 9, 2020 Page No. 1 of 7

STANDARD: Center for Disease Control (CDC), American Practitioners of Infection Control (APIC)

POLICY: The Lincoln Facility will ensure a sustainable healthcare response to Pandemic COVID-19 (Policy for Emergency Medical Care 115.6.6).

PURPOSE: To provide early detection and containment of Pandemic COVID-19 while maintaining the overall operation of Lincoln Facility and meet basic needs of the facility.

RESPONSIBILITY: All staff

EQUIPMENT: Personal Protective Equipment (PPE), N-95 filter masks, Surgical Masks, Clean Isolation Gown, Eye Protection, Emergency Operations Manual, Infection Control Manual, Contingency Staffing Plan.

PROCEDURE:

I. INITIAL IMPLEMENTATION

A. Lincoln Facility will work with State, Lancaster County Health Department and other local Health Departments.
B. Contingency Staffing Plan for Managing Widespread Outbreaks / Disaster, as detailed in the Emergency Operations Manual, will go into effect.
C. Designated Lincoln Facility leadership will meet daily and as needed to address essential needs and emergent situations as they arise.
D. Identification of Essential Personnel will be reassessed daily by designated Lincoln Facility leadership and are as follows:
    1. All employees will be considered essential for anti-viral therapy when available and these staff will be identified daily, based on availability, potential for exposure, and the need to meet minimal departmental staffing requirements, as per contingency staffing plan. This includes allowing for rotation of specific departmental staff in order to meet the essential services of the facility and care of the Youth.
    2. Ancillary staff will be rotated to areas of need.
    3. Once a vaccine is available staff designated to receive the vaccine will be identified at time of availability of vaccine, based on employees who have had the Pandemic COVID-19 and available staff.

II. CONTAINMENT

A. Signs and Symptoms associated with an infectious agent. Severity ranges from little to no symptoms to being severely ill and dying:
    1. Fever
    2. Cough
    3. Shortness of breath
    4. Sore Throat
    5. Fatigue

B. If above signs and symptoms are identified, they have recently traveled to China, Iran, South Korea, Italy, or Japan, Hong Kong, or had close contact (within 6 feet) with a person who is under investigation/has laboratory confirmed COVID-19 place youth in Airborne/Droplet precaution IMMEDIATELY until Lab Test can confirm a diagnosis.
1. Signs will be placed throughout the facility notifying visitors that if they have symptoms of respiratory illness they will need to reschedule their visit until a time they are not symptomatic.
2. Staff returning to work from being ill will provide medical documentation indicating they are cleared to return to work.
    a. Staff may be asked to wear a mask while working for up to 14 days
    b. Staff may be asked to visit their doctor and obtain a return to work note
    c. Staff may be asked to return home for up to 14 days for safety

C. If Signs and Symptoms indicate an infectious agent in our youth population:
1. Notify the nurse, if not available call on-call nursing
2. Isolate youth pending lab results
3. Confirmed positive test results require quarantine
4. Call Dr. Fromm or Dr. Wittry for consult and for transfer orders if possible

D. Appropriate lab procedures will be used to perform diagnostic testing.
1. Testing is available through the Nebraska Public Health Lab (NPLH)
2. NPLH will send test to CDC who will confirm the positive test results
3. Results will be obtained within in 24 hours.

E. Director of Facilities, Facility Administrator, Facility Physicians, and Nursing will be involved in decision to cohort all ill youth together away from non-ill youth, if needed. During outbreaks, confine youth with confirmed illness to the quarantine area for the building. Youth with suspected Covid-19 should be placed in the isolation area of the building until lab test confirms a diagnosis (Approximately 24 hours). This may be expanded to all youth being served meals in their rooms and closing down communal areas to dining and other gatherings. Due to medical limitations of Lincoln Facility, youth needing immediate rehydration or emergency medical attention may need to be transported to a hospital for treatment. If transfer of a youth is required, record and communicate the transfer to the Director of Facilities.
1. Separation/Isolation areas are as follows:
    a. Individual rooms and separate housing units can be utilized for separation.
    b. 2 ADA compliant rooms for medical isolation.
    c. Transfer to YRTC-K if necessary.
    d. Transportation vehicle onsite for emergency transportation.

F. **Personal Protective Equipment (PPE)**
1. **Caring for Youth with pandemic infections**
Healthcare personnel should be particularly vigilant to AVOID:
    a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before youth contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.

b. Contaminating environmental surfaces that are not directly related to Youth care (e.g., door knobs, light switches).
c. Encourage youth in isolation to wear a surgical mask. .

2. **Masks (N-95 if available or surgical/procedure): 50 boxes of surgical masks in stock. Procurement is currently trying to order 1000 N-95 Masks.**

- If N-95 is back ordered or out of stock Lincoln Facility will consult with the SEMRS coalition to obtain emergency supplies through the SNS. If N-95 is not available surgical masks will then be utilized.

a. Wear a mask when entering a youth room. A mask should be worn once and then discarded. If pandemic COVID-19 youth are cohorted in a common area or in several rooms on a nursing unit, and multiple youth must be visited over a short time, it may be practical to wear one mask and eye protection for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between youth and hand hygiene performed.
b. Change masks when they become moist.
c. Do not leave masks dangling around the neck.
d. Upon touching or discarding a used mask, perform hand hygiene.

3. **Gloves:**
   a. A single pair of youth care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on a Youth; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.
   e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive Youth or environmental contact with blood or body fluids.
   f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a youth's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. **Gowns:**
   a. Wear an isolation gown, if soiling of personal clothes or uniform with a youth's blood or body fluids, including respiratory secretions, is anticipated. Most youth interactions do not necessitate the use of gowns. A disposable gown made of synthetic fiber or a washable cloth gown may be used.
   c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.

d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.

e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., youth gowns) could be used. There are no data upon which to base a recommendation for reusing an isolation gown on the same youth. To avoid possible contamination, it is prudent to limit this practice.

5. **Goggles or Face Shield:**

a. In general, wearing goggles or a face shield for routine contact with youth with pandemic COVID-19 is necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet precaution.

6. **PPE for Special Circumstances**

a. **PPE for aerosol - generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., nebulizer treatment), healthcare personnel should wear gloves, gown, face/eye protection, and an N-95 respirator if fit tested by the Infection Control Manager.

G. **Hand Hygiene**

1. Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based or non-alcohol based products (gels, rinses, foams) containing an emollient that do not require the use of water.
2. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
3. In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based or non-alcohol based products for hand disinfection are preferred.
4. Always perform hand hygiene between youth contacts and after removing PPE.
5. Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based or non-alcohol based products) are readily accessible in areas in which youth care is provided.

H. **Disposal of Solid Waste**

1. Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus:
2. Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of

medical waste, including used needles and other sharps, and non-medical waste. Directions for disposing of medical waste found in Infection Control Manual.

3. Discard as routine waste used youth-care supplies that are not likely to be contaminated (e.g., paper wrappers).
4. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

I. **Linen and Laundry**

1. Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from Youth with pandemic COVID-19:
2. Place soiled linen directly into a laundry bag in the youth's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area. Please follow-direction per Lincoln Facility policy.
3. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
4. Wear gloves for transporting bagged linen and laundry.
5. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
6. Wash and dry linen according to routine standards and procedures.

J. **Dishes and Eating Utensils**

Standard precautions are recommended for handling dishes and eating utensils used by a youth with known or possible pandemic COVID-19:

1. Wash reusable dishes and utensils in a dishwasher with recommended water temperature per Lincoln Facility policy.
2. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of youth) should be discarded with other general waste.
3. Wear gloves when handling youth trays, dishes, and utensils.

K. **Youth-care equipment**

Follow standard practices for handling and reprocessing used youth-care equipment, including medical devices:

1. Wear gloves when handling and transporting used youth-care equipment.
2. Wipe heavily soiled equipment with an Lincoln Facility approved surface disinfectant before removing it from the youth's room. Follow current recommendations for cleaning and disinfection of reusable care equipment.
3. Wipe external surfaces of portable equipment for performing x-rays and other procedures in the area with a Lincoln Facility approved surface disinfectant upon removal from the Youth's room.

L. **Environmental cleaning and disinfection**

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Multiguard and Sani Cloths will be used for disinfection.

M. **Cleaning and disinfection of Youth-occupied rooms**

1. Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are necessary for routine cleaning of an infection positive room when youth is present.
2. Keep areas around the youth room free of unnecessary supplies and equipment to facilitate daily cleaning.
3. Use any Lincoln Facility approved hospital detergent-disinfectant
4. Follow facility procedures for regular cleaning of Youth-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.
5. Clean and disinfect spills of blood and body fluids.

N. **Cleaning and disinfection after Youth discharge or transfer**

1. Follow standard facility cleaning policy for post-discharge cleaning of a room.
2. Clean and disinfect all surfaces that were in contact with the youth or might have become contaminated during care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
3. Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.
4. Disinfectants utilized will be Multiguard Spray and Sani-Cloth wipes

O. **Postmortem care**

1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.
2. The Health Department will provide body bags for deceased youth.

P. **Laboratory specimens and practices**

1. Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

III. OUTBREAK NOTIFICATION

A. All doors will remain locked. Only employees with facility access will be allowed to enter. Vendors or suppliers will be instructed to drop off all supplies at the delivery door.

B. If public announcements are needed:

1. Visual alerts will be at entrances advising visitors that visitation is restricted.
2. Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:

a. cover the nose/mouth when coughing or sneezing.
b. use tissues to contain respiratory secretions.
c. dispose of tissues in the nearest waste receptacle after use.
d. perform hand hygiene after contact with respiratory secretions.

C. Facility Group activities and new admissions will be cancelled until the outbreak is over. Individual activities and Unit activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the Youth.

D. Nursing and physician will decide what departments and activities continue during the duration of the outbreak.

E. Department Heads/Supervisors will contact the Infection Control Coordinator for any clarification of memos/orders/notifications/questions.

F. Infection Control Coordinator in collaboration with the Medical Director will contact the State Health and Human Services division of Infectious Disease and the Lancaster Health Department.

G. Remain vigilant for another outbreak of pandemic COVID-19.

IV. MONITORING OF HEALTH CARE PERSONNEL

A. Screening of all employees will be done by nursing or physician. All symptomatic staff will be sent home for self-isolation and asked to contact health care provider before returning.

C. Any healthcare staff who have recovered from the pandemic COVID-19 will be prioritized for care of youth with active pandemic COVID-19 and its complications.

D. Staff at high risk for complications of pandemic COVID-19 (i.e. pregnant, immuno-compromised, and older in age) should be informed about this medical risk and offered an alternative work assignment away from COVID-19 youth care or considered for administrative leave.

E. Staff age will be assessed when staffing quarantine and isolation areas due to increased age increasing risk of Acute Respiratory Distress Syndrome.
1. Staff under the age of 39 with no compromising issues will be staffed in quarantine and isolation areas first if possible.

V. TREATMENT

A. No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated.

Please note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

Maintenance Tracking

Attachment YFL4

Youth Rehabilitation and Treatment Center - Lincoln Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. Please provide a copy of the most recent inspections and/or audit reports as of today. To include, but not limited to applicable reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, permits, alarm system, sprinkler, etc.

    a. All inspection and audit information regarding the YRTC-Lincoln has been attached in Section A of this packet.

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

    a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not identified any major construction projects of the facility.

2. Please provide a summary of completed major projects as of today.
    a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not completed any major construction projects in the facility.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

    a. All ongoing building maintenance and major construction projects for YRTC-Lincoln is contracted through Lancaster County. However, YRTC-Lincoln keeps track of all routine repair work completed for the facility by the maintenance department

4. Please provide the number of work orders submitted since December 2020.

    a. Approximately 73

5. What kind of system do you use to track non-major repair projects?

a. YRTC-Lincoln currently tracks non-major repair projects through electronic methods and through internal Maintenance Work Order forms.

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

1. Please provide a copy of your <u>most recent</u> COVID protocols.

    a. All of YRTC-Lincoln's most recent COIVD-19 protocols can be located in Section C of this packet.

2. Please provide a copy of your <u>most recent</u> letter to family/guardians/visitors on COVID updates

    a. All of YRTC-Lincoln's most recent letter to family/guardians/visitors regarding COVID-19 updates can be located in Section C of this packet.

3. Please provide an update on your current COVID situation. To include visitation, testing, etc.

    a. YRTC-Lincoln continues to screen for symptoms for all individuals entering the facility; in addition to following any recommendations set forth by the Lancaster County Health Department.

4. Please provide a copy of your <u>most recent</u> COVID-19 planning meeting minutes.

    a. Not applicable
    b. Weekly updates are provided to OJS Director

Inspection Reports

Fire Alarm

Fire sprinkler

Attachment YFL5

NEBRASKA

Good Life. Great Service.

COMMISSION ON LAW ENFORCEMENT AND CRIMINAL JUSTICE

October 19, 2021

Interim Director Melissa Hood
Lancaster County Youth Services Center
1200 Radcliff Street
Lincoln, NE 68512

Dear Director Hood,

On October 7, 2021, Dan Evans, Criminal Justice Field Representative for the Nebraska Commission on Law Enforcement and Criminal Justice, conducted an annual evaluation of the Lancaster County Youth Services Center Secure Detention to determine its compliance with the Nebraska Juvenile Detention Facility Standards. The facility was determined to be in full compliance with the Standards at the time of the inspection.

The Jail Standards Board will review your report during their meeting at 9:00 a.m., Friday, November 5, 2021, in Room Lower Level C, Nebraska State Office Building, 301 Centennial Mall South, Lincoln, Nebraska.

If you have any questions, or if I can be of assistance, please do not hesitate to call.

Sincerely yours,

Denny Macomber, Chief
Jail Standards Division

DM: dm

XC: County Attorney
Chairperson, County Board

Don Arp, Jr., Executive Director
Nebraska Commission on Law Enforcement and Criminal Justice
P.O. Box 94946
301 Centennial Mall South
Lincoln, Nebraska 68509
OFFICE 402-471-2194 FAX 402-471-2837
NCC.Webmaster@Nebraska.gov
ncc.nebraska.gov

STATE OF NEBRASKA
JUVENILE DETENTION FACILITY
INSPECTION REPORT

NEBRASKA COMMISSION ON LAW ENFORCEMENT AND CRIMINAL JUSTICE
JAIL STANDARDS DIVISION

Facility Name:	Lancaster County Youth Services Center		
Address:	1200 Radcliff Street, Lincoln, Nebraska 68512		
Type of Facility:	Juvenile Detention	**Facility Administrator:**	Melissa Hood, Interim Director
Date of Inspection:	10/07/21	**Inspected by:**	Dan Evans

Year facility was built: 2002 Any remodeling/construction since last inspection? No
If yes, briefly describe:

HOUSING:	**Male**	**Female**		
Single occupancy cells:	20	20	Holding cells:	1
Multiple occupancy beds:	0	0	Detoxification cells:	1
Dormitory beds:	0	0	Segregation cells:	3
Work release beds:	0	0	Special purpose cells:	0

Total number of beds: 40

DATA SINCE LAST INSPECTION:	**2020**	**Statistics Year:**	**2020**
Suicides / Attempts:	0/0	Average daily population:	17
Detainee assaults-staff/Juvenile:	2/16	Average length of stay:	31.59 days
Facility fires:	0	Longest stay:	
In-custody deaths	0	Total held:	200
Escapes/Attempts:	0/0		
Law Suits Pending:	0		

Does the facility hold for other jurisdictions? Yes
If yes, Who? Several counties in the State

FACILITY PERSONNEL:

	Male	**Female**
Full-time Direct Care Staff:	14	12
Part-time Direct Care Staff:	14	9

Other administrative, program, or support staff:	
Title:	**Number:**
Administrator	1
Admin. Support/Supervisors	10

Total number of staff employed in the facility: 49

Notes: 43 FT and PT specialist are contracted for medical, mental health, education and maintenance

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PHONE (402) 471-2194
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Nebraska Jail Standards
Juvenile Facility Inspection

Standard		Compliance Status In	Out	N/A	Comments
CHAPTER 2 - ADMINISTRATION, ORGANIZATION AND MANAGEMENT		X			The facility is governed by the Lancaster County Board.
2-001	The governing body has the legal authority to establish and operate the juvenile detention facility.				
2-002	The facility has a designated administrator who is responsible for facility operations	X			Melissa Hood is the Interim facility Director.
2-003	The facility has a written organizational chart which reflects the authority, responsibility and accountability within the facility.	X			
2-004	The facility has a written mission statement describing its philosophy and goals, who it will house and for what purpose and the programs and services to be offered.	X			
2-005	The facility administrator has developed and maintains written policies and procedures describing all aspects of the facility administration and operation.	X			
2-005.01	All policies and procedures are reviewed at least annually and revised as necessary. Copies of policies and procedures being replaced are kept on permanent file.	X			
2-005.02	Written policies and procedures are made available to all facility employees.	X			Staff can access facility policy and procedures on the facility's computer system.
2-005.03	Written policies and procedures form the basis for new facility employee orientation and training.	X			
2-005.04	There is a procedure for disseminating new or revised policies and procedures to facility employees prior to implementation.	X			
2-005.05	Written policies and procedures are approved by the governing body having jurisdiction over the facility. The governing body receives copies of revision to the written policies and procedures and reviews and approves subsequent revisions on at least an annual basis.	X			Policy and procedures are reviewed and approved by the County Attorney's office, the County Board and jail Standards.
2-006	The facility has written post orders stating the duties and responsibilities for staff with post assignments. Post orders are reviewed at least annually and updated as necessary.	X			
CHAPTER 3 - FISCAL MANAGEMENT		X			
3-001	Annual budget requests provide for an adequate allocation of resources for facility operations and programming.				
3-002	The facility utilizes a fiscal system which accounts for all income and expenditures on an ongoing basis.	X			
3-003	Accepted accounting procedures are used for collecting, safeguarding and disbursing all funds held by the facility.	X			
3-004	Monies collected at the facility are secured daily in an officially designated and secure space.	X			
3-005	The facility administrator maintains current and complete records of all property, equipment and stores. An inventory is conducted at least annually.	X			Lancaster County operational rules require an annual audit of all facility inventories.
3-006	There is a written plan for the review of equipment needs and replacement of equipment.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
CHAPTER 4 – PERSONNEL		X			Eight direct care, line staff are assigned to each shift.
4-001	The facility is staffed by facility employees awake and on duty on a twenty-four hour basis where juveniles are housed.				
4-002	The facility has sufficient staff to perform all functions relating to security, supervision, services, programs and to operate the facility in conformance with these Standards. The facility administrator prepares and updates a staffing plan annually. The plan details staff assignments and the number of full and part-time staff.	X			Facility staffing and associated training is directed by policies and procedures sections 0100.1 through 0100.9 of the facility SOP manual.
4-003	A minimum of two (2) employees are on duty at all times who are responsible for the direct supervision of the juveniles being detained. At least one employee on duty is female when females are housed and at least one is male when males are housed in the facility.	X			
4-004	At the time of employment, all newly hired employees working in positions involving direct and continuing contact with juveniles meet the following requirements:	X			
4-004.01	At least nineteen (19) year old;	X			
4-004.02	A citizen of the United States;	X			
4-004.03	Free of any convictions of crimes punishable by imprisonment in a federal or state penitentiary for a term of 1 year or more from which a pardon has not been received. At the time of employment, new employees are fingerprinted and a search made of local, state and national fingerprint files for disclosure of any criminal records;	X			Lancaster County Personnel receives and screens applications for minimum qualifications. Potential candidates are referred to the Detention Center for interviews and background checks.
4-004.04	Graduated from high school or possesses certification of an educational development of at least high school level.	X			
4-005	The facility has a written personnel manual that is made available to each employee and is explained to new employees during orientation. New employees sign a statement acknowledging review or receipt of the manual and their responsibility for being aware of its contents. Employees are notified of any changes to the personnel manual when they occur. When the personnel manual is revised, a copy of the portion revised is kept on permanent file.	X			
4-006	The facility has a written disciplinary process that ensures basic due process rights of employees in any adverse personnel actions.	X			
4-007	The facility has a written grievance procedure for employees to follow in filing a grievance. The procedures identify the hearing body and provisions for appeal.	X			
4-008	The facility or governing body maintains a current, accurate and confidential record for each employee. Employees have access to the information in their files.	X			
4-009	If consultants or contract personnel are used to provide services or programs, the facility requires such personnel to complete an orientation and training program appropriate for their services and requires adherence to applicable policies and procedures.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
4-010	Where volunteer services are utilized, the facility has written policies and procedures which address the following:	X			
4-010.01	The roles and types of job assignments for which volunteers may be utilized;	X			
4-010.02	Recruitment, screening, selection and assignment criteria; and	X			Initial background checks are conducted on all staff and volunteers and then every 3 years.
4-010.03	Lines of authority, responsibility and accountability for the volunteer services program. Volunteers are required to complete a training and orientation program prior to assignment, and abide by the facility's policies and procedures where applicable.	X			
CHAPTER 5 - TRAINING		X			The facility's training program is comprehensive and well developed.
5-001	The facility has developed a training and staff development plan.				
5-001.01	Policy and procedure provide for active staff participation in the training and staff development plan.	X			
5-001.02	The training and staff development plan is reviewed at least annually.	X			
5-001.03	A qualified supervisor or manager will be responsible for the training and staff development plan.	X			Johanna Machmer is the facility's training coordinator.
5-002	Space, equipment and resources for personnel training is available at the facility or at selected sites.	X			
5-003	The annual budget includes the necessary funds to meet the training requirements of the standards.	X			
5-004	New full and part-time employees, volunteers and contract personnel are provided orientation training prior to assignment, which is consistent with Standards 5-004.01I.	X			Orientation training is part of the initial training curriculum which is approximately 160 hours.
5-004.02	All facility employees, volunteers and contract personnel sign a statement acknowledging completion of the orientation training.	X			
5-005	Within the first year of employment, all new facility employees have completed initial training that is related to their job classification.	X			Newly hired employees and contractual staff complete initial/orientation training before assuming any duties and shift assignments.
5-005.01	Direct care personnel. Employees whose positions involve supervision or regular daily contact with juveniles have received initial training that meets the requirements of Standards 5-005.01A through 005.01CC.	X			
5-005.02	Supervisory personnel. Employees whose positions involve supervision of direct care personnel on an assigned shift and regular juvenile contact, have received initial training as specified in Chapter 5-005.01 and 005.01A through 005.02E.	X			Shift supervisors receive training according to the requirements of this standard.
5-005.03	Professional specialist personnel. Employees whose positions involve regular juvenile contact and who provide professional services within the facility have received initial training as specified in Standards 5-005.03A through 005.03Q.	X			This includes the contracted education, mental health, maintenance, volunteers and medical staff.

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
5-005.04	Administrative management personnel. Employees whose positions may involve regular juvenile contact but have primary responsibility for management of the facility have received initial training as specified in Standards 5-004.04A through 005.04M.	X			
5-005.05	Support personnel. Employees whose positions may involve regular juvenile contact but who have primary responsibility for providing maintenance and operational support services to the facility have received initial training as specified in Standards 5-005.05A through 005.05J.	X			Thirteen staff members are considered administrative support personnel including, records, trainers and team leaders.
5-005.06	Clerical personnel. Employees whose position involve minimal or no contact with juveniles and who have primary responsibility for clerical or administrative support services to the facility have received initial training as specified in Standards 5-005.06A through 005.06H.			X	
5-005.07	Part-time personnel. Employees who work less than 40 hours per week have received initial training as specified in Standards 005.07A through 005.07J.	X			
5-006	Curriculum utilized to provide initial training specified in 005, is certified by the Jail Standards Board.	X			
5-006.01	Information regarding the curriculum has been provided to the Jail Standards Board to be evaluated for certification as specified in Standards 5-006.01A through 006.01F.	X			
5-007	A copy of the certificate or proper written documentation demonstrating successful completion of training is maintained in the employee's personnel file.	X			
5-008	Employees not completing training as specified by 005 of this chapter have received and provided proof of comparable training and received a waiver by the Jail Standards Board.			X	All staff complete the facility's new employee orientation and the certified initial training course.
5-008.02	Documentation of the full or partial waiver is maintained in the employee's personnel file.			X	
5-009	After the first year of employment all employees receive at least the minimum hours of annual in-service training as identified below for their respective position:	X			This includes certification in First Aid, CPR and PPCT.
5-009.01	Direct Care - 20 hours.	X			
5-009.02	Professional Specialist - 20 hours	X			
5-009.03	Clerical - 8 hours			X	
5-009.04	Administrative/Management - 40 hours	X			
5-009.05	Support - 20 hours	X			
5-009.06	Volunteer - 1 hour	X			
5-009.07	Contract - 1 hour	X			
5-010	A complete and current record of all training received for each employee is maintained in the employee's personnel file. Copies of certificates issued are maintained.	X			All training records are complete, very detailed and provided during each annual inspection.
CHAPTER 6 - FACILITY INFORMATION SYSTEMS		X			A Records Manager maintains the facility's records that include computerized admission and release records, facility operations, documents of detainee activities, programs and services.
6-001	The facility has a written policy and procedure to govern the collection, management and retention of information pertaining to juveniles and the operation of the facility. Written policy and procedure address, at a minimum, the following:				

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
6-001.01	Accuracy of information, including procedures for verification;	X			
6-001.02	Security of information, including access and protection from unauthorized disclosure;	X			
6-001.03	Content of records;	X			
6-001.04	Maintenance of records;	X			
6-001.05	Length of retention; and	X			
6-001.06	Method of storage or disposal of inactive records.	X			
6-002	Information regarding a juvenile is not released to agencies other than criminal justice authorities and agencies with court ordered access, without a written release of information obtained from the juvenile's parent or legal guardian with a copy placed in the juvenile's file.	X			
6-003	Juveniles are permitted reasonable access under appropriate supervision to information in their own files and records. When access is denied, reasons are documented.	X			
6-004	An accurate record of all persons admitted to the facility is maintained.	X			
6-005	The facility maintains documentation on each shift which at a minimum includes:	X			A computerized records management system is employed.
6-005.01	Personnel on duty;	X			
6-005.02	Time and results of checks and resident counts;	X			
6-005.03	Names of juveniles received or discharged with times recorded;	X			
6-005.04	Names of juveniles temporarily released or returned to the facility with times recorded;	X			
6-005.05	Time of meals served;	X			
6-005.06	Shift activities, including unusual or routine incidents;	X			
6-005.07	Entry and exit of all visitors, physicians, attorneys, volunteers, and others;	X			
6-005.08	Notations of problems, disturbances, escapes; and	X			
6-005.09	Notations of any use of emergency or restraint equipment.	X			
6-006	The facility maintains documentation of juveniles placed in temporary confinement away from the general population. The following information, at a minimum, shall be recorded:	X			
6-006.01	Incidents where juveniles are placed in temporary confinement, including date and time;	X			
6-006.02	Visits to juveniles housed in temporary confinement;	X			
6-006.03	Services or programs provided to juveniles housed in temporary confinement;	X			
6-006.04	Disciplinary action taken on juveniles housed in temporary confinement; and	X			
6-006.05	Deprivation or removal of an authorized item, with the reason noted.	X			
6-007	The facility maintains a master file or roster board indicating the current housing assignment and status of all juveniles detained.	X			A computer printout of detainees and housing locations is available to direct care staff and supervisors.
6-008	Facility employees prepare written reports of all incidents resulting in any physical harm or threats to individual safety or the security of the facility.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
6-009	An accurate record of all meals served to juveniles is maintained.	X			
6-010	A visitor's register containing the name of each visitor, time and date, the name of the juvenile to be visited and the relationship of the visitor to the juvenile is maintained.	X			
6-011	A record of the initial telephone calls made upon admission is maintained.	X			
6-012	An accurate and current file is maintained for each juvenile detained. The material contained in the file is consistent with the requirements of Standards 6-012.01 through 012.13.	X			Detainee files maintained by the facility are consistent with the requirements of these standards.
6-013	A separate medical file is maintained for each juvenile's medical record. The material contained in the files is consistent with the requirements of Standards 6-013.01 through 013.09.	X			Separate medical files and records are maintained by medical staff.
6-014	The facility administrator and the facility physician have established procedures to determine access to medical files.	X			
CHAPTER 7 - FIRE SAFETY AND EMERGENCY PROCEDURES		X			Emergency procedures are directed by sections 0300.1 through 0300.12 of the facility SOP manual.
7-001	The facility has a written policy and procedure to address fire safety, safety-related practices and plans for responding to emergencies.				
7-002	The facility complies with the life safety codes established by the State Fire Marshal. Documentation of compliance is maintained.	X			
7-003	A facility employee is designated and trained to coordinate safety-related functions.	X			
7-003.01	The safety coordinator conducts at least a weekly safety inspection of the facility.	X			
7-003.02	The safety coordinator schedules and coordinates fire drills at least quarterly.	X			
7-003.03	The safety coordinator arranges for the inspection and testing of fire detection and suppression equipment by licensed persons at least semi-annually.	X			The training coordinator schedules emergency drills.
7-003.04	The time, date and results of all safety inspections, fire drills, equipment testing and inspections is documented.	X			
7-004	The facility has a written fire evacuation plan which includes evacuation routes and provisions for housing juveniles after evacuation. Evacuation plans are posted.	X			
7-005	The facility administrator involves the local fire department in fire emergency planning, training and drills as appropriate.	X			
7-006	Safe storage and accountability is provided for all flammable, toxic or caustic materials. Juveniles do not have access to these materials without constant staff supervision.	X			This is managed by the two building maintenance staff.
7-007	The facility has written plans and procedures for emergency situations such as fire, disturbances, natural disasters, escape or taking of hostages. Emergency plans and procedures are made available to staff and are reviewed and updated at least annually.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

Standard		Compliance Status In	Out	N/A	Comments
CHAPTER 8 - SECURITY AND CONTROL		X			All facility housing units are direct supervision. Staff conducts and records their detainee observation checks every 15 to 30 minutes.
8-001	Employees observe all juveniles at least every 30 minutes on an irregular schedule and observations are documented.				
8-003	At least 3 documented resident counts during which the juvenile's physical presence is confirmed are conducted every 24 hours.	X			Detainee headcounts are conducted and recorded on each shift.
8-003.01	At least l count is conducted each shift with at least 4 hours between counts.	X			
8-003.02	Juveniles on work release, educational release or other temporary leave status are accounted for when absent from the facility.	X			
8-004	Staff are located in or adjacent to juvenile housing and activity areas.	X			
8-005	Electronic surveillance does not replace staff's personal observation of juveniles as required by Standard 8-001. Video surveillance equipment is used primarily to monitor hallways, stairwells, security perimeter doors and common areas. If living areas are monitored with electronic equipment, shower and toilet areas are shielded to protect juveniles' privacy.	X			
8-006	Facility employees' use of physical force is restricted to instances of self-protection, the protection of others or property, to prevent escapes or suppression of disorder and only to the degree necessary to restore order.	X			Security and Control measures are detailed in sections 1100.1 through 1100.10 of the facility policies and procedures.
8-006.01	Physical force is not used as punishment.	X			
8-006.02	Employees prepare written reports following any use of force. Reports are reviewed by the facility administrator.	X			Reports are prepared and submitted by staff on all significant incidents.
8- 007	Restraint equipment is only used as a precaution against escape during transfer, for medical reasons under the direction of the physician, or to prevent self-injury, injury to others or damage to property.	X			
8 -007.01	Restraint equipment is applied only for the amount of time that is absolutely necessary.	X			
8-007.02	The use of restraints for other than routine purposes, is approved by the employee in charge and documented. The facility administrator reviews the report which states the reason restraints were used and the length of time used.	X			
8-008	The facility has a security perimeter to prevent access to the facility by unauthorized personnel.	X			
8-009	All security perimeter entrances, exterior doors and other doors which the facility administrator determines should be kept locked are kept locked except when in use.	X			Security doors are remotely controlled by staff operating master control.
8-010	The facility administrator or designee conducts weekly inspections of all locks, windows, floors, walls, ventilator covers, access plates, glass panels, protection screens, doors and other security equipment. The date, time and results of the inspections are recorded on a checklist or log. The facility administrator promptly corrects any problems identified.	X			Shift supervisors conduct weekly checks of these components to ensure they are operating properly. Equipment needing attention is referred to maintenance.

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
8-011	A list of items designated as contraband is maintained and described in the juveniles' rule book and visiting rules. Employees are familiar with items designated as contraband.	X			
8-012	The facility has established a search plan to control contraband and weapons.	X			
8-013	Procedures to control contraband require that all materials and supplies are inspected.	X			
8-014	The facility has a plan for searching juveniles to control contraband and weapons which includes at a minimum, the following:	X			
8-014.01	Search of juveniles upon re-entering the security perimeter;	X			
8-014.02	Search of newly admitted juveniles in accordance with Chapter 15-004;	X			
8-014.03	Periodic unannounced and irregularly timed searches of juveniles;	X			
8-014.04	Strip searches at such times when reasonable suspicion exists that a juvenile is in possession of contraband or weapons.	X			
8-015	Except in cases of emergency, pat searches should be conducted by facility employees of the same sex. If a juvenile objects to a pat search from a staff member of the opposite sex, an employee of the same sex will conduct the search.	X			
8-016	Strip searches and body cavity searches are conducted in private, under sanitary conditions and in a manner that preserves the dignity of the juvenile. All strip searches are conducted by facility employees of the same sex as the juvenile or by the facility physician or medical personnel. Body cavity searches are conducted by the facility physician or medical personnel. Persons of the opposite sex of the juvenile, other than medical staff, are not present during strip or body cavity searches.	X			
8-016.01	All strip and body cavity searches are documented as prescribed in Chapter 15-004.07. Documentation of strip and body cavity searches are maintained in facility files and in the juvenile's file.	X			
8-017	Contraband and weapons found during searches are seized. The seizure and disposition of contraband is documented. When a crime is suspected to have been committed in the facility, all evidence is maintained and made available to the proper authorities.	X			
8-018	Facility employees are familiar with the facility locking system and are able to release juveniles immediately in the event of a fire or other emergency.	X			Keys issued to staff are generally secondary keys as security doors are controlled by master control staff.
8-019	The facility has a key control system which includes, at a minimum, the following provisions:	X			
8-019.01	All keys not issued to employees are stored in a secure depository which is accessible only to authorized staff;	X			
8-019.02	There is an accounting procedure for the issuance and return of keys;	X			
8-019.03	There is a procedure for reporting and repair of any broken key or lock;	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
8-019.04	A duplicate set of keys is maintained in a separate, secure place;	X			
8-019.05	Juveniles are prohibited from handling keys which operate perimeter security locks;	X			
8-019.06	Emergency keys are readily accessible for issuance in accordance with emergency procedures;	X			
8-019.07	A key inventory is maintained in which each lock is identified with its location, number of keys available and key labels recorded; and	X			Key security, issuance and inventory is managed by staff operating master control center.
8-019.08	Precautions are taken to ensure the security of non-key operated locks such as electrical switches or mechanical levers.	X			
8-020	The facility has a tool control system which includes at a minimum, the following provision:	X			
8-020.01	Facility tools and potentially dangerous equipment is securely stored in a locked area or outside the security perimeter;	X			Tools and equipment are secured by maintenance employees.
8- 020.02	There is an accounting system to record the issuance and return of all facility tools and equipment;				
8-020.03	Employees carefully monitor the use of tools and equipment by maintenance and repair workers within the security perimeter;				
8-020.04	Tools and equipment are only used by juveniles under the direct supervision of facility employees;	X			
8-020.05	The loss or misplacement of tools or equipment is promptly reported to the facility administrator.	X			
8-021	Except in emergencies, no firearms, chemical agents or other weapons are permitted within the facility's security perimeter.			X	No weapons are used in this facility.
8-021.01	Employees use only the security equipment issued and approved by the facility administrator and only when authorized by the facility administrator. Employees use only the security equipment for which they have received training and qualification.	X			
8-021.02	A weapons locker is provided at the security perimeter entrances for the temporary storage of weapons belonging to law enforcement officers entering the facility.	X			Two firearm lockers are located in this facility for arresting officers to secure their duty weapons.
8-022	The use of any security equipment to control the behavior of juveniles is documented promptly by facility employees involved in a written report to the facility administrator.	X			
8-023	The facility has a written policy and procedure for the handling of emergency situations including at a minimum escape, hostage taking, riots or disturbances, suicides, natural disasters and group arrests.	X			These are specified in policies and procedures 0300.1 through 0300.12.
CHAPTER 9 - FOOD SERVICES		X			
9-001	The food services operation is supervised by a designated employee who has experience and/or training in meal preparation, menu planning, staff supervision, ordering procedures, health and safety policies, theft precautions and inventory control.				

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
9-001.01	If food is obtained through a food service contract from an outside source, provisions are made to assure that the contractor complies with the applicable section of these Standards.	X			Food service is provided by a private contractor located at the County's adult corrections facility.
9-002	The food service meets the dietary allowances as stated the current edition of Recommended Dietary Allowances, of the National Academy of sciences.	X			Menus are established by dieticians with the food service contractor to meet these requirements.
9-003	Menus are planned, dated and available for review at least one week in advance. Notations are made of any menu changes. Menus are kept at least 1 year after use.	X			
9-004	Special diets prescribed are followed according to the orders of the treating physician or dentist.	X			
9-005	Provisions are made for special diets required by a juvenile's religious beliefs.	X			
9-006	An accurate record of all meals served to juveniles including special diets, is maintained. Items served and the time and date served is recorded. A notation is made when a juvenile refuses to eat.	X			All meals and menu plans are documented by the food service contractor.
9-007	Menus and records of meals served are reviewed at least annually by a dietician or nutritionist. Documentation is maintained regarding the review and verification of nutritional adequacy. Subsequent menus are promptly revised to eliminate any deficiencies noted.	X			Food service is well documented as the facility is reimbursed for two meals a day through the Federal School Lunch Program.
9-008	Three meals, at least one of which includes a hot entree, is served daily.	X			
9-008.01	Meals are served at approximately the same time every day. No more than 14 hours between the evening meal and breakfast the next day unless an evening snack is served.	X			
9-008.02	Youth out of the facility attending approved functions when meals are served have a meal provided upon their return if they have not already eaten.	X			
9-009	Meals are prepared with consideration for flavor, texture, temperature, appearance and palatability. Food is served promptly after preparation. Hot food is served hot and cold food is served cold.	X			Food is only served at this location. Preparation occurs at the county's adult facility.
9-010	Food is not withheld, nor the menu varied as a disciplinary sanction.	X			
9-011	Meals are served under the direct supervision of facility employees.	X			
9-012	The facility has a control system for the issuance and return of food preparation and eating utensils.	X			
9-012.01	The facility maintains an adequate supply of the appropriate utensils to accommodate preparation and serving requirements.	X			
9-012.02	An adequate supply of food preparation equipment is maintained.	X			
9-013	Food service and related sanitation practices comply with the requirements of the State Health Department or other appropriate regulatory bodies.	X			The food service area is inspected as part of the building inspections conducted by the County Health Department.

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	Standard	Compliance Status In	Out	N/A	Comments
9-013.01	The facility administrator solicits at least an annual sanitation inspection by a qualified entity. The inspection results are documented with prompt action taken to correct problems.	X			Inspections are also required by the Federal School Lunch Program.
9-013.02	A daily inspection of the food service area and equipment is conducted by the facility administrator, food service personnel or other employee familiar with sanitation requirements.	X			
9-013.03	If food is obtained through a food service contract from a source outside of the facility, the facility maintains documentation that the food service contractor complies with applicable food service sanitation codes, based on an annual inspection by the appropriate regulatory authority.	X			The contractor at the adult jail is licensed and inspected by the State of Nebraska Department of Agriculture, Consumer Protection Division.
9-014	Written policy requires all persons assigned to food service work, including juveniles, to be in good health and free from communicable or infectious disease, vermin or open, infected wounds.	X			
9-015	All persons assigned to food service work are required to maintain adequate personal hygiene and wear appropriate garments while working.	X			
9-016	All persons assigned to food service work are familiar with food service sanitation practices and requirements.	X			
9-017	All dishes, utensils, pots, pans, trays and food carts used to prepare and serve food are washed and rinsed promptly after every meal. Disposable utensils and dishes are not reused.	X			
9-018	A daily cleaning schedule is established and followed.	X			
9-019	Storage and pantry areas are maintained in a clean, sanitary condition and free from contamination at all items.	X			
9-020	Garbage is stored in water tight containers with plastic trash liners and tight fitting covers. Garbage is removed at least daily.	X			
9-021	All food or food products are stored in clean, seamless containers after opening of the original container. Non-perishable food is stored off the floor on washable shelving and is protected from insects, rodents, overhead leakage and excessive heat. Perishable food shall be refrigerated at the proper temperature.	X			
9-022	Food items stored for future use are rotated on a first in, first out basis. All opened food is used within an appropriate time to avoid spoilage or is disposed of.	X			
9-023	Cleaning solutions, insect sprays or any other toxic or poison material is kept in a separate locked storage area.	X			These are secured in the maintenance equipment storage rooms.
9-024	Kitchen floors shall be constructed of smooth, durable material to provide a cleanable surface.	X			
9-025	Kitchen walls, shelves, ceilings and cabinets are finished with smooth, washable, light-colored finishes.	X			
9-026	At least 20 foot-candles of artificial lighting is provided in the kitchen.	X			
9-027	Adequate ventilation is available to dispel excessive heat, steam, condensation, odors, vapors, smoke and fumes from the kitchen area.	X			

Nebraska Jail Standards
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Standard		Compliance Status In	Out	N/A	Comments
9-028	Vent openings to outside air are screened to prevent entrance of contaminants.	X			
9-029	Adequate supplies of hot and cold water are available in the kitchen as required by the food service sanitation manual.	X			
9-030	Toilet and lavatory facilities are available to food service workers in the vicinity of the kitchen.	X			
CHAPTER 10 - SANITATION AND HYGIENE		X			The entire facility was observed to be exceptionally clean and well maintained.
10-001	The facility is maintained in a clean and healthful condition. The facility administrator or their designee conducts at least weekly sanitation and maintenance inspections of all areas of the facility.				
10-002	The facility has a plan for the control of vermin and pests that includes inspections and treatments by a licensed professional.	X			
10-003	The facility has a written housekeeping plan that provides for the daily housekeeping and maintenance of the physical plant. The plan includes:	X			Custodial employees are contracted to provide cleaning, maintenance and sanitation services.
10-003.01	Work is assigned and supervised by facility employees. Juveniles are not allowed to assign work to other juveniles;	X			
10-003.02	Bars, screens, ledges and other exposed surfaces are dusted and/or washed weekly or when soiled:	X			
10-003.03	Floors are swept daily and scrubbed and rinsed at least weekly. Carpeted floors are vacuumed daily. Floors are kept free of hazardous objects;	X			
10-003.04	Walls and ceilings are cleaned when soiled. Juveniles are prohibited from placing any pictures on walls or ceilings;	X			
10-003.05	Toilets, lavatories, sinks, showers and other sanitary equipment is cleaned daily;	X			
10-003.06	Juveniles are responsible for keeping their room or sleeping area clean at all times. Rooms and dormitories are kept free of accumulations of food or unnecessary articles which might attract vermin;	X			Housekeeping plans involve juveniles participating as part of their self-improvement program.
10-003.07	Durable, fire-retardant trash receptacles are provided throughout the facility and are emptied and cleaned daily;	X			
10-003.08	Cleaning tools and supplies are provided to juveniles to be used under the supervision of facility employees. Supplies are not stored in living areas. Mops and other cleaning tools are stored in a well-ventilated place. Juveniles access to cleaning material is controlled;	X			
10-003.09	Mop sinks and janitor's closets are cleaned after each use.	X			
10-003.10	To the extent possible, cleaning supplies are nontoxic to humans. All hazardous cleaning solutions are clearly labeled and securely stored in an area apart from all other articles.	X			
10-004	Painted surfaces are not scaled or deteriorated.	X			
10-005	All plumbing, lighting, ventilation equipment, furnishings and security hardware in living areas is kept in good working order. Any broken devices are promptly repaired or replaced.	X			

Nebraska Jail Standards
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	Standard	Compliance Status In	Out	N/A	Comments
10-006	Where the facility's water supply is obtained from a private source, the source is properly located, constructed and operated to protect it from contamination and pollution. The water meets all current purity standards as set by state or local authorities.			X	Water is supplied by the City of Lincoln water system.
10-007	Sufficient shower facilities with adequate supplies of hot and cold water are available in the living areas to allow for daily showers or bathing. Juveniles are encouraged to shower or bathe at least 3 times a week.	X			There is one shower located in intake and two in each housing unit dayroom.
10-008	Provisions are made for juveniles to receive hair care as needed.	X			
10-009	The facility provides without charge soap, shampoo, deodorant, toothbrush, toothpaste, comb, shaving equipment upon request and products for female hygiene as required by Standards 009.01 through 009.08.	X			Hygiene items are supplied during admission and replaced as needed.
10-010	Toilet paper is available at all times in juvenile toilet areas.	X			
10-011	Clean clothing, bedding, linens and towels are issued to juveniles held overnight. At a minimum, the following are provided.	X			
10-011.01	A set of clean clothing is provided when the juvenile's personal clothing is not allowed or is unsuitable. Clean socks and underwear is provided daily and other clothing at least twice a week;	X			
10-011.02	Fire-retardant mattress and pillow;	X			
10-011.03	Pillow case;	X			
10-011.04	Two (2) sheets or one (1) sheet and one (1) mattress cover. Sheets and mattress covers are exchanged at least weekly;	X			
10-011.05	Fire-retardant blankets; and	X			
10-011.06	Clean towel and washcloth, exchanged daily.	X			
10-012	Laundry services are sufficient to allow required exchanges of clothing, bedding and towels.	X			
10-013	The facility inventory of clothing, bedding, linen and towels exceeds the maximum population to ensure that a reserve is always available.	X			
10-014	Juvenile's personal clothing is cleaned upon admission, when necessary, before storage or before it is allowed to be worn.	X			
CHAPTER 11 - HEALTH SERVICES		X			The facility contracts with a private medical care provider.
11-001	The facility has a written agreement or contract with a physician, hospital or clinic to provide health care services. If the health authority is a hospital or clinic, medical judgments rest with a single, designated, responsible physician licensed in this state.				
11-002	Except for regulations to ensure safety and order, matters of medical, mental health and dental judgment are determined entirely by the responsible physicians.	X			Health services are specified in policy and procedures, sections 0700.2 through 0700.08.
11-003	The facility has written policies and procedures, approved by the facility physician, to govern the delivery of medical, dental and mental health services. Policies and procedures address at a minimum, the following:	X			

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Standard	Compliance Status In	Out	N/A	Comments
11-003.01 Receiving screening;	X			Directed by policy section 0700.01 of the facility SOP manual.
11-003.02 Collection of health appraisal data;	X			
11-003.03 Non-emergency medical services;	X			
11-003.04 Emergency medical and dental services;	X			
11-003.05 First-aid and CPR;	X			
11-003.06 Screening, referral and care of juveniles who may be suicide-prone, or experience physical, mental or emotional disabilities;	X			The facility has contracted specialists to provide mental health counseling and services.
11-003.07 Arrangements for providing chronic and convalescent care:	X			
11-003.08 Arrangements for providing close medical supervision of juveniles with special medical or psychiatric problems;	X			
11-003.09 Delousing procedures;	X			
11-003.10 Infectious disease control;	X			
11-003.11 Arrangements for providing detoxification;	X			
11-003.12 Handling of pharmaceuticals; and	X			
11-003.13 Notification of next of kin in case of serious illness, injury or death.	X			
11-004 State licensing, certification and/or registration requirements apply to medical personnel. Copies of credentials for each medical employee are kept on file at the facility or contracting entity.	X			
11-005 The facility has written job descriptions for all medical personnel that define their roles in the facility health care system.	X			
11-006 The facility employs at least one full-time or part-time medical professional, such as a nurse, physician assistant or emergency medical technician. If the facility administrator designates non-medical personnel to coordinate the delivery of health care services, employees must be appropriately trained and carry out those duties under joint supervision of the facility administrator and physician.	X			Contract Nurses provide on-site and on-call medical services.
11-007 Space, equipment, supplies and materials necessary for health care services provided at the facility are available.	X			The medical area includes an office, records storage and exam room.
11-008 First-aid supplies are available in the facility at all times. Location and content of first-aid supplies is determined by the facility physician. The facility administrator has established a procedure for the monthly inspection and maintenance of supplies.	X			
11-009 Medical screening is performed on all juveniles upon admission to the facility. The findings are recorded on a printed form approved by the facility physician. The medical screening includes the following:	X			The nurses meet with all detainees within 24 hours of detention for health evaluations.
INQUIRY INTO: 11-009.01 Current illness and health problems, dental problems and infectious diseases;	X			
11-009.02 Medication taken and special health requirements;	X			

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Standard	Compliance Status In	Out	N/A	Comments
11-009.03 Drug or alcohol use, including types, methods, date and time of last use, and a history of problems that may have occurred after ceasing use;	X			
11-009.04 Past or present treatment or hospitalization for mental disturbance or suicidal behavior;	X			
11-009.05 Mental illness; and	X			A Suicide Risk Inventory is completed and forwarded to the mental health/counseling staff.
11-009.06 Other health problems designated by the facility physician.	X			
OBSERVATION OF:	X			
11-009.07 Behavior, including state of consciousness, mental status, appearance, conduct, tremor or sweating; and				
11-009.08 Body deformities, physical injuries, trauma, markings, bruises, jaundice, rashes, evidence of body vermin, ease of movement, etc.	X			
DISPOSITION OF:	X			
11-009.09 General population;				
11-009.10 General population and referral to appropriate health care services; or	X			
11-009.11 Immediate referral to health care services.	X			
11-010 Request for medical treatment is collected daily. Requests are reviewed by medical professionals or a trained employee to determine disposition or referral to facility physician.	X			Detainee medical requests or recommendations from staff are delivered to the nursing staff.
11-011 Treatment provided by medical personnel other than physicians are performed pursuant to standing or direct orders.	X			
11-012 Juveniles suspected of having contagious or infectious diseases are temporarily isolated immediately from other juveniles and are examined by a physician promptly. If transfer to a hospital is not ordered, the physician's instructions are carefully followed.	X			
11-013 Reasonable dental care is available and provided when the health of a juvenile during the confinement would otherwise be adversely affected.	X			
11-014 Detoxification programs are provided and under medical supervision for alcohol and drug-dependent juveniles either on-site or through transfer to other facilities.			X	Intoxicated juveniles are not admitted until they have detoxified at a local hospital and cleared by physicians.
11-015 Examinations and treatments affected by informed consent requirements are observed for juveniles' care.	X			
11-016 Emergency medical and dental care is available at all times. Written plans for emergency services include arrangements for:	X			Emergency medical care is provided at Bryan West and other local hospitals.
11-016.01 Emergency evacuation of juveniles from the facility;	X			
11-016.02 Use of an emergency vehicle;	X			
11-016.03 Use of one or more hospital emergency rooms or other appropriate health care facility; and	X			
11-016.04 Emergency on-call physician and dental services when the emergency health care facility is not located nearby.	X			

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Standard		Compliance Status In	Out	N/A	Comments
11-017	Written procedures are established for the proper management of pharmaceuticals.	X			
11-017.01	Prescription medicines kept at the facility are securely stored.	X			
11-017.02	Prescriptions are labeled with the prescription number, type of medication, prescribed dosage, time to be administered, date of prescription, juvenile's name and the name of the prescribing physician. A copy of each prescription is placed in the juvenile's medical file.	X			Medications are secured, controlled and managed by the contract medical care provider.
11-017.03	Prescriptions are administered in the prescribed dosage at the prescribed time by the facility physician, medical personnel or a designated and appropriately trained facility employee.	X			Medical staff or the shift supervisors administers prescription medication.
11-017.04	The administration of medication is recorded in the manner and on a form approved by the facility administrator.	X			
11-018	The facility has a procedure for notification of those designated by the juvenile to be contacted in the case of serious illness, injury or death.	X			
11-019	In the event of a juvenile's death, the coroner, county attorney and appropriate law enforcement agency is notified immediately.	X			
11-020	The facility physician and medical personnel have access to the juvenile's confinement records when needed.	X			
11-021	Facility employees are appraised of a juvenile's medical condition when they have a need to know to ensure the safety and well-being of the juvenile or others.	X			Medical files on detainees are managed by the medical contractor.
CHAPTER 12 - RIGHTS OF JUVENILES		X			These are specified in the facilities policy and procedures manual section 1000.01and are consistent with the requirements of these standards.
12-001	The facility safeguards the basic rights of juveniles through written policies and procedures that are consistent with fundamental legal principles, sound correctional practice and humane treatment. Policies and procedures provide, at a minimum, the following:				
12-001.01	Access to attorneys and their authorized representatives and to the courts;	X			Video court appearances are provided to local courts and contract counties courtrooms.
12-001.02	Access to basic medical and dental care;	X			
12-001.03	Access to religious services and religious counseling on a voluntary basis, subject to limitations necessary to maintain facility security and order;	X			
12-001.04	Opportunity to receive visits and to communicate and correspond with persons, organizations or representatives of the media, subject to limitations necessary to maintain facility security and order;	X			
12-001.05	Freedom from personal abuse, corporal or unusual punishment, humiliation, mental abuse or punitive interference with daily functions of living, such as eating or sleeping;	X			
12-001.06	Freedom from discrimination based on sex, race, creed, religion, national origin, disability or political belief and to have equal access to available programs and work assignments;	X			

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Standard	Compliance Status In	Out	N/A	Comments
12-001.07 Access to opportunities for physical exercise and equipment;	X			Both indoor and outdoor exercise areas are provided.
12-001.08 Access to education services to the level mandated by law.	X			The facility provides education with a certified school and educators.
12-002 The facility has a written grievance procedure which includes:	X			
12-02.01 Any juvenile has the right to report and file a grievance;	X			
12-002.02 The facility administrator or designee promptly investigates, makes a written report and responds to all grievances, providing reasons for the decision. Responses to grievances are within a prescribed, reasonable time period, with special provisions for responding to emergencies;	X			
12-002.03 Juveniles reporting a grievance are not subject to reprisals;	X			
12-002.04 Juveniles are provided at least one level of appeal; and	X			
12-002.05 Notation of any grievances filed are made in the shift log and/or the juveniles' individual record.	X			
CHAPTER 13 - RULES AND DISCIPLINE 13-001 The facility has written policies and procedures for maintaining discipline and regulating juveniles' conduct.	X			The Records Supervisor is the designated disciplinary hearing officer.
13-001.01 Conduct is regulated in a manner which encourages and supports appropriate behavior;	X			
13-001.02 Disciplinary actions are of such a nature to regulate juveniles behavior within acceptable limits and is taken at such items and in such degrees as necessary to accomplish this objective.	X			Detainee rules and discipline are specified in sections 1000.2 and 1000.3 of facility policy and procedures.
13-001.03 The behavior of juveniles is controlled in an impartial and consistent manner;	X			
13-001.04 Disciplinary action is not capricious, retaliatory or revengeful. Group punishment is prohibited;	X			
13-001.05 Corporal punishment is prohibited;	X			
13-001.06 Use of mechanical restraints as punishment is prohibited;	X			
13-001.07 Withholding food or variation of diet as punishment is prohibited; and	X			
13-001.08 Juveniles are not subject to any situation in which juveniles impose discipline on each other.	X			
13-002 The facility has written rules of conduct which specify prohibited acts within the facility, the penalties that may be imposed and the disciplinary procedures to be followed. Upon admission, each juvenile is provided with a copy of the rules.	X			Rule books are provided to each detainee during intake and they are posted in each of the living units.
13-003 The facility has guidelines for informally resolving minor misbehavior. Guidelines may include room restriction of a juvenile for up to 60 minutes for "cooling off". This form of room restriction is noted in the shift activity documentation.	X			Three cells in the admissions area are used as temporary housing for detainees facing disciplinary proceedings for major misconduct.
13-004 Rule infractions for which the maximum penalty is temporary room restriction, not exceeding 24 hours, deprivation or limitation of privileges for 7 days or less, a warning, a verbal reprimand or counseling, is considered a minor rule infraction. Procedures for handling minor rule infractions include:	X			Sanctions have been revised according to the directives of statutes implemented by LB 230.
13-004.01 The juvenile is informed of the specific rule he or she is alleged to have violated;	X			

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Standard		Compliance Status In	Out	N/A	Comments
13-004.02	The juvenile is given an opportunity to explain the reasons for the violation;	X			
13-004.03	The juvenile is advised of any actions taken and the reasons for taking such actions;	X			
13-004.04	The juvenile has the right to appeal any disciplinary decision or action on a minor rule violation. Employees handling minor rule infraction prepare an incident report describing the rule infraction and the action taken.	X			
13-005	Rule infractions for which the possible sanctions include limitation or deprivation of privileges for more than 7 days, or placement in disciplinary confinement not to exceed 7 days, except in cases involving violence, the violation is treated as a major infraction. Procedures for handling major infractions include:	X			
13-005.01	Employees alleging a major rule violation prepare a disciplinary report and forward it to the disciplinary officer without delay. The report includes, at a minimum:	X			
13-005.01A	A description of the incident;	X			
13-005.01B	Specific rule violated;	X			
13-005.01C	Unusual behavior;	X			
13-005.01D	Staff or juvenile witnesses;	X			
13-005.01E	Disposition of any physical evidence;	X			
13-005.01F	Immediate action taken, including use of force and pre-hearing confinement; and	X			
13-005.01G	Reporting staff member's signature with date and time report is made.	X			
13-005.02	An investigation of a reported major rule infraction is started within 24 hours of the time the alleged violation was reported, unless exceptional circumstances justify a delay.	X			
13-005.03	Those charged with major rule infractions are provided with a written statement of the charges, with a description of the incident, the specific rule violated and notice of the hearing on the incident. The juvenile has at least 24 hours prior to the hearing to prepare a defense.	X			
13-005.04	A hearing on the major rule infraction is held by the designated disciplinary hearing officer or committee, within 96 hours of the time the statement of charges is delivered to the juvenile. The officer or committee has not been directly involved in the incident. Hearing procedures include the following provisions:	X			
13-005.04A	The juvenile may be present at the hearing unless he or she waives that right in writing or if the juvenile's behavior justifies exclusion from the hearing;	X			
13-005.04B	The juvenile may request the services from a staff member to represent them during the hearings;	X			
13-005.04C	The juvenile is allowed to call witnesses and present documentary evidence in his or her defense;	X			
13-005.04D	The disciplinary officer renders decisions based on the preponderance of evidence presented and prepares written records of decisions and sanctions imposed; and	X			

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	Standard	Compliance Status In	Out	N/A	Comments
13-005.04E	Copies of decisions and the sanctions imposed are provided to the juveniles.	X			
13-005.05	Juveniles have the right to appeal disciplinary decisions on major rule violations to the facility administrator who considers the following:	X			
13-005.05A	That there was substantial compliance with facility policy and procedures on discipline;	X			
13-005.05B	That the decision was based on a preponderance of evidence; and	X			
13-005.05C	That the sanction imposed was proportionate to the infraction.	X			
13-005.06	When juveniles are found not guilty of an alleged infraction, all reference to the incident are removed from his of her file.	X			
13-005.07	Juveniles are placed in pre-hearing confinement only when they are charged with a major infraction and when it is necessary to ensure the safety of the juvenile or the facility. Confinement beyond 24 hours is reviewed by the facility administrator or designee daily.	X			
13-006	When a juvenile allegedly commits an act that violated federal, state or local criminal law, the case is promptly referred to the appropriate authority for possible prosecution.	X			Facility policy requires law enforcement notification.
13-007	When juveniles are confined separate from the general resident population, they are afforded the following:	X			
13-007.01	Living conditions and access to programs and services approximating those available to the general population, subject to restrictions necessary to ensure safety and security. When services or programs are withheld, written justification is provided.	X			
13-007.02	Juveniles placed in separate confinement are visually checked every 30 minutes and are visited by staff at least once each shift. Documentation of staff visits are recorded as provided in Standard 6-006.	X			
CHAPTER 14 - MAIL, VISITING, TELEPHONE		X			
14-001	The length, source or volume of mail a juvenile may send or receive, at his or her own expense, is not limited, except where there is clear and convincing evidence to justify limitations for reasons of public safety, facility order or security.				
14-002	Juvenile mail, both incoming and outgoing, is not read or rejected, except where there is reason to believe that such correspondence threatens the safety and security of the facility, another juvenile, any public official or the general public or is being used in the furtherance of illegal activities.	X			
14-003	Incoming mail is opened and inspected for contraband. Cash, check and money orders are removed from incoming mail and credited to the juvenile's account. If contraband is discovered in either incoming or outgoing mail, it is removed with disposition recorded.	X			

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	Standard	Compliance Status In	Out	N/A	Comments
14-004	If publications, correspondence or contents of a package or mail is rejected, the sender and the person to whom it is addressed is notified in writing of the reasons for rejection. Rejected items are returned to sender or placed in the juvenile's property, unless it contains illegal materials to be kept for evidence.	X			
14-005	Juveniles are permitted to send sealed letters to attorneys, courts, government officials and officials of the confining authority.	X			
14-006	Incoming mail from attorneys, courts, government officials, officials of the confining authority or administrators of grievance systems may be opened only to inspect for contraband and in the presence of the juvenile to whom it is addressed. This mail is not read unless there is probable cause to believe the contents pose a threat to safety and security of the facility or another person or is being used in the furtherance of criminal activities.	X			
14-007	Indigent juveniles are provided with writing supplies and postage for all letters to their attorneys, the courts, government officials or officials of the confining authority.	X			
14-008	Indigent juveniles are provided with writing supplies and postage for 2 personal letters a week.	X			
14-009	Incoming mail is delivered to juveniles within 24 hours of receipt, excluding weekends and holidays. Outgoing mail is delivered to the postal service daily, excluding weekends and holidays. Attempts are made to forward mail when juveniles have been released.	X			
14-010	All juveniles, except those on disciplinary restriction, are provided the opportunity to make at least 1 personal telephone call daily.	X			
14-010.01	At least 5 minutes is allotted for each telephone call.	X			
14-010.02	Telephone calls are not monitored unless authorized by law.				
14-011	Juveniles are allowed to make a reasonable number of telephone calls to their attorneys, caseworkers, probation or parole officers and counselors at the juveniles' expense unless they are indigent.	X			Juveniles are allowed unrestricted phone usage for legal and professional calls.
14-011.01	Privileged telephone calls are of reasonable duration.	X			
14-011.02	Privileged telephone calls are not monitored.	X			
14-011.03	Privileged telephone calls are not revoked as a disciplinary measure.	X			
14-012	The facility has an established visiting schedule with sufficient hours set aside weekly to fulfill the visiting requirements of all juveniles in the facility.	X			Video visiting hours are scheduled 3 days during the week for personal visits.
14-012.01	Visiting times are scheduled on at least 2 days a week, one of which is during the weekend.	X			
14-012.02	Each juvenile, except those on disciplinary restriction, have at least 2 hours of visiting each week in two or more visits.	X			
14-012.03	Visits are not limited to less than 30 minutes in duration.	X			

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	Standard	Compliance Status In	Out	N/A	Comments
14-012.04	The number of visitors a juvenile may receive is only limited by facility space constraints, except where substantial reasons justify limitations.	X			
14-012.05	Persons under age 18, when accompanied by a parent or legal guardian, may be permitted to visit.	X			
14-013	Visitors may be excluded for one or more of the following reasons:	X			
14-013.01	Visiting restrictions have been placed on the juvenile by the parents/legal guardians, probation officer, parole officer or the Court of jurisdiction;	X			
14-013.02	The visitor refuses to register and show proper identification, consent to search or abide by the visiting rules;	X			
14-013.3	The visitor represents a reasonable danger to the facility;	X			
14-013.04	The visitor has a past history of disruptive conduct at the facility;	X			
14-013.05	The visitor appears to be under the influence of alcohol or drugs; or	X			
14-013.06	The juvenile refuses the visit.	X			
14-014	Rules governing (visitor's conduct) are posted in the visiting area.	X			
14-015	Visitors are required to register prior to visiting.	X			
14-017	A secure and suitable visiting area is provided for juveniles and visitors to converse at normal voice levels.	X			
14-018	Visitors may be pat or strip searched prior to a contact visit if probable cause exists.	X			
14-019	Juveniles are provided adequate opportunities to meet with attorneys, probation and parole officers, counselors, caseworkers and the clergy.	X			This is provided in confidential, contact visiting areas.
14-019.01	Attorneys, probation and parole officers, counselors, caseworkers and clergy are permitted to visit juveniles at reasonable hours other than during regular visiting hours.	X			
14-019.02	Visits with professionals listed in 019.01 of this chapter are not monitored, except staff may make visual observations to maintain security.	X			
14-019.03	Visits with professional listed in 019.01 of this chapter are of the contact type unless otherwise indicated by the juvenile, the visitor or the facility administrator when there is a substantial security justification to require a non-contact type. When a contact visit is not allowed, the reasons are documented.	X			
14-019.04	A private area or room for confidential communication for up to 4 people with adequate writing space is provided for contact visits.	X			
14-019.05	Professionals as those listed in 019.01 of this chapter may be subject to a search prior to a contact visit.	X			
CHAPTER 15 - ADMISSION AND RELEASE		X			Admissions, classification and releases are specified in sections 0500.1 through 0500.7 of the facility's policies and procedures.
15-001	The admitting staff member positively identifies the committing officer and verifies the committing officer's authority to have the juvenile detained.				

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	Standard	Compliance Status In	Out	N/A	Comments
15-001.01	When juveniles are taken into custody, the committing officer secures the authorization for detention from the court of jurisdiction or a probation officer prior to admission.	X			The arresting officer contacts probation for screening and admissions on new law violations.
15-001.02	The facility has provisions to assure there is valid authority to:	X			
15-001.03	Detain all juveniles presented for admission.	X			
15-001.04	The committing officer remains present during the admission process until all pertinent information is recorded and the admitting staff member accepts custody of the juvenile.	X			Juveniles are admitted according to probation officer screenings, allowances and determinations.
15-002	The admitting staff member, to the best of his or her ability, ascertains the identity and age of the juvenile.	X			
15-003	Juvenile's showing signs of illness, injury or if they are incoherent or unconscious, are not admitted to the facility until the committing officer has been provided with documentation from a physician or facility medical personnel of examination, treatment and fitness for confinement.	X			
015-04	The admitting staff member conducts a thorough search of the juvenile being admitted. Written policies and procedures regarding searches upon admission are consistent with the following provisions:	X			Section 1100.04 of the facility's SOP manual specifies the required search criteria and procedures.
15-004.01	All searches are the least intrusive type necessary to satisfy the safety and security needs of the facility.	X			
15-004.02	Pat searches are considered the initial method of searching juveniles upon admission. Pat searches are conducted as prescribed in Standard 8-015.	X			
15-004.03	Strip searches upon admission are authorized only upon individualized determination of reasonable suspicion or probable cause as set forth in Standards 15-004.03A through 004.04H.	X			
15-004.05	Body cavity searches upon admission are authorized only when there is probable cause to believe that contraband will be discovered.	X			
15-004.05A	Body cavity searches must be authorized by the facility administrator or designee.	X			
15-004.05B	Body cavity searches are not conducted unless the pat search, strip search and clothing search has failed to satisfy safety and security needs.	X			
15-004.06	All strip searches and body cavity searches are conducted under the condition prescribed in Standard 8-016.	X			
15-004.07	A written record is made of strip searches and body cavity searches of juveniles upon admission, consistent with Standards 15-004.07A through 004.07E.	X			
15-005	A standardized intake and release form is completed on every new juvenile.	X			A computerized intake and release form is completed.
15-006	Juveniles under age 14 are not fingerprinted, except by court order. Juveniles age 14 or older may be printed. The fingerprints of any juvenile are not sent to a federal or state depository except for felony convictions, escape from a YDC or to identify and return a runaway.	X			Juveniles are fingerprinted according to statute, using AFIS equipment.

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	Standard	Compliance Status In	Out	N/A	Comments
15-007	Juveniles are screened and observed to determine if immediate medical or mental health attention is needed.	X			Admissions involve thorough screenings and assessments for medical and mental health status.
15-008	Juveniles detained are allowed to complete at least 2 unmonitored telephone calls at the time of admission to communicate with family, an attorney or a bail bondsman.	X			Initial phone calls are noted on the juvenile detainee's intake form.
15-009	Money, valuables and other personal property not allowed in the facility is taken from juveniles during admission and securely stored. An itemized inventory signed by the juvenile and admitting staff is prepared and placed in the juvenile's file. Personal property released to a third party has the juvenile's signature of approval and the third parties signature of receipt.	X			
15-010	After the booking process is completed, juveniles to be housed are required to shower.	X			Juveniles are required to shower in the intake shower area.
15-011	Newly admitted juveniles are issued clothing as necessary and standard issue bedding and hygiene items.	X			
15-012	Newly admitted juveniles are assigned to initial housing according to the facility's classification plan. Male and female juveniles do not occupy the same sleeping rooms.	X			Completed classification forms are maintained in the detainee's file.
15-013	Newly admitted juveniles receive orientation to the facility within 24 hours of admission. Juveniles are provided with written information and regulations governing treatment and conduct, daily activity schedules, programs and services, acquiring assistance, making complaints and emergency procedures.	X			
15-013.01	The written information includes a copy of the rules, a listing of prohibited acts, the range of possible sanctions and the disciplinary procedures followed. Juveniles have access to the written information during their entire stay at the facility.	X			
15-013.02	Assistance is provided where a language or literacy barrier prevents juveniles from understanding the orientation materials.	X			
15-013.03	Juveniles verify with their signature that they have been made aware of the facility's rules, programs and services.	X			Juveniles receive a facility handbook during admission.
15-013.04	When requested, parents or guardians of detained juveniles receive a copy of the facility rules.	X			
15-014	If a juvenile's physical condition, mental condition or behavior prevents completion of the admissions process, it can be delayed until the juvenile is capable of being processed in a safe and orderly manner.	X			
15-015	When detainees are brought into the facility, employees of the same sex are present to assist with the admission process.	X			
15-016	Releasing staff positively identify the juvenile to be released and the authority for the release. When a juvenile is released to another authority, the identity of the receiving officer is verified.	X			A digital photograph is taken of detainees during the admission process and attached to the booking records.
15-017	Releasing staff record the time, date, authority for release and receiving authority, if any, on the facility's release form. Releasing staff sign the completed form.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
15-018	Upon release, the juveniles' personal property is returned. The juvenile and the releasing staff sign a receipt for all property returned.	X			
15-019	The facility has a procedure for handling complaints about property.	X			
15-020	Property not claimed within 6 months of a juvenile's discharge may be disposed of by the facility if it is documented that the juvenile, parent/legal guardian or a responsible party were notified at least 3 times to pick up the property.	X			
CHAPTER 16 - PROGRAMS AND SERVICES		X			Programming is addressed in policy and procedures sections 0900.1 through 0900.5.
16-001	Written policies and procedures provide that available programs and services include at a minimum, counseling, religious services, exercise and recreational activities, library services and educational programs.				
16-002	At least one employee is designated to be responsible for assessing the needs of juveniles, coordinating the delivery of services and programs and developing local resources.	X			Professional specialists provide mental health services, life skills and educational services.
16-003	The facility has a plan for juvenile services and programs that provides for the use of community resources.	X			
16-004	All facility employees are familiar with services and programs available to juveniles.	X			
16-005	Counseling services should be available in the following areas: substance abuse, mental health, religion, education, anger control, survival skills/independent living skills, health and welfare, sexual abuse and family problems.	X			
16-006	Educational opportunities are available to all juveniles except where there is substantial justification for restriction.	X			
16-006.01	The educational program is available a minimum of 3 hours per day during the days the local school district hold classes. Exercise and recreation time not included in the 3 hour minimum.	X			The education department is a licensed ESU rule 18 school with contracted LPS teachers. Classes are scheduled for five hours each day.
16-006.02	The educational program includes contact and coordination with the juveniles' home schools.	X			
16-006.03	The educational program includes remedial education.	X			
16-006.04	The educational program provides for GED opportunities or classes and courses recognized by the Nebraska Department of Education.			X	
16-006.05	The educational program should include: life skills and vocational training activities.	X			
16-006.06	The educational program is supported with sufficient equipment and materials that meet state educational standards.	X			There are classrooms, a life skills center, library and a resource center available.
16-006.07	Juveniles may participate in educational release programs as authorized by the court having jurisdiction.	X			
16-006.08	The facility utilizes certified teachers and curriculum in the delivery of educational services. Copies of current credentials for each teacher are kept on file.	X			Teachers, an education coordinator, a programming coordinator and their support staff are contracted though Lincoln Public Schools.

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
16-006.09	An adequate number of educational personnel are available to provide educational programming.	X			
16-006.10	Juveniles should be counseled regarding the importance of education to continue school attendance or re-enrolling upon discharge.	X			
16-006.11	Arrangements may be made for youth to enroll in higher education courses.	X			
16-007	Every juvenile, upon request, is allowed to practice the religion of their choice and have access to clergy, publications and religious symbols, subject only to limitations necessary to maintain safety, security and order.	X			
16-008	The facility has a designated Chaplain or facility employee to identify religious needs and coordinate facility religious programs.	X			A Chaplain coordinates religious programming.
16-09	The facility provides a recreational program which includes active exercise and leisure time activities.	X			
16-009.01	The facility provides an established exercise schedule to ensure that juveniles have at least 1 hour of physical exercise and at least 1 hour of structured leisure-time activities per day. Written documentation is maintained when exercise and leisure activities are provided.	X			
16-09.02	Sufficient space in the facility is designated for exercise. It is in a secure area that is sufficient in size to allow the maximum number of users at any one time to participate in exercise and which is appropriate for the types of exercise offered.	X			An indoor gymnasium with an exercise room and several outdoor recreation areas are offered.
16-009.03	Enough equipment is provided to ensure that all juveniles have the opportunity to participate in exercise activities during their designated exercise period.	X			Basketball and exercise equipment is provided.
16-009.04	Provisions are made for passive recreational activities.	X			
16-010	Library services are available to all detained juveniles.	X			
16-010.01	Library materials are responsive to the educational informational and recreational needs of juveniles and include a reasonable selection of fiction, non-fiction, educational and reference materials, as well as current magazines and newspapers.	X			Educational staff manages the school library within the facility and have access to LPS library materials.
16-010.02	Library services are available at least 5 days per week.	X			
16-010.03	Library services can be provided by a community library or similar resources.	X			
16-011	The facility may have a work assignment plan to involve juveniles in facility housekeeping and maintenance.			X	Juveniles are not assigned to work.
16-011.01	Written policy and procedure prohibit discrimination in work assignments.			X	
16-011.02	Work assignments do not conflict with educational programs.			X	
16-011.03	Juveniles are not permitted to perform any work prohibited by state or federal regulations and child labor laws.			X	

Nebraska Jail Standards
Juvenile Facility Inspection

Standard		Compliance Status In	Out	N/A	Comments
CHAPTER 18 – NEW FACILITY DESIGN AND CONSTRUCTION		X			
18-001	All standards in this section apply to new juvenile detention facilities and renovation of existing juvenile detention facilities for which construction is initiated after the effective date of these Standards.				
18-002	The facility has a rated capacity established in accordance with these Standards.	X			The approved capacity is based on final plans which provide for secure detention of 60 juvenile detainees and 5 special purpose beds.
18-003	All new construction and renovation complies with the building, safety and health codes of the local authority and the applicable requirements of the State Fire Marshal.	X			
18-004	New facilities or major renovations are designed only after a thorough assessment of needs has been conducted.	X			The needs assessment was completed and submitted to Jail Standards Staff in 1998.
18-005.01-08	A written program statement which provides the basis upon which architectural plans are drawn was prepared for all new construction and major renovation projects. The program statement was submitted to the Jail Standards Division for review and comment upon completion.	X			Jail Standards Staff reviewed pre-architectural program plans in June 1998.
18-007.01-03	A copy of all architectural design documents were submitted to the Jail Standards Division for review and comment.	X			Design documents were submitted and approved by the Jail Standards Board July, 1999.
18-008	Contracts were not let until approval of final documents was received by the governing body from the Jail Standards Board. No addenda, change orders, or modifications which affect compliance with these Standards were made to final documents except upon approval of the Jail Standards Division.	X			Final design and construction plans were approved by the Jail Standards Board on December 21, 1999.
18-010	All newly constructed or renovated juvenile detention facilities shall conform to the following general conditions:	X			
18-010.01	Light levels in all housing areas are at least twenty (20) foot-candle measured three feet above the floor. Light levels in other areas are appropriate for the use and type of activities which occur. Night lighting does exceed five (5) foot-candle during sleeping hours.	X			All light readings taken confirm that between 20 and 30 foot candle levels are provided in all secure areas of the facility.
18-010.02	In all new construction, there is a window in each sleeping room which provides at least three (3) square feet of transparent glazing to the exterior, or the rooms open into a dayroom which provides windows with transparent glazing in an amount equivalent to that required for all of the rooms served by the dayroom.	X			All windows in the secure areas provide 3 square feet. Sky lights are located in each dayroom to provide additional natural light into the housing units.
18-010.03	A combination of skylights and windows may be utilized to meet the quantitative requirements for windows in housing units.	X			
18-010.04	In all renovated facilities, all housing units provide visual access to natural light. If windows are replaced as part of the renovation project, natural light requirements for new construction apply.			X	

Nebraska Jail Standards
Juvenile Facility Inspection

Standard		Compliance Status In	Out	N/A	Comments
18-010.05	Sustained noise levels within areas occupied by juveniles do not average higher than seventy (70) decibels during the day and forty-five (45) decibels during sleeping hours.	X			
18-010.06	Heating and cooling systems provide a comfortable and healthful living environment with temperatures maintained between sixty-five (65) and eighty (80) degrees Fahrenheit.	X			Temperature and ventilation found to be quite comfortable.
18-010.07	Ventilation systems provide circulation of at least ten (10) cubic feet of fresh or recirculated purified air per minute per occupant in all areas of the facility.	X			
18-010.08	Untiled walls and metalwork in the housing areas are finished predominately with a light, soft-toned washable paint.	X			A combination of tiled walls and painted surfaces was incorporated in the finish work.
18-010.09	All locks, detention hardware, fixtures, furnishings, and equipment have the proper security value for the areas in which they are used. The use of padlocks in place of security locks on sleeping room or housing unit doors is prohibited.	X			All locks controlling secure areas are security grade, remote controlled with key overrides.
18-010.10	Juveniles' rights to privacy from unauthorized or degrading observation are protected without compromising the security and control of the facility.	X			
18-010.11	The facility has a security perimeter which is secured in such a way that juveniles remain within the perimeter and that access by the general public is denied without proper authorization.	X			The secure perimeter is remotely controlled by staff in the master control unit.
18-010.12	The security area of the facility is equipped with an audio communication system designed to monitor activities and to allow juveniles to communicate emergency needs to facility employees. Closed circuit television shall not be used to monitor the interior of sleeping rooms and is not recommended for monitoring dayroom and program space.	X			Master control has surveillance and control over all aspects of the facility utilizing audio and video surveillance equipment. Corridors, programs rooms, entrances and the segregation dayroom are under electronic surveillance.
18-010.13	All newly constructed facilities provide an emergency source of power to supply electricity for entrance lighting, exit signs, circulation corridors, fire alarm, electrically operated locks and the ventilation system.	X			
18-010.14	The facility shall have an intake and release area which is located inside the security perimeter, but apart from other housing and activity areas. It includes the required components:	X			The intake center includes a records office, transportation office, identification room, holding cells and a booking area.
18-010.14A	Sallyport;	X			Designed for 4 vehicles.
18-010.14B	Booking, identification area;	X			
18-010.14C	Shower and search area with modesty screening;	X			
18-010.14D	Secure storage for property and valuables;	X			
18-010.14E	Storage and issue for clothing, hygiene and linens;	X			
18-010.14F	Telephone facilities;	X			
18-010.14G	Interview and release screening;	X			
18-010.14H	Medical screening;	X			
18-010.14I	Release processing;	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
18-010.14J	One or more temporary holding rooms (8hrs); may be multiple occupancy; 25 sq. ft. minimum per person; no smaller than 50 sq. ft.; must have benches, high security toilet, sink, hot & cold water, drinking fountain; and modesty screening of toilet area.	X			Two 80 square foot cells are located in the intake center for temporary holding. Three 70 square foot cells are located within a sub-dayroom for special needs detainees.
18-011	The facility has a sufficient number of housing units in an appropriate configuration so that juveniles can be separated according to the facility's classification plan.	X			The facility has 1 housing unit for females, 4 housing units for general population, 1 housing unit for orientation and segregation.
18-012	Single occupancy sleeping rooms provide at least seventy (70) square feet of floor space and are equipped with at least a mirror, table, seating, storage shelf or compartment, clothes hook and a bed above the floor.	X			All cells are single occupancy and provide at least 70 square feet.
18-013	Multiple occupancy sleeping rooms provide at least fifty (50) square feet of floor space per occupant at capacity and are equipped with at least a bed above the floor, storage shelf or compartment and clothes hook for each occupant at capacity. A mirror, table and seating are also provided.	X			
18-014	All single or multiple occupancy sleeping rooms are equipped with, or have unrestricted access to a toilet, wash basin with hot and cold running water and drinking water.	X			
18-015	Dayroom space which provides a minimum of thirty-five (35) square feet of floor space per juvenile at capacity, exclusive of a three (3) foot circulation area in front of sleeping room door openings, toilets, and showers, is available adjacent to all single and multiple occupancy sleeping rooms in each housing unit. No dayroom is smaller than one hundred (100) square feet in size.	X			Dayrooms are more than adequate to meet the requirements of this standard. Each dayroom serves housing units with a capacity of 20 detainees.
18-016	Each housing unit is equipped with at least one shower for every twelve (12) juveniles or fraction thereof, one toilet for every eight (8) juveniles or fraction thereof, one wash basin with hot and cold running water for every eight (8) juveniles or fraction thereof, and tables and seating sufficient for all juveniles.	X			Two showers and two toilets are located in each dayroom.
18-017	The facility has at least one administrative segregation cell or room designed for single occupancy. Administrative segregation cells or rooms have at least seventy (70) square feet of floor space and are equipped with at least a toilet, wash basin with hot and cold water, drinking fountain, mirror, table, seating, shelf or storage compartment and a bed above the floor.	X			The 3 special purpose cells in the intake center are intended to function as segregation cells.
18-018	Adequate space is allocated for the required program functions.	X			
18-018.01	Educational programs;	X			The education unit includes 3 classrooms, a life skills room and a resource center.
18-018.02	Individual and group activities;	X			
18-018.03	Indoor recreation and exercise;	X			
18-018.04	Outdoor recreation and exercise;	X			
18-018.05	Visitation;	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
18-018.06	Confidential attorney visits;	X			
18-018.07	Counseling;	X			
18-018.08	Library;	X			
18-019	At least one (1) multi-purpose room located within the security perimeter is provided for indoor recreation, activities and programs. The space is sufficient to accommodate exercise and program offerings for the maximum number of users at any one time.	X			Several rooms are available for programs including indoor and outdoor exercise rooms and a gymnasium. Central dinning is utilized for programs and dayrooms provide sufficient space for several activities.
18-020	Adequate visiting space is provided to accommodate the demand projected by the number of visitors, visiting schedule and the requirements of Chapter 14.	X			Visiting takes place in a supervised, contact visitation room that accommodates at least 30 users. One secure, non-contact visitation booth is available.
18-021	A sufficient number of confidential interview areas to accommodate the projected demand of visits by attorneys, counselors, clergy or other officials is provided. At least one (1) confidential interview area is sufficient in size to accommodate up to four (4) persons and are acoustically private to satisfy the needs of confidential interviews.	X			Two conference rooms serve as confidential visitation space and will accommodate 4 to 6 people.
18-022	Sufficient outdoor exercise space is provided to accommodate the projected facility capacity, the exercise functions for which the space will be utilized, the maximum number of users at any one time, and the requirements of Chapter 17. At least one (1) outdoor exercise area of not less than fifteen hundred (1500) square feet of unencumbered space is required.	X			
18-023	Staff posts are located in close proximity to juvenile housing areas in order to hear and respond promptly to disturbances or calls for help. At least one (1) staff post is provided on each floor of housing.	X			All housing units were designed and constructed to provide for direct supervision of detainees by direct care and supervisory staff.
18-024	Space is provided for routine medical examinations, emergency first-aid, emergency equipment storage and secure medicine storage.	X			The medical unit consists of 4 rooms for the Nurse's office, examinations, showers/dressing, records and storage.
18-025	Where food is to be prepared in-house, the kitchen has sufficient space for food preparation, serving, disposal, and clean-up to serve the facility at its projected capacity. The kitchen is properly equipped and has adequate storage space for the quantity of food prepared and served. Provisions are made for the secure storage of knives and other utensils.	X			The dining room and the food service areas are sufficient to serve meals prepared and delivered from the adult facility.
18-026	Where laundry services are provided in-house, there is sufficient space available for heavy duty or commercial type washers, dryers, soiled laundry storage, clean laundry storage and laundry supply storage.	X			

Nebraska Jail Standards
Juvenile Facility Inspection

	Standard	Compliance Status In	Out	N/A	Comments
18-027	At least one (1) secure janitor's closet containing a mop sink and sufficient space for storage of cleaning supplies and equipment is provided within the security perimeter of the facility.	X			
18-028	A secure storage area is provided for all chemical agents, weapons and security equipment.	X			This area was designed and constructed to be supervised and controlled by the maintenance supervisor.
18-029	Sufficient space is provided for administrative and clerical personnel.	X			The administrative section includes a reception area, 6 offices and 2 support areas.
18-031	A public lobby or waiting area is provided which includes sufficient seating, toilets and drinking fountains. Public access to security and administrative work areas is restricted. All public areas of the facility are accessible to the handicapped.	X			There is a large public lobby with access to the visiting areas, the assessment center, master control and the administrative offices.
18-032	Sufficient parking for visitors and official vehicles is provided on the site.	X			

ADDITIONAL COMMENTS

The facility governing board has entered into a 5 year contract with Nebraska Department of Health and Human Services to implement a 20 bed YRTC unit in this facility. The facility accordingly is operating with 40 detention beds, managed by the county to house juveniles pending adjudication.

SIGNATURE Dan Gaul DATE 10/19/21

Lincoln-Lancaster County Health Department
Environmental Health Division
3131 O Street
Lincoln, Nebraska 68510

Time In	Purpose	Inspection Date
10:40 AM	Regular	02/23/2021
Time Out	Facility Codes	
11:10 AM	20X	

FIRM LANCASTER YOUTH SERVICES OWNER LANCASTER YOUTH SERVICES

ADDRESS 1200 RADCLIFF ST LINCOLN NE, 68512

TOTAL VIOLATONS
PRIORITY 0 CORE 1
PRIORITY FOUNDATION 0

FOOD ESTABLISHMENT INSPECTION REPORT

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Supervision

1	IN COMPLIANCE	PIC present, demonstrates knowledge, and performs duties

Employee Health/Responding to Contamination Events

2	IN COMPLIANCE	Management and food employee knowledge,
3	IN COMPLIANCE	Proper use of restriction and exclusion

Good Hygienic Practices

4	IN COMPLIANCE	Proper eating, tasting, drinking, or tobacco use
5	IN COMPLIANCE	No discharge from eyes, nose, and mouth

Control of Hands as a Vehicle of Contamination

6	NOT OBSERVED	Hands clean properly washed
7	NOT OBSERVED	No bare hand contact with RTE foods or a pre-approved alternate properly followed
8	IN COMPLIANCE	Adequate handwashing sinks, properly supplied and accessible

Approved Source

9	IN COMPLIANCE	Food obtained from approved source
10	NOT OBSERVED	Food received at proper temperature
11	IN COMPLIANCE	Food in good condition, safe, and unadulterated
12	NOT APPLICABLE	Required records available: shellstock tags, parasite destruction

Protection from Contamination

13	IN COMPLIANCE	Food separated and protected
14	IN COMPLIANCE	Food-contact surfaces: cleaned sanitized
15	IN COMPLIANCE	Proper disposition of returned, previously served, reconditioned, and unsafe food

Time Temperature Control for Safety Food (TCS Food)

16	NOT APPLICABLE	Proper cooking time and temperatures
17	NOT OBSERVED	Proper reheating procedures for hot holding
18	NOT OBSERVED	Proper cooling time and temperatures
19	IN COMPLIANCE	Proper hot holding temperatures
20	IN COMPLIANCE	Proper cold holding temperatures
21	NOT OBSERVED	Proper date marking and disposition
22	NOT APPLICABLE	Time as a Public Health Control: procedures and records

Consumer Advisory

23	NOT APPLICABLE	Consumer advisory provided for raw or undercooked food

Highly Susceptible Population

24	NOT APPLICABLE	Pasteurized foods used; prohibited foods not offered

Food/Color Additives and Toxic Substances

25	NOT APPLICABLE	Food additives: approved and properly used
26	IN COMPLIANCE	Toxic substances properly identified, stored, and used; held for retail sale, properly stored

Conformance with Approved Procedures

27	NOT APPLICABLE	Compliance with variance, specialized process, ROP criteria or HACCP plan

GOOD RETAIL PRACTICES

Safe Food and Water

28	IN COMPLIANCE	Pasteurized eggs used where required
29	IN COMPLIANCE	Water and ice from approved source
30	IN COMPLIANCE	Variance obtained or specialized processing methods

Food Temperature Control

31	IN COMPLIANCE	Proper cooling methods used; adequate equipment for temperature control
32	IN COMPLIANCE	Plant food properly cooked for hot holding
33	IN COMPLIANCE	Approved thawing methods used
34	IN COMPLIANCE	Thermometers provided and accurate

Food Identification

35	IN COMPLIANCE	Food properly labeled; original container

Prevention of Food Contamination

36	IN COMPLIANCE	Insects, rodents and animals not present
37	IN COMPLIANCE	Contamination prevented during food preparation, storage and display
38	IN COMPLIANCE	Personal cleanliness; hair restrained
39	IN COMPLIANCE	Wiping cloths; properly used and stored
40	IN COMPLIANCE	Washing fruits and vegetables

Proper Use of Utensils

41	IN COMPLIANCE	In-use utensils; properly stored
42	IN COMPLIANCE	Utensils, equipment and linens; properly stored, dried, handled
43	IN COMPLIANCE	Single-use/single-service articles; properly stored, used
44	IN COMPLIANCE	Gloves used properly

Utensils, Equipment and Vending

45	OUT OF COMPLIANCE	Food and non-food contact surfaces cleanable, properly designed, constructed, and used
46	IN COMPLIANCE	Warewashing facilities, installed, maintained, used, test strips
47	IN COMPLIANCE	Non-food-contact surfaces clean

Physical Facilities

48	IN COMPLIANCE	Hot and cold water available; adequate pressure
49	IN COMPLIANCE	Plumbing installed; proper backflow devices
50	IN COMPLIANCE	Sewage and waste water properly disposed
51	IN COMPLIANCE	Toilet facilities: properly constructed, supplied, clean
52	IN COMPLIANCE	Garbage and refuse properly disposed; facilities maintained
53	IN COMPLIANCE	Physical facilities installed, maintained, and clean
54	IN COMPLIANCE	Adequate ventilation and lighting; designated areas used

TEMPERATURE OBSERVATIONS			STAFFING/RECORDS REQUIREMENTS	
FOOD PRODUCT	°F	LOCATION	Food Handler Permits	NOT APPLICABLE
Turkey	45	Cooler (reach-in)	Permit Records	NOT APPLICABLE
Green Beans	145	Hot-Holding		

VIOLATION DETAIL

Code / Priority Level / Location	Critical	Repeat / Risk Factor	Violation Description / Remarks / Food Code Citation	Corrected	Correct By
4-101.19	☐	☐	**Bare wood shims on floor underneath serving table. Paint/seal.**	☐	**03/25/2021**
		RF 45	Nonfood-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling or that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, and smooth material.		

Remarks: *Ice machine is being replaced this month.*

338469330223202110572 5 ☐ **Follow-up**

Printed 02/23/2021 11:08:47 AM FIR201

Environmental Health Specialist
DAVE VOBORIL, REHS, CP-FS 65
dvoboril@lincoln.ne.gov (402) 441-8633

Received by Person-In Charge
MELISSA HOOD
ADMINISTRATOR

Obtain Food Handler and alcohol server/seller permits at
www.lincoln.ne.gov search word "Food".

INSPECTION CHECKLIST
FOR RESIDENTIAL BOARD & CARE/HEALTH INSTITUTIONS

CITY OF LINCOLN NEBRASKA
lincoln.ne.gov

BUILDING & SAFETY DEPARTMENT
Bureau of Fire Prevention
555 S. 10th St., Suite 203, Lincoln, NE 68508
P: 402-441-7521

Occupancy Class Institutional License Number L1900171

Address 1200 Radcliff St.

Name of Business Youth Services Center

Date of Inspection 8/27/2020 Approved Occupant Load 45 beds

FACILITY	EVACUATION CAPABILITY	LOCATION
☐ Small	☑ Existing	☐ Prompt	☐ Above Grade
☑ Large	☐ New	☑ Slow	☐ Below Grade
	☐ Remodeling	☐ Impractical	☑ Grade
	☐ Licensing Change		# of Stories _____

All Code Numbers from 2012 101 Life Safety Codes

Yes	No	N/A	EXITS
☑	☐	☐	Unobstructed 33.3.2.1
☑	☐	☐	Properly identified 33.3.2.1
☑	☐	☐	Proper door swing 33.3.2.1
☑	☐	☐	Emergency lighting (if required) 33.3.2.9
☑	☐	☐	Generator 2012 IFC 604

Yes	No	N/A	MISCELLANEOUS
☑	☐	☐	Mechanical rooms in compliance 33.2.3.2
☑	☐	☐	Storage areas in compliance 33.2.3.2
☑	☐	☐	Housekeeping 33.3.2.5
☑	☐	☐	Room Doors closes/latches 33.2.3.6.3
☑	☐	☐	Illegal cords, spices, makeshift 605.5 2012 IFC 605

Yes	No	N/A	GAS APPLIANCES
☐	☐	☑	Approved venting 33.2.5.2.1
☐	☐	☑	Approved installation 33.2.5.2.1

Yes	No	N/A	HAZARDOUS AREAS
☑	☐	☐	Meets rating requirements 33.2.3.2
☑	☐	☐	Door closes/latches 33.2.3.2
☑	☐	☐	Corridor penetrations 33.2.3.6.2

Yes	No	N/A	EMERGENCY PLANNING
☑	☐	☐	Safety & Evacuation Plan 33.7.1
☑	☐	☐	Fire drills 33.7.3
☑	☐	☐	Training 33.7.2

Yes	No	N/A	ALARM SYSTEMS
☑	☐	☐	Required alarm system 33.3.3.4.1 P.I.U
☐	☑	☐	Properly maintained 33.3.3.4.1
☑	☐	☐	Sprinkler system (if required) 33.2.3.5.2
☐	☐	☑	Approved range hood system 9.7.3
☑	☐	☐	Carbon monoxide alarms 9.8

Yes	No	N/A	FLOOR SEPARATION
☐	☐	☑	Primary means escape 33.2.2.2.1
☐	☐	☑	Bedroom egress windows 33.2.2.3
☐	☐	☑	Smoke detectors 33.3.3.4.7
☐	☐	☑	Rating between floors 33.2.3.1.1

LARGE FACILITIES ONLY

Yes	No	N/A	FIRE EXTINGUISHERS
☑	☐	☐	Approved size 9.7.4.1
☑	☐	☐	Approved type 9.7.4.1
☑	☐	☐	Properly maintained 9.7.4.1

Yes	No	N/A	TRAVEL DISTANCE TO EXITS
☐	☐	☐	Under 75 feet 33.3.2.6.1
☑	☐	☐	Under 125 feet (sprinkled) 33.2.6.1

☑ Approved 9/22/2020 KH
☑ Denied (see comments)

COMMENTS: P.I.U tamper still not working

You are ordered to comply with all 'No' items by the following date: 10/27/2020 In accordance with provisions of the Regulations Promulgated by the Nebraska State Fire Marshal, governing Safety to Life from Fire and Like Emergencies.

FIRE INSPECTOR: Ken Hilger Date: 8/27/2020

REV. 09/2018

Major Projects

Attachment K1

Youth Rehabilitation and Treatment Center - Lincoln Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. [redacted]

   a. [redacted]

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

   a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not identified any major construction projects of the facility.

2. Please provide a summary of completed major projects as of today.
   a. During the reporting period: December 2020 through November 2021, YRTC-Lincoln has not completed any major construction projects in the facility.

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

   a. All ongoing building maintenance and major construction projects for YRTC-Lincoln is contracted through Lancaster County. However, YRTC-Lincoln keeps track of all routine repair work completed for the facility by the maintenance department

4. Please provide the number of work orders submitted since December 2020.

   a. Approximately 73

5. What kind of system do you use to track non-major repair projects?

a. YRTC-Lincoln currently tracks non-major repair projects through electronic methods and through internal Maintenance Work Order forms.

Facility Staffing Information

Attachment K2

Youth Rehabilitation and Treatment Center – Kearney Staffing & Assault Data
Reporting Period: December 1, 2020 through November 30, 2021
Neb. Rev. Stat. 83-104

A. **Facility Staffing Levels:**

a. The number of positions filled as of November 30, 2021.

i. 133

b. The number of positions vacant as of November 30, 2021.

i. 125

c. The number of positions needed in your HR staffing plan for FY22 as of November 30, 2021.

i. 258

d. The number of position filled in your HR staffing plan for FY22 as of November 30, 2021.

i. 133

e. The monthly turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 3%

f. The aggregate turnover rate for the period of 12/01/2020 – 11/30/2021.

i. 35%

B. Staff Assaults:

a. The number of assaults on staff for the period of 12/01/2020 through 11/30/2021.

i. 57 total youth on staff assaults

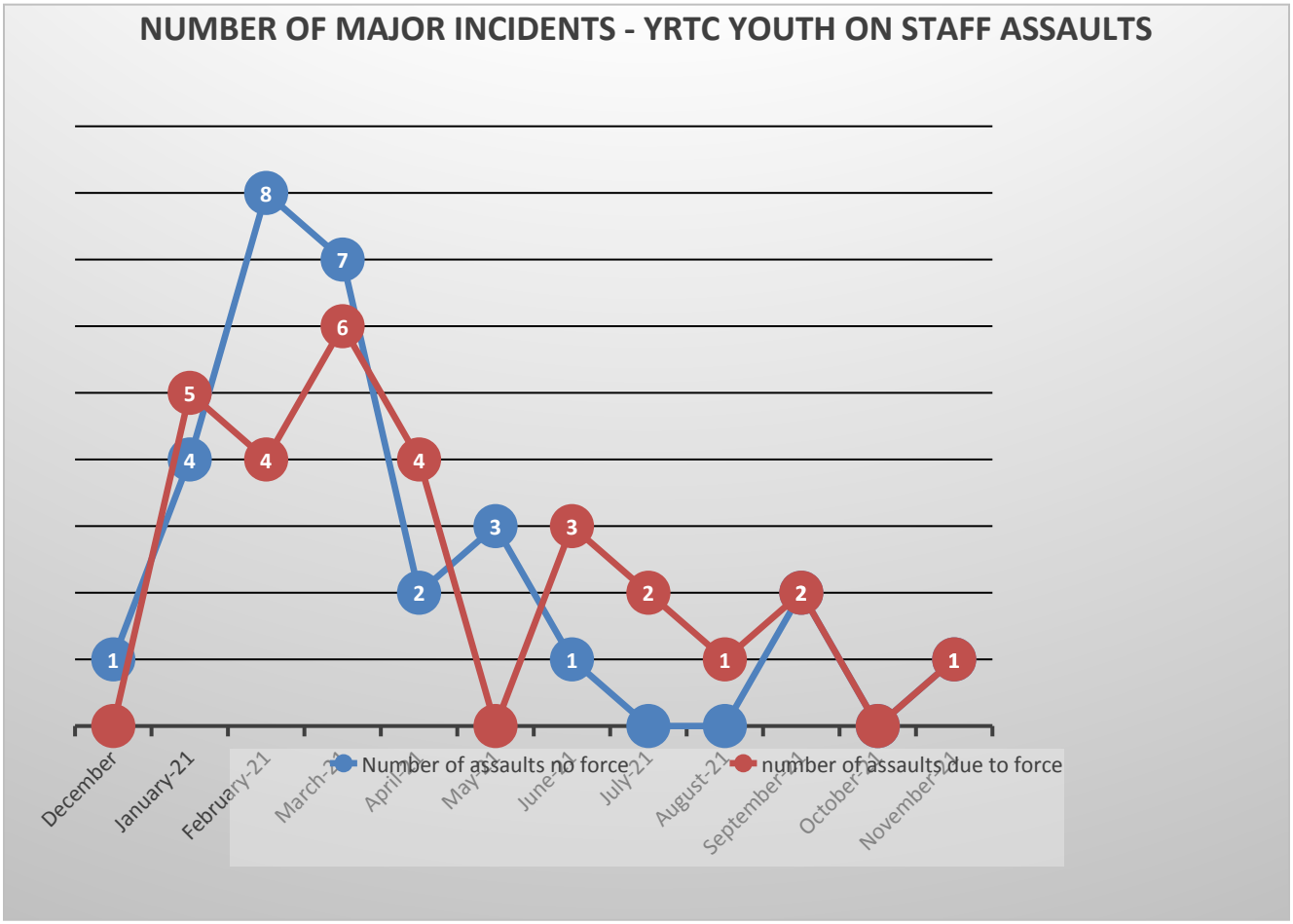
b. Number of assaults as a result of a use of force event.

i. 28 youth on staff assaults during physical interventions

Nebraska Department of Health and Human Services (NEDHHS) - Facility Data
12/1/2020 - 11/30/2021

Facility: YRTC-K Beatrice State Developmental Center

		11/30/2021			12/1/2020	12/1/2020 - 11/30/2021			
		133	125	258	163	60	77	3%	35%
Job Code	Position	Filled	Vacant	Total	Start	Additions	Separations	TO % - M	TO % - A
A19211	ACCOUNTANT I	0	0	0	1	0	0	0%	0%
A19011	ACCOUNTANT I (NEW)	2	0	2	0	0	1		
S19112	ACCOUNTING CLERK II	0	0	0	1	0	0	0%	0%
V09121	ADMINISTRATIVE ASSISTANT I	0	0	0	1	0	0	0%	0%
V75015	ADMINISTRATIVE NURSE (NEW)	1	0	1	1	0	0	0%	0%
V09011	ADMINISTRATIVE PROGRAMS OFFICER I (NEW)	1	0	1	0	1	0	0%	0%
V09012	ADMINISTRATIVE PROGRAMS OFFICER II (NEW)	1	0	1	0	0	0		
V01014	ADMINISTRATIVE SPECIALIST (NEW)	1	0	1	0	0	0		
V01013	ADMINISTRATIVE TECHNICIAN (NEW)	1	0	1	0	0	0		
H72551	BEHAVIORAL HEALTH PRACTITIONER I (NEW)	0	0	0	0	0	1		
H72552	BEHAVIORAL HEALTH PRACTITIONER II (NEW)	0	3	3	0	0	0		
H72554	BEHAVIORAL HEALTH PRACTITIONER IV (NEW)	5	1	6	0	0	1		
V72556	BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II (NEW)	1	0	1	0	0	0		
V09212	BUSINESS MANAGER II	0	0	0	1	0	0	0%	0%
V72460	CLINICAL PROGRAM MANAGER	1	0	1	1	0	0	0%	0%
K76410	COMPLIANCE SPECIALIST	2	0	2	2	0	0	0%	0%
S05712	CORR CANTEEN OPERATOR	1	0	1	1	0	0	0%	0%
M82121	CUSTODIAN/HOUSEKEEPER	0	0	0	2	0	0	0%	0%
N78560	DHHS FACILITY ADMINISTRATOR	0	0	0	1	0	0	0%	0%
V78791	DHHS PROGRAM MANAGER I	1	0	1	1	1	1	4%	50%
V78792	DHHS PROGRAM MANAGER II	0	1	1	1	0	1	8%	100%
N00750	FACILITY OPERATING OFFICER	2	0	2	1	0	0	0%	0%
R80011	FOOD SERVICE ASSISTANT (NEW)	0	1	1	0	0	0		
M80123	FOOD SERVICE COOK	0	0	0	3	1	2	4%	50%
V80311	FOOD SERVICE DIRECTOR I	1	0	1	1	0	0	0%	0%
M80124	FOOD SERVICE LEADER	0	0	0	1	0	1	8%	100%
V80220	FOOD SERVICE SUPERVISOR	1	0	1	1	0	0	0%	0%
M80012	FOOD SERVICE WORKER (NEW)	3	5	8	0	5	3	5%	60%
N67700	JUVENILE SERVICES ADMINISTRATOR	1	0	1	1	0	0	0%	0%
M79112	LAUNDRY WORKER	1	0	1	1	0	0	0%	0%
I75013	LICENSED PRACTICAL NURSE (NEW)	1	0	1	1	0	0	0%	0%
R75013	LICENSED PRACTICAL NURSE (NEW)	0	1	1	0	0	0		
M84011	MAINTENANCE TECHNICIAN (NEW)	2	0	2	0	0	0		
H72431	MENTAL HEALTH PRACTITIONER I	0	0	0	1	0	0	0%	0%
H72432	MENTAL HEALTH PRACTITIONER II	0	0	0	8	0	2	2%	25%
V72433	MENTAL HLTH PRACTITIONER SUPERVISOR	0	0	0	1	0	0	0%	0%
S01113	OFFICE CLERK III	0	0	0	1	0	1	8%	100%
S01012	OFFICE SPECIALIST (NEW)	2	0	2	0	0	0		
V01012	OFFICE SPECIALIST (NEW)	1	0	1	0	0	0		
V01120	OFFICE SUPERVISOR	0	0	0	1	0	0	0%	0%
R01011	OFFICE TECHNICIAN (NEW)	0	1	1	0	0	0		
S01011	OFFICE TECHNICIAN (NEW)	4	0	4	0	3	0	0%	0%
K17123	PERSONNEL MANAGER II	1	0	1	0	1	0	0%	0%
K17121	PERSONNEL OFFICER	1	0	1	0	2	1	4%	50%
G11900	PRINCIPAL	0	1	1	0	0	0		
N74823	PSYCHOLOGIST/LICENSED	0	1	1	0	0	0		
I77042	RECREATION ASSISTANT	1	3	4	2	0	4	17%	200%
V77045	RECREATION MANAGER	1	0	1	1	0	0	0%	0%
H75014	REGISTERED NURSE (NEW)	2	0	2	1	1	0	0%	0%
C79920	RELIGIOUS COORDINATOR	1	0	1	1	0	1	8%	100%
S01411	SECRETARY I	0	0	0	1	0	1	8%	100%
S01841	STAFF ASSISTANT I	0	0	0	2	0	0	0%	0%
V01842	STAFF ASSISTANT II	0	0	0	1	0	0	0%	0%
S05012	SUPPLY TECHNICIAN II (NEW)	1	0	1	0	0	0		
T11360	TEACHER (SCATA CONTRACT)	18	7	25	20	0	4	2%	20%
R11370	TEACHER/SUBSTITUTE	0	2	2	1	0	0	0%	0%
R11380	TEACHER/TEMPORARY	0	9	9	0	1	1	8%	100%
A11124	TRAINING COORDINATOR	0	0	0	1	0	0	0%	0%
A11012	TRAINING COORDINATOR (NEW)	1	0	1	0	0	0		
M05221	WAREHOUSE TECHNICIAN	0	0	0	1	0	0	0%	0%
C72481	YOUTH COUNSELOR I	7	7	14	13	0	1	1%	8%
V72483	YOUTH COUNSELOR SUPERVISOR	6	2	8	8	0	0	0%	0%
P76752	YOUTH SECURITY SPECIALIST II	35	73	108	52	35	40	4%	46%
R76752	YOUTH SECURITY SPECIALIST II	6	5	11	6	7	4	3%	31%
V76753	YOUTH SECURITY SUPERVISOR	15	2	17	16	2	6	3%	33%
		133	**125**	**258**	**163**	**60**	**77**	**3%**	**35%**



Data included male and female youth until April 2021 when female youth were moved to Hastings

Total assault numbers by the month
December 2020- 1
January 2021- 9
February – 12
March – 13
April- 6
May- 3
June- 4
July -2
August – 1
September – 4
October – 0
November-2

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Kearney		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	8	0	1	0	0	0	9
February	6	4	0	2	0	0	12
March	11	2	0	0	0	0	13
April	5	1	0	0	0	0	6
May	3	0	0	0	0	0	3
June	0	4	0	0	0	0	4
July	0	2	0	0	0	0	2
August	1	0	0	0	0	0	1
September	0	4	0	0	0	0	4
October	0	0	0	0	0	0	0
November	1	1	0	0	0	0	2
Total	**36**	18	1	2	0	0	57

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Lincoln		Injury Rating				Total
Month	1	2	3	4	5	6	
December	1	0	0	0	0	0	1
January	0	0	0	0	0	0	0
February	1	0	0	0	0	0	1
March	1	0	0	0	0	0	1
April	1	0	0	0	0	0	1
May	4	0	0	0	0	0	4
June	2	0	2	2	0	0	6
July	2	0	1	0	0	0	3
August	2	0	1	0	0	0	3
September	0	0	1	0	0	0	1
October	1	0	0	0	0	0	1
November							
Total	**15**	0	5	2	0	0	22

YRTC INJURY RATINGS YOUTH ON STAFF ASSAULTS

2020/2021	Hastings		Injury Rating				Total
Month	1	2	3	4	5	6	
December	n/a	n/a	n/a	n/a	n/a	n/a	n/a
January	n/a	n/a	n/a	n/a	n/a	n/a	n/a

February	n/a	n/a	n/a	n/a	n/a	n/a	n/a
March	n/a	n/a	n/a	n/a	n/a	n/a	n/a
April	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0
August	2	0	0	0	0	0	2
September	0	0	0	0	0	0	0
October	3	0	0	0	0	0	3
November	3	0	0	0	0	0	3
Total	**8**	0	0	0	0	0	8

COVID -19 Impact

Impact

Leadership Update

Family Member Letter

Pandemic plan

Attachment K3

Impact

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Whitehall Facility Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

[redacted]

[redacted]

a. [redacted]

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

    a. COVID-19 presented some major challenges for all facilities but one of the biggest perceived challenges that the Whitehall facility faced during the first shut down was the facility's ability to meet with stakeholders and families about treatment updates on the children. Administration had to redesign the entire process so that Whitehall could meet health department standards for the amount of people that could be in a room at one time. The use of WebEx has revolutionized how facilities conduct team meetings each week with the youth, their families, and other interested parties. The onset of the COVID-19 pandemic has resulted in the facility having the ability to get more outside people involved remotely with youth on campus than even was possible before. In a sense the pandemic forced the facility to grow and think of new ways to do things so that quality treatment could still be provided even in the midst of a global pandemic. Even now that families are starting to come back onto the campus and have the youth back into the community we continue to have great participation from outside parties in the treatment of the youth.

2. Please provide a copy of your most recent COVID protocols.

    a. Attached as LRC-Pandemic COVID-19 Protocols (These are what Whitehall adopted as well) in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. The Whitehall visitation letter that was sent to families via USPS and pronation via email is attached and can be located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

a. Currently, the campus is open to visitation and the youth are allowed to visit with their families off grounds. When Whitehall gains a new youth, they are tested for COVID-19 and are placed temporarily into quarantine until that test result comes back. If the test result comes back positive the Medical department at Whitehall will call the health department and quarantine the youth for 10 days. Currently there is one youth on quarantine due to arriving to the facility COVID positive and will be off quarantine on November 10th, 2021. When visitors come to campus they are required to check their temperature when signing in to our administration building. Whitehall currently does not require masks on campus unless the health department has suggested otherwise in response to a positive case on campus which has been very far and few between. If a staff member believes they have been exposed they are directed to call the health department and go with their recommendation on whether the staff member should quarantine or be tested.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. Whitehall does not have any COVID-19 planning meeting minutes, but rather follows the direction of LRC and DHHS administration for any updates regarding COVID-19 protocols.

Leadership Update

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Dear Family Members,

The Youth Rehabilitation and Treatment Center in Kearney (YRTC-K) understands the importance of our youth being able to have visitation with their family members. As of August 20 2021, we are being cautious and are following the recommendations of the Two Rivers Health District and suspending all parental / legal guardian on-campus visits. This recommendation stems from the Two Rivers Health District being raised to the Covid-19 orange threat level dial, which Buffalo County is a part of. During this time, WebEx visits on weekends will resume.

- Visitation process:
  - WebEx visits on the weekend can be scheduled through the Receptionist office by calling 308-865-5313 Ext 0 or if you're requesting a WebEx visit during the week you must contact your youth's case manager.
  - All WebEx visits must be scheduled ahead of time by calling the facility Monday – Friday 8-5.
  - **Youth are only allowed one 30 minute visit per week.**

Please remember the health and safety of your youth, family members and our staff is important to us. As a program, we are very hopeful that this increase of precautions will be for a limited time and we will be able to resume on-campus visits.

Thank you for assisting us in maintaining a safe environment for the youth in our care.

_____

Paul Gordon, Facility Administrator

Family Member Letter

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

September 14, 2021

Dear Family/Guardians,

The staff and youth of YRTC-K would like to thank you for your patience and understanding during the Covid 19 pandemic in regards to the visitation policy. YRTC recognized that it was crucial that we take extra precautions to maintain the health and safety of your loved ones who we support. As you know, these steps included temporarily prohibiting in-person visitation with youth. YRTC-K is now taking steps toward resuming in person visitation. Before we are able to open visitation, we need to make sure we are using the best practices available to help ensure a safe environment for your youth and the staff that support them.

These are some of the steps we are taking as we move toward the resumption of visitation:

For our youth and staff

- Providing COVID-19 testing to staff and youth if needed
- Continued health screenings for staff at the beginning of their shift or work day
- Continued health screenings of the youth in our programs on a daily basis
- Increased awareness and expectations for hand hygiene and cleaning within the facility
- Reminding staff to stay home if they are sick or showing any signs of illness
- Encouraging staff to self-quarantine if they believe they have been exposed to COVID-19

For family members

- A continuation of virtual visits with family and other approved contacts, Monday through Friday by contacting your youths case manager
- Begin in person visitation for immediate family members, starting September 18, 2021. Please contact the facility at 308-865-5313 M-F 8-5 to set up an appointment.
- Visitation areas will be set up to accommodate social distancing requirements
- A staggered visitation schedule will allow small groups of youth to have face to face visitation
- Establishing an adequate supply of PPE for use in managing infection control concerns
- All visitors must wear facemasks when attending in person visits. If they are not able to provide their own, the facility will provide one.
- Health screenings for visitors entering the facilities
- A focus on social distancing and limiting physical contact to emergency situations only
- In person visits are limited to 4 approved family members and are on Saturday or Sunday
- Only 1 visit per week is allowed (if you schedule a webex visit you cannot have a in person visit on the same week)

We understand this a difficult time for everyone. We will continue to offer and support alternative visitation options in our efforts to keep families safe. Please do not hesitate to contact the facility if you would like help in setting up a call or video visit option.

As this pandemic evolves, we will keep you informed of any changes regarding visitation. Should there be an increase in exposure and positive testing, we may need to re-evaluate our visitation practices with little to no prior notice.

Thank you for your understanding and continued support and assistance during this difficult time.

Sincerely,

Paul Gordon,
Facility Administrator

Pandemic Plan

Youth Rehabilitation and Treatment Center Kearney (YRTC-K)

SUBJECT: COVID-19 PANDEMIC PLAN

Effective Date: March 2, 2020 Page No. 1 of 8

PURPOSE: To provide early detection and containment of Pandemic COVID-19 while maintaining the overall operation of YRTC-K and meet basic needs of the facility.

RESPONSIBILITY: All staff

EQUIPMENT: Personal Protective Equipment (PPE), Surgical Masks, Hand Sanitizer, Eye Protection, Safety Gloves, Contingency Staffing Plan

PROCEDURE:

I. INITIAL IMPLEMENTATION

A. YRTC-K will work with Two Rivers Health Department.
B. Contingency Staffing Plan for Managing Widespread Outbreaks / Disaster,
C. Designated YRTC-K leadership will meet daily, as needed to address essential needs and emergent situations as they arise.
D. Identification of Essential Personnel will be reassessed daily by designated YRTC-K leadership and are as follows:
    1. All employees will be considered essential for anti-viral therapy when available and these staff will be identified daily, based on availability, potential for exposure, and the need to meet minimal departmental staffing requirements, as per contingency staffing plan. This includes allowing for rotation of specific departmental staff in order to meet the essential services of the facility and care of the Patients.
    2. Ancillary staff will be rotated to areas of need.
    3. Once a vaccine is available staff designated to receive the vaccine will be identified at time of availability of vaccine, based on employees who have had the Pandemic COVID-19 and available staff.

II. CONTAINMENT

A. Signs and Symptoms associated with an infectious agent. Severity ranges from little to no symptoms to being severely ill, including the risk of death:
    1. Fever
    2. Cough
    3. Shortness of breath
    4. Sore Throat
    5. Fatigue
    6. Loss of taste and/or smell

B. If above signs and symptoms are identified, or persons have recently traveled internationally (to areas listed as high risk), or had close contact (within 6 feet) with a person who is symptomatic, or who has had potential exposure identified through contact tracing, or has laboratory testing screening for COVID-19, place person in Airborne/Droplet precaution IMMEDIATELY until Lab Test can confirm a diagnosis.

1. Signs will be placed at each entrance notifying visitors, to each building, that if they have symptoms of illness they will need to reschedule their visit until a time they are not symptomatic
2. Staff returning to work from being ill will complete an employee assessment form and be assessed by a Nurse, if flagged on screening tool, before being allowed back in the unit
3. Staff returning from vacation time where they have traveled outside of the country will consult with Two Rivers Public Health and the medical team.
    a. Staff may be asked to be tested for COVID prior to returning to work.
    b. Staff may be asked to visit their doctor and obtain a return to work note.
    c. Staff may be asked to self-isolate at home for up to 14 days for safety.

C. If Signs and Symptoms indicate an infectious agent in our youth/staff population:
    1. Notify medical team, or on call nurse.
    2. Isolate person pending lab results
    3. Confirmed positive test results require quarantine
    4. Call MD (Family Practice) for consultation if symptoms warrant.

D. Appropriate lab procedures will be used to perform diagnostic testing.
    1. Testing is available through the Nebraska Public Health Lab (NPHL).
    2. Courier services available through Kearney Regional Medical Center.
    3. Results will be obtained within in 24 hours, once specimen has arrived at lab.

E. Nurse Supervisor, the YRTC Medical Authority, and DHHS Executive Medical Officer will be involved in decision making to cohort all ill youth together away from non-ill youth, if needed. During outbreaks, confine youth with Confirmed Illness to the designated quarantine area. Patients with suspected Covid-19 should be placed in the isolation area of the designated building until lab test confirms a diagnosis (Approximately 24 hours). This may be expanded to all youth being served meals in their designated area, closing down communal areas to dining and other gatherings. Due to medical limitations of YRTC-K, youth needing immediate rehydration or emergency medical attention may need to be transported to a Medical Hospital for treatment (KRMC).

1. Isolation Areas for each building are as follows, note that beds may need to be added to these areas until the diagnosis is confirmed (Approximately 24 hours).

    a. Dickson Behavior Stabilization Unit. 25 Bed Capacity

    b. Creighton Sleeping Quarters will isolate patients that overflow from DBSU. 50 patient capacity

F. **Personal Protective Equipment (PPE)**
    1. **Caring for Patients with pandemic infections**
    Healthcare personnel should be particularly vigilant to AVOID:

a. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
b. Contaminating environmental surfaces that are not directly related to youth care (e.g., door knobs, light switches).
c. Encourage youth in isolation and quarantine to wear a mask since no AIIR's, single patient rooms at negative pressure relative to the surrounding areas and with a minimum of 6 air changes per hour, are available on campus.

2. **Surgical masks/N-95/KN-95 Masks. (In stock)**
   - If N-95 is back ordered or out of stock YRTC-K will consult with the SEMRS coalition to obtain emergency supplies through the SNS. If N-95 is not available surgical masks will then be utilized.

   a. Wear a mask when entering a youth room. A mask should be worn once and then discarded. If pandemic COVID-19 youth are cohorted in a common area or in several rooms in a building or living unit, and multiple youth must be visited over a short time, it may be practical to wear one mask and eye protection for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between youth and hand hygiene performed.
   b. Change masks when they become moist.
   c. Do not leave masks dangling around the neck.
   d. Upon touching or discarding a used mask, perform hand hygiene.

3. **Gloves: (In stock)**
   a. A double pair of youth care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of vinyl, nitrile, or other synthetic materials are appropriate for this purpose.
   b. Gloves should fit comfortably on the wearer's hands.
   c. Remove and dispose of gloves after use on youth; do not wash gloves for subsequent reuse.
   d. Perform hand hygiene after glove removal.
   e. If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive youth or environmental contact with blood or body fluids.
   f. Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a youth's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

4. **Gowns: (In stock)**
   a. Wear an isolation gown, if soiling of personal clothes or uniform with a youth's blood or body fluids, including respiratory secretions, is anticipated, or the youth is in isolation. Most youth interactions do not necessitate the use of gowns. A disposable gown made of synthetic fiber or a washable cloth gown may be used.
   c. Ensure that gowns are of the appropriate size to fully cover the area to be protected.
   d. Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
   e. If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., cloth gowns) could be used. There are no data upon which to base a recommendation for reusing an isolation gown on the same youth. To avoid possible contamination, it is prudent to limit this practice.

4. Goggles or Face Shield: (In stock)
These can be sanitized between uses.
   a. In general, wearing goggles or a face shield for routine contact with youth with pandemic COVID-19 is necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for Airborne/Droplet precaution.

6. **PPE for Special Circumstances**
   a. **PPE for aerosol - generating procedures**
   During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., nebulizer treatment), healthcare personnel should wear gloves, gown, face/eye protection, and an N-95 mask.

G. **Hand Hygiene**
1. Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings and is an essential element of standard precautions. The term "hand hygiene" includes handwashing with antimicrobial soap and water, non-antimicrobial soap and water, and use of alcohol-based or non-alcohol based products (gels, rinses, foams) containing an emollient that do not require the use of water.
2. If hands are visibly soiled or contaminated with respiratory secretions, wash hands with antimicrobial soap and water or non-antimicrobial soap and water.
3. In the absence of visible soiling of hands and soap/water are not readily available, approved alcohol-based or non-alcohol based products for hand disinfection are preferred.
4. Always perform hand hygiene between patient contacts and after removing PPE.
5. Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, antimicrobial or non-antimicrobial soap, disposable paper towels)

and hand disinfection (i.e., alcohol-based or non-alcohol based products) are readily accessible in areas in which patient care is provided.

H. **Disposal of Solid Waste**
1. Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with the pandemic COVID-19 virus:
2. Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste.
3. Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
4. Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

I. **Linen and Laundry**
1. Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from Patients with pandemic COVID-19:
2. Place soiled linen directly into a hot water soluble laundry bag. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
3. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
4. Wear gloves for transporting bagged linen and laundry.
5. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
6. Wash and dry linen according to routine standards and procedures.

J. **Dishes and Eating Utensils**

Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic COVID-19:
1. Wash reusable dishes and utensils in a dishwasher with recommended water temperature per YRTC-K policy.
2. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of Patients) should be discarded with other general waste per Emergency Disaster Manual.
3. Wear gloves when handling Patient trays, dishes, and utensils.

K. **Youth-care equipment**

Follow standard practices for handling and reprocessing used youth-care equipment, including medical devices:
1. Wear gloves when handling and transporting used youth-care equipment.
2. Wipe heavily soiled equipment with an YRTC-K approved surface disinfectant before removing it from the youth's room. Follow current recommendations for cleaning and disinfection of reusable care equipment.

3. Wipe external surfaces of portable equipment used for procedures in the area with an YRTC-K approved surface disinfectant upon removal from the youth's room.

L. **Environmental cleaning and disinfection (In stock)**
Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic COVID-19 follow the same general principles used in healthcare settings. Multiguard and Sani Cloths will be used for disinfection.

M. **Cleaning and disinfection of youth-occupied rooms**
1. Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are necessary for routine cleaning of an infection positive room when youth is present.
2. Keep areas around the youth room free of unnecessary supplies and equipment to facilitate daily cleaning.
3. Use any YRTC-K approved detergent-disinfectant.
4. Follow facility procedures for regular cleaning of youth-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.
5. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions and per YRTC-K Small and Large Spill Cleanup Policy.

N. **Cleaning and disinfection after youth is returned to unit/designated area**
1. Follow standard facility cleaning policy for cleaning of a room.
2. Clean and disinfect all surfaces that were in contact with the youth or might have become contaminated during care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
3. Do not aerosolize (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.
4. Disinfectants utilized will be Multiguard Spray and Sani-Cloth wipes

O. **Postmortem care**
1. Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.
2. The Health Department/County Coroner will provide body bags for deceased.

P. **Laboratory specimens and practices**
1. Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

III. OUTBREAK NOTIFICATION

A. All doors will remain locked. Only employees with access cards will be allowed to enter. Vendors or suppliers will be instructed to drop off all supplies at the Dock.

B. Infection Control Manager will direct all means of media notification in connection with Public Information Officer if public announcements are needed.
   1. Visual alerts will be at entrances advising visitors that visitation is restricted.
   2. Post signs regarding source control measures in common areas where they can serve as reminders to all persons to:
      a. cover the nose/mouth when coughing or sneezing.
      b. use tissues to contain respiratory secretions.
      c. dispose of tissues in the nearest waste receptacle after use.
      d. perform hand hygiene after contact with respiratory secretions.

C. Facility Group activities and new admissions will be cancelled until the outbreak is over. Individual activities and Unit activities will need to be identified and provided on a daily basis contingent on outbreak and illness of the youth.

D. Facility administrator and Nursing Supervisor will decide what departments and activities continue during the duration of the outbreak.

E. Department Heads/Supervisors will contact the Medical team for any clarification of memos/orders/notifications/questions.

F. Nursing Supervisor in collaboration with the Medical Health Authority will contact the State Health and Human Services division of Infectious Disease and Two Rivers Public Health. Remain vigilant for another outbreak of pandemic COVID-19.

IV. MONITORING OF HEALTH CARE PERSONNEL

A. Employees who report to work will be asked to be screened for signs and symptoms of the COVID-19 before reporting for duty and/or to be given antiviral therapy if necessary and available. Especially with staff working in isolation and quarantine areas.

B. Screening of all employees will be done by the medical team. All symptomatic staff will be sent home for self-isolation and asked to contact health care provider before returning.

C. Any staff who have recovered from the pandemic COVID-19 will be prioritized for care of youth with active pandemic COVID-19 and its complications.

D. Staff at high risk for complications of pandemic COVID-19 (i.e. pregnant, immuno-compromised, and older in age) should be informed about this medical risk and offered an alternative work assignment away from COVID-19 youth care or considered for administrative leave.

E. Staff age will be assessed when staffing quarantine and isolation areas due to increased age increasing risk of Acute Respiratory Distress Syndrome.
   1. Staff under the age of 39 with no compromising issues will be staffed in quarantine and isolation areas first if possible.

V. **TREATMENT**

A. No specific treatment for COVID-19 infection is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced treatment support if indicated.

Please note: This is an "evergreen" document and is constantly being revised to be consistent with National directives, changing priorities, new technologies and developing medical science. These guidelines may be changed at any time but especially when changes in 2019-nCoV surveillance and viral technology occur.

Corrigo Tracking

Attachment K4

Youth Rehabilitation and Treatment Center - Kearney Conditions
Reporting Period: December 2020 through November 2021
Neb. Rev. Stat. 83-104

A. **Inspection and Audits.**

1. Please provide a copy of the most recent inspections and/or audit reports as of today. To include, but not limited to applicable reports from the Fire Marshal's office, DHHS inspections, internal safety, emergency inspections, independent standards audits, Licenses, permits, alarm system, sprinkler, etc.

    a. All inspection and audit information regarding the YRTC-Kearney has been attached in Section A of this packet.

B. **Construction Projects:**

1. Please provide a list of the most recent major construction projects identified.

    a. HVAC replacement on the Dickson Living Unit (309) is the most recent construction project within the reporting period.

2. Please provide a summary of completed major projects as of today.

    a. 100 linear feet of sidewalk was replaced by the Chapel (SBD)
    b. The sink and counter in the Morton Living Unit was replaced through materials only request by 309 task force

3. Do you utilize the defined work order system utilized by DAS and DHHS to track repair work?

    a. Yes, YRTC-K utilizes a Maintenance Work Order form and the DAS electronic system

4. Please provide the number of work orders submitted since December 2020.

    a. 1699 preventative maintenance orders
    b. 780 work order requests

5. What kind of system do you use to track non-major repair projects?

a. YRTC-Kearney has both and internal fillable pdf form and a DAS electronic system to track all non-major repair projects.

C. **COVID-19 Impact.**

1. The Ombudsman's Office is interested in how the COVID-19 Public Health crisis has posed challenges for your operations in these unprecedented times. With that said, we would be interested in a summary addressing the operations and challenges the institution has faced during these unprecedented times. Additionally, please provide the following information:

2. Please provide a copy of your most recent COVID protocols.

    a. Attached is the YRTC-K, COVID-19 Pandemic Plan located in Section C of this packet.

3. Please provide a copy of your most recent letter to family/guardians/visitors on COVID updates.

    a. Our visitation letter that was sent to families via USPS is located in Section C of this packet.

4. Please provide an update on your current COVID situation. To include visitation, testing, etc.

    a. Currently, the YRTC-Kearney facility is continuing to follow the recommendations set forth by the Two Rivers Health District in regards to on campus visitation for family members. At this time YRTC-Kearney is allowing only weekend visitation for in-person visits and is continuing to allow online virtual visitation during the week days.
    b. All youth and staff are provided the opportunity to receive a COVID-19 test if they feel that it is necessary. All new intakes will be tested upon arrival and placed on a quarantine status until the test results are received.
    c. The protocols being followed can be located in Section C of this packet.

5. Please provide a copy of your most recent COVID-19 planning meeting minutes.

    a. YRTC-Kearney does not have any COVID-19 planning meeting minutes, but rather follows the direction of DHHS administration for any updates regarding COVID-19 protocols and the recommendations of the Two Rivers Health District.

Inspection Reports

Occupancy

Fire sprinkler

Boiler

Food Establishment

Attachment K5

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 11475

Name of Facility:	**Youth Rehabilitation and Treatment Center**
Type of Facility:	**Substance Abuse Treatment Center**
Location:	**2802 30th Ave, Kearney**
Maximum Occupancy:	**170 Persons**
Date Issued:	**3/4/2021**

Inspected By: **Todd Brehm**
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
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC Byant/Creighton Cottage

2802 South 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

Living Unit
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
✓	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
09564	1	In Compliance	☑Yes	☐No	Main Riser
09565	5	In Compliance	☐Yes	☐No	N/A Tested 6/24/21
30270	1	In Compliance	☑Yes	☐No	Basement
30272	1	In Compliance	☑Yes	☐No	1st Floor
30271	1	In Compliance	☑Yes	☐No	2nd Floor
		In Compliance	☐Yes	☐No	

STATUS OF SYSTEM-CHECK ONE

✓ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

David Roesler
INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL• 246 S 14TH ST • LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

)AMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

'roperty Being Evaluated YRTC Byant/Creighton Cottage — Area of Inspection All
;treet 2802 South 30th Avenue — Inspector Doug Roeder
;ity, State Zip Kearney, NE 68845 — Date 10/1/2021

'his work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

)wner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

)wner or representative (print nam Signature and Date

ıspector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☐ Yes	☐ No	☑ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☐ Yes	☐ No	☑ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection) (2016)	☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition? (2016)	☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure _____ psi and			
Residual Pressure Page 2 psi			
Current Results:			
Record Static Pressure _____ psi			
Residual Pressure _____ psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION

Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

Byant/Creighton

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☑ Yes	☐ No	☐ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
K. Specific gravity of antifreeze correct?	☐ Yes	☐ No	☑ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☑ No	☐ N/A
N. Backflow devices passed full flow test?	☐ Yes	☑ No	☐ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installation or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

6/24/21	Static	Residual
Main	80	70
Basement	80	70
1st Floor	75	65
2nd Floor	75	65

Current

	Static	Residual
Main	80	70
Basement	80	70
1st Floor	95	65
2nd Floor	75	65

5 year done 2016
QR Heads 2009
SR Heads 2009
Dry type heads 2009
Alarms base 35 main 45 1st 50
2nd 35 sec

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: Doug Roeder Date: 10-1-21
License or Certification Number (if applicable):

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC Dickinson Cottage

2802 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

Living Unit
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
✓	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
94402	1	In Compliance	☑Yes	☐No	
94401	5	In Compliance	☐Yes	☐No	N/A Tested 6/24/21
		In Compliance	☐Yes	☐No	
		In Compliance	☐Yes	☐No	
		In Compliance	☐Yes	☐No	
		In Compliance	☐Yes	☐No	

STATUS OF SYSTEM-CHECK ONE

✓ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL▪ 246 S 14TH ST ▪ LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

AMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

roperty Being Evaluated YRTC Dickinson Cottage — Area of Inspection All
treet 2802 30th Avenue — Inspector Doug Roeder
ity, State Zip Kearney, NE 68845 — Date 10/1/2021

his work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

wner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

wner or representative (print nam Signature and Date

ispector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☐ Yes	☐ No	☑ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
. Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☐ Yes	☐ No	☑ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection)	2016 ☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition?	2016 ☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure 70 psi and			
Residual Pressure 60 psi			
Current Results:			
Record Static Pressure 70 psi			
Residual Pressure 60 psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION

Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011 Dickinson

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☑ Yes	☐ No	☐ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
K. Specific gravity of antifreeze correct?	☐ Yes	☐ No	☑ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☐ No	☑ N/A
N. Backflow devices passed full flow test?	☐ Yes	☐ No	☑ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installation or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

QR Heads 2009

5 year done 2016

Alarms 30 seconds

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: Doug Roeder Date: 10-1-202

License or Certification Number (if applicable):

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC Dodge

2802 South 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

Offices/Hall
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
✓	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
05249	1	In Compliance	☑ Yes	☐ No	
05248	1	In Compliance	☑ Yes	☐ No	
05250	1 & 7	In Compliance	☑ Yes	☐ No	Anti-Freeze. Tested at -30
05245	5	In Compliance	☐ Yes	☐ No	N/A Tested 6/24/21
		In Compliance	☐ Yes	☐ No	
		In Compliance	☐ Yes	☐ No	

STATUS OF SYSTEM-CHECK ONE

✓ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL▪ 246 S 14TH ST ▪ LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

SAMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

Property Being Evaluated: YRTC Dodge
Area of Inspection: Dodge
Street: 2802 South 30th Avenue
Inspector: Doug Roeder
City, State Zip: Kearney, NE 68845
Date: 10/1/2021

This work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

Owner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

Owner or representative (print nam Signature and Date

Inspector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☑ Yes	☐ No	☐ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☐ Yes	☐ No	☑ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection) (2017)	☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition? (2017)	☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure _____ psi and			
Residual Pressure Page 2 psi			
Current Results:			
Record Static Pressure psi			
Residual Pressure psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION

Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011 Dodge

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
K. Specific gravity of antifreeze correct?	☑ Yes	☐ No	☐ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☐ No	☑ N/A
N. Backflow devices passed full flow test?	☐ Yes	☐ No	☑ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installation or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

Main Drain Test

6/24/21	Static	Residual
Main	80	70
Basement	80	70
1st Floor	70	60
2nd Floor	70	60
Current:		
Main	80	70
Basement	70	60
1st Floor	70	60
2nd Floor		

Antifreeze tested -30

5 year 2017

Q R Heads 2011

Alarms 45 1st 45 main 45 2nd 65 sec

Basement 50 sec

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: _____ Date: _____
License or Certification Number (if applicable): _____

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC Lincoln/Washington Cottage

2802 South 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

Living Unit
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
✓	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
09403	1	In Compliance	☑ Yes	☐ No	Main Riser
09404	5	In Compliance	☐ Yes	☐ No	N/A Tested 6/24/21
30268	1	In Compliance	☑ Yes	☐ No	Basement
30269	1	In Compliance	☑ Yes	☐ No	1st Floor
30267	1	In Compliance	☑ Yes	☐ No	2nd Floor
		In Compliance	☐ Yes	☐ No	

STATUS OF SYSTEM-CHECK ONE

✓ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL▪ 246 S 14TH ST ▪ LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

SAMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

roperty Being Evaluated YRTC Lincoln/Washington Cottage — Area of Inspection All
treet 2802 30th Avenue — Inspector Doug Roeder
ity, State Zip Kearney, NE 68845 — Date 10/1/2021

his work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

wner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

wner or representative (print nam Signature and Date

ispector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☐ Yes	☐ No	☑ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
. Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☑ Yes	☐ No	☐ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection)	2016 ☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition?	2016 ☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure _____ psi and			
Residual Pressure Page 2 psi			
Current Results:			
Record Static Pressure _____ psi			
Residual Pressure _____ psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

Lincoln/Washington

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☑ Yes	☐ No	☐ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☑ Yes	☐ No	☐ N/A
K. Specific gravity of antifreeze correct?	☐ Yes	☐ No	☑ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☐ No	☑ N/A
N. Backflow devices passed full flow test?	☐ Yes	☐ No	☑ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installation or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

Main Drain Test

6/24/21	Static	Residual
Main	80	70
Basement		
1st Floor	75	65
2nd Floor	70	60

Current	Static	Residual
Main	80	70
Basement		
1st Floor	65 75	65
2nd Floor	70	60

Basement Not Piped Outside

5 year 2016
QR Heads 2009
Dry type heads 2009
Alarms base 30 main 40 1st 45
2nd 50 sec

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: Doug Roeder Date: 10-1-202
License or Certification Number (if applicable):

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC Morton Cottage

2802 South 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

School/Dorm
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☑	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
9405	1	In Compliance	☑ Yes	☐ No	Main Riser
9406	5	In Compliance	☐ Yes	☐ No	N/A Tested 6/24/21
30266	1	In Compliance	☑ Yes	☐ No	Basement
30264	1	In Compliance	☑ Yes	☐ No	1st Floor
30265	1	In Compliance	☑ Yes	☐ No	2nd Floor
		In Compliance	☐ Yes	☐ No	
		Need to add sprinkler head in riser room			

STATUS OF SYSTEM-CHECK ONE

☑ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

Doug Bowden
INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL▪ 246 S 14TH ST ▪ LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

)AMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

'roperty Being Evaluated YRTC Morton Cottage
Area of Inspection All
Street 2802 South 30th Avenue
Inspector Doug Roeder
City, State Zip Kearney, NE 68845
Date 10/1/2021

This work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

Owner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

Owner or representative (print nam Signature and Date

Inspector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☐ Yes	☐ No	☑ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
i. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
. Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☐ Yes	☐ No	☑ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection) 2016	☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition? 2016	☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure _____ psi and			
Residual Pressure page 2 psi			
Current Results:			
Record Static Pressure _____ psi			
Residual Pressure _____ psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

Morton

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
K. Specific gravity of antifreeze correct?	☐ Yes	☐ No	☑ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☐ No	☑ N/A
N. Backflow devices passed full flow test?	☐ Yes	☐ No	☑ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installatior or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

Main Drain Test

6/24/21	Static	Residual
Main	85	75
Basement	85	75
1st Floor	75	65
2nd Floor	70	60

Current	Static	Residual
Main	80	70
Basement	80	70
1st floor	70	60
2nd Floor	70	60

5 year done 2016
Q R Heads 2009
Dry type heads 2009
Alarms main 45 base 40 1st 40
2nd 50sec

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: Doug Roeder Date 5-1-2021
License or Certification Number (if applicable):

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM
YRTC - Wimberly Gym & School

2802 South 30th Avenue

Kearney, NE 68845

10/1/2021
INSPECTION DATE

School
TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
☐	UNDERGROUND TEST CERTIFICATION (FORM 85-AB)	☐	INITIAL ACCEPTANCE OF SYSTEM
☐	ABOVEGROUND TEST CERTIFICATION (FORM 85-AC)	☐	REINSPECTION DUE TO REMODEL, REPAIR, ETC
☑	REPORT OF INSPECTION Quarterly	☐	PERIODIC ANNUAL INSPECTION
☐	DRY PIPE VALVE TEST	☐	BACKFLOW PREVENTER TEST

ITEM # DIRECTORY

1-WET RISER
2-DRY RISER
3-PREACTION RISER
4-FIRE PUMP
5-BACKFLOW PREVENTER
6-STANDPIPE
7-OTHER

DEFICIENCIES

ITEMIZE DEFICIENCIES NOTED ON INSPECTION
AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#				MAJOR DEFICIENCIES/COMMENTS
5243	5	In Compliance	☐Yes	☐No	N/A Tested 6/24/21
5245	1	In Compliance	☑Yes	☐No	1st Floor/School
5246	1	In Compliance	☑Yes	☐No	2nd Floor/Pool/Gym
5247	1	In Compliance	☑Yes	☐No	Locker/Office Hallway
		In Compliance	☐Yes	☐No	
		In Compliance	☐Yes	☐No	
		Alarms gym 50 1st 60 2nd 55 seconds			
		School basement 60 1st 55 2nd 65 seconds			

STATUS OF SYSTEM-CHECK ONE

☑ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION

BAMFORD, INC.

PO BOX 1868
KEARNEY, NE
68848-1868

PHONE 308-237-2157
FAX 308-237-4607

Doug Roeder
INSPECTOR SIGNATURE

NEBRASKA LICENSE # 98011

TESTER BFP LICENSE #

OWNER REPRESENTATIVE SIGNATURE

SEND TO: NEBRASKA STATE FIRE MARSHAL▪ 246 S 14TH ST ▪ LINCOLN NE 68508
A COPY OF THIS INSPECTION REPORT SHALL BE LEFT ATTACHED TO THE SYSTEM RISER

3AMFORD, INC.
O Box 1868
earney, NE 68848-1868
Phone (308)-237-2157
Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

'roperty Being Evaluated YRTC Wimberly Gym
Area of Inspection School/Gym
;treet 2802 South 30th Avenue
Inspector Doug Roeder
;ity, State Zip Kearney, NE 68845
Date 10/1/2021

'his work is: ☐ Monthly ☑ Quarterly ☐ Annual ☐ Third Year ☐ Fifth Year

'wner's Section

. Is the Bulding Occupied?	☑ Yes	☐ No
. Has the occupancy classification and hazard of contents remained the same since the last inspection?	☑ Yes	☐ No
. Are all fire protection systems in service?	☑ Yes	☐ No
. Has the system remained in service without modification since the last inspection?	☑ Yes	☐ No
. Was the system free of actuation of devices or alarms since the last inspection?	☑ Yes	☐ No

'wner or representative (print nam Signature and Date

ıspector's Section

. Control valves supervised with seals in correct (open or closed) position?	☐ Yes	☐ No	☑ N/A
. Backflow Preventers:			
Valves in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
Sealed, locked or supervised & accessible?	☑ Yes	☐ No	☐ N/A
Relief port on RPZ device not discharging?	☐ Yes	☐ No	☑ N/A
. Control valves with locks or electrical supervision in correct (open or closed) position?	☑ Yes	☐ No	☐ N/A
. Sprinkler wrench with spare sprinklers?	☑ Yes	☐ No	☐ N/A
. Gauges on wet-pipe system in good condition and showing normal water supply pressure?	☑ Yes	☐ No	☐ N/A
. Alarm Valves: Gauges show normal supply water pressure, free from physical damage, valves in correct (open or closed) position and no leakage from retarding chamber or drains?	☐ Yes	☐ No	☑ N/A
. Pressure Reducing Valves: In open position, not leaking, maintaining downstream pressure per design criteria, and in good condition with handwheels not broken?	☐ Yes	☐ No	☑ N/A
. Hydraulic nameplate (calculated systems) securely attached to riser and legible?	☑ Yes	☐ No	☐ N/A
Fire Department Connections: Visible, accessible, couplings and swivels not damaged and rotate smoothly, plugs or caps in place and undamaged, gaskets in place and in good condition, identification sign(s) in place, check valve is not leaking, clapper is in place and operating properly and automatic drain valve in place and operating properly? (If plugs or caps are not in place, inspect interior for obstructions.)	☑ Yes	☐ No	☐ N/A
Alarm devices free from physical damage?	☑ Yes	☐ No	☐ N/A

K. Proper number and type of spare sprinklers?	☑ Yes	☐ No	☐ N/A
L. Visible sprinklers:			
Free of corrosion and physical damage?	☐ Yes	☐ No	☑ N/A
Free of obstructions to spray pattern including 18" rule)?	☐ Yes	☐ No	☑ N/A
Free of foreign materials including paint?	☐ Yes	☐ No	☑ N/A
Liquid in all glass bulb sprinklers?	☐ Yes	☐ No	☑ N/A
M. Visible pipe:			
In good condition/no external corrosion?	☐ Yes	☐ No	☑ N/A
No mechanical damage and no leaks?	☐ Yes	☐ No	☑ N/A
Properly aligned and no external loads?	☐ Yes	☐ No	☑ N/A
N. Visible pipe hangers and seismic braces not damaged or loose?	☐ Yes	☐ No	☑ N/A
O. Hose, hose couplings and nozzles on sprinkler system passed inspection in accordance with NFPA 1962?	☐ Yes	☐ No	☑ N/A
P. Adequate heat in areas with wet piping?	☑ Yes	☐ No	☐ N/A
Q. Has an internal inspection of the pipe been performed by removing the flushing connection and one sprinkler near the end of a branch line within the last 5 years? If "No," conduct an internal inspection) (2017)	☑ Yes	☐ No	☐ N/A

Fifth Year Inspection Items

A. Alarm valves and their associated strainers, filters and restriction orifices passed internal inspection?	☐ Yes	☐ No	☑ N/A
B. Check valves internally inspected and all parts operate properly, move freely and are in good condition? (2017)	☑ Yes	☐ No	☐ N/A

Testing

A. Mechanical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☐ Yes	☐ No	☑ N/A
B. Post indicating valves opened until spring or torsion is felt in the rod, then closed back one-quarter turn?	☑ Yes	☐ No	☐ N/A
C. Main Drain Test:			
Date of Previous Results 6/24/21			
Static Pressure _____ psi and			
Residual Pressure Page 2 psi			
Current Results:			
Record Static Pressure _____ psi			
Residual Pressure _____ psi			
Was flow observed?	☑ Yes	☐ No	☐ N/A
Are results comparable to previous test?	☑ Yes	☐ No	☐ N/A
D. Valve supervisory stiches indicate movement?	☑ Yes	☐ No	☐ N/A
E. Electrical waterflow alarm devices passed tests by opening in the inspector's test connection or bypass connection with alarms actuating and flow observed?	☑ Yes	☐ No	☐ N/A

BAMFORD, INC.
PO Box 1868 Phone (308)-237-2157
Kearney, NE 68848-1868 Fax 308-237-4607

REPORT OF INSPECTION
Of Wet Pipe Fire Sprinkler System
Nebraska License @ 98011

Wimberly

Testing Continued

F. Are all sprinklers dated 1920 or later?	☑ Yes	☐ No	☐ N/A
G. Fast response sprinklers 20 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
H. Standard response sprinklers 50 or more years old replaced or successfully sample tested within last 10 years?	☐ Yes	☐ No	☑ N/A
I. Standard response sprinklers 75 or more years old replaced or successfully sample tested within last 5 years?	☐ Yes	☐ No	☑ N/A
J. Dry-type sprinklers replaced or successfully sample tested within last 10 years?	☑ Yes	☐ No	☐ N/A
K. Specific gravity of antifreeze correct?	☐ Yes	☐ No	☑ N/A
L. All control valves operated through full range and returned to normal position?	☑ Yes	☐ No	☐ N/A
M. Backflow devices passed backflow test?	☐ Yes	☐ No	☑ N/A
N. Backflow devices passed full flow test?	☐ Yes	☐ No	☑ N/A
O. Pressure reducing valves passed partial flow test?	☐ Yes	☐ No	☑ N/A
Test to be done every third year:			
A. Hose (more than 5 years old) connected to the system has been service tested in accordance with NFPA 1962. Water discharged and water flow alarms operated?	☐ Yes	☐ No	☑ N/A
Tested to be done every fifth year:			
A. Sprinklers rated above High temperature tested?	☐ Yes	☐ No	☑ N/A
B. Gauges checked by calibrated gauge or replaced?	☑ Yes	☐ No	☐ N/A
C. Pressure reducing valves passed full flow test?	☐ Yes	☐ No	☑ N/A
Maintenance			
A. If sprinklers have been replaced, were they proper replacements?	☐ Yes	☐ No	☑ N/A
B. Used hose was cleaned, drained and dried before being placed back in service? Hose exposed to hazardous materials was disposed of or decontaminated in an approved manner?	☐ Yes	☐ No	☑ N/A
C. Systems normally filled with fresh water were drained and refilled twice if raw water got into the system?	☐ Yes	☐ No	☑ N/A
D. If any of the following were discovered, was an obstruction investigation conducted?	☐ Yes	☐ No	☑ N/A

Explain reason(s) and obstruction investigation findings in comments

1 Defective intake screen on pump with suction from open sources.
2 Obstructive material discharged during waterflow tests.
3 Foreign materials found in dry-pipe valves, check valves or pumps.
4 Foreign material in water during drain test or plugging of inspector's test connection.
5 Plugging of pipe or sprinklers found during activation or alteration.
6 Failure to flush yard piping or surrounding public mains following new installatior or repairs.
7 Record of broken mains in the vacinity.
8 Abnormally frequent false-tripping of dry-pipe valves.
9 System is returned to service after an extended period out of service (greater than one year).
10 There is reason to believe the system contains sodium silicate or its derivatives or highly corrosive fluxes in copper pipe systems.

E. If conditions were found that required flushing, was flushing of system conducted?	☐ Yes	☐ No	☑ N/A
F. Operating stem of all OS&Y valves lubricated, completely closed, and reopened?	☐ Yes	☐ No	☑ N/A
G. Sprinklers and spray nozzles protecting commercial cooking equipment and ventilating systems replaced except for bulb-type which show no signs of grease buildup?	☐ Yes	☐ No	☑ N/A

Comments (Any "No" answers, test failures or other problems found with the sprinkler system must be explained here. Also, note here any products noticed on the system that have been the subject of a recall or a replacement program.)

Main Drain Test

6/24/21	Static	Residual
-School-		
Main	80	70
Basement	80	70
1st Floor	80	70
2nd Floor	80	70
-Pool-	80	70
-Gym-	80	70
-Locker/Hall-	80	70

Current	Static	Residual
-School-		
Main	80	70
Basement	80	70
1st Floor	80	70
2nd Floor	80	70
-Pool-	80	70
-Gym-	80	70
-Locker/Hall-	80	70

Inspector's Information

Inspector: Doug Roeder

I state that the information on this form is correct at the time and place of my inspection, and that all equipment tested at this time was left in operational condition upon completion of this inspection except as noted in comments above.

Signature of Inspector: Doug Roeder Date 10-1-2021

License or Certification Number (if applicable):

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Chris Cantrell
Chief Boiler Inspector
State Fire Marshal

Youth Development Center
ATTN: Kevin Quail
2802 30th Ave
Kearney, NE 68845-4035

10/22/2021

If you sell, transfer, scrap, disconnect, or relocate this boiler, please notify our office @ (402) 471-9902 or sfm.boilers@nebraska.gov. This certificate shall be posted on or near the unit described. If this unit is exposed to the weather or other possible damage, the certificate may be kept in a central location but shall be available to the inspector or any other legal authority.

CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner **4545747**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

Location **1962775**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

State ID Number: NE02326
Type: FTSM - FTS Marine Dry Back
Last External Inspection: 05/21/2021
Expiration Date: 05/31/2022
Inspected By: David Sutheimer
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 07/27/2021
National Board Number: 28755

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 85 PSI
Manufacturer: Burnham
Year Built: 2004
Print Date: 10/22/2021
Next Internal Due Date: 07/27/2022
Serial Number: 72792-2
Owner's Equip ID: Boiler #3

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

Christopher B. Cantrell

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Chris Cantrell
Chief Boiler Inspector
State Fire Marshal

Youth Development Center
ATTN: Kevin Quail
2802 30th Ave
Kearney, NE 68845-4035

10/22/2021

If you sell, transfer, scrap, disconnect, or relocate this boiler, please notify our office @ (402) 471-9902 or sfm.boilers@nebraska.gov. This certificate shall be posted on or near the unit described. If this unit is exposed to the weather or other possible damage, the certificate may be kept in a central location but shall be available to the inspector or any other legal authority.

CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner **4545747**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

Location **1962775**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

State ID Number: NE02327
Type: FTSM - FTS Marine Dry Back
Last External Inspection: 05/21/2021
Expiration Date: 05/31/2022
Inspected By: David Sutheimer
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 08/16/2021
National Board Number: 28747

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 85 PSI
Manufacturer: Burnham
Year Built: 2004
Print Date: 10/22/2021
Next Internal Due Date: 08/16/2022
Serial Number: 72792-1
Owner's Equip ID: Boiler #2

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

Christopher B. Cantrell

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Chris Cantrell
Chief Boiler Inspector
State Fire Marshal

Youth Development Center
ATTN: Kevin Quail
2802 30th Ave
Kearney, NE 68845-4035

10/22/2021

If you sell, transfer, scrap, disconnect, or relocate this boiler, please notify our office @ (402) 471-9902 or sfm.boilers@nebraska.gov. This certificate shall be posted on or near the unit described. If this unit is exposed to the weather or other possible damage, the certificate may be kept in a central location but shall be available to the inspector or any other legal authority.

CERTIFICATE OF INSPECTION

Nebraska State Fire Marshal Agency
Boiler Inspection Division
246 S. 14th Street, Suite 1
Lincoln, NE 68508
Phone (402) 471-9902, Email sfm.boilers@nebraska.gov

Owner **4545747**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

Location **1962775**

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

State ID Number: NE02332
Type: FTSM - FTS Marine Dry Back
Last External Inspection: 07/27/2021
Expiration Date: 05/31/2022
Inspected By: Michael Hamer
Inspecting Agency: OneCIS Insurance Compan
Last Internal Inspection: 05/21/2021
National Board Number: 28757

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 85 PSI
Manufacturer: Burnham
Year Built: 2004
Print Date: 10/22/2021
Next Internal Due Date: 05/21/2022
Serial Number: 72793
Owner's Equip ID: Boiler #1

This is to certify that the described unit may be operated at a pressure not to exceed the "Pressure Allowed" as shown. This certificate is valid until the expiration date, another inspection is made, or is withdrawn for cause. Issuance of this certificate does not create liability nor guarantee personal safety. If you have any questions regarding the operation or safety of this unit, contact the owner or the State Chief Boiler Inspector.

Chief Boiler Inspector/State Fire Marshal

Christopher B. Cantrell

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

☐ CAR
☐ HACCP

Firm: Kearney West High (YRTC)	Firm ID: 19-15 / Inspector Code: 25
Address: 2202 30th Ave	Facility Codes: / Inspection Date: 9-22-21
City: Kearney County: Buffalo	

Unless otherwise stated, violations cited in this report shall be corrected within the period noted: Priority (P) items within 3 days, Priority Foundation (PF) items within 10 days (§8-405.11) or 90 days for core items (§8-406.11).

Priority / Priority Foundation Violations: 2 **Core Violations:** 3

Purpose

(Regular: 1) Follow-up: 2 Complaint: 3	Investigation: 4 Other: 5

Temperature Observations

Food Product	Product Temp.	Location	Food Product	Product Temp.	Location
Pulled pork	200.5	steam table			

Foodborne Illness Risk Factors and Public Health Interventions

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable

Mark "X" in appropriate box for C and/or R
C=corrected on site during inspection R=repeat violation

	Compliance Status		C	R
	Demonstration of Knowledge			
1	(IN) OUT	Certification by accredited program, compliance with code, or correct responses		
	Employee Health			
2	(IN) OUT	Management awareness; policy present		
3	(IN) OUT	Proper use of reporting, restriction & exclusion		
	Good Hygienic Practices			
4	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
5	(IN) OUT N/O	No discharge from eyes, nose & mouth		
	Preventing Contamination by Hands			
6	(IN) OUT N/O	Hands clean & properly washed		
7	(IN) OUT N/A N/O	No bare hand contact with RTE foods		
8	(IN) OUT	Adequate handwashing facilities supplied & accessible		
	Approved Source			
9	(IN) OUT	Food obtained from approved source		
10	IN OUT N/A (N/O)	Food received at proper temperature		
11	(IN) OUT	Food in good condition, safe & unadulterated		
12	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
13	(IN) OUT N/A	Food separated & protected		
14	(IN) OUT N/A	Food-contact surfaces; cleaned & sanitized		
15	(IN) OUT	Proper disposition of returned, previously served, recondition, unsafe food		

	Compliance Status		C	R
	Time/Temperature Control for Safety (TCS Food)			
16	IN OUT N/A (N/O)	Proper cooking time & temperature		
17	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
18	IN OUT N/A (N/O)	Proper cooling time and temperatures		
19	(IN) OUT N/A N/O	Proper hot holding temperatures		
20	(IN) OUT N/A	Proper cold holding temperatures		
21	(IN) OUT N/A N/O	Proper date marking and disposition		
22	IN OUT (N/A) N/O	Time as a public health control; procedures & record		
	Consumer Advisory			
23	IN OUT (N/A)	Consumer advisory provided for raw or under cooked foods		
	Highly Susceptible Populations			
24	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Chemical			
25	(IN) OUT N/A	Food additives; approved & properly used		
26	IN OUT	Toxic substances properly identified, stored & used		
	Conformance with Approved Procedures			
27	(IN) OUT N/A	Compliance with variance, specialized process, & HACCP plan		
	(IN) OUT N/A	Ventilation adequate in dry storage to maintain ideal temperatures		
	(IN) OUT N/A	Thermometer in dry storage areas		
	(IN) OUT N/A	Locks on all storage areas to prevent pilferage		

P or PF	Item #	Code Reference	Violation Description/Remarks/Corrections
PF	11	3-202.15	Food packaging integrity- bad seams
			cheese sauce, spaghetti, queso
PF	14	4-602.11	Clean floor mixer

Follow-up
Yes 1 No 2

Received by: _____ Inspected by: _____

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

Firm: Kearney West High (YRTC)	
Address: 2802 30th Ave	
City: Kearney County: Buffalo	

Firm ID: 10-15	Inspector Code: 25
Facility Codes:	Inspection Date: 9-22-21

Good Retail Practices

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

	Safe Food and Water	C	R
28	Pasteurized eggs used where required		
29	Water & ice from approved source		
30	Variance obtained for specialized processing methods		
	Food Temperature Control		
31	Proper cooling methods used; adequate equipment for temperature control		
32	Plant food properly cooked for hot holding		
33	Approved thawing methods used		
34	Thermometers provided & accurate		
	Food Identification		
35	Food properly labeled; original container		
	Prevention of Food Contamination		
36	Insects, rodents, & animals not present; no unauthorized persons		
37	Contamination prevented during food preparation, storage, & display		
38	Personal cleanliness; hair restraints		
39	Wiping cloths; stored in sanitizing solution and properly used		
40	Washing fruits & vegetables washed prior to use		

	Proper Use of Utensils	C	R
41	In-use utensils; properly stored		
42	Utensils, equipment, & linens; properly stored, dried & handled		
43	Single-use & single-service articles; properly stored & used		
44	Gloves used properly		
	Utensils, Equipment, and Vending		
45	Food & non-food contact surfaces cleanable, properly designed, constructed & used		
46	Warewashing facilities; installed, maintained, & used; test strips		
47	Non-food contact surfaces clean		
	Physical Facilities		
48	Hot & cold water available; adequate pressure		
49	Plumbing installed, proper backflow devices		
50	Sewage & waste water properly disposed		
51	Toilet facilities; properly constructed, supplied & cleaned		
52	Garbage & refuse properly disposed; facilities maintained		
53	Physical facilities installed, maintained, & clean		
54	Adequate ventilation & lighting; designated areas used		

P or PF	Item #	Code Reference	Violation Description/Remarks/Corrections
	45	4-402.11	Equipment shall be sealed to adjacent wall
			→ Dishwasher table - seal like 3 comp sink
	53	6-501.12	Clean floor under single stainless sink
			by 2 door cooler
	53	6-501.11	Replace seal on walk-in freezer
			→ moisture / ice formation. Seal
			is cracking
			Dishwasher 169.8
			Thermometers in all units
			Using single use disposables 50% of time
			pork 5-7-21 2nd door freezer

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Received by: _____ Inspected by: _____

PREA

Attachment K6

PREA Facility Audit Report: Final

Name of Facility: Youth Rehabilitation and Treatment Center Kearney
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 12/04/2021

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Candace L. Snydere	**Date of Signature:** 12/04/2021

AUDITOR INFORMATION	
Auditor name:	Snyder, Candy
Email:	Snyder@gwtc.net
Start Date of On-Site Audit:	10/19/2021
End Date of On-Site Audit:	10/20/2021

FACILITY INFORMATION	
Facility name:	Youth Rehabilitation and Treatment Center Kearney
Facility physical address:	2802 30th Avenue, Kearney, Nebraska - 68845
Facility Phone	
Facility mailing address:	

Primary Contact	
Name:	Ralph Healey
Email Address:	ralph.healey@nebraska.gov
Telephone Number:	402-630-4117

Superintendent/Director/Administrator	
Name:	Paul Gordon
Email Address:	paul.gordon@nebraska.gov
Telephone Number:	308-293-6385

Facility PREA Compliance Manager	
Name:	Karen Frye
Email Address:	karen.frye@nebraska.gov
Telephone Number:	M: (308)-338-2006
Name:	Ralph Healey
Email Address:	ralph.healey@nebraska.gov
Telephone Number:	O: (402) 630-4117

Facility Health Service Administrator On-Site	
Name:	Joni Suhr
Email Address:	joni.suhr@nebraska.gov
Telephone Number:	308-991-2070

Facility Characteristics	
Designed facility capacity:	170
Current population of facility:	40
Average daily population for the past 12 months:	48
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	14 to 18
Facility security levels/resident custody levels:	Highest level of care for juveniles males in DHHS-OJS
Number of staff currently employed at the facility who may have contact with residents:	130
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	3
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Nebraska Division of Children and Family Services
Governing authority or parent agency (if applicable):	
Physical Address:	301 Centennial Mall S, Lincoln, Nebraska - 68509
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Shaylee Fortner	**Email Address:**	shaylee.fortner@nebraska.gov

AUDIT FINDINGS

Narrative:
The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-audit, on-site audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

An audit of the Nebraska Office of Juvenile Services Youth Rehabilitation and Treatment Center (YRTC-Kearney) in Kearney, Nebraska was conducted on October 19 and 20, 2021 by Candy Snyder, a Department of Justice certified PREA auditor.

The YRTC-Kearney for male youth and Youth Rehabilitation and Treatment Center-Hastings (YRTC-Hastings) for female youth utilize a compliance team. The compliance team is led by Shaylee Fortner, the Compliance Manager and the PREA Coordinator, Ralph Healey, Fred Boon, and Samantha Mooney, Compliance Specialists who fill the role as PREA Compliance Managers for both YRTC-Kearney and YRTC-Hastings. The compliance team is responsible for PREA standards, American Corrections Association (ACA) standards, Performance based Standards (PbS) and the grievance process. In addition, the compliance team has completed specialized training through the PREA Resource Center for investigations and they conduct all administrative investigations for the two facilities.

Audit notices were properly posted six weeks in advance of the dates of the on-site audit and verified by dated stamped photographs submitted to the auditor. The auditor observed the notices posted throughout the facility during the on-site tour. A pre-audit questionnaire with supporting documentation was provided to the auditor in advance of the on-site audit dates.

An entrance meeting began with staff to include OJS Administrator, Mark LaBouchardiere; YRTC-Kearney Facility Administrator Paul Gordon and most of the compliance team. In addition, various department managers were present. Following the entrance meeting the facility administrator and the compliance team conducted the auditor on a facility tour. During the tour the auditor located camera positions, security mirrors for better lines of sight, locked doors and the presence of staff providing direct supervision of the youth. The facility has upgraded and added additional cameras over the past year. There are now cameras in all the classrooms and throughout the school building in addition to many other locations throughout the campus. The digital video recording system (DVRS) is able to securely retain video for up 90 days. All direct care staff carry hand-held radios for communication across the campus. The auditor physically observed every sleeping room and every shower and toileting facility utilized by youth with the exception of Lincoln/Washington (see paragraph below). In addition, to the audit notice, PREA posters in both English and Spanish were located consistently throughout the campus. Female staff consistently announced their presence when entering youth housing units.

The auditor then began interviewing specialized staff. Suitable and private accommodations were made for the auditor to conduct interviews. The auditor was not limited in any way from speaking with staff or youth or inspecting any area of the facility. The auditor was given access to the facility at all hours of the day in order to conduct interviews with staff on all shifts. The auditor did not inspect one building with two units as these units were under quarantine due to an outbreak of the COVID-19 virus. The auditor did view these areas via camera and interviewed youth and staff from these units using video conferencing. The Administrator and his staff were extremely polite and accommodating throughout the audit.

The auditor conducted a review of the application and hiring process, employee background checks and sexual abuse registry checks. The auditor also reviewed education files, investigative files, and screenings for vulnerability to sexual abuse and perpetration. The auditor conducted specialized interviews to include the administrators, the PREA Coordinator, Compliance Specialists , investigators, higher level staff who perform unannounced rounds and incident reviews, medical and mental health staff, staff who perform screenings and staff who monitor for retaliation.

A compliance specialist provided a copy of the staff schedule, staff roster, and youth roster. The auditor randomly selected 13 staff for interviews to include staff representing all three shifts, varying degrees of longevity and serving in different job positions. The auditor returned during the evening to interview staff coming in for the overnight shift. The auditor asked specialized questions of staff regarding screenings, searches, first response and the intake process.

The auditor interviewed ten (10) male youth. The auditor used interview guides for youth as indicated by a review of their screening. There were no residents who were limited English speaking to be interviewed, there were no residents at the facility who were victims of sexual abuse or harassment at the facility and there were no residents who identified as LGBTI.

An exit briefing was held with staff to include the OJS Administrator, Mark LaBouchardiere, PREA Coordinator Shaylee Fortner, YRTC-Kearney facility administrator, Paul Gordon, and PREA Compliance Managers, Ralph Healey and Fred Boon. The auditor provided a preliminary finding of each standard with the caveat that this was subject to change as the auditor continued to review documents, may have questions to be answered and prepares the interim report. The auditor thanked the staff for their hard work and, their dedication to and caring for the youth under their charge.

AUDIT FINDINGS

Facility Characteristics:
The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate or resident population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The Youth Rehabilitation and Treatment Center-Kearney (YRTC-Kearney) for boys is a sprawling campus with lush lawns and beautiful trees sitting upon a hill overlooking a golf course. The campus can house up to 170 male youth. At the time of the on-site portion of the audit there were 40 male youth in residence. It is important to note that this campus temporarily housed female youth from the Geneva, Nebraska campus until April 2021 when they were moved to their new facility in Hastings, Nebraska.

The Administration building consists of offices and meeting rooms on the first floor and storage on the second floor. Reynolds Hall is a very large school building with an adjoining gymnasium and pool that provide for the educational needs of the youth. Staff are strategically placed throughout the school building throughout instructional hours in addition to the teaching staff for supervision of youth and to provide assistance with any issues. There is a vocation building where youth are taught welding and building trades. Gomez Hall houses the dining facility and kitchen on the first floor and laundry, food storage and a warehouse on the lower level. A chapel is also located on the campus. There are four youth housing buildings with two housing units in each building.

Dickson is the intake unit and special management unit for the Kearney campus. Dickson has a north hall and an east hall spoking from the central staff office and classroom/lounge forming an L-shaped building. A shared, fenced-in, outside exercise yard flanks the wings. Youth are initially housed in individual sleeping rooms in Dickson. Youth are housed in Dickson until assessments have been completed to determine their appropriate housing. Staff conduct ten minute or less staggered room checks. Each sleeping room has a fixed bed, desk and a toilet/sink. Each hall has a lounge. The west wing has a staff office and intake office. There is a dayroom and individual showers in each wing. Dickson is the most secure unit. There are four rooms located behind the staff office that are used for youth on confinement status that may need a cool down period for aggressive behavior or for quarantine/sick quarters.

Bryant/Creighton houses two living units. They are located in one building that is divided exactly in half with the housing units as mirror images – Bryant to the east and Creighton to the west. There are separate entrances to each unit on the first floor. Each housing unit consists of a dayroom, multipurpose room, staff office and shower/locker room on the first floor and youth sleeping rooms on the second floor. The youth sleeping rooms have a staff office in the center of the dividing wall with windows that have direct observation into both Bryant's and Creighton's sleeping areas. Passing between the two units can only be done by using the doors in this center staff office on the second floor. Each sleeping unit has one restroom and the unit manager's office on either side of the staff office. The restroom has a single toilet and sink that one youth at a time may use. In addition, this building has one-story additions that house the canteen on the southeast corner of the building and medical and dental offices on the southwest corner of the building. These additions have their own entrances and cannot be accessed directly from the housing units.

Lincoln/Washington houses two living units. They are located in one building that is divided exactly in half with the housing units as mirror images – Lincoln to the east and Washington to the west. There are separate entrances to each unit on the first floor. Each housing unit consists of a dayroom, multipurpose room, staff office and shower/locker room on the first floor and youth sleeping rooms on the second floor. The youth sleeping rooms have a staff office in the center of the dividing wall with windows that have direct observation into both Lincoln's and Washington's sleeping areas. Passing between the two units can only be done by using the doors in this center staff office on the second floor. Each sleeping unit has one restroom and the unit manager's office on either side of the staff office. The restroom has a single toilet and sink that one youth at a time may use. In addition, this building has one-story additions that house the barber and a group room on the southeast corner of the building and the case managers with group rooms on the southwest corner of the building. These additions have their own entrances and cannot be accessed directly from the housing units.

Morton Hall is divided into two distinct areas. The therapists' offices and group rooms for counseling are located on the first floor in the western wing of the building. This is the only programming area currently being used in Morton Hall. The living spaces for the Morton housing unit are located in the eastern end of the building. The living spaces consists of a dayroom, game room, staff office and shower/locker room on the first and the sleeping rooms on the second floor with 20 individual sleeping rooms. Morton Hall living spaces are currently not occupied.

AUDIT FINDINGS

Summary of Audit Findings:
The OAS will automatically calculate the number of standards exceeded, number of standards met, and the number of standards not met based on the auditor's compliance determinations. If relevant, the auditor should provide the list of standards exceeded and/or the list of standards not met (e.g. Standards Exceeded: 115.xx, 115.xx..., Standards Not Met: 115.yy, 115.yy). Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	2
Number of standards met:	41
Number of standards not met:	0

It was apparent that the staff have continued their efforts in maintaining PREA compliance measures over the past three years. All measures put in place previously were continued. Following the on-site portion of the audit, the auditor began work on the interim report and continued work with the facility on any questions and issues.

There were no corrective actions required and therefore a final PREA audit report was issued.

The auditor determined that YRTC-Kearney's compliance efforts substantially exceed the requirements for standards 115.311 and 115.341.

STANDARDS EXCEEDED

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

The auditor determined that YRTC-Kearney substantially exceeds this standard. The OJS has a dedicated compliance team that includes the Compliance Manager who is the agency level PREA Coordinator and two Compliance Specialists who are responsible for PREA compliance at this facility. The compliance team reports outside of the facilities' chains of command and reports directly to the OJS Administrator. This team as well as facility staff work to ensure that compliance with every standard in both policy and procedure is maintained. The team has the authority to develop, implement and oversee the efforts and has the complete support of both the agency administrator and the facility administrator. Their processes are very organized. They research and provide training and resources to the facility staff at Kearney, Hastings, and Lincoln (in coordination with the Lincoln and Hastings Compliance Specialists). The auditor believes that the commitment of time and resources to compliance and that the compliance team does not report to anyone within the facility command structure is by far the absolute best approach to achieving and maintaining compliance with the standards.

Standard 115.341 Obtaining information from residents

The auditor determined that YRTC-Kearney substantially exceeds this standard. The screening is very thorough and conducted by a licensed mental health professional who takes the time to get a clear picture of responses to all this standard's required questions both through a detailed interview with the youth and a complete review of all records. If a youth identifies a sexual abuse or sexual perpetration history, the screener ensures that appropriate medical and mental health department heads are notified so that a therapist can be assigned and/or medical care provided if needed. This facility's model approach to the special mental health treatment needs of adolescents involved in the juvenile justice system is exceptional and it begins with the appropriate and thorough screening of youth upon intake.

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	The YRTC-Kearney has a well-written PREA policy. The policy is titled Operational Memorandum 115.17.6 Prevention, Detection, Reporting, Staff Response, & Investigation of Abuse, Neglect, Sexual Harassment, Sexual Abuse/Assault. This policy will be referred throughout this report as the PREA policy. The PREA policy mandates zero-tolerance and outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The auditor observed that the procedures for following the standards were being met through directive and standard operating procedure. The auditor determined that YRTC-Kearney substantially exceeds this standard. The OJS has a dedicated compliance team that includes the Compliance Manager who is the agency level PREA Coordinator and two Compliance Specialists who are responsible for PREA compliance at this facility. The compliance team reports outside of the facilities' chains of command and reports directly to the OJS Administrator. This team as well as facility staff work to ensure that compliance with every standard in both policy and procedure is maintained. The team has the authority to develop, implement and oversee the efforts and has the complete support of both the agency administrator and the facility administrator. Their processes are very organized. They research and provide training and resources to the facility staff at Kearney, Hastings, and Lincoln (in coordination with Lincoln and Hastings Compliance Specialists). The auditor believes that the commitment of time and resources to compliance and that the compliance team does not report to anyone within the facility command structure is by far the absolute best approach to achieving and maintaining compliance with the standards.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility does not contract for the confinement of its residents with other private agencies/entities.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	YRTC-Kearney has a documented staffing plan that is updated annually. In addition, they provided documents to demonstrate to the auditor their thought process in compiling their staffing plan. A thorough assessment of camera coverage was completed in 2019. Following that assessment many additional cameras were installed to include cameras in every classroom and throughout the education building. The staffing ratios of 1:8 staff to resident ratio during waking hours and a 1:16 staff to resident ratio during sleeping hours is always maintained. They have been no documented incidents of falling below the standards ratio. However, they have been utilizing a lot of overtime to continue to meet this need. They recognize that this way of operating cannot continue and are working diligently to recruit staff to fill vacant positions. Each living unit is assigned a Living Unit Manager responsible for supervising their building. Youth Program Specialists (YPS) and Youth Case Managers (YC) are direct reports of the Living Unit Manager. The Living Unit Manager will occasionally be responsible for the direct supervision and care of the youth. In addition to the Unit Manger, the Youth Program Specialists and the Case Managers, there are 17 youth Security Supervisors (YSS) and 2 Youth Security Supervisor Managers. Depending on the programming occurring there are also therapists, teachers, and recreation staff. The PREA policy requires intermediate- and higher-level staff to conduct and document unannounced rounds. This duty is completed by both administrators/department heads and by the Youth Security Supervisors. A review of checks confirm that administrators and the Youth Security Supervisors complete these rounds. Rounds are documented in the unannounced rounds logbook and in the Shift Report section of the Morning Report. The auditor verified this by reviewing documentation and through interviews. Department heads stated during interviews that they have unannounced rounds assigned for a week at a time every eight to ten weeks. They go through every unit and interact with the youth during their walk-through.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility does not conduct cross-gender pat-down searches except in exigent circumstances. The agency trains security staff on how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents. Staff at YRTC-Kearney are instructed to conduct all searches with the back of their hands and in a manner that is respectful of all residents. The facility does not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it is determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. The YRTC-Kearney has policies and procedures that enable residents to shower, perform bodily functions and change clothing without nonmedical staff of the opposite gender viewing them in a state of undress except in exigent circumstances or when such viewing is incidental to routine cell checks. If during a routine cell check a youth is seen in a state of undress, an entry is made in the exigent circumstance log. Showers are supervised by male staff and female staff typically post themselves at the opposite end of the dayroom near the staff office where they administer medication during shower times. The windows between the locker room and the dayroom are obscured by opaque film over the windows. In other areas of the facility there are single-occupant restrooms for privacy. Female staff announce their presence on the intercom before entering a resident housing unit. The auditor noted the announcement was made during the tour of the facility. The youth and staff indicated during interviews that these announcements are made consistently.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney uses a list of state contracted interpreters for youth who may not speak English or speak through Sign Language. The facility does not use residents to interpret for other residents. All staff are instructed in the procedures for assisting youth who may need additional assistance. Staff sign a verification form that they understand these procedures. Staff acknowledged these procedures during the interviews. Staff work with youth who have either visual impairments or reading and comprehension issues by verbally reviewing the material. The agency takes appropriate steps to ensure residents with disabilities (for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The policy states the facility does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility's personnel files are maintained on-line. The Human Resources staff brought up employee files for the auditor to review electronically. The facility has performed background checks at the time of employment of new hires. The auditor reviewed personnel files to confirm the background checks were completed as per the standard. YRTC-Kearney performs Child Abuse and Neglect Registry checks at the time of employment. They have a form asking the questions regarding sexual misconduct that is completed upon hiring and during the annual review process. The continuing duty to report is outlined in policy and all staff are required to sign that they have read and understood the policy. The facility conducts the required checks with former institutional employees regarding sexual misconduct while employed.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility is well designed and facility staff continue to review for blind spots or changes to the facility through their incident review and annual review process. There are over 199 cameras throughout the campus with cameras in all key areas. Video retention is up to 90 days which enhances investigation efforts. Mirrors are located in many of the stairwells and staff are continuously modifying and upgrading when the need dictates or when discovered during physical inspections of the campus. Housing was modified and cameras were added when the girls were temporarily housed on this campus.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	As soon as sexual abuse is reported the protocol is to call the Child Protective Services hotline and/or the Nebraska State Police. Both of these agencies use the Family Advocacy Network (FAN) in Kearney to advocate and assist youth who have been sexually assaulted. The staff take direction from the State Police and the FAN on when and where to transport sexual assault victims for a forensic examination. Typically, they will be transported to FAN, the Kearney Regional Medical Center or to Good Samaritan Hospital. The facility has a Memorandum of Understanding (MOU) with the FAN who provide counseling to survivors of sexual abuse and provide accompaniments to the hospital, during interviews and throughout the investigative and criminal proceedings process.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The policy and procedures are in place to always notify the Youth Security Supervisor on shift for every incident of sexual abuse or sexual harassment. PREA policy 115.17.6 then specifically states that the YRTC-Kearney will ensure all allegations of sexual abuse or sexual harassment are referred for investigation to the Nebraska State Police that involves potentially criminal behavior. Allegations that are not criminal are investigated by trained investigators at the facility. The PREA policy (which includes Section V. Investigation – Criminal & Administrative) is posted on their website at https://dhhs.ne.gov/Pages/YRTC-Reports.aspx

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney provides PREA training to all staff. The training is based on training resources that the compliance team has compiled from the PREA Resource Center website. The auditor reviewed the training material to include PowerPoint presentations, reviewed the training forms with staff signatures and interviewed staff about the training they received.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Due to Covid-19 the YRTC-Kearney contractors and volunteers who would have contact with youth is limited. They are aware of the training requirements should the situation change. The auditor reviewed their volunteer and contractor training materials. Compliance staff would provide the training and the contractors/volunteers will be required to sign training acknowledgment forms.

115.333	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility provides information to residents upon intake while the youth is assigned to the Dickson housing unit. This training covers the YRTC-Kearney's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility verbally goes over written orientation information with the youth and then has the youth sign the form when complete. On the 7th day, the day they are classified and moving to their assigned cottage, they receive the video training and the PREA comic book End the Silence from the Washington College of Law. Their training includes their right to be free from sexual abuse and sexual harassment, to be free from retaliation for reporting such incidents, and regarding the YRTC-Kearney's policies and procedures for responding to such incidents. Youth sign acknowledgment forms that they have received the training. This information is continuously and readily available through posters throughout the facility as well as in the handbook. The Family Advocacy Network (FAN) number is on the bulletin board near the phone. The auditor reviewed documentation for both the initial training done at intake and comprehensive training.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Nebraska State Patrol conducts sexual abuse investigations. The compliance team members are trained to conduct internal administrative, non-criminal investigations and provided the auditor the training material and their certificates of completion. In addition, all abuse allegations are turned over to the Department of Health and Human Services Children and Family Services.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Through interviews with medical and mental health staff it is apparent they are knowledgeable in how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The facility has documentation of specialized training as well as the PREA training required of all facility staff.

115.341	Obtaining information from residents
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	The auditor reviewed policy, the screening tool that the YRTC-Kearney uses and interviewed screening staff. The facility maintains and uses information about each resident's personal history and behavior to assist in reducing the risk of sexual abuse by or upon a resident. The screening is objective and assigns points or use a specific number of questions to assign an outcome to provide an outcome of low, moderate, or high risk in either the potential for victimization and/or perpetration. Only limited staff have access to the risk screening form. If a youth, through the screening process, is determined to be susceptible to victimization or perpetration of sexual abuse, this is shared with staff only to the extent necessary to provide for the well-being of youth. The auditor determined that YRTC-Kearney substantially exceeds this standard. The screening is very thorough and conducted by a licensed mental health professional who takes the time to get a clear picture of responses to all this standard's required questions both through a detailed interview with the youth and a complete review of all records. If a youth identifies a sexual abuse or sexual perpetration history, the screener ensures that appropriate medical and mental health department heads are notified so that a therapist can be assigned and/or medical care provided if needed. This facility's model approach to the special mental health treatment needs of adolescents involved in the juvenile justice system is exceptional and it begins with the appropriate and thorough screening of youth upon intake.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Youth are typically housed in a dorm setting at the YRTC-Kearney. Interviews indicate that a transgender or intersex resident's own view with respect to his or her own safety would be given serious consideration on how they are placed. The facility does not place gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status, nor does the facility consider gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. YRTC-Kearney makes placement decisions based on all information obtained to make housing, bed, program, and education assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Transgender youth will shower separately after the group has showered. The facility indicates through interviews that they will consider on a case-by-case basis assignment to a living unit that will ensure the resident's health and safety, and whether the placement would present management or security problems. Facility procedure is to manage a resident's housing placement rather than using isolation as a means for protecting the resident's safety. If residents are placed on safekeeping/isolation, it is used as a last resort when least restrictive measures cannot keep a resident safe.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	YRTC-Kearney provides multiple internal and external ways for residents to privately report sexual abuse and sexual harassment, or retaliation. They can report to staff including medical and mental health staff or write a grievance. They also can speak with the Administrator or any member of the compliance team by making a request at any time. They have regular contact with their family, probation, attorney or Children and Family Services case worker. They can call externally to the Child Abuse & Neglect Hotline provided by the Nebraska Department of Health and Human Services Children and Family Services. This number is available on posters posted in the dayroom near the telephone and in the handbook. The auditor placed a call within the housing unit to the abuse hotline and spoke with a staff worker who walked through the process if a youth calls to report abuse. The call was free and did not require a PIN. Youth are always able to request staff to place a call to the hotline on their behalf. The staff accepts reports made verbally, in writing, anonymously, and from third parties and promptly documents any verbal reports. The facility provides residents with access to tools necessary to make a written report.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Residents may submit a grievance alleging sexual abuse or harassment without submitting it to a staff member that is subject of the allegation. The youth does not have to complete any other prior steps in order to submit a grievance for an allegation of sexual abuse. There is no time limit on when a youth can submit a grievance regarding an allegation of sexual abuse. Staff and youth interviews confirmed their knowledge of how the grievance process can be used to report sexual abuse and sexual harassment, but it does not have to be reported by that method.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney has an MOU with the Family Advocacy Network (FAN) for crisis support services. The FAN contact information is posted on their bulletin board near the phones. The YRTC-Kearney provides youth with reasonable and confidential access to their attorneys and parents. In addition, youth reported that they had contact with their families regularly. Youth have therapists at the facility and some youth reported they were more apt to request support services from the therapists at the facility because they have already developed a relationship with them. However, the external advocates are available to them.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The agency has posted publicly on their website at http://dhhs.ne.gov/Pages/YRTC-Reports.aspx the YRTC-Kearney Parent Handbook which includes a paragraph about how to report to the Child Abuse & Neglect Hotline. Also, the opening webpage for Youth Rehabilitation has in bold, large print and outlined in red the Child Abuse and Neglect Hotline Number. This is also on posters posted in the visit area.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney requires all staff to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials and designated State agency, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical staff are required to report sexual abuse to designated supervisors and officials as well as to the designated State service agencies. Such practitioners are required to inform the residents at the initiation of services of their duty to report and the limitation of confidentiality. There is also a sign posted in the medical offices that informs youth that if they tell medical staff they were hurt by anyone or themselves they must report it. The staff reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to designated investigators. Upon receiving any allegation of sexual abuse, the Administrator or designee promptly reports the allegation to the Department of Health and Human Services Children and Family Services Child Abuse and Neglect hotline and to parents or the legal guardian.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Through a review of policy, interviews with the Administrator and random staff, the facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. There have been no instances that a resident was subject to risk of imminent sexual abuse.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Through interviews with the OJS Administrator, the facility administrator, and the PREA Coordinator there are procedures in place to appropriately act upon receiving an allegation of sexual abuse of a resident while at another facility with such action initiated no later than 72 hours and actions documented. They stated that this notification must be from Administrator to Administrator. There have been no instances of these allegations received regarding abuse at other facilities.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	YRTC-Kearney staff were well versed in first responder duties and were aware of all elements of this standard (separate alleged victim/abuser, preservation, and protection of crime scene, to include collection of physical evidence as soon as possible by law enforcement or the SANE nurse, including the request of the victim not to take any actions which could destroy any physical evidence). A review of policy as well as interviews with random staff confirmed knowledge of these procedures.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility has a coordinated response plan in their PREA policy. The policy outlines the coordinated actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, facility leadership and the external responders. Staff always call or assist the youth in calling the Abuse and Neglect Hotline. The Children and Families staff's response are coordinated between the Nebraska State Police and the Family Advocacy Network. Staff interviews and interviews with the Administrator and the PREA Coordinator indicate staff are aware of their responsibilities to coordinate responses within the facility.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The staff are represented by collective bargaining agreements. However, after a review of the agreement and interviewing administrators there are no barriers preventing the Administrator from removing alleged staff, volunteer, or contractor sexual abusers from contact with residents pending the outcome of the investigation and a determination of discipline.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility has a PREA policy that includes measures to protect against retaliation. Case Managers are assigned to monitor for retaliation for youth and Unit Managers are assigned to monitor for retaliation against staff. Should any person who cooperates with a sexual misconduct investigation express fear of retaliation appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. The monitoring is documented for up to 90-days or longer if needed on the Protection Against Retaliation form and an electronic copy is kept which includes the date, time and monitoring comments.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility typically does not use segregated housing of residents as a means to keep them safe from sexual misconduct. Youth have dorm-style sleeping with clear sight lines and adequate distances between beds. Youth are always in the direct supervision of many staff. Adequate precautions can be taken such as keeping the youth in more close proximity of staff or separate the youth by giving them different housing assignments to keep them safe. It would be a very rare circumstance and perhaps only if there was a consensual relationship and they were keeping two youth separate while they investigated the facts.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The auditor reviewed agency investigative files. The facility had multiple incidents of youth violating the no-touch policy and making one-time comments of a sexual nature. There was one criminal investigation of staff-on-resident sexual abuse which was reported appropriately, investigated by the Nebraska State Patrol and referred for prosecution. All incidents were properly investigated as outlined by agency policy and PREA standards and appropriate consequences were issued following the investigations. Administrative investigations include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports that include physical/testimonial evidence. All written reports will be retained for at least seven (7) years from resident(s) discharge or until the age of majority is reached whichever is longer.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney uses no standard higher than a preponderance of evidence in making a determination of alleged sexual abuse/harassment. The auditor determined this through a review of policy, interviews and a review of investigatory files.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility documented their outcome of the investigation reported to the resident on their investigatory documents. Their investigation forms have a form that documents their notification to residents as to whether the allegation was substantiated, unsubstantiated or unfounded and also requires that the resident sign the form.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	All staff members who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions. There has been one staff from this facility that has been reported to law enforcement following their termination for violating sexual abuse or sexual harassment policies. A review of policy, interviews conducted with the Administrator and a review of investigatory files verified compliance with this standard.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Any contractor or volunteer who violate sexual abuse, sexual harassment and retaliation policies are subject to disciplinary sanctions including termination of service. There have been no contractors or volunteers who have been accused of sexual misconduct.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	For incidents of youth-on-youth sexual abuse, sexual harassment or retaliation, administrative sanctions will be handed out following the formal disciplinary processes and applied commensurate with the level of infraction. A youth's access to general programming or education is not conditional on receiving interventions designed to address/correct underlying reasons or motivations for abuse.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The licensed mental health professional confirmed that if the screening tool indicates there was previous sexual abuse victimization or perpetration, the youth will be assigned a therapist to begin counseling. The first meeting with the therapist will occur within 14 days of the intake screening. This offer for follow-up care will be documented within the medical record or therapists' records. Residents are notified that if they report prior sexual victimization even incidents that did not occur in an institutional setting and they are under 18 years of age, they must notify Department of Health and Human Services Children and Family Services Child Abuse & Neglect Hotline. The medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting if the resident is 18.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility provides access to emergency medical and mental health services. In the event services after hours are not available by the facility medical health staff, residents would be taken to Kearney Regional Medical Center. The facility health services staff work in coordination with Kearney Regional Medical Center to ensure that resident victims of sexual abuse are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Nebraska has a state law (Neb. Rev. Stat. §81-1429.03) which requires that the full out-of-pocket cost or expense that may be charged to a sexual assault victim in connection with a forensic medical examination are to be paid from the Sexual Assault Payment Program Cash Fund. This program is administered by the Nebraska Department of Justice.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility requires that medical and mental health evaluations and treatment be offered at no cost to sexual abuse victims and abusers. If the youth is taken to the hospital, they would follow any recommendations made by hospital staff or provide any services needed that were not provided by the hospital. The nurse and the Director of Clinical programming stated that in many instances mental health services are provided on-site by their mental health professionals. If a youth is taken to the hospital, tests for sexually transmitted infections and pregnancy tests will be offered there by the SANE, but they also have standing orders for those if for some reason they were not done at the hospital. It is important to note that female youth were housed on this campus temporarily until April 2021. The facility currently is an all-male facility.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility conducts incident reviews as outlined within their PREA policy. They conduct formal sexual abuse incident reviews following each sexual abuse investigation specifically answering the questions posed within the standard. This review includes upper-level staff, supervisors, investigators, and medical staff. The auditor verified this through interviews, a review of policy and a review of investigatory files with documented incident reviews when required by the standard.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility collects uniform data for all allegations of sexual abuse based on incident reports and investigation files. Aggregate annual data is available and was provided to the auditor. The facility has provided this information to the Department of Justice through the Survey of Sexual Victimization.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility has completed an annual review of data and prepared an annual report. This review reports findings and corrective actions as well as the progress made through the previous year in addressing sexual abuse. The 2020 review is posted on the agency's website at https://dhhs.ne.gov/Pages/YRTC-Reports.aspx

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Agency posts PREA related data on the Agency's website https://dhhs.ne.gov/Pages/YRTC-Reports.aspx. Data collected is retained via limited access and through a secure server for at least ten (10) years.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The YRTC-Kearney was initially audited in 2015, completed its second audit cycle in 2018 and this audit in 2021. This agency operates three juvenile facilities. All facilities are audited every three years. Audits are posted on the agency website at https://dhhs.ne.gov/Pages/YRTC-Reports.aspx. The auditor had complete access to the facility and was able to observe all areas of the facility. The auditor was provided numerous documents, viewed camera systems, and interviewed residents and staff from all shifts. The YRTC-Kearney staff provided private accommodations to conduct interviews, made adjustments to routines and staff schedules and allowed after-hours access to the auditor. The staff were very professional throughout the audit. The auditor notices were posted throughout the facility and the facility provided a dated photograph to verify that the notice was posted six weeks in advance of the audit. The auditor did not receive any confidential communication from residents at this facility.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This is the third audit for the YRTC-Kearney and previous audits are published on their website.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	na

115.313 (a)	Supervision and monitoring	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes

115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities)	yes
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes

115.315 (c)	Limits to cross-gender viewing and searches	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

115.316 (a)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes

115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.318 (b)	**Upgrades to facilities and technologies**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes

115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is not responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na

115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes

115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.332 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes

115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes

115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	na
115.341 (a)	**Obtaining information from residents**	
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes

115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	**Placement of residents**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	yes
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	yes
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes

115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	no
115.352 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes

115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.352 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes

115.352 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes

115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes

115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes

115.367 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes
115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes

115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371 (f)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes

115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes
115.373 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes

115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.376 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes

115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes

115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	
	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	yes

115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes

115.387 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?	yes
115.388 (c)	**Data review for corrective action**	
	Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes

115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	no
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	yes
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes