STATE OF NEBRASKA
Office of Public Counsel/Ombudsman

ANNUAL REPORT

Neb. Rev. Stat. § 83-104
Review of Nebraska State Institutions

December 15, 2025

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ABBREVIATIONS

American Correctional Association	ACA
Beatrice State Development Center	BSDC
Center for Medicare and Medicaid Services	CMS
Hastings Regional Center	HRC
Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities	ICF-IDD
Lancaster County Youth Services Center	LCYSC
Lincoln Regional Center	LRC
Mental Health Substance Use	MHSU
Nebraska Department of Health and Human Services	DHHS
Norfolk Regional Center	NRC
Office of Juvenile Services	OJS
Office of Public Counsel/Ombudsman	OPC
Performance-Based Standards Project	PbS Project
Psychiatric Residential Treatment Facility	PRTF
Youth Rehabilitation and Treatment Center	YRTC

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Background

Neb. Rev. Stat. § 83-104, passed by the Nebraska Legislature in July 2020, requires the Office of Public Counsel/Ombudsman (OPC) 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;[1]
2. The Youth Rehabilitation and Treatment Center – Kearney;
3. Any other facility operated and utilized as 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.

Neb. Rev. Stat. § 83-104(2) further requires the OPC to report to the Legislature on the conditions of the facilities 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 current year. Neb. Rev. Stat. § 83-104(2) continues by requiring that each report shall, for each institution, include findings and observations from the annual physical review; recent inspection reports regarding the facility; staffing information; reports received by the OPC; and any systemic issues identified.

Prior to Neb. Rev. Stat. § 83-104's requirements in 2021, OPC staff generally visited state institutions as a result of individual complaints or reports to the OPC or identification of specific systems issues. The statutory reporting requirement was part of the Legislature's response to the crisis at Youth Rehabilitation and Treatment Center (YRTC) at Geneva in August 2019, in which the female youth there suddenly needed to be relocated to YRTC-Kearney, due to the unsafe conditions at YRTC-Geneva.[2] In the year leading up to the crisis, the OPC received a total of three complaints regarding YRTC-Geneva, and none were about the facility's conditions.

In January 2020, the Legislature's Health and Human Services Committee issued a report with several recommendations, including requiring an annual facilities review and subsequent report to the Legislature by the OPC.[3] Legislative Bill 1144 was introduced with such requirements in January 2020, passed by the Legislature on July 31, 2020, and signed by Governor Pete Ricketts

[1] YRTC-G campus was closed by DHHS, and the girl's program moved to the Hastings campus in 2021, previously used by the Hastings Regional Center program and the Hastings Juvenile Chemical Dependency Program.
[2] State of Nebraska, Office of Public Counsel/Ombudsman and Office of Inspector General of Nebraska Child Welfare, "The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center, Special Report of Investigation," January 5, 2021, https://nebraskalegislature.gov/pdf/reports/public_counsel/Geneva_Special_Report_2021.pdf.
[3] Nebraska Legislature Health and Human Services Committee, "Report to the Nebraska Legislature on the Youth Rehabilitation and Treatment Centers," Jan. 22, 2020, p. 47, https://nebraskalegislature.gov/pdf/reports/committee/health/yrtc_2020.pdf.

on August 11, 2020. This report aims to assist the Legislature in improving state institutions, including YRTCs, through highlighting current conditions, efforts towards improvement, and opportunities for improvement.

This report is organized by grouping institutions under the headings "Adult Facilities," which includes the DHHS adult behavioral health hospitals and other licensed facilities, and "Juvenile Facilities," which includes the YRTCs in Hastings, Kearney, and Lincoln, and Whitehall. Behavioral Health facilities statutorily fall within the DHHS Division of Developmental Disabilities and the DHHS Division of Behavioral Health.[4] Beatrice State Development Center (BSDC) falls under the DHHS Division of Developmental Disabilities, and Lincoln Regional Center (LRC) and Norfolk Regional Center (NRC) are under the DHHS Division of Behavioral Health. Within LRC's organization is the adolescent Psychiatric Residential Treatment Facility (PRTF) at Whitehall. The Office of Juvenile Services (OJS) is statutorily within the DHHS Division of Children and Family Services. The YRTC Facilities fall under OJS.

Summaries of observations and documentation review related to the internal and external conditions of each of the state institutions is provided. The attachments include inspection reports and compliance and licensing documentation for each institution as required by Neb. Rev. Stat. § 83-104. Particular data points going back to the initial 2021 Annual Facilities Report are summarized in order to exhibit longevity trends.

Annual Physical Review & Report Process

The Deputy for Institutions and other OPC staff visited each required state institution and requested and reviewed information, including staff assault data, capacity and staffing data, information related to major projects and improvements, and facility inspections reports. The OPC also reviewed reports/complaints received by its office for each institution for the reporting period. Residents of the facilities, their loved ones, staff, and members of the public may file complaints with the OPC throughout the year.

In addition to other visits throughout the year, each of the facilities were visited on the following respective days for the purpose of a thorough facility inspection.

- BSDC: September 25, 2025
- NRC: September 30, 2025
- LRC: September 16, 2025
- YRTC-Kearney: September 11, 2025
- YRTC-Hastings: September 11, 2025
- YRTC-Lincoln: September 09, 2025
- Whitehall: September 09, 2025

[4] Neb. Rev. Stat. § 81-3116.

The Office of Public Counsel would like to express our appreciation to the facilities' management and compliance teams for their time touring each of the facilities and providing our office with the requested data to complete the report in a timely manner.

Facility Overview

Table 1 provides a general facility program description overview. The information provided is summarized from information available at the DHHS website.[5] (See Table 1.)

Table 1

Facility	Location	Program Description
LRC	Lincoln	LRC serves people who need very specialized psychiatric services and provides services to people who, because of mental illness, require a highly structured treatment setting. The patients served at the Lincoln Regional Center are limited to people who meet involuntary admission criteria and are referred by either the courts or Mental Health Boards.
NRC	Norfolk	NRC was created by an act of the Nebraska Legislature in 1885. NRC is a Sex Offender Treatment Center providing Phase I services in the Nebraska Sex Offender Treatment Program. The Nebraska Sex Offender Treatment Program is a three-phase treatment program meant to reduce dangerousness and risk of re-offense for patients involved in treatment
BSDC	Beatrice	BSDC is a 24-hour state and federally funded residential treatment facility dedicated to the provision of specialized psychological, medical and developmental supports to people with intellectual and developmental disabilities. BSDC is a campus-like setting with 188 acres.
YRTC-Kearney	Kearney	YRTC-Kearney serves adolescent males who are committed to the care and custody of the OJS.
YRTC-Lincoln	Lincoln	YRTC-Lincoln opened in February 2020 in Lincoln, Nebraska. The program is located within the Lancaster County Youth Services Center operating as a separate program from the county, which also provides services to other youth. The program was established to provide services to both male and female youth ranging in age from 14 to 18 years who are securely housed separately by gender. Youth of higher behavior acuity needing more individualized care due to behavioral and mental health needs are typically transferred from either the Kearney or the Hastings YRTCs to YRTC-Lincoln for that treatment.
YRTC-Hastings	Hastings	YRTC-Hastings serves adolescent females who are committed to the care and custody of the OJS.

[5] https://dhhs.ne.gov/Pages/default.aspx

Whitehall	Lincoln	Whitehall provides two treatment programs for male adolescents. A residential substance use treatment program began at Whitehall in 2020. Another program addresses the treatment needs of male adolescents who have offended sexually.

General Facility Observations

Through OPC's site inspections, information reviews, and review of complaints to its office, the OPC has identified a number of positive observations as well as some challenges facing the facilities. In the subsequent sections of this report, greater detail will be provided regarding each facility, however this section will provide an overview of our findings.

Regional Hospital Administrator- The 2022 Annual Facilities Report provided a description of the newly created Regional Hospital Administrator position within the DHHS Division of Behavioral Health. This position provided a level of increased administration and oversight for the adult facilities – BSDC, NRC, and LRC – and paralleled the Office of Juvenile Services Administrator position for the youth facilities. In the Spring of 2024, the position was vacated by the former Administrator. Throughout the rest of 2024 and all of 2025, the Office of Juvenile Service Administrator assumed the oversight of all adult facilities in addition to the youth facilities.

Aging Facilities- Several of the facilities, serving both youth and adults, are aging and in dire need of improvements, particularly in the bathrooms and sleeping quarters. The facilities with the most concerning conditions are LRC, parts of BSDC, YRTC-Kearney, and Whitehall. The pictures provided in each respective facility section in the upcoming pages of this report will assist in providing a visual perspective on the facilities in need of improvements.

As mentioned above, each of the facilities appeared to be maintained as well as possible considering the age of several of the structures. However, the conditions and age of some of the buildings make it difficult to maintain a high level of cleanliness, regardless of staff efforts. Factors such as poor ventilation in the bathrooms and flooring in the sleeping units that are nearly impossible to clean create challenges in maintaining cleanliness at a level that is sufficient.

In addition, OPC staff observed that some of the furniture is very dated, particularly the beds and mattresses. Some of the mattresses are very old and thin, likely making sleeping conditions difficult. Some of the beds were old wooden platforms. The pictures of the Whitehall campus show these beds, although Whitehall does have recently updated furniture in common areas.

Grounds- While each of the campuses appeared to be regularly mowed with some degree of landscaping upheld, most of the campuses lacked green lawns for residents to enjoy when spending time outdoors. Unlike what may be seen at Nebraska Veteran's Homes, the grounds appeared to not be equipped with underground sprinkler systems, making them dependent on annual rainfall or manual watering. While it is understandable that the campuses are large and

the cost of watering the entire area may not be feasible, finding key areas to water where individuals spend time outdoors could lend to overall better care.

LRC-is a very large campus that has several buildings. Discussions with the facility administration suggest that a campus housing all of the patients in one building, similar to the campus at NRC, rather than the current set-up may provide operational efficiencies. Much of the campus is outdated and showing signs of age, particularly in the bathrooms and sleeping quarters.

It should be noted that overall, the campus smelled much better and appeared cleaner on our annual overall tour than it has during past visits. This was most noticeable in the bathrooms.

Staff assaults have continued to rise over the past 3 years, and nearly doubled since 2023. The facility does report that staff assaults requiring medical intervention has significantly lowered, and the census has increased by 53%.

NRC-is generally in good condition and maintenance efforts seem to be occurring on a regular basis. However, while this building is in good condition overall, most bathrooms are showing signs of age and could use an overhaul. Space for the population seems to be adequate and conducive to the programming to support the population.

BSDC-has a variety of building conditions. Some buildings are newer and in relatively good condition. Other buildings are older and work is being done to make them usable.

YRTC-Kearney-youth have access to a pool, a large gym, a chapel, baseball/kickball field, disc golf baskets, and on-campus vocational services. However, the youth currently sleep in large bunk-style quarters and have communal bathrooms, which creates a number of safety hazards. Fortunately, the campus will soon have a new living unit which will house the majority of youth. This living unit will have private sleeping rooms and bathrooms. Although, with the current census, this unit will not be large enough to house all youth committed to the facility, and some youth will need to continue using the old units that are very outdated and in need of renovation, particularly in the bathrooms.

The other primary concern regarding YRTC-Kearney is regarding a number of concerning reports regarding staff sexual assault on several youth. This investigation is on-going and the facility is cooperating with all requests from our office.

YRTC-Hastings-is a primary newly built campus and has been maintained very well since opening in 2020. However, this campus lacks recreation facilities, compared to YRTC-Kearney where the boys are housed. The only on-campus recreation is a building that was previously designated as the Chapel. The Chapel was repurposed to become a gym area. YRTC-Kearney youth also have access to vocational training on-campus that is not available at YRTC-Hastings.

Staff at YRTC-Hastings have been creative in meeting some needs of the youth by allowing youth to go to the YMCA in Hastings and have added things like a greenhouse for

gardening. They also do a number of outdoor activities when they are able to. The Hastings campus also has individual sleeping quarters and private bathrooms.

YRTC-Lincoln-is located in a leased space from the Lancaster County Youth Services Center, and is in generally good condition structurally. However, this facility has a detention-like feel and may not offer the most therapeutic environment for extended stays by youth that may be for several months to a year or more.

Youth who exhibit behavioral episodes end up spending significant time in their room, or isolation in order to ensure safety of all youth due to the overall lack of space, and in the inability for staff to separate youth. The staff also have limitations on access to the classrooms, recreation areas, cafeteria, and visitation rooms due to sharing the space with the Lancaster County Youth Services Center detention center.

Whitehall-is the most concerning of all of the facilities in terms of structural conditions. The living units leak water into the basement when it rains, leaving up to several inches of standing water and mud on some occurrences. (Pictures of the flooding and cleanup efforts can be found on pages 119 and 120 of this report.) The basements are essentially unusable and create a risk of potential mold and mildew growth in the basement of where youth sleep, eat, and spend a great deal of time. Maintenance crews were observed cleaning the flooding that occurred the night before our tour nearly immediately. It should be noted that rainfall in Lincoln, NE the evening before our tour was an average rainfall, at .04 inches, according to the National Weather Service.

In addition, Whitehall's campus is old and showing significant signs of age, including fire alarm panels and other related components that have been recommended to be updated. The bathrooms are outdated and seem to lack proper ventilation to avoid mold growth. Many of the sidewalks have damage and in general the facility is not up to ADA standards.

Capacity, Occupancy, and Staffing Levels

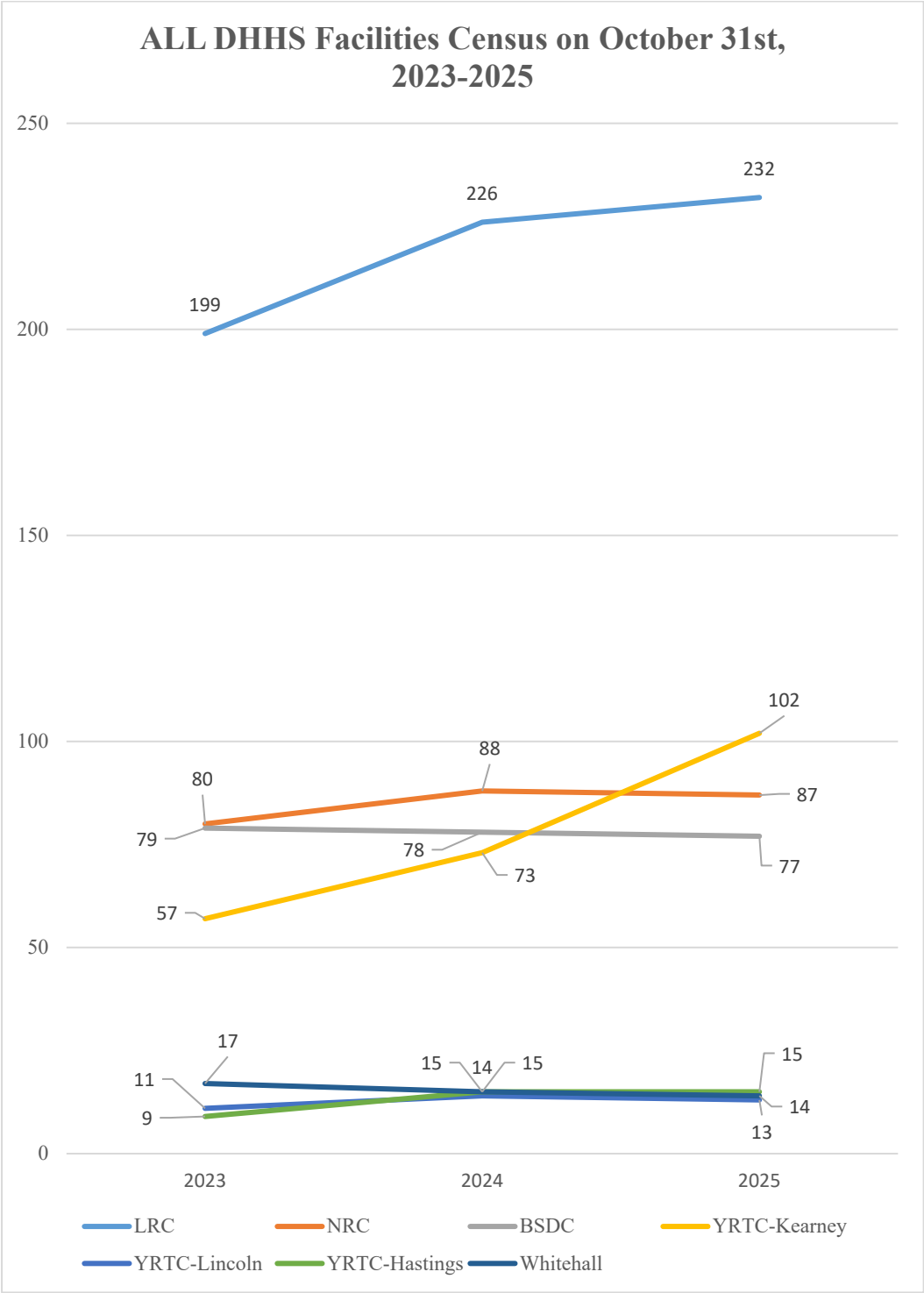
Table 2 illustrates the total licensed capacity as reported by DHHS for each facility, and the census on the last reporting day of this report, October 31, 2025. Monthly census information will be shared in each facility's respective reporting section later in this report. (See Table 2.)

Table 2

Facility	CAPCITY Oct. 31, 2025	CENSUS Oct. 31, 2025
LRC	246	232
NRC	114	87
BSDC	168	77
YRTC-Kearney	142	102
YRTC-Lincoln	20	13
YRTC-Hastings	24	15
Whitehall	24	14

Chart 1 illustrates the census for all facilities on the last reporting day of each respective year, on October 31. (See Chart 1.)

Chart 1



Charts 2A-8B illustrate the census and staffing plan comparison for each facility.

As shown in **Charts 2A and 2B**, LRC's staffing plan increased by 20%, while the average census increased by 51% between 2023 and 2025. (See Charts 2A and 2B.) Overtime rates also decreased by 18%. (See Chart 10.)

Chart 2A

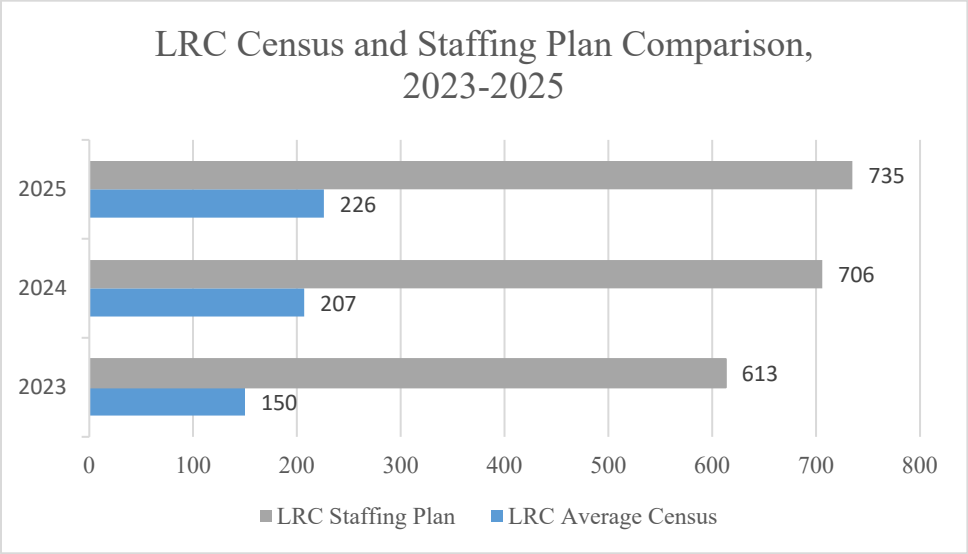
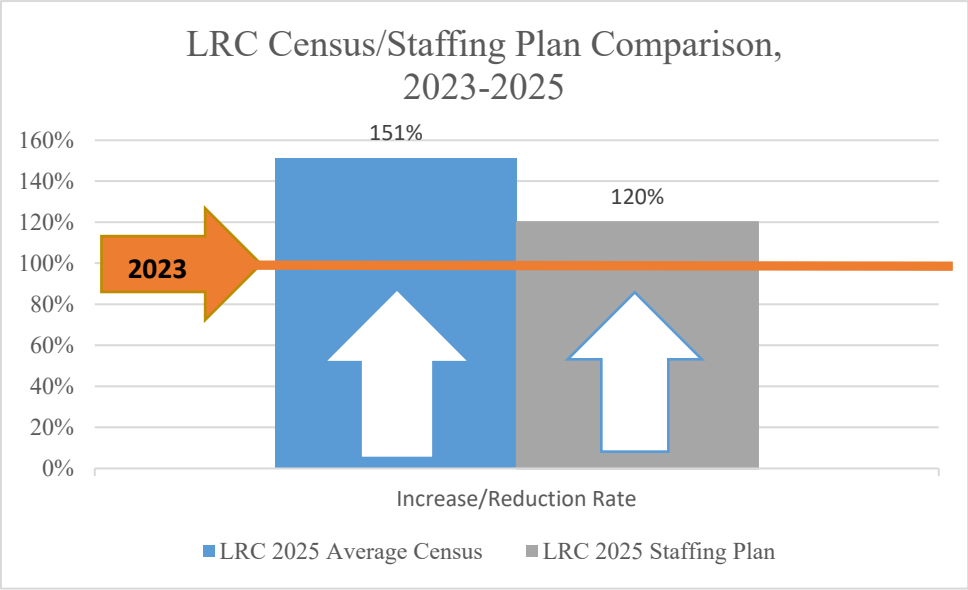


Chart 2B



As shown in **Charts 3A and 3B**, NRC's staffing plan decreased by 4%, while the average census increased by 6% between 2023 and 2025. (See Charts 3A and 3B.) Overtime rates increased by 6%. (See Chart 10.)

Chart 3A

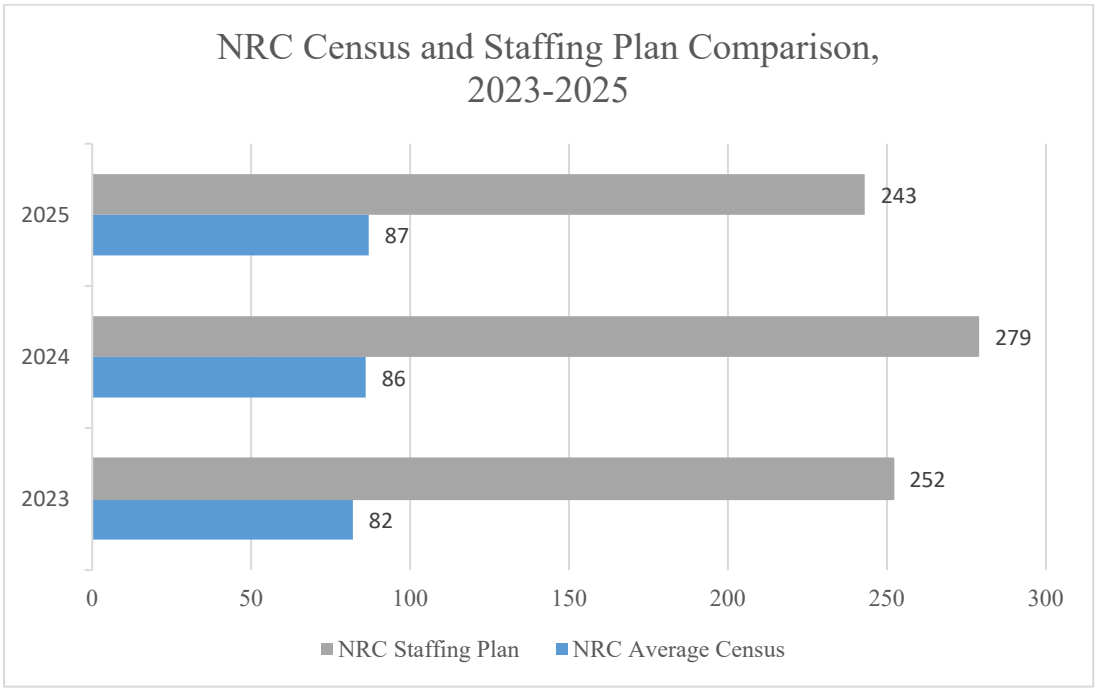
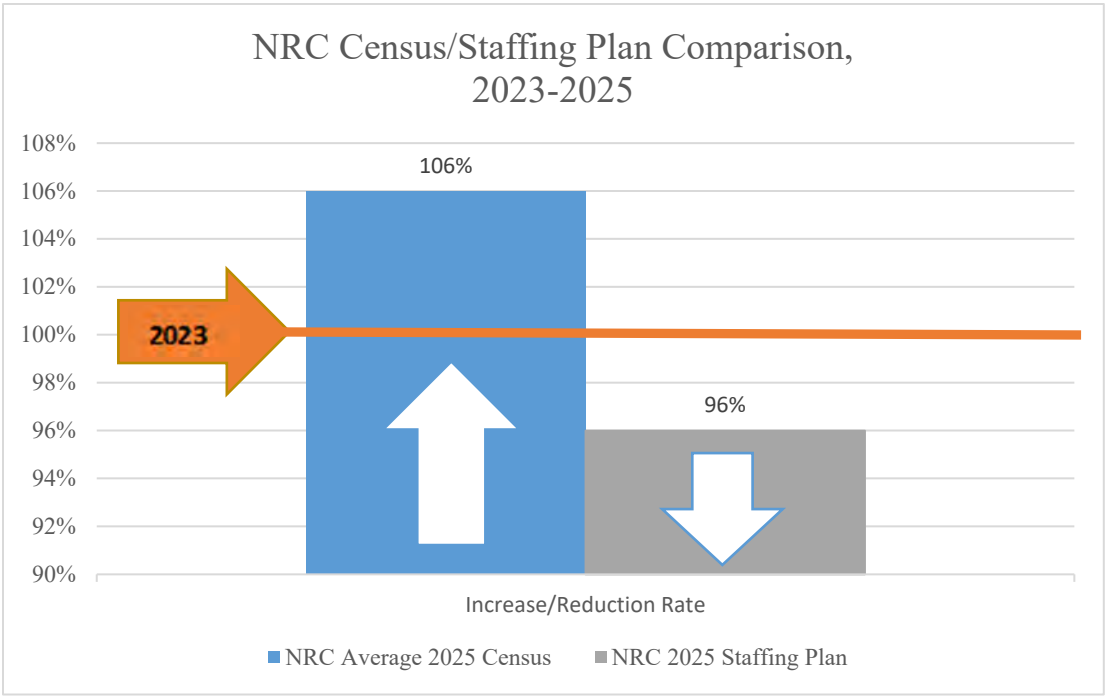


Chart 3B



As shown in **Charts 4A and 4B**, BSDC's staffing plan decreased by 19%, while the average census also decreased by 4% between 2023 and 2025. (See Charts 4A and 4B.) Overtime rates increased by 6%. (See Chart 10.)

Chart 4A

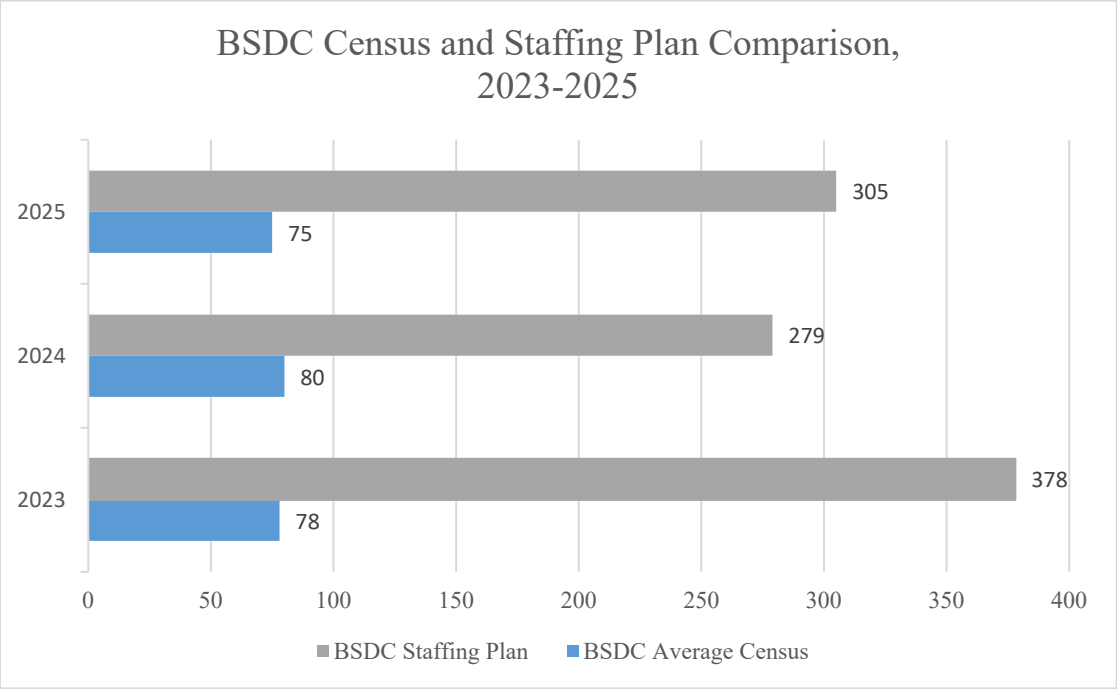
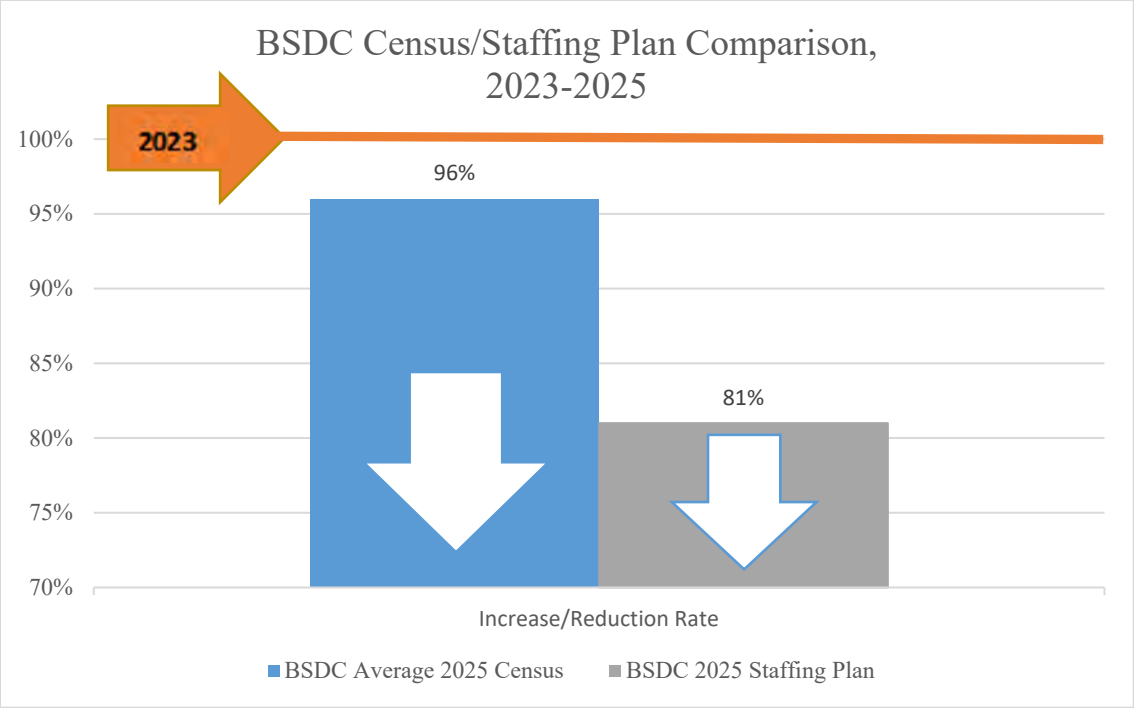


Chart 4B



As shown in **Charts 5A and 5B**, YRTC-Kearney's staffing plan decreased by 12%, while the average census increased by 33% between 2023 and 2025. (See Charts 5A and 5B.) Overtime rates also increased by 24%. (See Chart 10.)

Chart 5A

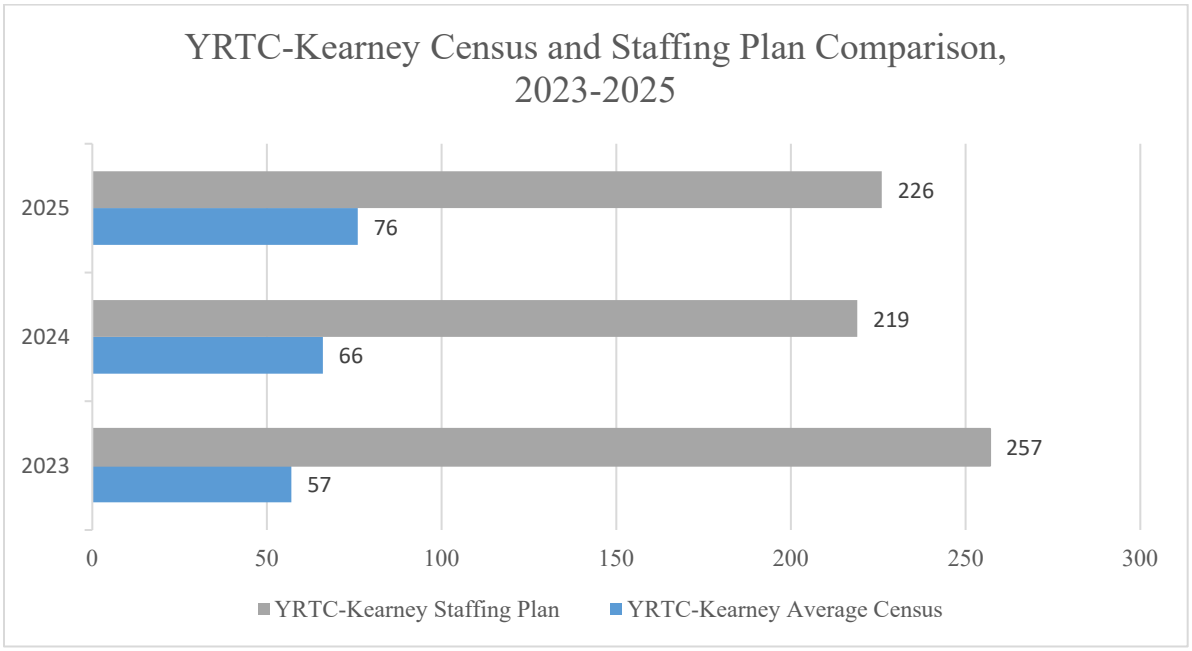
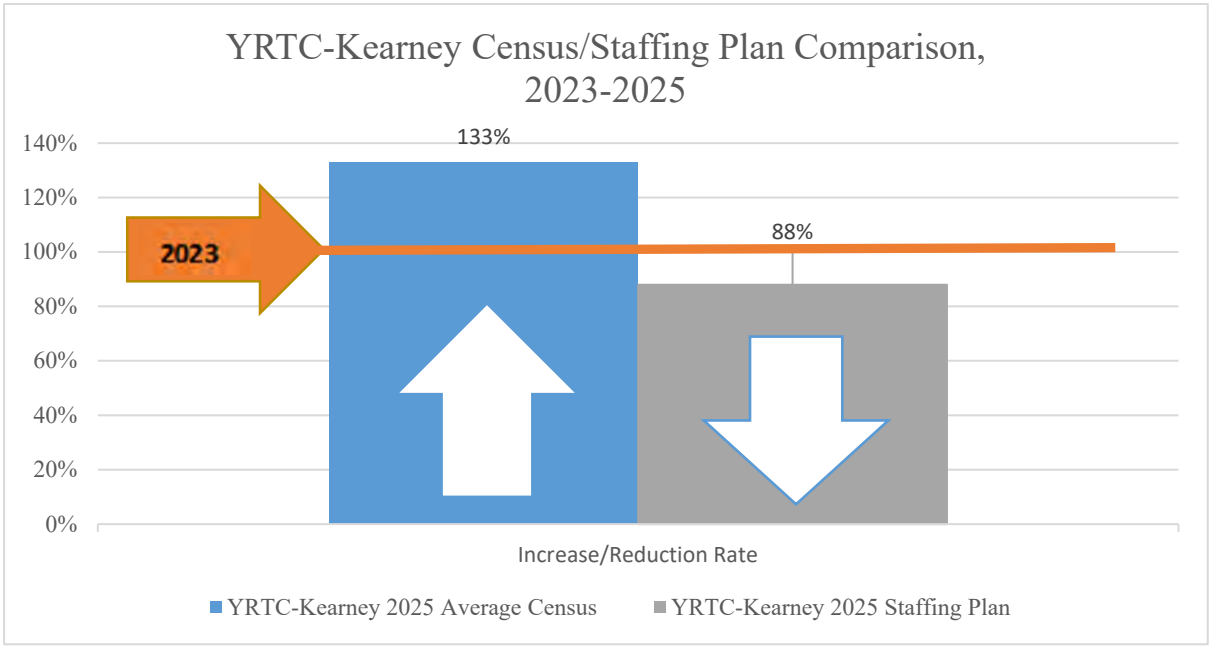


Chart 5B



As shown in **Charts 6A and 6B**, YRTC-Hastings's staffing plan decreased by 7%, while the average census increased by 15% between 2023 and 2025. (See Charts 6A and 6B.) Overtime rates decreased by 17%. (See Chart 10.)

Chart 6A

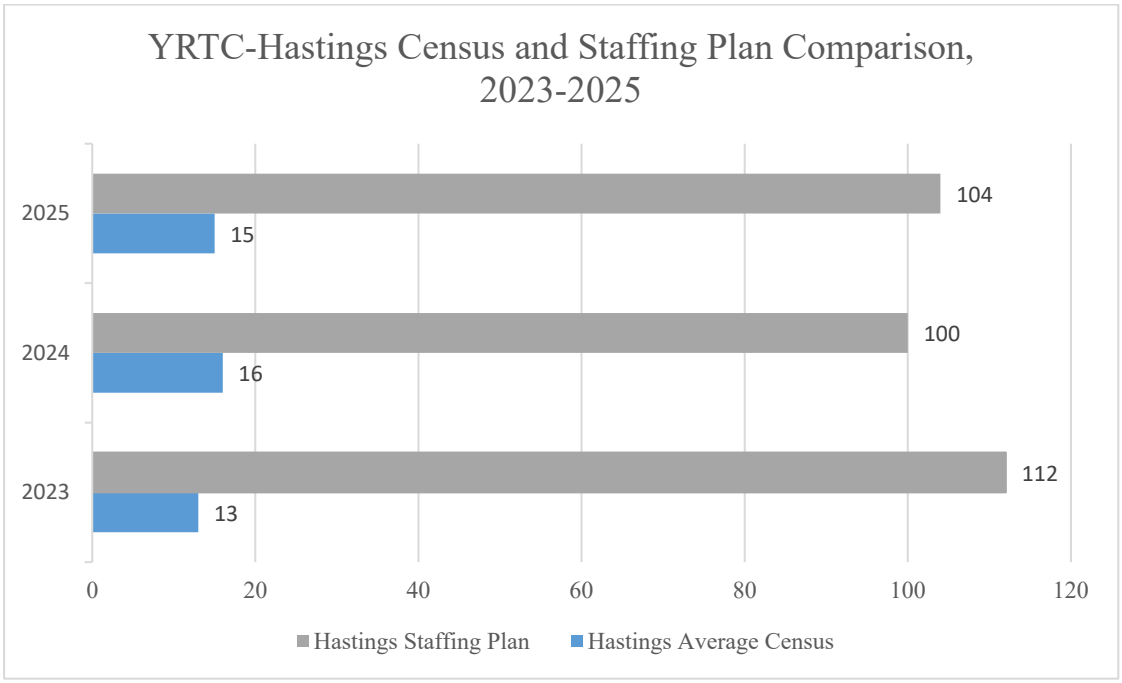
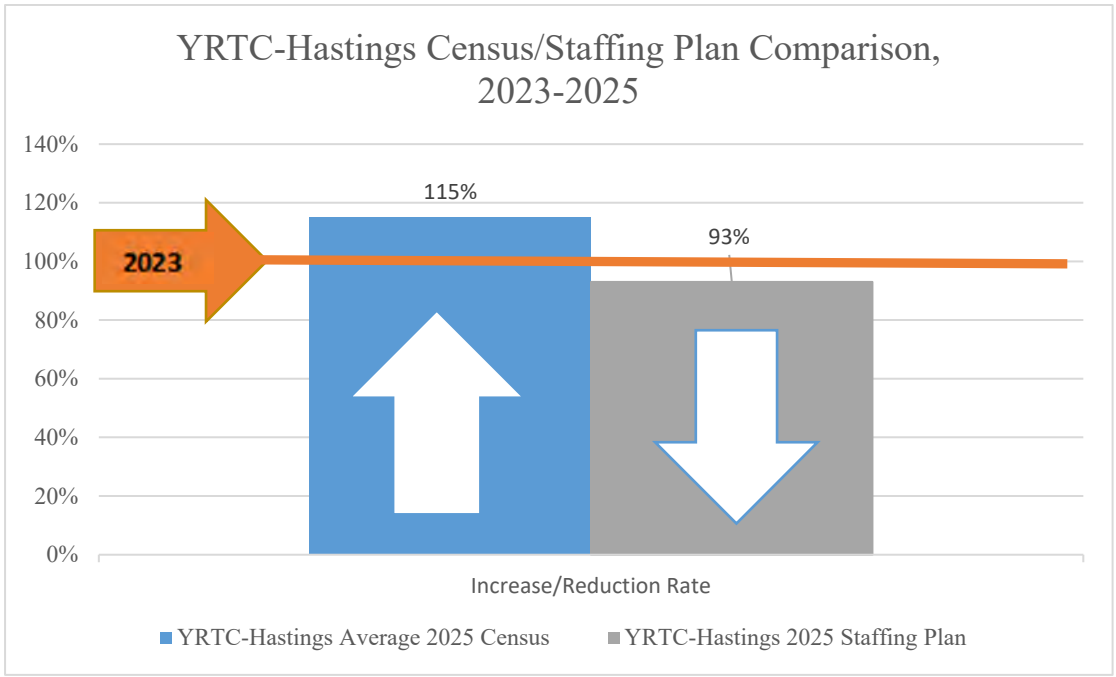


Chart 6B



As shown in **Charts 7A and 7B**, YRTC-Lincoln's staffing plan decreased by 23%, while the average census increased by 9% between 2023 and 2025. (See Charts 7A and 7B.) Overtime rates increased by 23%. (See Chart 10.)

Chart 7A

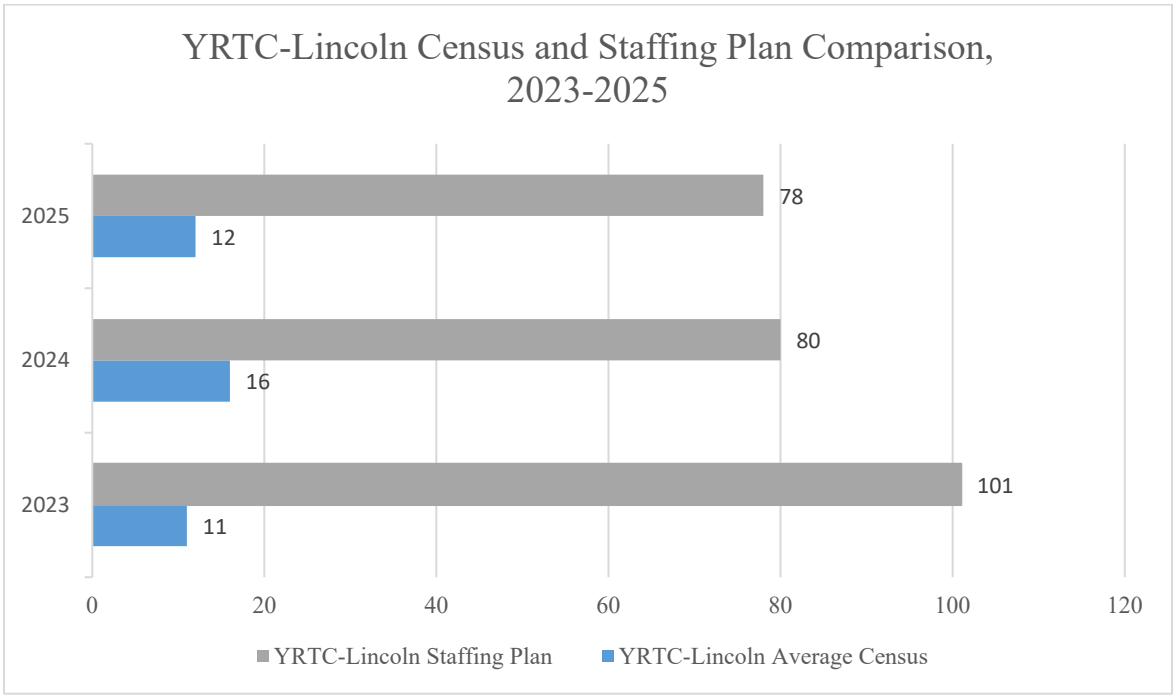
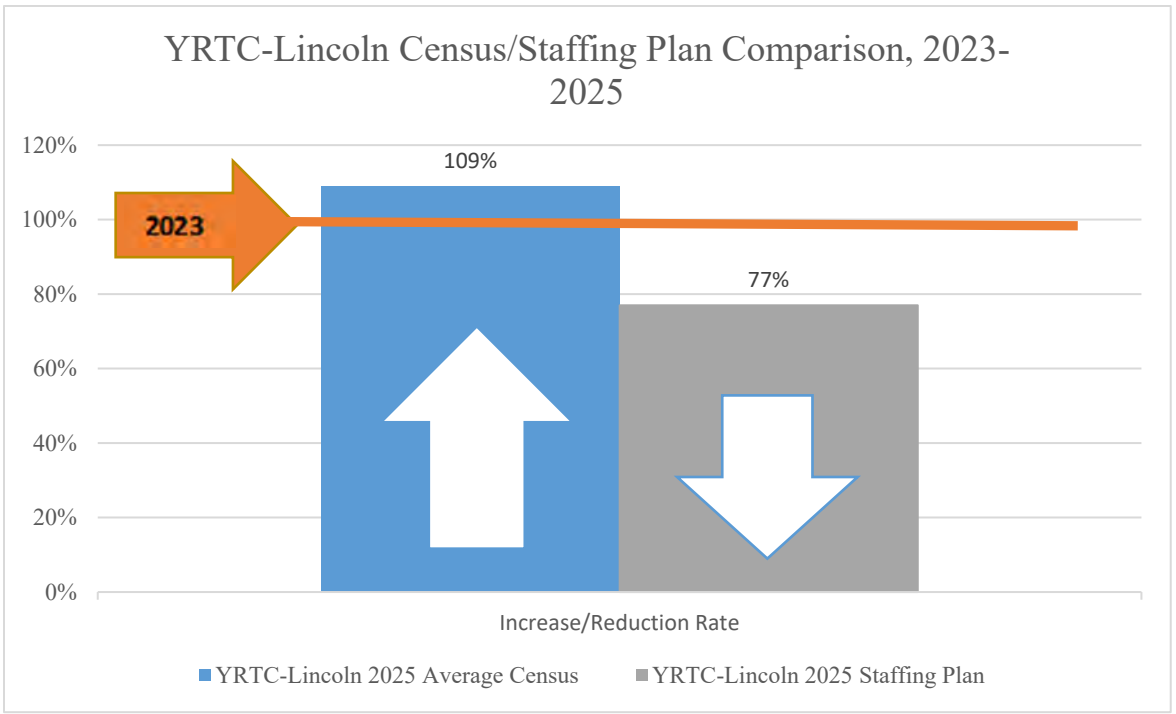


Chart 7B



As shown in **Charts 8A and 8B**, Whitehall's staffing plan decreased by 17%, while the average census also decreased by 12% between 2023 and 2025. (See Charts 8A and 8B.) Overtime rates decreased as well by 14%. (See Chart 10.)

Chart 8A

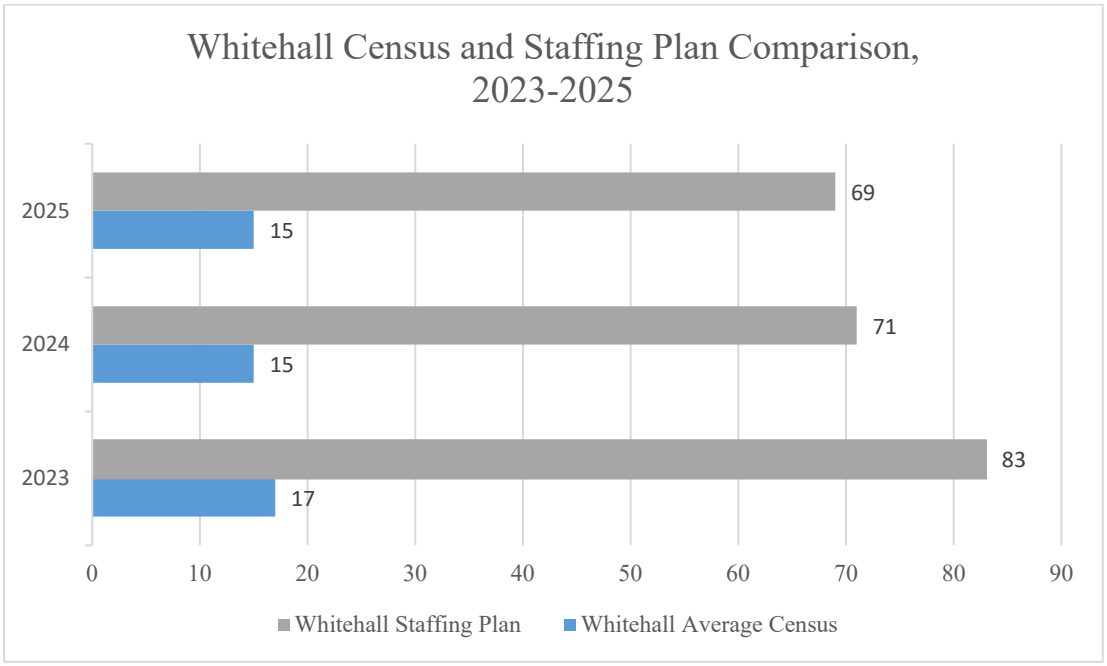
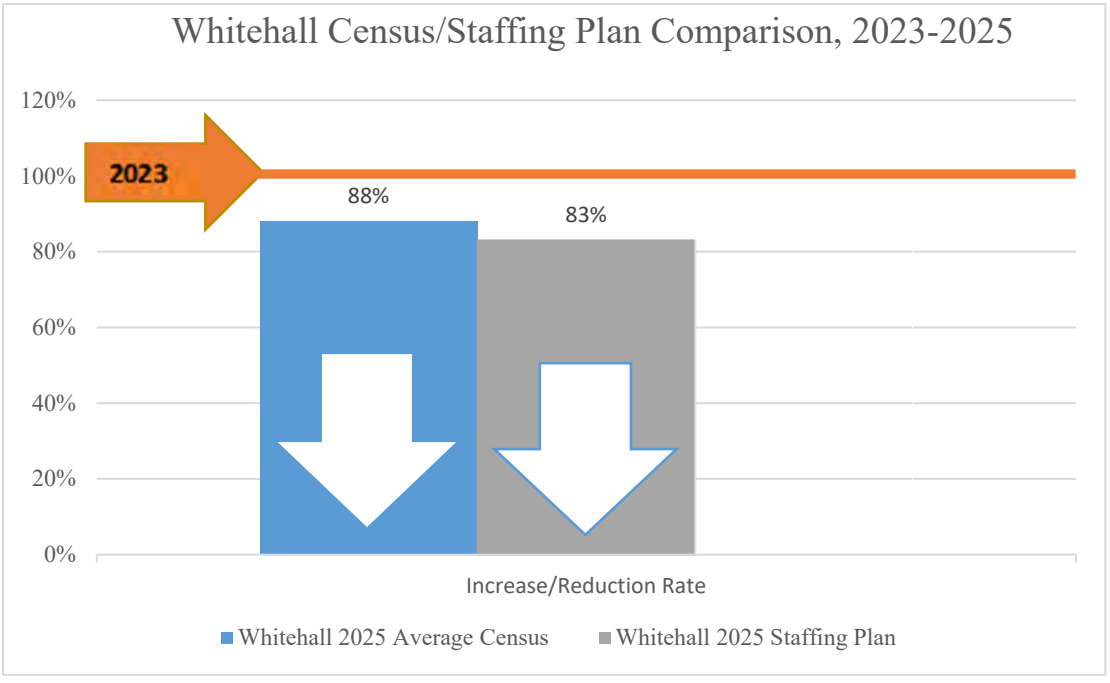


Chart 8B



Staffing remains a challenge for many facilities across Nebraska, including in key areas such as nursing and behavioral health positions (additional details are available later in the report in the facility-specific sections). The percentage of positions filled have increased for most facilities, however this may be in part due to the reduction in the overall staffing plan numbers. Facility leadership reported that some positions are only filled when census levels increase. (See Table 3).

Table 3

Facility	2023	2024	2025
LRC	74%	86%	90%
NRC	79%	93%	95%
BSDC	57%	86%	80%
YRTC-Kearney	57%	69%	81%
YRTC-Hastings	71%	73%	80%
YRTC-Lincoln	52%	80%	68%
Whitehall	76%	86%	96%

Charts 9 exhibits the 2025 staffing plan as compared to positions filled. (See Chart 9.)

Chart 9

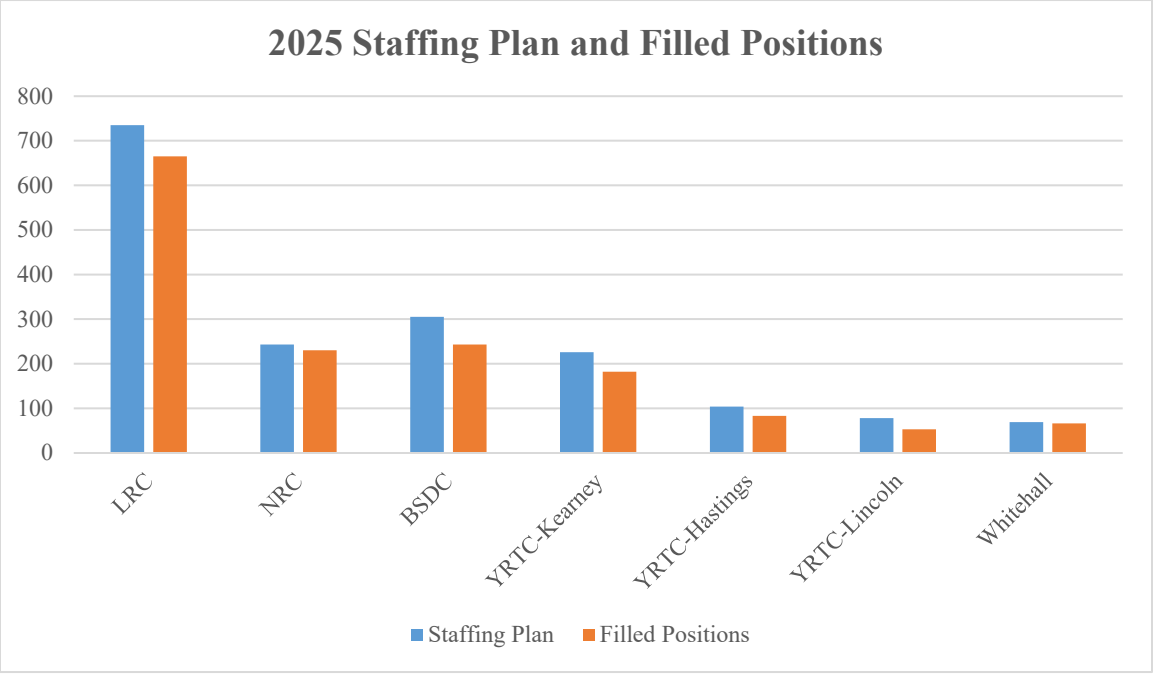
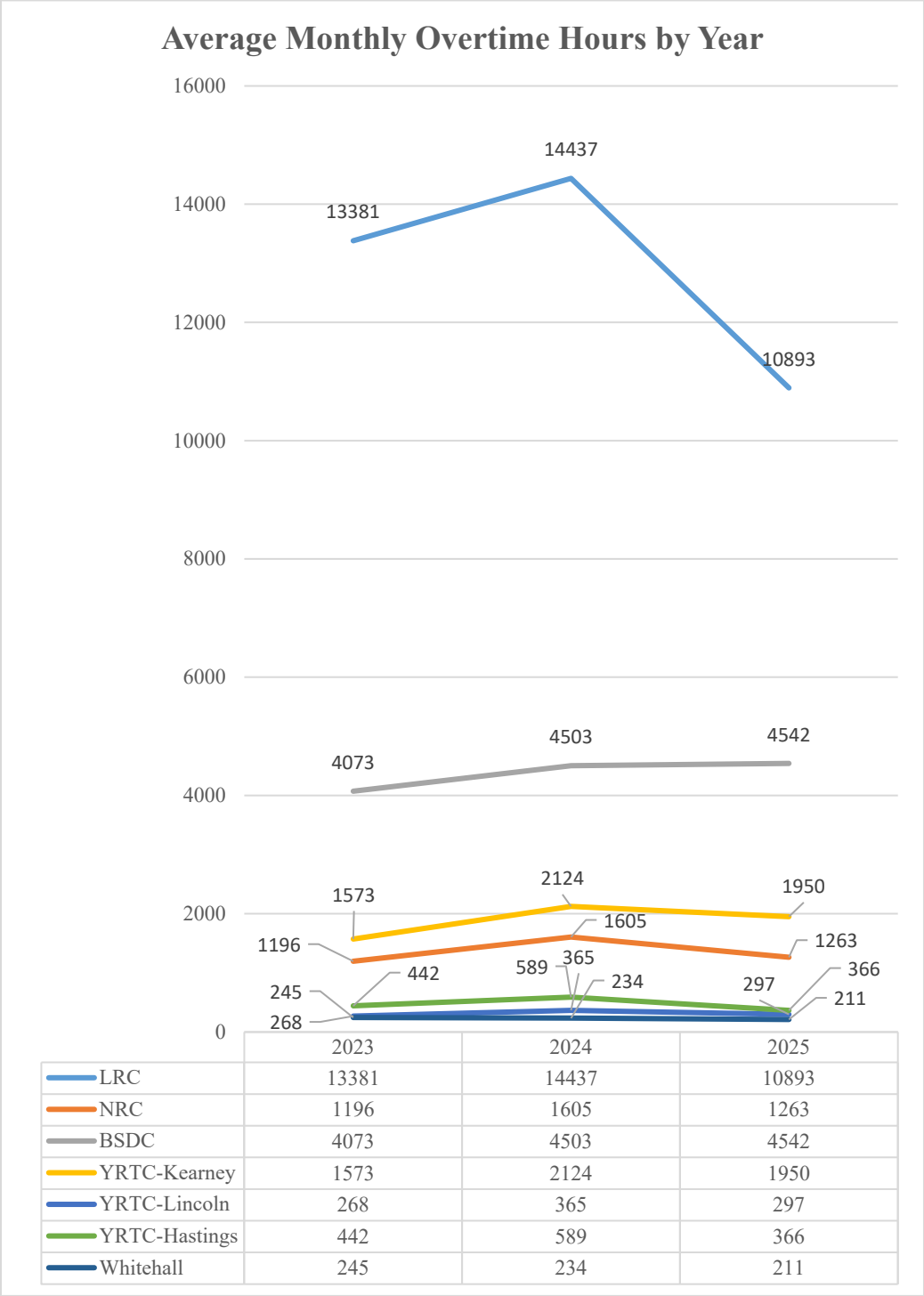


Chart 10 below illustrates the average overtime hours worked for all facilities. While the overtime rates are not directly tied to the staffing plan and census information detailed in the above charts, it is another factor that is relevant in the details of the staffing level engagements with patients. (See Chart 10.)

Chart 10



	2023	2024	2025
LRC	13381	14437	10893
NRC	1196	1605	1263
BSDC	4073	4503	4542
YRTC-Kearney	1573	2124	1950
YRTC-Lincoln	268	365	297
YRTC-Hastings	442	589	366
Whitehall	245	234	211

Reported Staff Assaults

Table 4 shows the number of assaults on staff as provided by DHHS in each respective year. (See Table 4.)

Table 4

Total Number of Reported Staff Assaults between November 1st and October 31st			
Facility	**2023**	**2024**	**2025**
LRC	97	161	195
NRC	9	6	7
BSDC	25	25	32
YRTC-Kearney	80	98	92
YRTC-Hastings / Geneva	45	53	30
YRTC-Lincoln	34	60	43
Whitehall	0	0	10
Total Reported Assaults	**290**	**403**	**409**

Chart 11 shows the number of assaults on staff as provided by DHHS in each respective year. (See Chart 11.)

Chart 11

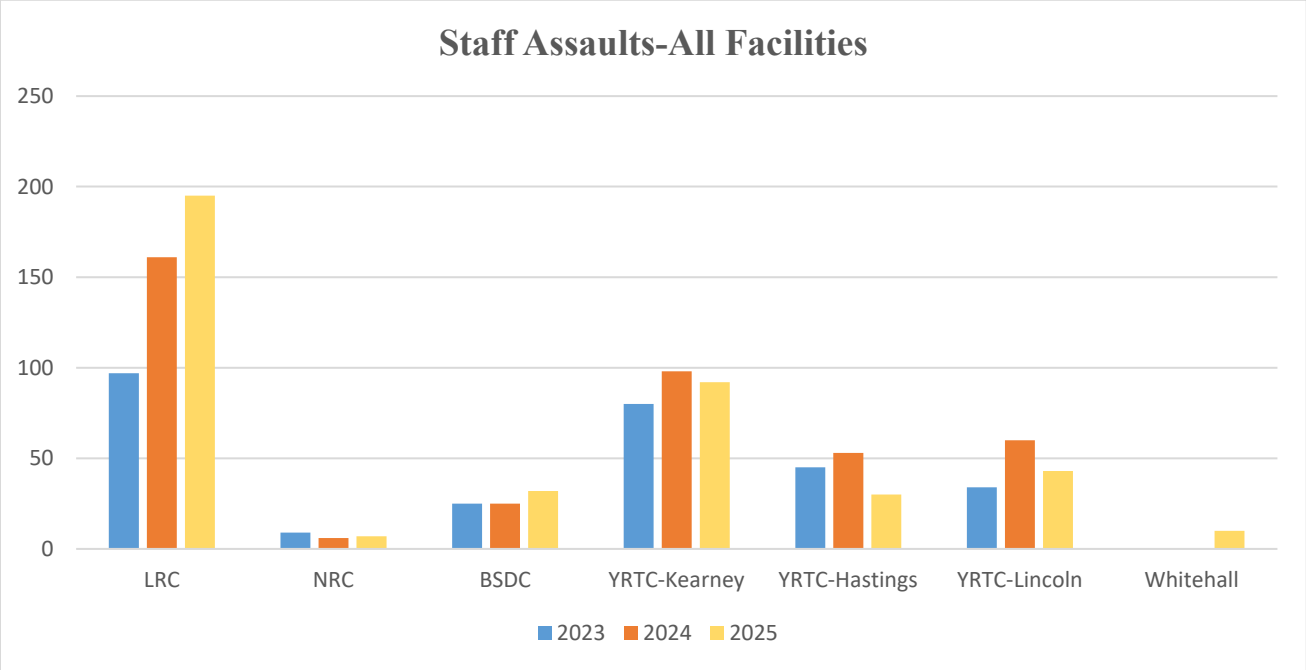
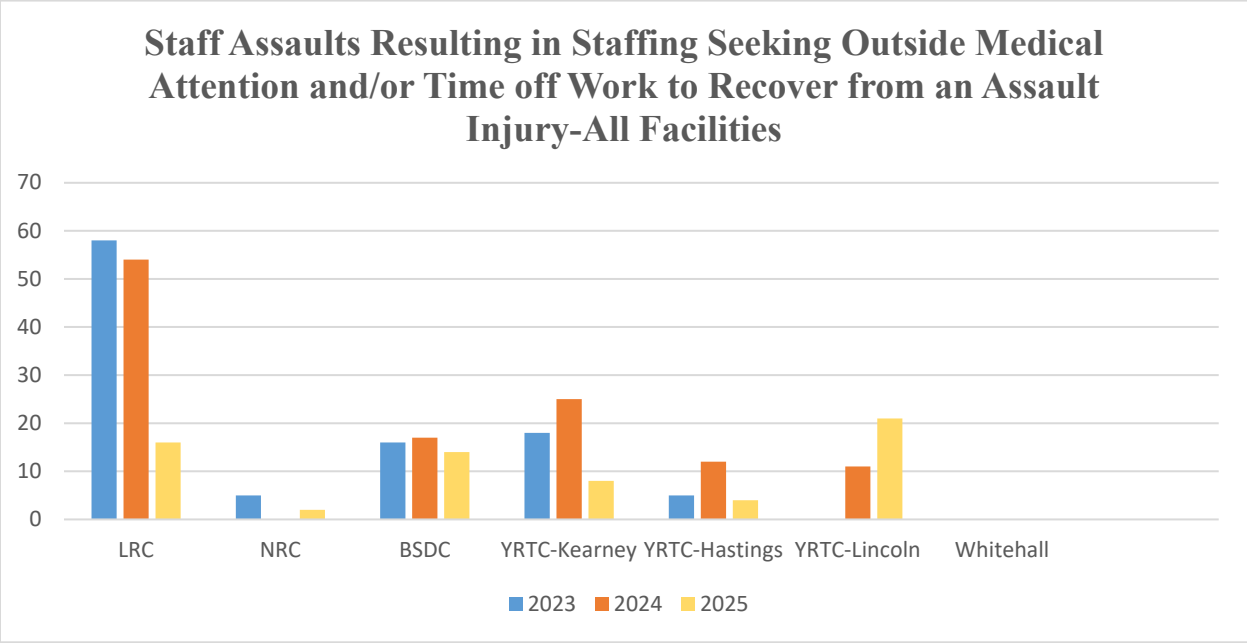


Chart 12 shows the number of assaults on staff resulting in staff seeking outside medical attention and/or time off work to recover from an assault, as provided by DHHS in each respective year. (See Chart 12.)

Chart 12



Complaints Involving Facilities to OPC

Residents of the facilities, their loved ones, staff, and members of the public may file complaints with the OPC throughout the year. For the period of December 1, 2024 through November 30, 2025, the OPC received 139 complaints regarding DHHS institutions. The following table demonstrates the number of complaints received for each facility for this period, as well as the five prior years. (See Table 5.) A summary of 2025 complaints is included in each respective facility's report section. Evidence was not present to prove all complaints, and each respective facility worked with our office to provide clarification or resolution to issues when needed.

Table 5

Complaints to OPC regarding DHHS Facilities in Neb. Rev. Stat. § 83-104						
Facility	**Number of Complaints**					
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
LRC	73	44	54	65	38	**67**
NRC	64	71	39	26	33	**40**
BSDC	2	3	1	2	4	**3**
YRTC-Kearney	14	4	5	1	8	**10**
YRTC-Hastings / Geneva	9	8	1	1	5	**3**
YRTC-Lincoln	2	2	3	3	4	**14**
Whitehall	1	1	0	0	1	**2**
Total Complaints	**165**	**133**	**104**	**98**	**93**	**139**

ADULT BEHAVIORAL HEALTH FACILITIES

LINCOLN REGIONAL CENTER (LRC)

LRC is a 242-bed hospital licensed as a Mental Health Substance Use (MHSU) Treatment Center and Psychiatric Hospital and accredited by the Joint Commission, the accreditation body for the Center for Medicare and Medicaid Services (CMS). LRC provides general and forensic psychiatric services and sex offender treatment for individuals in need of specialized psychiatric services in a highly structured setting. Psychiatric services are conducted with the goal of helping individuals achieve stability and transition back to the community. Patients at LRC must meet involuntary admission criteria and are referred by Mental Health Boards or courts. LRC provides treatment for convicted sex offenders and those committed under an inpatient mental health board order for sex offender treatment. A transition program works towards successful reentry to the community with appropriate safeguards.

LRC, which originally opened in 1870, sits on a 107-acre campus. The campus is comprised of several different buildings to meet individuals' housing, dining, medical services, administrative services, religious functions, and recreation needs. Buildings 3, 5, 10, and 14 serve as the main buildings where patients reside and receive treatment.

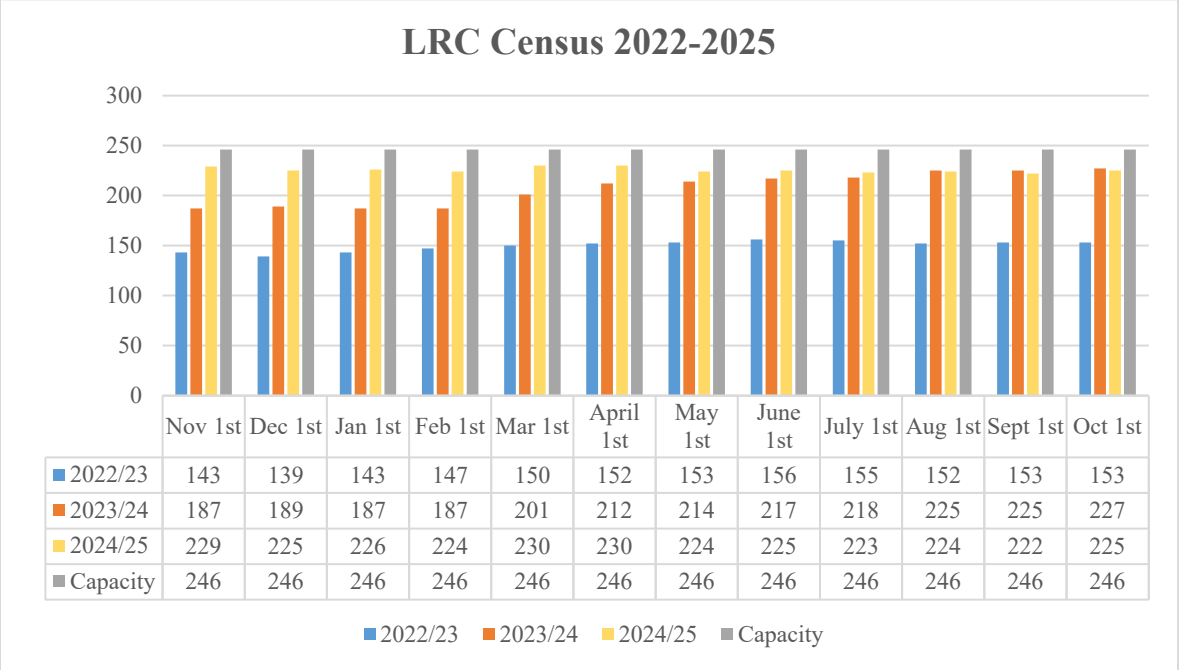
Building 3 currently houses female patients in need of acute care or forensic services and competency restoration. Building 5 is a forensic unit for male patients suspected of having mental illness that affects their competency and who have pending criminal court cases. Most of Building 5's patients have been deemed by the courts as "not competent to stand trial" and have been admitted to LRC for competency restoration treatment. Building 5 also houses some patients who have been referred by State Mental Health Boards and newly admitted male patients being evaluated for placement. Building 10 houses males receiving acute psychological care, the on-site dental office, the main library, and cafeteria.

Building 14 is divided into four units, each with a different programming focus: one program for patients who have sexually offended, one designed for individuals transitioning from general psychological care, one for patients who have completed treatment in Building 5, and one for acute individuals who need extra assistance in making connections in the community.

Capacity and Census

The licensed capacity total for LRC is 246. For the current reporting period, the average monthly census in was 226, as compared to 150 in 2022/23 and 207 in 2023/24. **Chart 13** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1, until October 31 of each respective year. (See Chart 13.)

Chart 13



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2022/23	143	139	143	147	150	152	153	156	155	152	153	153
2023/24	187	189	187	187	201	212	214	217	218	225	225	227
2024/25	229	225	226	224	230	230	224	225	223	224	222	225
Capacity	246	246	246	246	246	246	246	246	246	246	246	246

Complaints to OPC regarding LRC

For the period of December 1, 2024 through November 30, 2025, the OPC received 67 complaints regarding LRC. While there was not evidence to support all complaints, the complaints involved concerns about medical treatment, programming and treatment plans, patient requests for outside psychological evaluations, facility cleanliness, evaluations, the patient grievance process, and issues with staff regarding overtime, staff assaults and safety concerns.

Facility Inspection

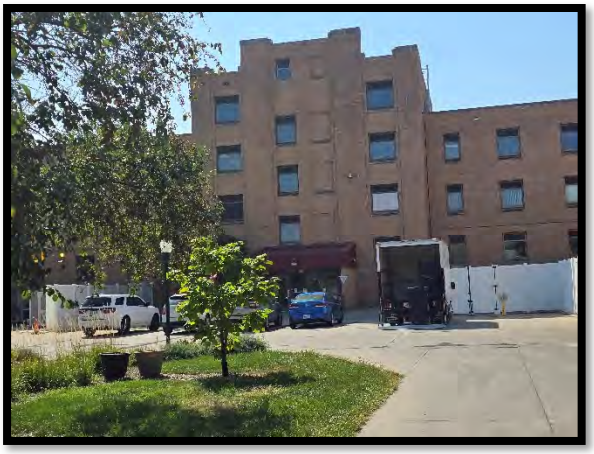
Each building operates as if it were a separate facility, resulting in a sense of discontinuity. The structures vary in age but are uniformly old, outdated, and deteriorating. Ideally, LRC would be one building like a modern hospital with all considerations for mental health treatment.

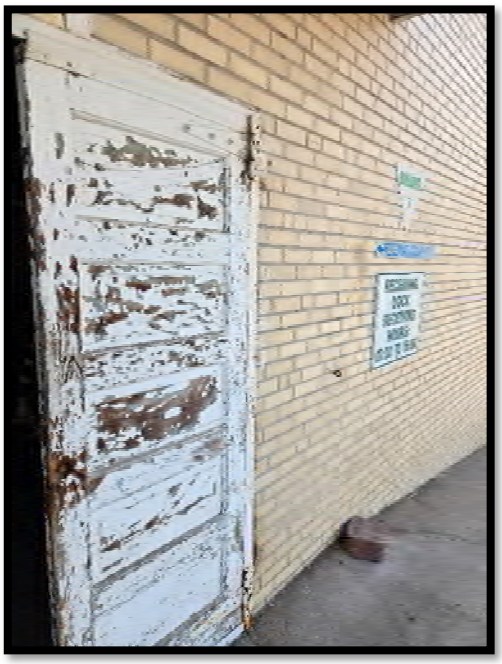
Table 6 provides any highlights observed by OPC staff during the facility inspection. (See Table 6.)

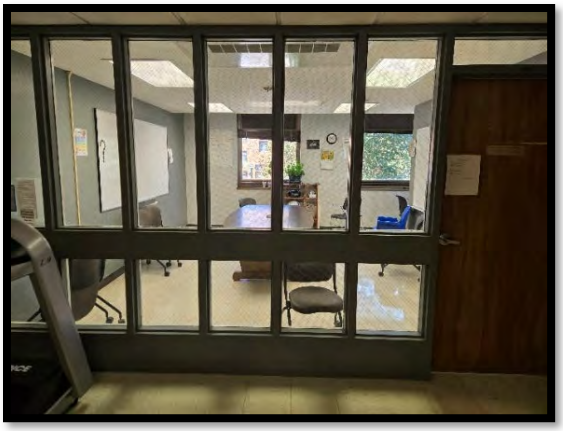
Table 6

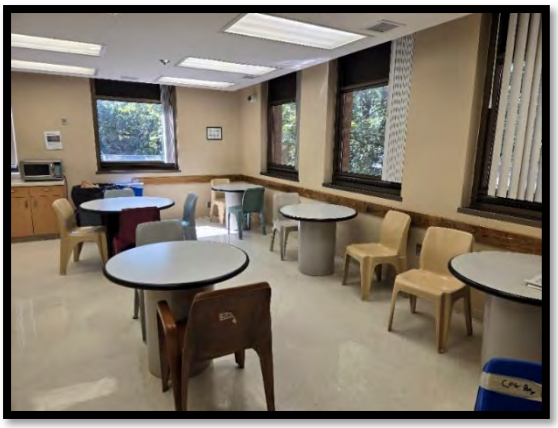
Facility Description	General Observations
Grounds	Campus is large, with expansive yard space and trees. Older buildings that are no longer in use outside of storage remain on the campus and may need attention at some point. Parking near some units seemed to be lacking, particularly near Building 5. The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Administration Building	No major destruction or structural issues identified. The reception area is attractive with updated furniture. Staff offices seem to be sufficient size and condition for their purpose.
Building 3	No major destruction or structural issues identified. Generally, Building 3 has a much better appearance and atmosphere as compared to some of the other buildings. However, it is starting to show its age.
Building 5	No major destruction or structural issues identified. Badge readers have been installed to enter onto the units, which allows for quick access in the case of emergency when staff from other floors need to respond. Medication rooms have physical key access only. This unit has large yards for the patients to have outdoor time but no outdoor furniture for the patients to utilize. The gym space is large and appeared to in good condition and equipped for patient use.

	This building is very old and is in need of updating in order to best serve the population and to maintain a clean environment. In patient bedrooms, the tile was removed in some rooms due to bodily fluids seeping into the cracks, making the tiles difficult to clean. The floors are painted as an alternative. The painted floors are less welcoming for patients and will likely not hold up to foot traffic. The mattresses are thin and many have vinyl peeling from the cover.
Building 10	No major destruction or structural issues identified. Ground floor has a more appealing appearance with clean carpet and updated furniture. Improvements to the canteen area located in the basement are in progress, though the progress is slow and appears not to be recent. Patients in this area have their own bathrooms in their rooms. Dining areas are clean.
Building 14	No major destruction or structural issues identified. The appearance and functionality of the building is much more conducive for serving the population's needs than some of the other buildings on campus. Patient rooms are much bigger and overall nicer, with wooden doors and desks. Patients are able to have more personal items. Cafeteria area is dated but appeared to be clean.



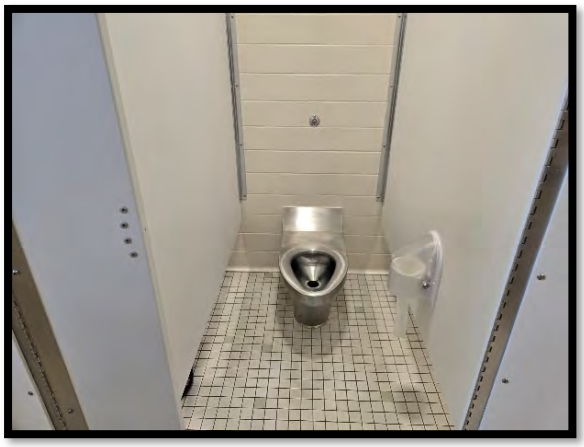




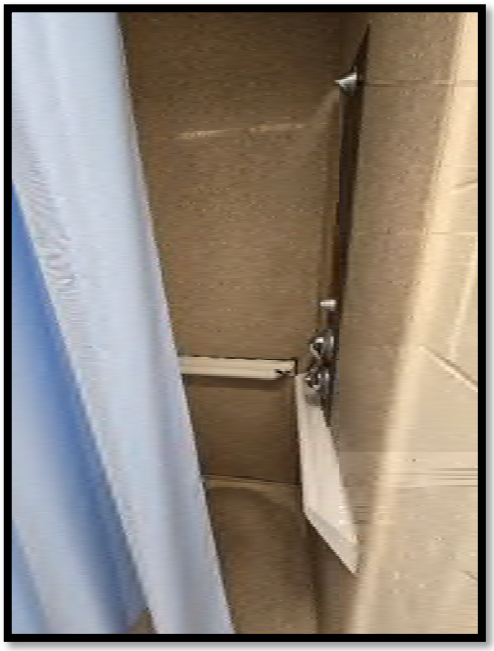


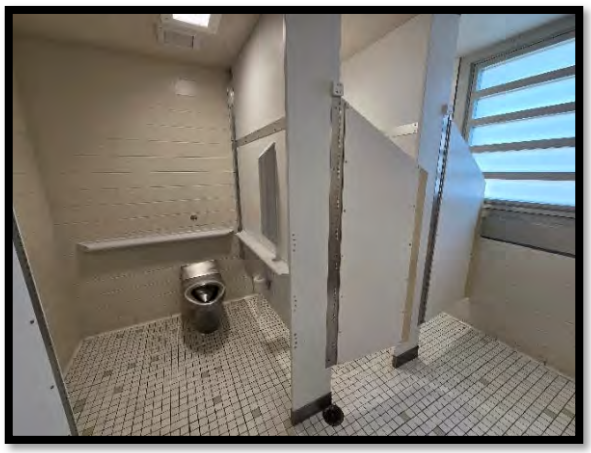
BOOK CARE RULES

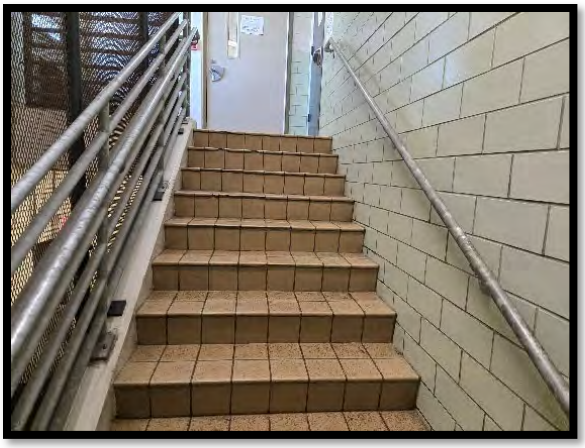
DO NO
GLASS
FROM
ROOM

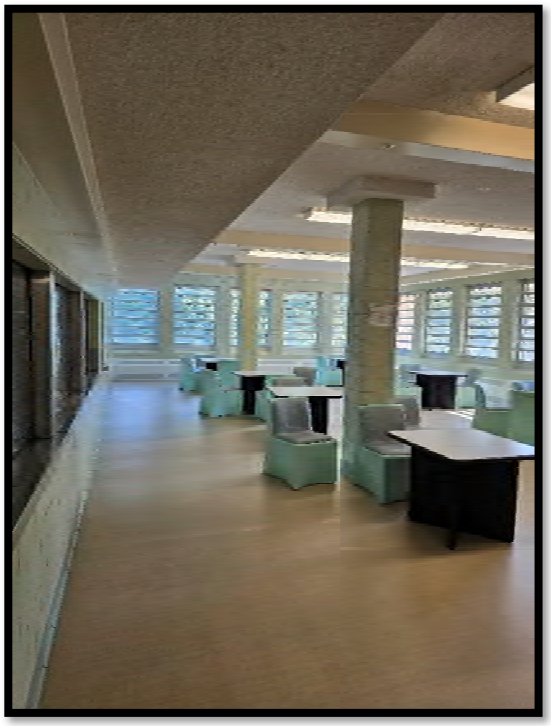


EX

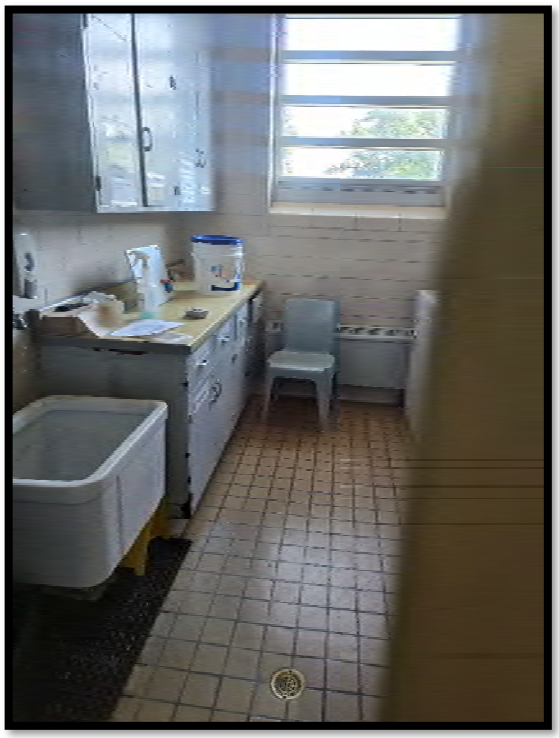


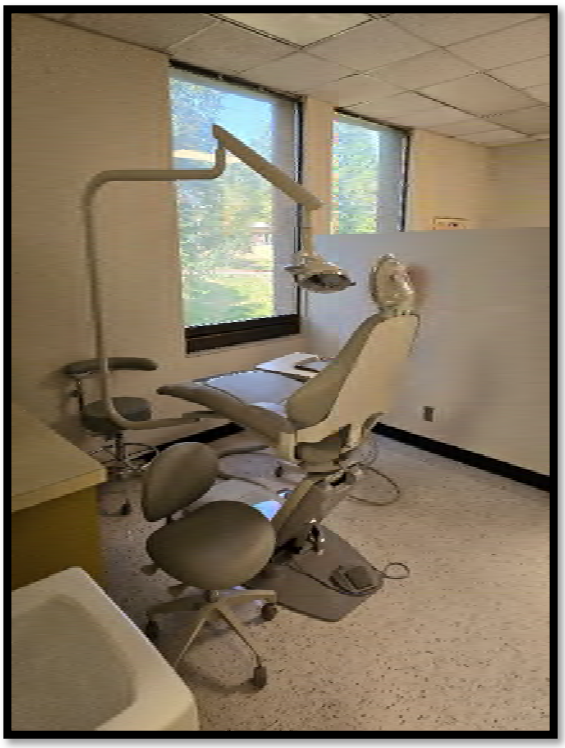


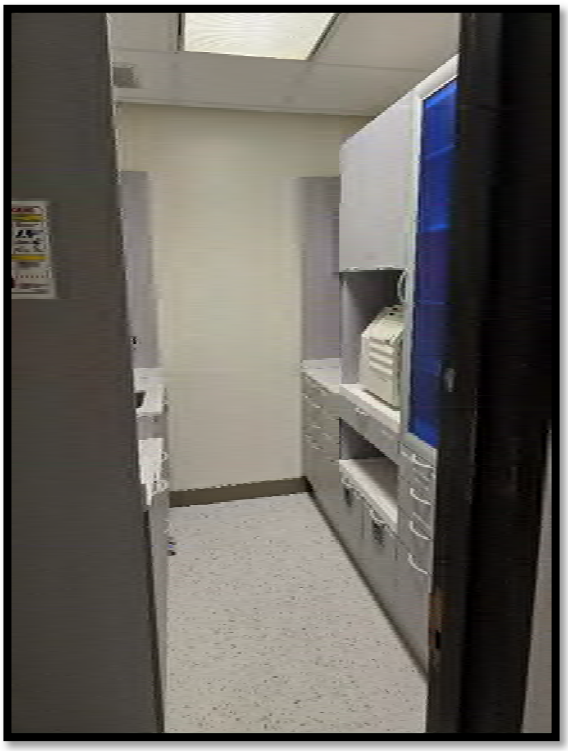




FLOOR







Major Projects/Improvements

In Progress Projects	**Projected Completion Date**
Mini Mesh Fencing to be installed for Buildings 3, 10, and 14. Buildings 3 and 5 will get added hardware to them.	December 2026
Water Main Project campus wide.	March 2026
New chiller in Building 10.	March 2026
Speed bumps installed/repaired on campus.	February 2026
Pending	**Projected Completion Date**
Improvements to the canteen area in the basement of Building 10.	Unknown

Yards are under evaluation for improved fencing and securing all yard furniture.	Unknown
Updated handrails on the exterior of Building 5.	Unknown
Technology improvements in the conference rooms are being discussed.	2/5 Completed, Unknown on the remaining

Completed Projects During the Current Reporting Year

Yard tables installed and secured to cement.

Windows added to patient room doors in Building 10 for safety and security purposes. Additional windows added throughout buildings on campus for safety and security as well.

New lighting throughout Building 5.

Parking lot repairs near Buildings 5 and 14.

Fire Lane repainted in front of Buildings 9 and 10.

Trees up against buildings cut down for better safety and security.

Ligature free bulletin boards installed in Buildings 3, 5, and 10 for patient advocacy information.

Small restroom remodel in Building 3.

LRC Staffing

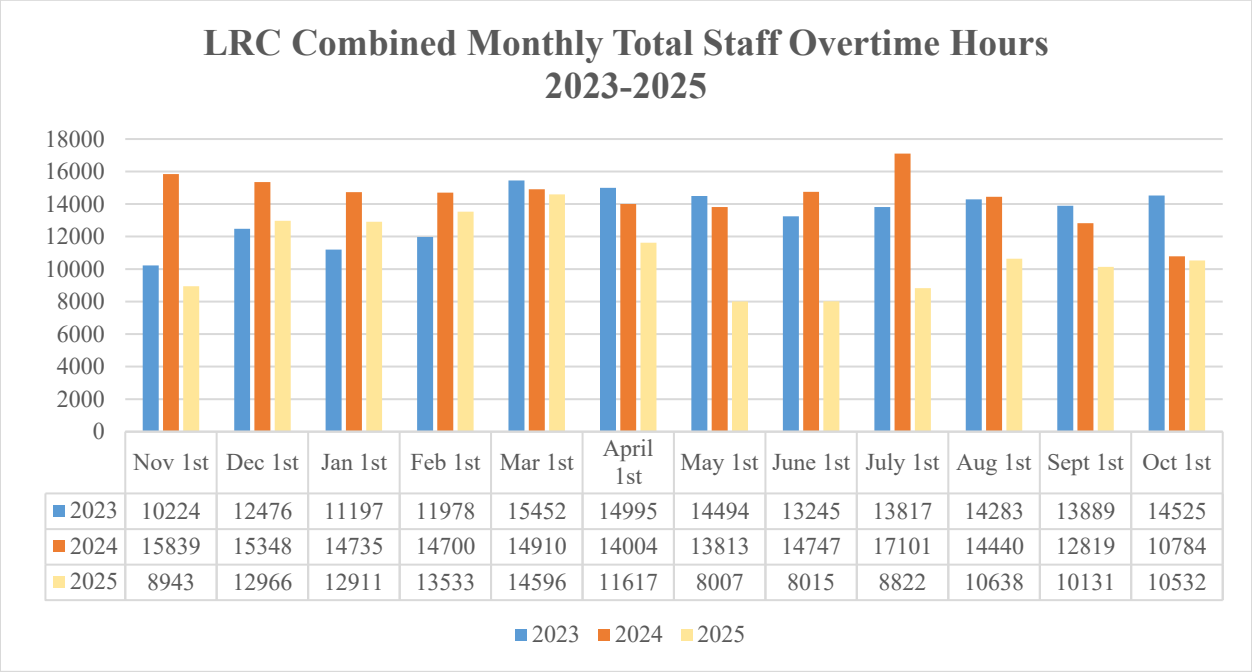
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See Table 7.)

Table 7

LRC Staffing – Permanent and Temporary Staff on October 31st of each Respective Year						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions Needed in HR Staffing Plan	626 for **FY21**	609 for **FY22**	624 for **FY23**	613 for **FY24**	706 for **FY25**	735 for **FY26**
Number of Positions Filled	505	422	533	455 Perm 47 Temp	532 Perm 73 Temp	599 Perm 66 Temp
Number of Positions Vacant	121	187	91	111	101	70
Monthly Turnover Rate	N/A	2%	1.5%	1.6%	1.8%	1.7%
Aggregate Turnover Rate	19%	26%	18%	19%	22%	20%

Chart 14 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 14.)

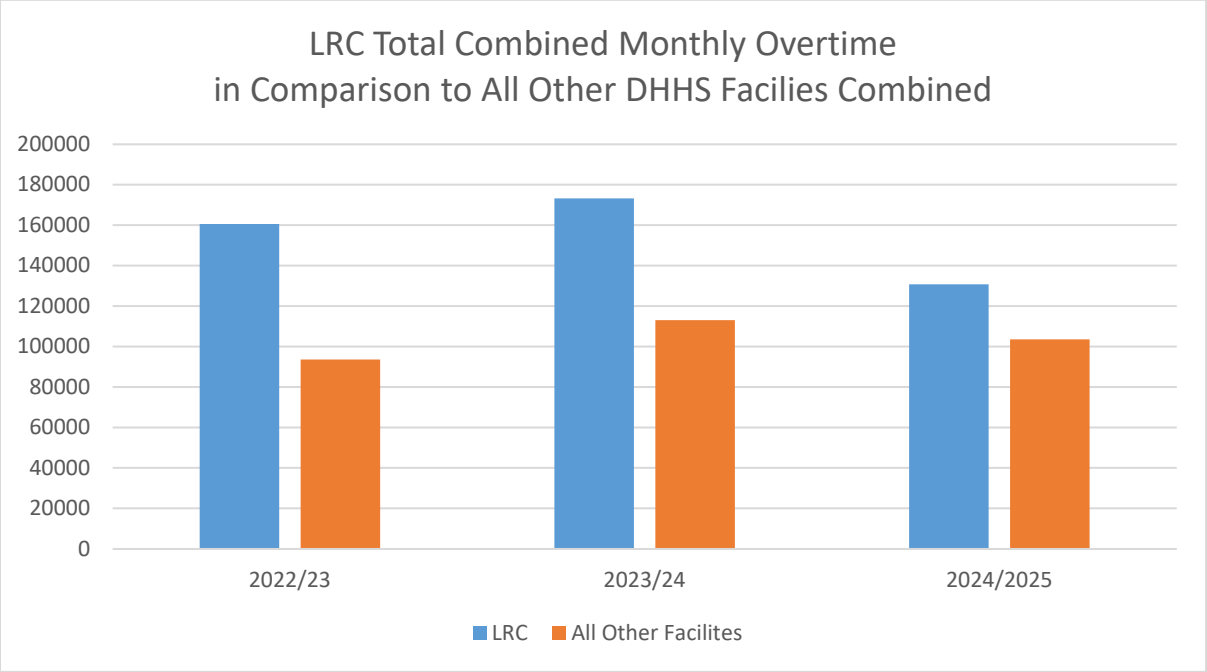
Chart 14



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	10224	12476	11197	11978	15452	14995	14494	13245	13817	14283	13889	14525
2024	15839	15348	14735	14700	14910	14004	13813	14747	17101	14440	12819	10784
2025	8943	12966	12911	13533	14596	11617	8007	8015	8822	10638	10131	10532

Similar to last year, the LRC overtime rates are significantly higher than all other facilities combined at 130,708 hours, or 56% of the total combined for all facilities for the 2024/2025 reporting period, while LRC served 45% of the total average population. The combined total from the other six facilities are 103,520 with 55% of the total DHHS facilities population served by those facilities. It should be noted that last year, LRC's overtimes rates accounted for 63% of the total overtime hours worked. (See **Chart 15**.)

Chart 15



Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type was filled on October 31, 2025. The percentage of filled positions reported was at an overall rate of 90%, compared to 86% in the last reporting year, as shown in the **Table 8**.

Table 8

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACCOUNTANT I	2	2	100%
ACTIVITY SPECIALIST	16	14	88%
ACTIVITY SUPERVISOR	1	1	100%
ADMINISTRATIVE NURSE	1	1	100%
ADMINISTRATIVE NURSE	8	5	63%
ADMINISTRATIVE SPECIALIST	2	2	100%
ADMINISTRATIVE TECHNICIAN	7	6	86%
ASSISTANT DIRECTOR OF NURSING	5	5	100%
BEHAVIORAL HEALTH PRACTITIONER I	3	3	100%
BEHAVIORAL HEALTH PRACTITIONER II	1	1	100%

BEHAVIORAL HEALTH PRACTITIONER IV	16	15	94%
BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II	2	2	100%
BUSINESS MANAGER III	1	0	0%
CERTIFIED MASTER SOCIAL WORKER	11	10	91%
CLINICAL NURSE TRAINER	4	4	100%
CLINICAL PROGRAM MANAGER	5	4	80%
COMPLIANCE SPECIALIST	5	5	100%
DENTAL ASSISTANT	1	1	100%
DENTIST	1	1	100%
DHHS FACILITY ADMINISTRATOR	1	0	0%
DHHS PROGRAM MANAGER II	1	1	100%
DHHS PROGRAM SPECIALIST	1	1	100%
DHHS PROGRAM SPECIALIST	2	2	100%
DHHS QUALITY ASSURANCE COORDINATOR	1	1	100%
DHHS TRUST OFFICER SUPERVISOR	1	1	100%
DIRECTOR OF NURSING	1	1	100%
DIRECTOR OF SOCIAL WORK	1	1	100%
FACILITY OPERATING OFFICER	1	1	100%
FOOD SERVICE ASSISTANT	3	3	100%
FOOD SERVICE DIRECTOR II	1	1	100%
FOOD SERVICE MANAGER	2	2	100%
FOOD SERVICE WORKER	25	24	96%
HEALTH INFORMATION MANAGER	1	1	100%
HR SPECIALIST MANAGER / HR BUSINESS PARTNER II	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
HUMAN SERVICES TREATMENT SPECIALIST I	6	6	100%
LICENSED PRACTICAL NURSE	34	32	94%
LICENSED PRACTICAL NURSE (TEMP)	3	1	33%
MAINTENANCE SPECIALIST I	4	4	100%
MAINTENANCE TECHNICIAN	9	8	89%
MASTER SOCIAL WORKER	3	3	100%
MEDICAL SERVICES DIRECTOR	1	1	100%
MENTAL HEALTH SECURITY UNIT SUPERVISOR	21	21	100%
MENTAL HEALTH SPECIALIST	295	275	93%
MENTAL HEALTH SPECIALIST (TEMP)	67	59	88%
NURSE PRACTITIONER	7	7	100%
OCCUPATIONAL THERAPIST	3	3	100%
OFFICE SERVICES MANAGER I	1	1	100%
OFFICE SPECIALIST	22	20	91%

OFFICE TECHNICIAN	5	4	80%
PHARMACIST/CLINICAL	3	3	100%
PHARMACY INVENTORY TECHNICIAN	1	1	100%
PHARMACY MANAGER	1	1	100%
PHARMACY TECHNICIAN	3	3	100%
PHYSICIAN	1	1	100%
PRINCIPAL	1	0	0%
PROCUREMENT SPECIALIST	1	1	100%
PSYCHIATRIC FACILTY RISK MNGMT ADMIN	1	1	100%
PSYCHIATRIST	1	1	100%
PSYCHIATRIST	3	2	67%
PSYCHOLOGIST/LICENSED	4	4	100%
PSYCHOLOGIST/PROV LICENSED	1	1	100%
PSYCHOLOGY DIRECTOR	2	2	100%
PSYCHOLOGY SUPERVISOR	4	3	75%
REGISTERED NURSE	63	54	86%
REGISTERED NURSE (TEMP)	11	6	55%
RELIGIOUS COORDINATOR	1	1	100%
SAFETY COORDINATOR	1	1	100%
STATISTICAL ANALYST III	1	1	100%
STATISTICAL ANALYST III	1	1	100%
SUPPLY TECHNICIAN II	2	2	100%
TEACHER (SCATA CONTRACT)	1	0	0%
TRAINING MANAGER	1	1	100%
TRAINING SPECIALIST	4	4	100%
YOUTH SECURITY SPECIALIST II	3	0	0%
YOUTH SECURITY SUPERVISOR	1	0	0%
Total	**735**	**665**	**90%**

Recent Licensure and Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns found are highlighted. The more significant concerns found regarding LRC include the following:

- A DHHS Public Health finding of the facility's failure to ensure the patient's rights were protected by failing to ensure a seclusion order was placed to protect the rights of a patient.
- A DHHS Public Health finding of the facility's failure to follow policies to protect patient's right to care in a safe setting.
- A DHHS Licensure Unit found the facility failed to follow their own policy on Complaints and Grievances regarding timeframes for investigative review and for a response to the consumer or designee.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate. The LRC Certification of Licensure is active at the time of this report.[6]

NORFOLK REGIONAL CENTER (NRC)

NRC is a licensed through DHHS Title 175 Nebraska Administrative Code: Health Care Facilities and Services Licensure - Chapter 9 Hospital Regulations. Established in 1885, NRC currently provides the first phase of the Nebraska Sex Offender Treatment Program, a three-phase program designed to reduce dangerousness and risk of re-offense. The treatment received at NRC prepares individuals for the final phases of the program, which is provided at LRC.

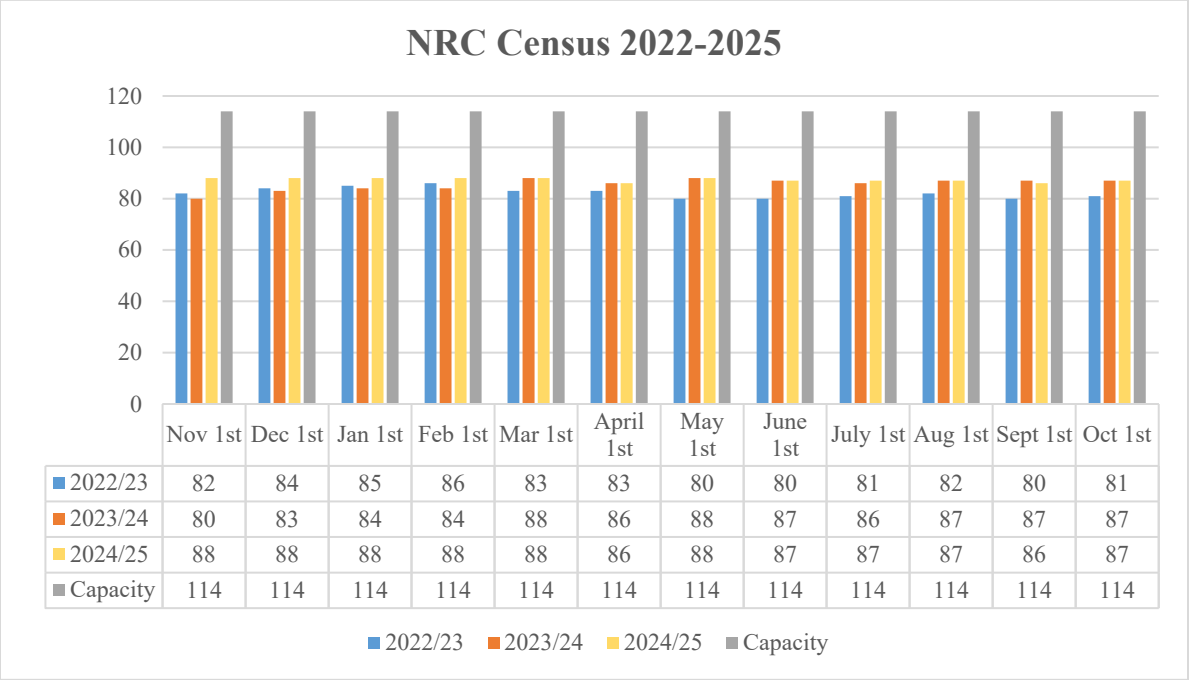
The NRC campus is secure and enclosed within a fence. The main building on campus, a three-story brick structure, houses all patient services. This main building has spaces for patients' dining, housing, medical, religious, recreation, and programming needs, as well as space for administrative services. There is also a maintenance building, basketball court, picnic/shelter area, and a courtyard/garden area.

Capacity and Census

The licensed capacity total for NRC is 114. For the current reporting period, the average monthly census in was 87, as compared to 82 in 2022/23 and 86 in 2023/24. **Chart 16** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1, until October 31 of each respective year.

[6] Licensure information was found at this website link: https://www.nebraska.gov/LISSearch/search.cgi

Chart 16



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2022/23	82	84	85	86	83	83	80	80	81	82	80	81
2023/24	80	83	84	84	88	86	88	87	86	87	87	87
2024/25	88	88	88	88	88	86	88	87	87	87	86	87
Capacity	114	114	114	114	114	114	114	114	114	114	114	114

Complaints to OPC regarding NRC

For the period of December 1, 2024 through November 30, 2025, the OPC received 40 complaints regarding NRC. While there was not evidence to support findings in all complaints, the complaints dealt with numerous topics, including treatment plans, medical and dental treatment, levels of restrictions, lack of time allowed outside, property issues, patient's access to making legal copies, concerns with the Mental Health Board process and the length of stay at the facility, concerns with the programming offered at NRC, the patient grievance process, and staff concerns.

Facility Inspection

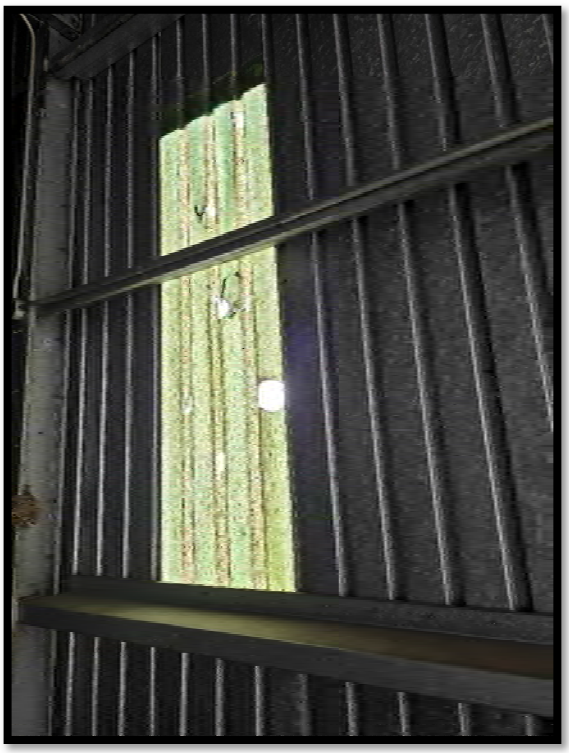
NRC is generally in good condition and the facilities are set up well to serve the population. On-going and regular maintenance is apparent.

Staffing trends are typically fairly stable at NRC, and assaults are very low in comparison to other facilities.

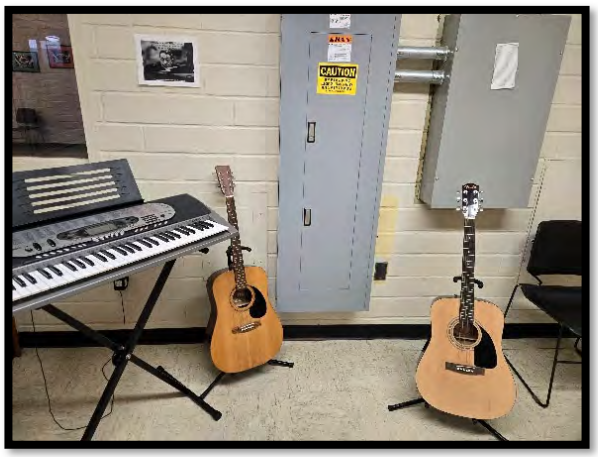
Table 9 provides any highlights observed by OPC staff during the facility inspection.

Table 9

Facility Description	General Observations
Grounds	Campus is large, with expansive yard space and trees. Sidewalks and driveways appeared to be in good condition. The entrance of the facility is well groomed with well-kept landscaping. The facility is lined with a tall fence enclosing the property. The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Main Building (which includes the administration office, as well as all patient living units and recreation areas)	No major destruction or structural issues identified. Overall, this campus is in very good condition and it is apparent that on-going maintenance is occurring. This includes fresh paint to walls and updated carpet in many areas. The single building design of NRC appears advantageous compared to campuses with numerous buildings to maintain and allows staff to all work within one space as opposed to being spread out. Staff offices seem to be of sufficient size and condition for their purpose. The facility is equipped with good conference room space, an extensive library, a large fitness room, a rec room with older pool tables, large hallways on the units, and larger sleeping areas for patients. Restrooms overall seemed to be clean, and OPC staff witnessed cleaning by NRC staff throughout the tour. However, showers and restrooms in some of the units show signs of aging that may be difficult to maintain and in need of updating.



8½ FT CLEARANCE
AMBULANCE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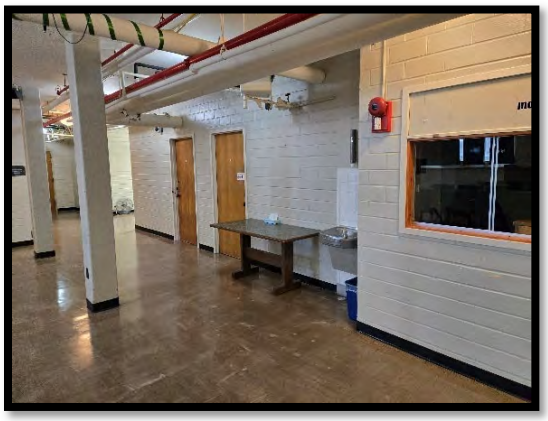

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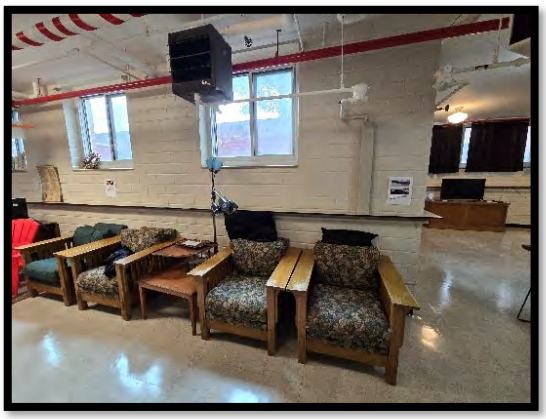
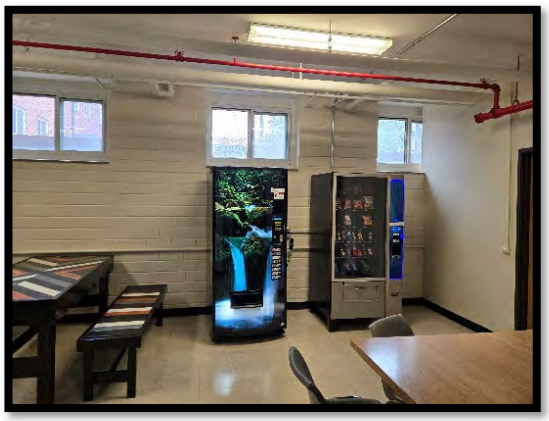
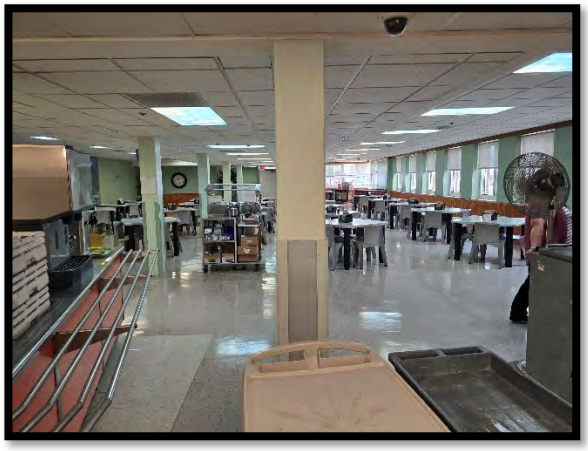
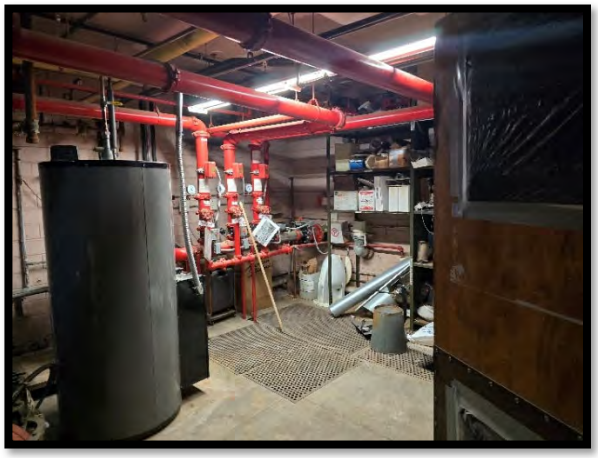
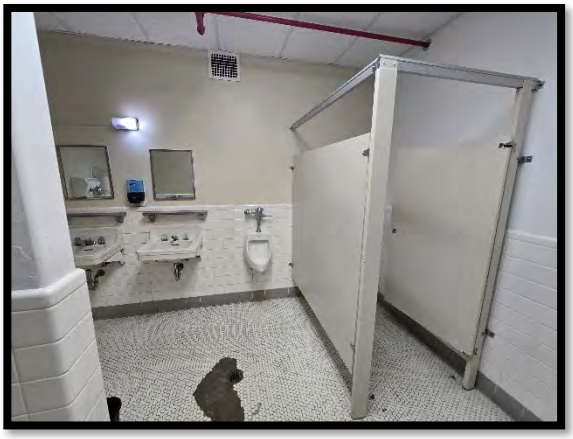


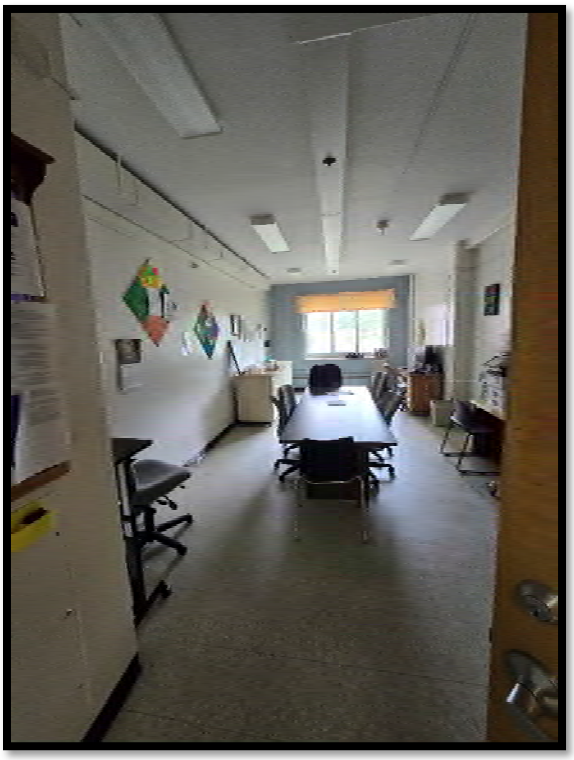






Life is good.





Major Projects/Improvements

In Progress Projects	Projected Completion Date
Fixing cracks in parking lot with tar.	Unknown
Pending	**Projected Completion Date**
Pending legislative approval of funding to update key locked doors to badge reader access doors.	Unknown
Pending legislative approval on funding for updating our fire escapes.	Unknown
Completed Projects During the Current Reporting Year	
Repaired collapsed line to Kitchen. New high-pressure sensor in chiller. Completed 13 new steam valves and actuators for steam.	

NRC Staffing

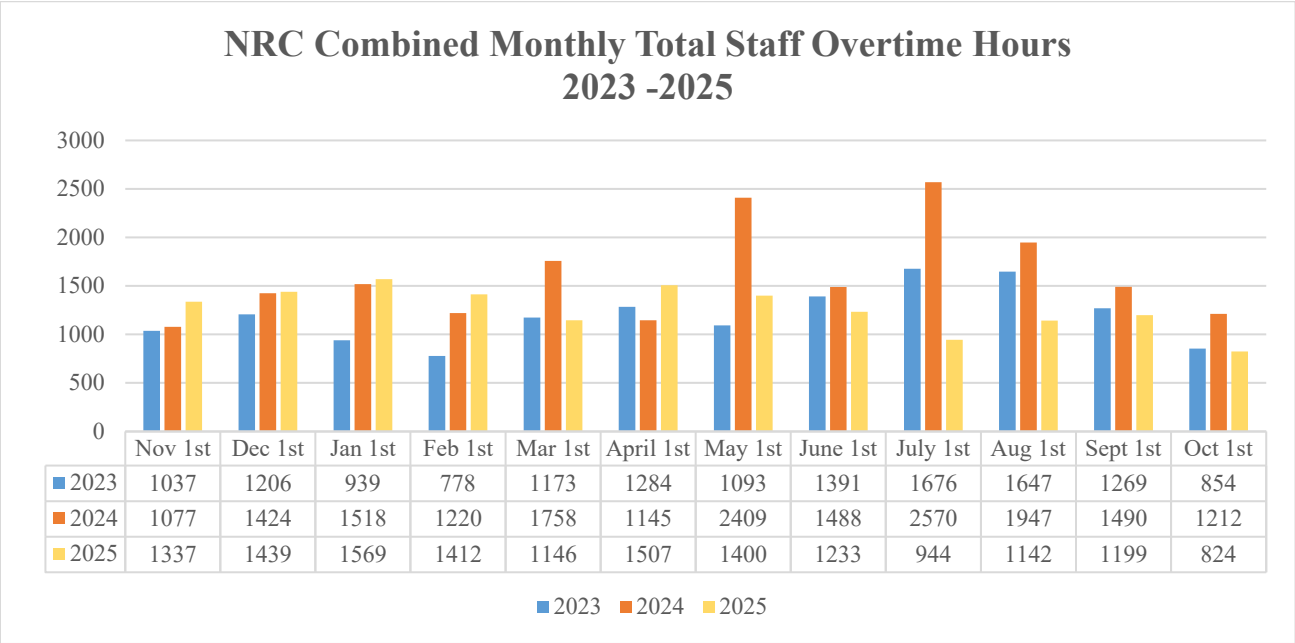
The table below shows the staffing numbers provided by DHHS for the past 5 reporting years. (See **Table 10**.)

Table 10

NRC Staffing – Permanent and Temporary Staff on October 31st of Each Respective Year						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions Needed in HR Staffing Plan	206 for **FY23**	245 for **FY23**	253 for **FY23**	252 for **FY24**	279 for **FY25**	243 for **FY25**
Number of Positions Filled	167	188	214	199 Perm 23 Temp	199 Perm 21 Temp	205 Perm 25 Temp
Number of Positions Vacant	39	57	39	30	17	13
Monthly Turnover Rate	N/A	2%	1.6%	1.5%	1.7%	1.4%
Aggregate Turnover Rate	20%	22%	17.2%	18%	21%	17%

Chart 17 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 17.)

Chart 17



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	1037	1206	939	778	1173	1284	1093	1391	1676	1647	1269	854
2024	1077	1424	1518	1220	1758	1145	2409	1488	2570	1947	1490	1212
2025	1337	1439	1569	1412	1146	1507	1400	1233	944	1142	1199	824

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported was at an overall high rate of 95%, as shown in the **Table 11**.

Table 11

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACTIVITY SPECIALIST	9	9	100%
ACTIVITY SUPERVISOR	1	1	100%
ADMINISTRATIVE NURSE	5	4	80%
ADMINISTRATIVE SPECIALIST	1	1	100%
ADMINISTRATIVE TECHNICIAN	2	2	100%
ASSISTANT DIRECTOR OF NURSING	1	1	100%
BEHAVIORAL HEALTH PRACTITIONER III	1	1	100%
BEHAVIORAL HEALTH PRACTITIONER IV	5	5	100%
BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II	1	1	100%
CERTIFIED MASTER SOCIAL WORKER	2	1	50%
CERTIFIED MASTER SOCIAL WORKER SUPERVISOR	1	1	100%
CLINICAL PROGRAM MANAGER	1	1	100%
COMPLIANCE SPECIALIST	1	1	100%
DHHS QUALITY ASSURANCE COORDINATOR	1	1	100%
DIRECTOR OF NURSING	1	1	100%
FACILITY OPERATING OFFICER	1	1	100%
FOOD SERVICE ASSISTANT (TEMP)	1	1	100%
FOOD SERVICE MANAGER	3	3	100%
FOOD SERVICE WORKER	12	11	92%
HEALTH INFORMATION MANAGER	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
HR SPECIALIST/GENERALIST	1	1	100%
HUMAN SERVICES TREATMENT SPECIALIST II	4	4	100%
LICENSED PRACTICAL NURSE	5	5	100%
LICENSED PRACTICAL NURSE (TEMP)	2	1	50%
MAINTENANCE SPECIALIST I	1	1	100%
MAINTENANCE TECHNICIAN	5	5	100%
MAINTENANCE TECHNICIAN (TEMP)	1	1	100%

MASTER SOCIAL WORKER	2	2	100%
MENTAL HEALTH SECURITY UNIT SUPERVISOR	6	6	100%
MENTAL HEALTH SPECIALIST	104	100	96%
MENTAL HEALTH SPECIALIST (TEMP)	19	18	95%
NURSE PRACTITIONER	3	3	100%
OFFICE SPECIALIST	4	4	100%
OFFICE TECHNICIAN	1	1	100%
PHARMACIST	1	1	100%
PHARMACY INVENTORY TECHNICIAN	1	1	100%
PHARMACY MANAGER	1	1	100%
PHYSICIAN ASSISTANT	1	1	100%
PSYCHIATRIST (TEMP)	1	1	100%
PSYCHOLOGIST/LICENSED	1	0	0%
PSYCHOLOGY DIRECTOR	1	1	100%
REGISTERED NURSE	17	15	88%
REGISTERED NURSE (TEMP)	4	3	75%
RELIGIOUS COORDINATOR	1	1	100%
SOCIAL WORKER II	2	2	100%
SUPPLY TECHNICIAN II	1	1	100%
TRAINING COORDINATOR	1	1	100%
Total	**243**	**230**	**95%**

Recent Licensure and Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding NRC found are highlighted.

Also attached is an Environmental Inspection form completed with areas for improvement self-identified by NRC that recognizes items in need of repair. These items primarily consisted of such things as such things as chipping paint, doors that are sticking, "daisy-chained" electrical lines, water damage on the ceiling in a storage room, and lights or light bulbs that needed replacing.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate. The NRC Certification of Licensure is active at the time of this report.[7]

[7] Licensure information was found at this website link: https://www.nebraska.gov/LISSearch/search.cgi

BEATRICE STATE DEVELOPMENT CENTER (BSDC)

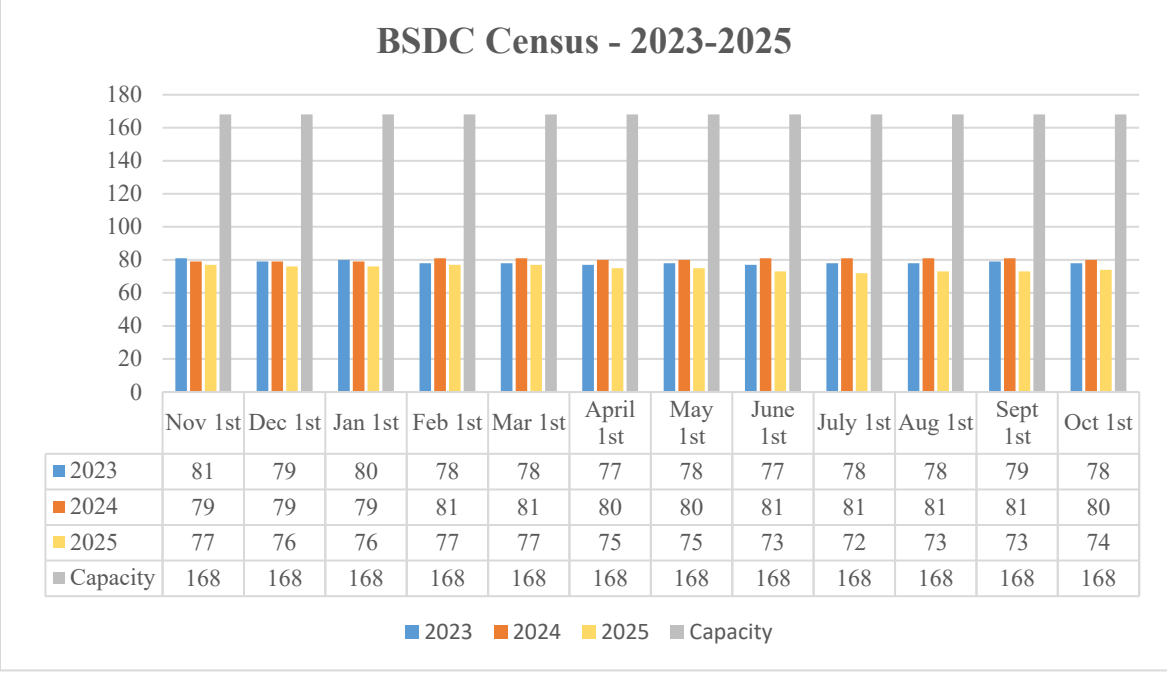
BSDC is an intermediate care facility for individuals with intellectual or developmental disabilities (ICF-IDD). It is a 24-hour state and federally-funded residential treatment institution divided into individually-licensed ICF-IDDs within a larger, 130-year-old campus. BSDC falls under the DHHS Division of Developmental Disabilities.

BSDC provides comprehensive, specialized medical, psychological, and developmental services to adults, and occasionally serve teenage youths. The campus is comprised of many buildings, including structures to meet individuals' housing, medical, dining, religious, and recreation needs, as well as administrative services. Individuals residing at BSDC generally live in one of the ten cottages, which have a home-like feel. Most units have separate bedrooms, bathrooms, a kitchen, a common area, and a laundry room. BSDC also has a Crisis Stabilization and Community Reintegration Program, in which individuals stay in one of four designated apartments for a temporary period between 30 and 180 days. This program aims to intake individuals from the community, provide them with treatment, habilitation, and stabilization, and then prepare them for transitioning back to the community stabilized.

Capacity and Census

The licensed capacity total for BSDC is 168. For the current reporting period, the average monthly census in was 75, as compared to 78 in 2022/23 and 80 in 2023/24. **Chart 18** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1, until October 31 of each respective year. (See Chart 18.)

Chart 18



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	81	79	80	78	78	77	78	77	78	78	79	78
2024	79	79	79	81	81	80	80	81	81	81	81	80
2025	77	76	76	77	77	75	75	73	72	73	73	74
Capacity	168	168	168	168	168	168	168	168	168	168	168	168

Complaints to OPC regarding BSDC

For the period of December 1, 2024 through November 30, 2025, the OPC received three complaints regarding BSDC. The complaints received involved resident care, and staff concerns regarding the leadership staff and human resources practices, staff overtime, and reduced programming due to staff shortages.

Facility Inspection

In 2024, BSDC came under new leadership, as the previous Facility Administrator left the position, and a new Facility Administrator was appointed. From complaints received by the OPC during this reporting period, including from a number of BSDC staff, it is clear that changes have been made under the new leadership; however, such staff believe it will take time to determine if the changes will have a positive or less than favorable effect. Many other staff had only very positive reviews of the change in leadership.

The buildings and facilities were in generally good condition upon the OPC staff tours, and updates to the facilities were in progress.

OPC staff attended the annual 2024 BSDC Fall Festival and had the opportunity to talk to a number of family members of the residents, and while some cited concerns with the facility in the past, all of the family members spoken to had very positive things to report regarding their loved one's current care at BSDC. However, staff at BSDC reported their number one concern is lack of staff and how that impacts staff overtime rates. Staff also reported concerns regarding the ability to do some of the extra programming that was once offered for residents, such as off-site activities. However, staff also reported that even with the reduction in programming, residents continue to receive overall good care.

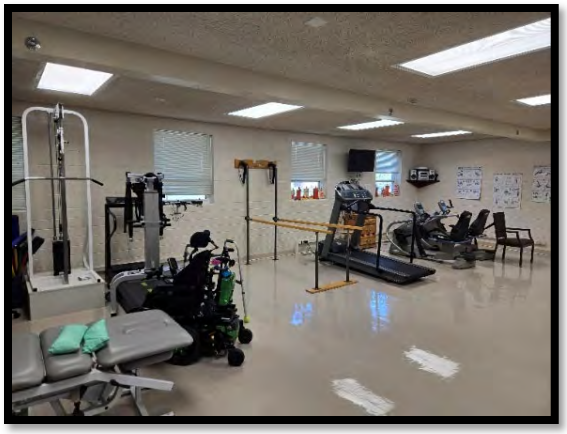
Table 12 provides any highlights observed by OPC staff during the facility inspection.

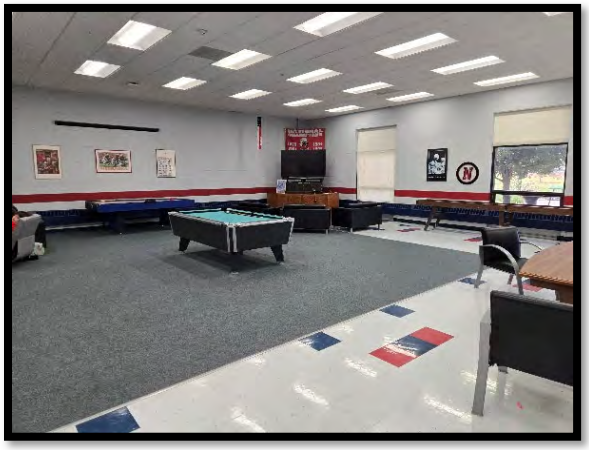
Table 12

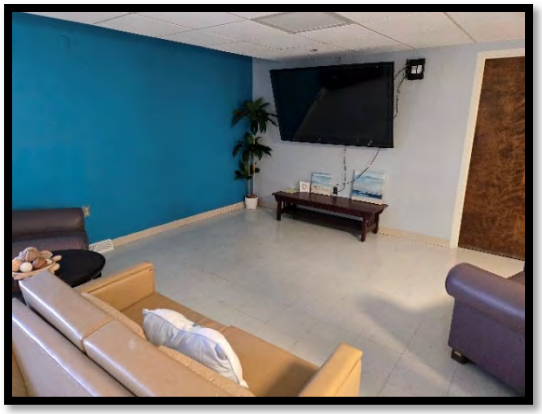
Facility Description	General Observations
Grounds	Campus is large and fairly spread-out, with expansive green space and trees. Due to recent demolition of a few aged buildings on the ground and ongoing clear up efforts, the campus has become more open. There are a decent number of wide sidewalks for residents to be able to take a walk or ride their bikes on.

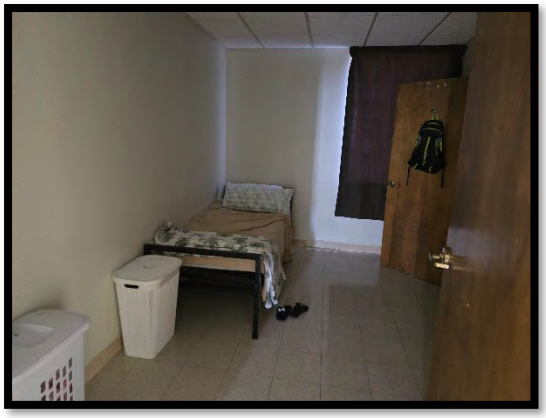
	The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Administration Building	No major destruction or structural issues identified. Staff offices seem to be sufficient size and condition for their purpose.
Solar Cottages	No major destruction or structural issues identified. The cottages designed for long-term care are very home-like, with separate bedrooms and bathrooms for each individual. Within the bedrooms, individuals have traditional bedroom furniture and are able to enjoy many of their own personal items. The living rooms have traditional furniture and a TV viewing area with newly mounted large flat-screen TV's. Each cottage has its own kitchen and dining area typical to a family home. The cottages were generally very clean, with minor clutter particularly in the kitchen areas, likely due to lack of storage space.
400 State Buildings	No major destruction or structural issues identified. Work was being completed when OPC staff toured to repaint this interior space and provide new curtains and other items to promote a more welcoming environment. The spaces are large, with large hallways, but do not have the home-like feeling of the on-campus cottages. This building is aging and will need continued upkeep.
Chapel	No major destruction or structural issues identified. Chapel is beautiful and inviting.
Carsten Center	No major destruction or structural issues identified. The gym is very large, in good condition, and appears to be well equipped. The swimming pool is in working order. The cafeteria area appeared to be clean and in good condition.
Bear Creek Craft Shop	No major destruction or structural issues identified. This area houses a workshop where residents make craft items to sell in the open-to-the-public store within this space.

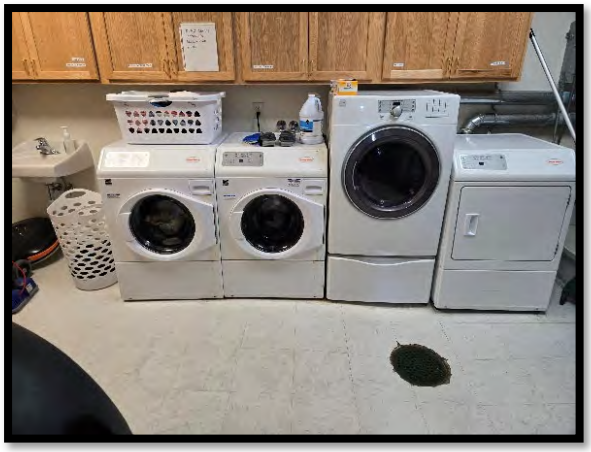
POOL

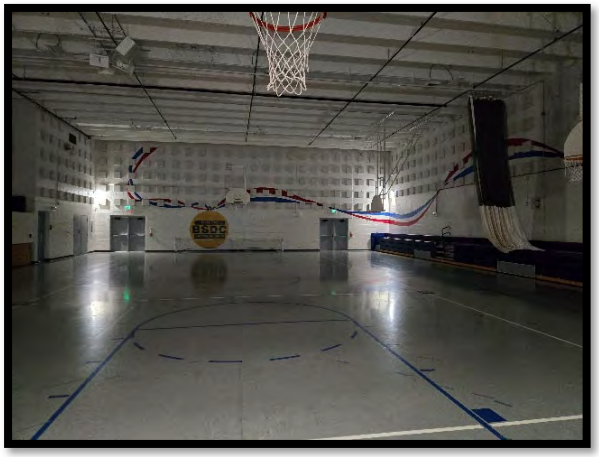


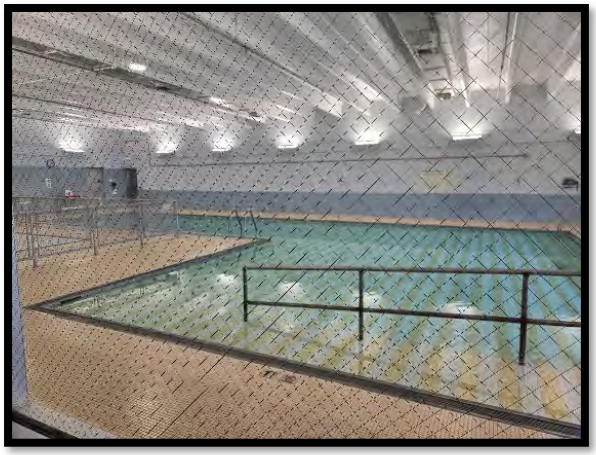




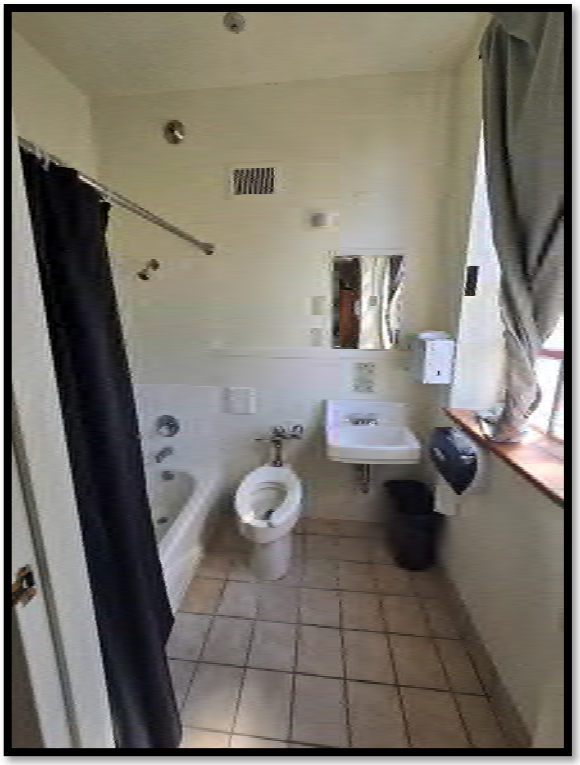








welcome



Major Projects/Improvements

In Progress Projects	**Projected Completion Date**
BSDC has designated a vacant home at the facility for renovations (3071 State). Plans for the renovation have been developed, submitted and approved through Public Health. Renovations are scheduled to begin at this home in October 2025. Once the renovations are completed the home will be dedicated to serving DD youth.	December 2025
Pending	**Projected Completion Date**
None known	
Completed Projects During the Current Reporting Year	
Concrete repair on Carstens Drive directly to the south of Carstens Center. Updated the cable system to digital cable.	

Updated the paint and interior design in the Crisis Building.
New roof on food service building.

Demolition of an old building.

Upgraded the water system.

BSDC Staffing

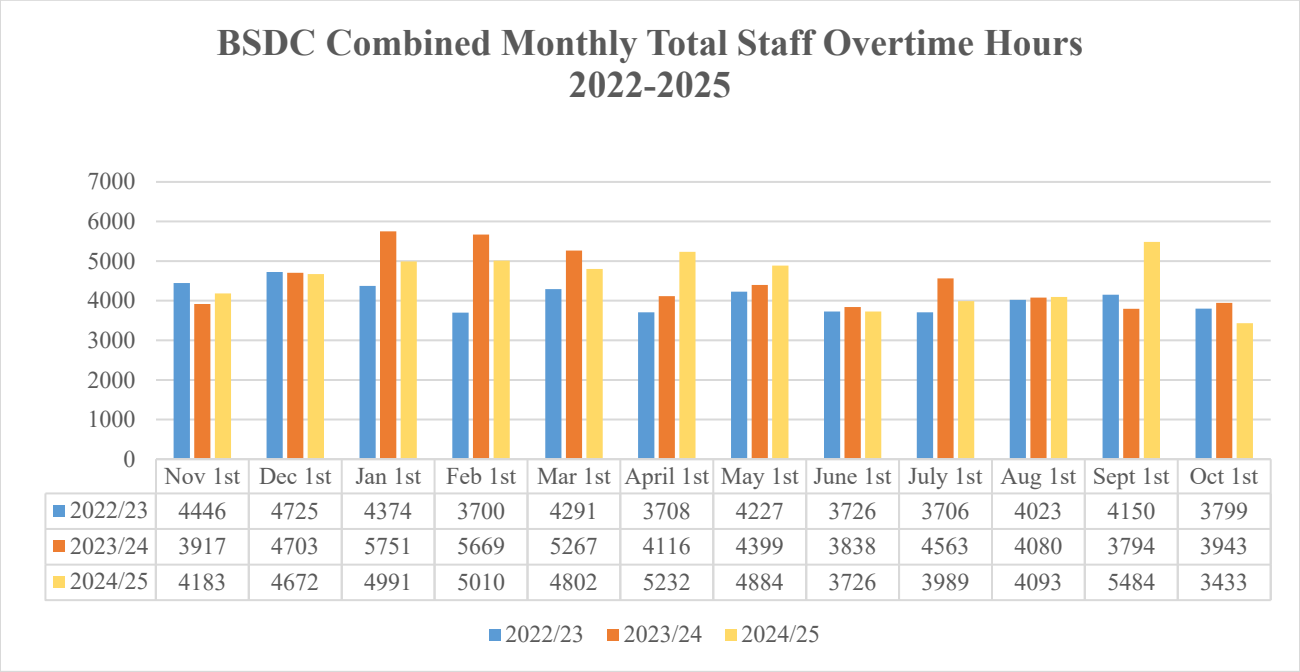
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See **Table 13**.)

Table 13

BSDC Staffing – Permanent and Temporary Staff on October 31st of Each Respective Year						
	2020	2021	2022	2023	2024	**2025**
Number of Positions Needed in HR Staffing Plan	138 for **FY21**	420 for **FY22**	410 for **FY23**	378 for **FY24**	279 for **FY25**	**305** for **FY25**
Number of Positions Filled	115	205	235	217 Perm 6 Temp	228 Perm 13 Temp	235 Perm 8 Temp
Number of Positions Vacant	40	215	175	155	38	62
Monthly Turnover Rate	N/A	3%	1.2%	2.3%	2.1%	1.9%
Aggregate Turnover Rate	8.4 Long-term / 14.8 Crisis	32%	14%	28%	26%	23%

Chart 19 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 19.)

Chart 19



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2022/23	4446	4725	4374	3700	4291	3708	4227	3726	3706	4023	4150	3799
2023/24	3917	4703	5751	5669	5267	4116	4399	3838	4563	4080	3794	3943
2024/25	4183	4672	4991	5010	4802	5232	4884	3726	3989	4093	5484	3433

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported was at an overall rate of 80% as shown in **Table 14**, compared to 86% in the last reporting year. (See Table 14.)

Table 14

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACCOUNTANT I	4	3	75%
ACTIVE TREATMENT PROGRAM AIDE	2	0	0%
ACTIVE TREATMENT PROGRAM ASSISTANT	14	12	86%
ACTIVE TREATMENT PROGRAM MANAGER	1	0	0%
ACTIVE TREATMENT PROGRAM SPECIALIST	3	3	100%
ACTIVE TREATMENT PROGRAM SUPERVISOR	2	2	100%
ACTIVITY SPECIALIST	3	3	100%
ADMINISTRATIVE NURSE	2	2	100%
ADMINISTRATIVE PROGRAMS OFFICER II	1	1	100%

ADMINISTRATIVE SPECIALIST	1	1	100%
ADMINISTRATIVE TECHNICIAN	3	3	100%
AUTOMOTIVE MECHANIC II	1	1	100%
BEHAVIOR SUPPORT SPECIALIST	2	2	100%
BOARD CERTIFIED BEHAVIOR ANALYST CLINICAL SUPERVISOR	1	1	100%
CHILD/FAMILY SERVICES SPECIALIST	3	3	100%
COMPLIANCE SPECIALIST	3	3	100%
CUSTODIAL / HOUSEKEEPING SUPERVISOR	1	0	0%
DD QDDP QUALITY CONTROL SUPERVISOR	1	1	100%
DEVELOPMENTAL DISABILITIES SAFETY & HABILITATION SPECIALIST	41	34	83%
DEVELOPMENTAL DISABILITIES SAFETY & HABILITATION SPECIALIST (TEMP)	4	4	100%
DEVELOPMENTAL DISABILITIES SAFETY AND HABILITATION SUPERVISOR	6	5	83%
DEVELOPMENTAL TECHNICIAN I	4	2	50%
DEVELOPMENTAL TECHNICIAN I (TEMP)	16	3	19%
DEVELOPMENTAL TECHNICIAN II	73	60	82%
DEVELOPMENTAL TECHNICIAN SHIFT SUPERVISOR	17	14	82%
DHHS PROGRAM COORDINATOR	1	1	100%
DHHS PROGRAM SPECIALIST	1	1	100%
DIETITIAN	2	2	100%
DIRECTOR OF NURSING	1	1	100%
FACILITY OPERATING OFFICER	1	0	0%
HR SPECIALIST MANAGER / HR BUSINESS PARTNER II	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
HR SPECIALIST/GENERALIST	2	2	100%
ICF/DD HOME MANAGER	5	3	60%
ICF/DD MANAGER	1	1	100%
INTERDISCIPLINARY TEAM LEADER/QDDP	11	8	73%
LICENSED PRACTICAL NURSE	22	18	82%
LICENSED PRACTICAL NURSE (TEMP)	1	0	0%
MAINTENANCE TECHNICIAN	9	9	100%
NURSE PRACTITIONER	2	1	50%
OCCUPATIONAL THERAPIST	1	1	100%
OFFICE SPECIALIST	4	4	100%
PHYSICAL THERAPIST II	2	1	50%
PHYSICAL THERAPY AIDE	3	3	100%
PHYSICAL THERAPY DIRECTOR	1	0	0%
PHYSICIAN	1	1	100%
PHYSICIAN ASSISTANT	1	1	100%

PROCUREMENT OFFICER	1	1	100%
PSYCHOLOGIST/PROV LICENSED	1	1	100%
RECREATION SPECIALIST	1	1	100%
REGISTERED NURSE	6	5	83%
REGISTERED NURSE (TEMP)	1	1	100%
RELIGIOUS COORDINATOR	1	1	100%
RESPIRATORY THERAPIST	1	1	100%
SAFETY COORDINATOR	1	1	100%
SECURITY COMMUNICATIONS SPECIALIST	1	1	100%
SUPPLY TECHNICIAN II	1	1	100%
TRAINING COORDINATOR	2	2	100%
TRANSPORTATION MANAGER	1	1	100%
VEHICLE OPERATOR I	1	1	100%
VEHICLE OPERATOR II	2	1	50%
Total	**305**	**243**	**80%**

Recent Licensure and Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding BSDC found are highlighted. The more significant concerns include the following:

DHHS Center for Medicare and Medicaid Services found:

- a failure by the facility to ensure the emergency preparedness plan included a current list of specific at-risk medical needs for 2 of 17 clients. The report noted that this had the potential to affect all clients living at the facility.
- that the facility failed to ensure staff demonstrated the skills necessary to provide dignity and respect to 1 of 6 sample clients.
- oxygen concentrators without warning signage, concerns with electrical adaptors, and concerns regarding items stored in front of panel boxes in the electrical room.
- that the facility failed to ensure prescription eyeglasses were available for 1 client as specified in the client's Individual Support Plan and associated records.
- that the facility failed to develop and implement a system identifying how the facility would ensure and provide education to clients regarding the benefits, risks, and potential side effects related to the Covid-19 vaccine.
- that the facility allowed storage to obstruct access to the electrical disconnects boxes. The Center stated that this deficient practice could cause a delay and injury when turning off the power during an electrical issue emergency.
- that the facility had failed to assure exit doors opened when the handle was engaged. The center further stated that this deficient practice would cause confusion and delay egress during an emergency.

- that the facility had failed to assure hazard area doors would latch within the doorframe. The Center stated that this deficient practice would allow fire, smoke, and gasses to spread.
- that the facility had failed to provide a self-closing device on areas of storage. The Center stated that this deficient practice increases the potential for fire, smoke, and gasses to spread.
- that the facility had failed to maintain a door within a vertical opening and allowed storage on the stairs. The Center stated that this deficient practice would allow smoke and gasses to move into the stair tower which would delay egress or render the stair enclosure useless during a fire emergency.
- that the facility had failed to provide self-closing devices and ensure undercut to the doors to hazardous areas were less than ¾ inches. The Center stated that this deficient practice would allow smoke to migrate into the exit corridors.
- that the facility had failed to install ceiling coverings that met interior finish rating requirements. The Center stated that this deficient practice would accelerate the spread of fire, smoke, and gasses.
- that the facility had failed to maintain means of egress free of obstruction and failed to assure that snow and ice was removed from the sidewalks. The Center stated that this deficient practice would delay egress and not impede it to full use in the case of fire or other emergency.
- that the facility had failed to maintain emergency lighting. The Center stated that this deficient practice would delay egress and cause confusion.
- that the facility had failed to prohibit the use of electrical power strips as a substitute for adequate wiring. The Center stated that this deficient practice would create electrical injury and increase risk of fire hazard.
- that the facility had failed to provide smoke resistant enclosures for hazardous areas to separate them from the rest of the facility. The Center stated that this deficient practice would allow fire and smoke to migrate out of the hazardous areas, which could delay egress.
- that the facility had failed to assure all fire alarm reports were provided and failed to assure junction boxes were covered. The Center stated that this deficient practice would increase the potential for the fire alarm system not to activate as designed.
- that the facility had failed to provide all sprinkler inspection reports. The Center stated that this deficient practice would not assure that the sprinkler system would operate as designed.
- that the facility had failed to assure portable fire extinguishers were not obstructed. The Center stated that this deficient practice would delay access to the extinguisher during a fire.
- that the facility had failed to prohibit the use of combustible decorations in a concentrated area. The Center stated that this deficient practice would allow fire, gasses, and smoke to spread within the exit corridor, which would affect exiting during an emergency.
- that the facility had failed to assure that the fire rated hatch between sprinkled and non-sprinkled areas was operational. The Center stated that this deficient practice would not assure that the sprinkler system would operate as designed.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate. The BSDC Certification of Licensure is active at the time of this report.[8]

OFFICE OF JUVENILE SERVICES AND JUVENILE BEHAVIORAL HEALTH FACILITIES

The Office of Juvenile Services within the DHHS Division of Children and Families operates the YRTCs, which are 24-hour state institutions to serve youth within Nebraska's juvenile justice system. There are currently YRTCs in Hastings, Lincoln, and Kearney; there is no longer a YRTC in Geneva. The mission of the YRTCs "is to help youth live better lives through effective services, giving youth the chance to become law abiding citizens."

YRTC-KEARNEY

YRTC-Kearney serves male youth committed to DHHS Office of Juvenile Services. Youth receive evidence-based behavioral and skill-building programming and individual therapy for mental health, behavioral health, and substance use needs. YRTC-Kearney also operates an on-campus junior/senior high school where youth may earn their high school diploma.
YRTC-Kearney sits on a large, fenced-in campus with a number of buildings. These buildings include an administration building, Dickson Behavioral Stabilization Unit (which houses newly-admitted youth, youth in seclusion/room confinement, and the transitional living unit), the Bryant, Lincoln, and Washington cottages (living units), the Creighton cottage (which includes the medical office), a woodworking building, a dining hall, a chapel, and a school building that includes a gym, weight room, and pool. Each cottage has a similar interior layout with a game/recreation area, bathroom/showers, and a TV/multi-purpose room on the first floor and barrack-style living quarters and a congregate restroom on the second floor.

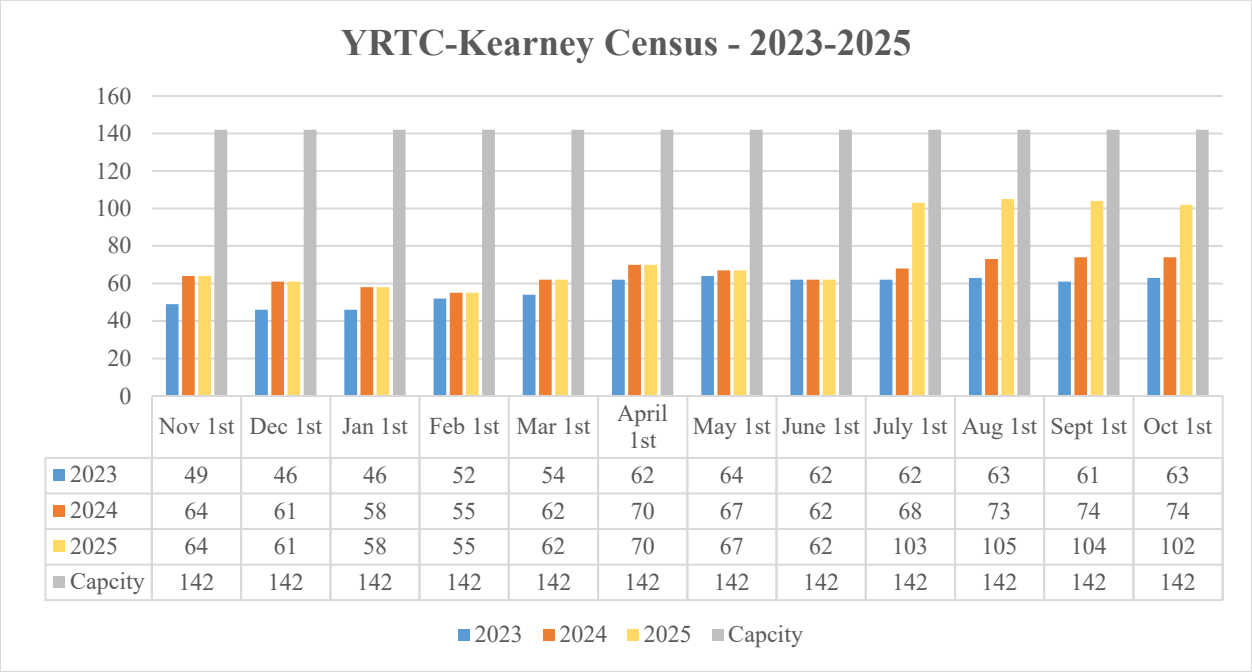
YRTC-Kearney is accredited with the ACA and PREA. It is no longer a member of the Council for Juvenile Correctional Administrators' PbS Project as of 2024. The PbS Project is a model which utilizes national standards and performance outcome measures to improve conditions of confinement and treatment in residential facilities.

Capacity and Census

The licensed capacity total for YRTC-Kearney is 142. For the current reporting period, the average monthly census was 76, as compared to 57 in 2022/23 and 66 in 2023/24. **Chart 20** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1 through October 31 of each respective year. (See Chart 20.)

[8] Licensure information was found at this website link: https://www.nebraska.gov/LISSearch/search.cgi

Chart 20



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	49	46	46	52	54	62	64	62	62	63	61	63
2024	64	61	58	55	62	70	67	62	68	73	74	74
2025	64	61	58	55	62	70	67	62	103	105	104	102
Capcity	142	142	142	142	142	142	142	142	142	142	142	142

Complaints to OPC regarding YRTC-Kearney

For the period of December 1, 2024 through November 30, 2025, the OPC received 10 complaints regarding YRTC-Kearney. While there was not supporting evidence in support of findings in all complaints, those received involved concerns with the food, facility cleanliness, the presence of bugs in the units, communication between staff and parents, concerns with the communal showers and bathrooms, inappropriate staff boundaries, and sexual abuse.

The OPC received complaints and other information regarding allegations of inappropriate staff relations with youth committed to the YRTC-Kearney. The OPC is continuing its investigation of sexual abuse in collaboration with the Inspector General of Nebraska Child Welfare. At this time, at least one YRTC-Kearney former staffer has been criminally charged in the matter.

Facility Inspection

Construction of the new living unit is projected to be complete in the spring of 2026. This construction project will allow youth housed within the new structure to have private sleeping rooms and bathroom facilities, as opposed to barrack style sleeping quarters and communal showers. This will be a very positive addition for the well-being of the youth served.

However, if the original units remain in use for any youth not served in the new living space, the existing buildings need updates as well, particularly in the bathrooms, sleeping areas, and common areas within the units. Based on the current census and not adding beds for male youth

elsewhere, utilization of the older buildings will be necessary to accommodate the male youth committed to OJS.

Facility staff have made visible efforts to try to make the existing buildings more youth-friendly with updated paint colors and newer furniture, particularly in the sleeping areas and classrooms.

Youth at the YRTC-Kearney seem to have more opportunity for community involvement as compared to most of the other facilities. Some examples are community service events, UNK homecoming parade, attendance at a law enforcement appreciation dinner, on-site picnics with law enforcement, and attending the annual Nebraska Juvenile Justice Conference.

YRTC-Kearney reported a decrease in the number of youths who escaped the facility, with only 2 recorded this year which occurred while the youth were on furlough to their home. The facility recorded 12 escapes in 2021, 6 in 2022, 11 in 2023, and 4 in 2024.

The YRTC-Kearney reported that 10 youth graduated high school while committed to the YRTC this year.

Table 15 provides any highlights observed by OPC staff during the facility inspection. (See Table 15.)

Table 15

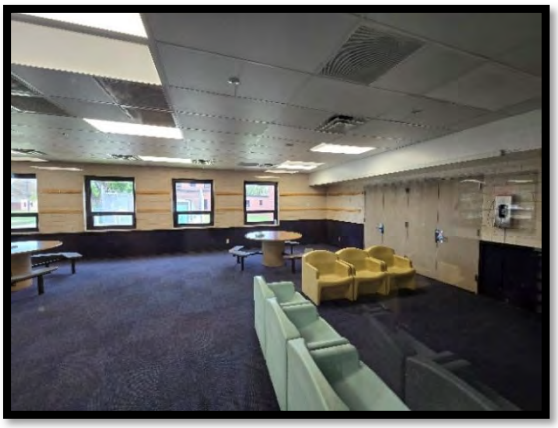
Facility Description	General Observations
Grounds	Campus is large, with expansive yard space for recreation and equipped with a baseball/kickball field. The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Administration Building	No major destruction or structural issues identified. Staff offices seem to be sufficient size and condition for their purpose.
Bryant Living Unit	No major destruction or structural issues identified. The wall décor is much more youth friendly than in previous years.
Creighton Living Unit	Canteen area is small and a bit cramped but nice. The sleeping unit is a barrack style room design that offers little or no privacy for youth.

Lincoln Living Unit	Dayroom is outdated and carpets were in need of updating or cleaning. Bathrooms are outdated and very worn.
Washington Living Unit	Showers are communal style, which youth often report feeling uncomfortable with. Tiles are very old and stained by water and mildew. Mattresses are thin and vinyl covered.
Dickson Behavioral Stabilization Unit	No major destruction or structural issues identified. Newer blue painted walls. This unit has long hallways and large metal locking doors. The newly painted blue area is softer to the eye than the previous color, but overall, the environment is of a detention setting and feels unsuitable for youth for extended lengths of time.
Dining Hall	No major destruction or structural issues identified. Appeared clean and in good condition.
Chapel	No major destruction or structural issues identified. Inviting setting.
Gym	No major destruction or structural issues identified. Gym is spacious and well equipped for recreation. The swimming pool is large and appears to be in good condition. The weight room is also well equipped and in good condition.
Classrooms	No major destruction or structural issues identified. Layout feels like a typical school and offers an excellent media center. Most classrooms look somewhat aged and outdated with mismatched furniture and flooring types and were in need of new whiteboards. The space does not offer much natural light.
New Construction Building	No major destruction or structural issues identified. This area is currently securely fenced off from youth access during construction with smaller than normal fence links to make it more secure and harder to enter. New building will have badge entry, more natural light, individual rooms, and private showers.

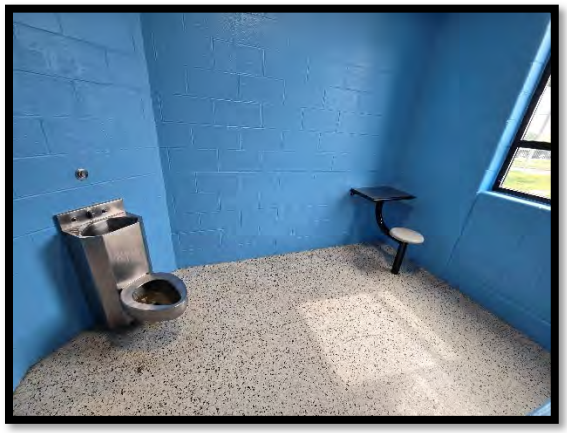
Laundry Warehouse	No major destruction or structural issues identified. Laundry room is well organized.
Vocational Building	No major destruction or structural issues identified. This building is well equipped with tools for wood working and art supplies, offering extensive learning and programming opportunities.

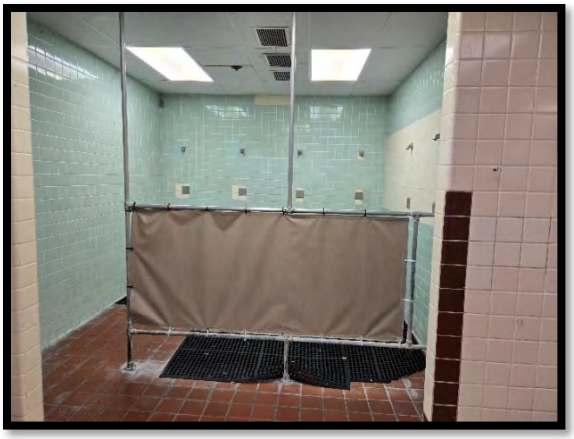
West Kearney High School

CHANGE
WORLD



CITIZENSHIP





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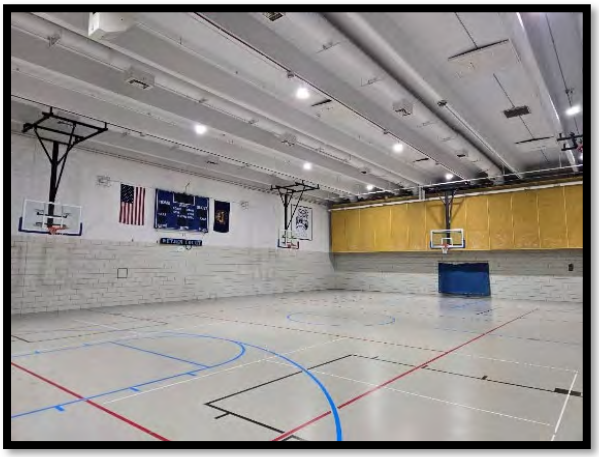
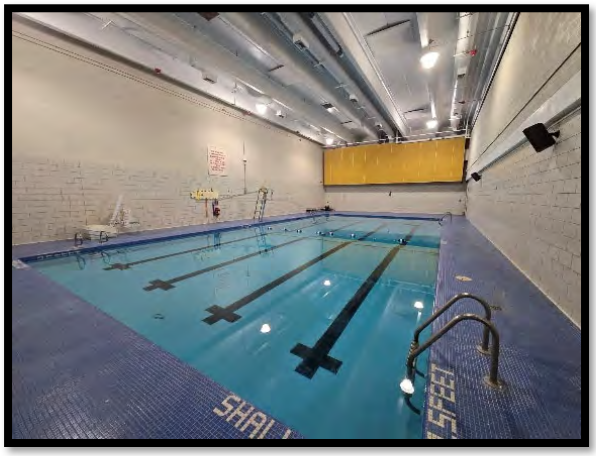




Major Projects/Improvements

In Progress Projects	Projected Completion Date
Construction of new living unit has begun. • The unit will have 48 beds (12x4 pods). • All case managers, unit managers, and therapists will be in offices within the building. • The vision is for rooms to feel like apartments.	Feb 2026
Pending	**Projected Completion Date**
None known	
Completed Projects During the Current Reporting Year	
Morton Living unit demolished in December of 2024. Under-ground sprinklers installed on the site of Morton Living unit – April 2025. Bryant and Creighton Living Units received new roofs. New fire sprinkler system throughout campus.	

YRTC-Kearney Staffing

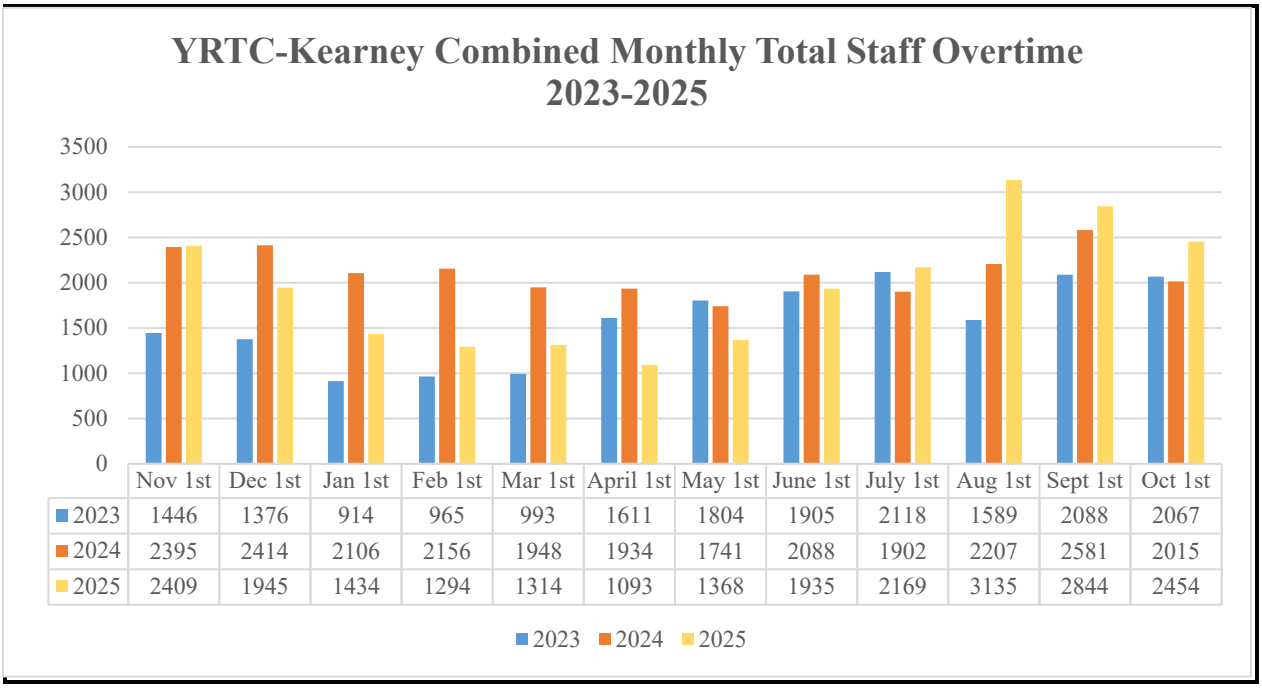
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See Table 16.)

Table 16

YRTC-Kearney Staffing – Permanent and Temporary Staff on October 31st of Each Respective Year						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions in HR Staffing Plan for FY23	255 for **FY21**	258 for **FY22**	260 for **FY23**	257 for **FY24**	219 for **FY25**	226 for **FY25**
Number of Positions Filled	153	133	156	138 Perm 3 Temp	151 Perm 1 Temp	181 Perm 1 Temp
Number of Positions Vacant	102	125	104	106	67	44
Monthly Turnover Rate	N/A	3%	1.6%	3.8%	3.9%	2.6%
Aggregate Turnover Rate	32%	35%	18%	46%	46%	31%

Chart 21 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 21.)

Chart 21



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	1446	1376	914	965	993	1611	1804	1905	2118	1589	2088	2067
2024	2395	2414	2106	2156	1948	1934	1741	2088	1902	2207	2581	2015
2025	2409	1945	1434	1294	1314	1093	1368	1935	2169	3135	2844	2454

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported was at an overall rate of 81%, as shown in the **Table 17**, as opposed to 69% in the past reporting year. (See Table 17.)

Table 17

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACCOUNTANT I	2	2	100%
ADMINISTRATIVE NURSE	1	1	100%
ADMINISTRATIVE PROGRAMS OFFICER I	1	1	100%
ADMINISTRATIVE PROGRAMS OFFICER II	1	1	100%
ADMINISTRATIVE SPECIALIST	1	1	100%
ADMINISTRATIVE TECHNICIAN	1	1	100%
ASSISTANT DIRECTOR OF NURSING	1	0	0%
ATTORNEY III	1	1	100%

BEHAVIORAL HEALTH PRACTITIONER I	2	2	100%
BEHAVIORAL HEALTH PRACTITIONER II	1	0	0%
BEHAVIORAL HEALTH PRACTITIONER IV	5	4	80%
BEHAVIORAL HEALTH PRACTITIONER SUPERVISOR II	1	0	0%
CLINICAL PROGRAM MANAGER	1	1	100%
COMPLIANCE SPECIALIST	2	1	50%
CORR CANTEEN OPERATOR	1	1	100%
DHHS FACILITY ADMINISTRATOR	1	1	100%
DHHS PROGRAM MANAGER I	1	1	100%
DHHS PROGRAM MANAGER II	1	0	0%
FOOD SERVICE DIRECTOR I	1	1	100%
FOOD SERVICE MANAGER	1	0	0%
FOOD SERVICE WORKER	8	6	75%
HR SPECIALIST MANAGER / HR BUSINESS PARTNER II	1	1	100%
JUVENILE SERVICES ADMINISTRATOR	1	1	100%
LAUNDRY WORKER	1	1	100%
LICENSED PRACTICAL NURSE	1	0	0%
MAINTENANCE TECHNICIAN	2	2	100%
OFFICE SPECIALIST	1	1	100%
OFFICE SPECIALIST	1	1	100%
OFFICE TECHNICIAN	3	2	67%
PRINCIPAL	1	1	100%
PROCUREMENT SPECIALIST	1	1	100%
PSYCHOLOGIST/LICENSED	1	0	0%
RECREATION ASSISTANT	4	2	50%
RECREATION MANAGER	1	1	100%
REGISTERED NURSE	3	3	100%
RELIGIOUS COORDINATOR	1	1	100%
SCHOOL SUPERINTENDENT	1	1	100%
SUPPLY TECHNICIAN II	1	1	100%
TEACHER (SCATA CONTRACT)	21	19	90%
TEACHER/SUBSTITUTE (TEMP)	1	1	100%
TEACHER/TEMPORARY (TEMP)	1	0	0%
TRAINING COORDINATOR	1	1	100%
YOUTH COUNSELOR	14	9	64%
YOUTH COUNSELOR SUPERVISOR	8	6	75%
YOUTH SECURITY SPECIALIST II	102	83	81%
YOUTH SECURITY SPECIALIST II (TEMP)	1	0	0%
YOUTH SECURITY SUPERVISOR	17	17	100%
Total	**226**	**182**	**81%**

Recent Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding YRTC-Kearney found are highlighted. The more significant concerns found include the following:

- The Nebraska Department of Environment and Energy found that hands had not been cleaned and properly washed, and proper cooling time and temperatures had not been utilized in the campus cafeteria.
- The Nebraska Department of Environment and Energy found that many floors were in need of a thorough cleaning.
- The PREA audit identified 31 incidents of "inmate-on-inmate" sexual abuse allegations, and four incidents of "staff-on-inmate" sexual harassment allegations.
- The PREA audit identified 25 incidents of "inmate-on-inmate" sexual harassment allegations, and four incidents of "staff-on-inmate" sexual harassment allegations.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate.

YRTC-HASTINGS

YRTC-Hastings serves female youth by providing evidence-based cognitive behavioral and skill-building programing, as well as individual therapy for mental health, behavioral health, and substance use needs. YRTC-Hastings includes educational programming as part of a youth's treatment plan and an on-campus junior/senior high school.

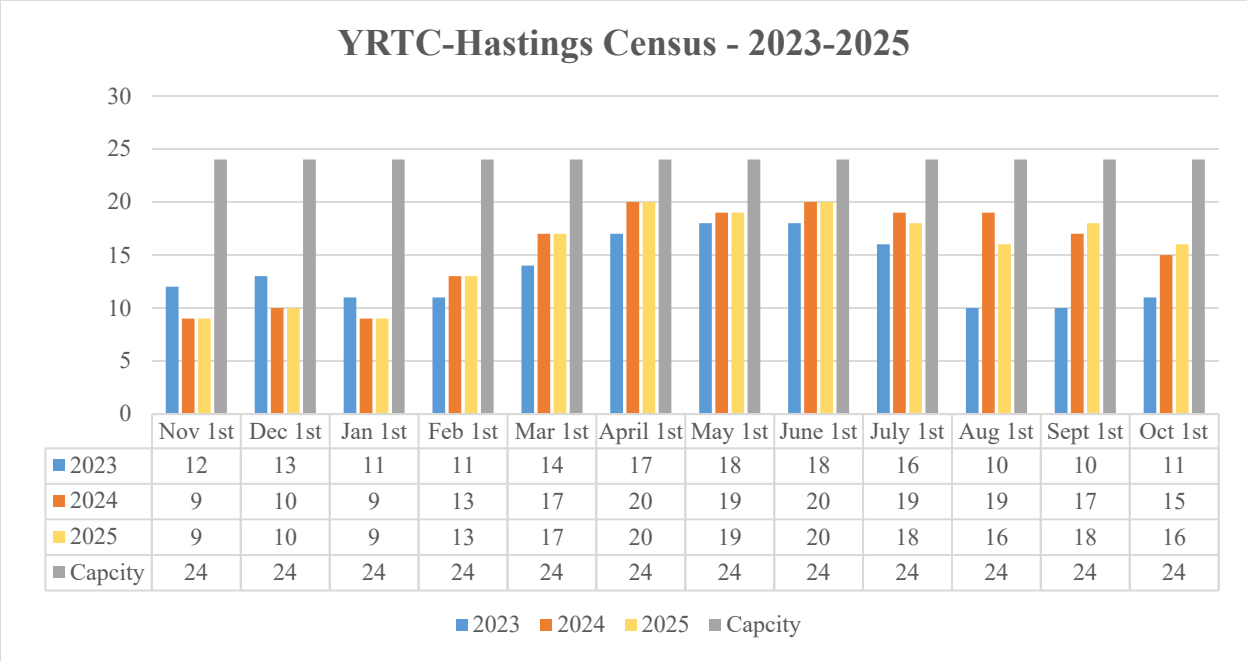
YRTC-Hastings sits on a large, open campus comprised of a number of buildings, including an administration building, a chapel used as a gym/recreation area, a school building that includes a kitchen and dining area, and two living units/cottages. Youth are not allowed to have any contact with the youth living in a unit other than the one in which they live.

YRTC-Hastings is accredited with the ACA and PREA. It is no longer a member of the Council for Juvenile Correctional Administrators' PbS Project as of 2024. The PbS Project a model which utilizes national standards and performance outcome measures to improve conditions of confinement and treatment in residential facilities.

Capacity and Census

The licensed capacity total for YRTC-Hastings is 24. For the current reporting period, the average monthly census was 15, as compared to 13 in 2022/23 and 16 in 2023/24. **Chart 22** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1, until October 31 of each respective year. (See Chart 22.)

Chart 22



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	12	13	11	11	14	17	18	18	16	10	10	11
2024	9	10	9	13	17	20	19	20	19	19	17	15
2025	9	10	9	13	17	20	19	20	18	16	18	16
Capcity	24	24	24	24	24	24	24	24	24	24	24	24

Complaints to OPC regarding YRTC-Hastings

For the period of December 1, 2024 through November 30, 2025, the OPC received 3 complaints regarding YRTC-Hastings. While there was not evidence to support findings in all complaints, those received involved concerns with the food, unfair treatment by staff and concerns regarding some staff members, medial responsiveness, and lack of programming.

Facility Inspection

This campus is new, in very good overall condition, and seems to be conducive for programming and educational needs. It does lack recreation facilities for the female youth, particularly when compared to YRTC-Kearney that serves boys. YRTC-Hastings does have a space utilized for recreation; however, it is the space originally intended as a chapel.

Currently, the YRTC-Hastings campus has two living units, and while the youth have individual sleeping quarters as compared to the YRTC-Kearney, it lacks common living spaces large enough to adequately accommodate the number of youths on each unit for extended periods of time. The additional unit in progress of being built will allow for the youth to have more space and potentially cut down on conflicts between the youth.

YRTC-Hastings staff reported staff to youth ratios have been maintained during periods of increased census and that staff assaults decreased in the past year by 43%. The facility staff also reported a reduction in confinement hours of 22%, while maintaining no youth elopements.

Additionally, it was reported that of the staff assaults, only 1 injury resulted in a leave of absence.

YRTC-Hastings reports one youth earned their GED, three graduated with diplomas, and two earned their Certified Nursing Assistant (CNA) certificate. Youth also planted, maintained, and harvested a garden this year, and were able to provide food to the Food Service Department, as well as donated several pounds of vegetables and fruit to local food banks/shelters.

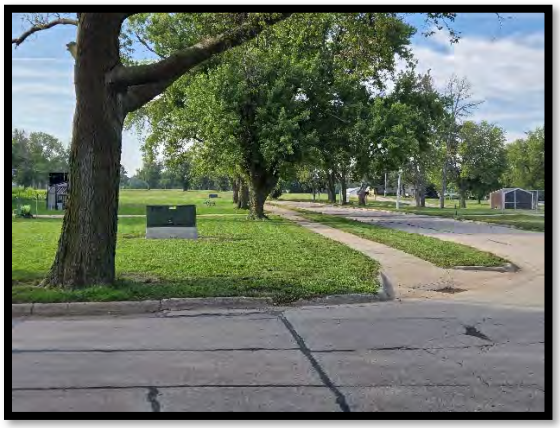
In September 2025, youth participated in the 3rd annual Cookie/Lemonade Drive through for Law Enforcement Appreciation. Youth were able to interact positively with local law enforcement officers and provide them with a cookie and a drink. Youth participated in our annual "Grinchmas" Fest in Dec 2024, Summer Fun Day July 2025, and Harvest Fest October of 2025. Those days are filled with games, activities, special meals, competitions, and either outdoor water inflatables or indoor movies.

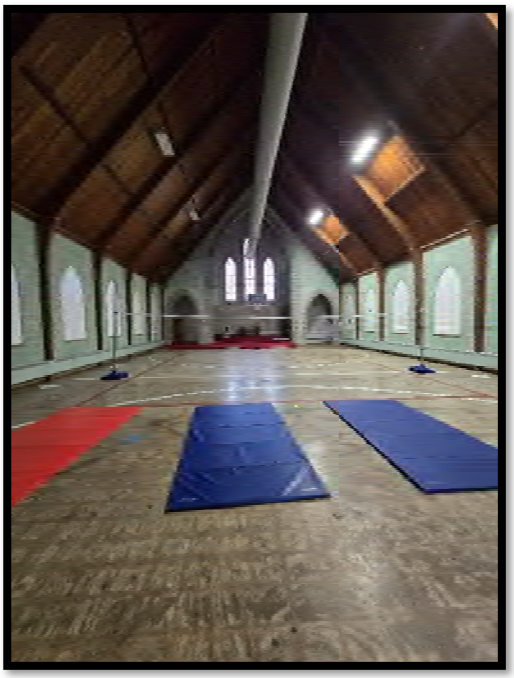
Table 18 provides any highlights observed by OPC staff during the facility inspection.

Table 18

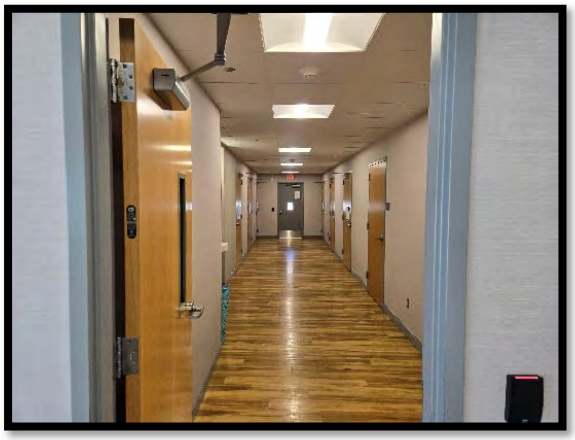
Facility Description	General Observations
Grounds	No major destruction or structural issues identified. Campus is large, with expansive yard space and trees. A small solar powered greenhouse has been added for the youth to enjoy gardening. The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Administration Building	No major destruction or structural issues identified. The reception area is attractive with updated furniture. Staff offices seem to be of sufficient size and condition for their purpose.
Unit A	No major destruction or structural issues identified. These buildings are new in the past 5 years; therefore, the units have a fresh design and newer furniture, the flooring is all in good condition, and overall, they appear very clean.
Unit B	Much of the trim around the windows and door casings has been replaced with trim that is less destructible due prior damage by the youth. Due to the layout of the buildings and being placed parallel to one another, the facility reports concerns with youth antagonizing each other through the

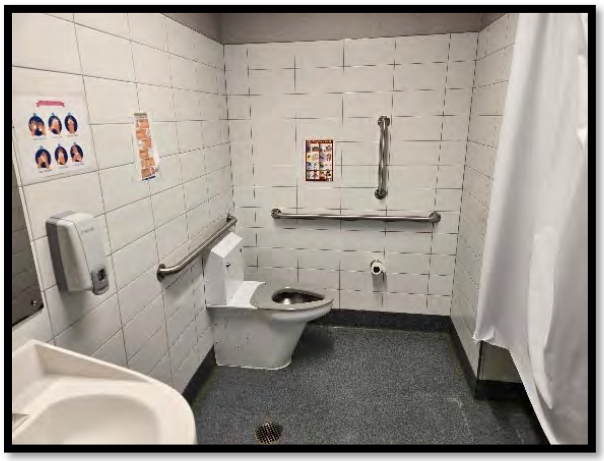
	windows. Therefore, the primary windows and doors have been frosted to eliminate this behavior, reducing the amount of natural sunlight onto the units.
School and Cafeteria	No major destruction or structural issues identified. The classrooms have sufficient space, fresh design, newer furniture, and flooring is all in good condition. Overall, they appear very clean. The cafeteria and kitchen are in new condition and well kept.
Chapel	The chapel has been transformed into a gym area. The space works for this use but is not ideal. It would be beneficial for the youth to have more recreation and programming areas like at YRTC-Kearney.





RISING ABOVE





Major Projects/Improvements

In Progress Projects	**Projected Completion Date**
None reported	
Pending	**Projected Completion Date**
Plans to break ground on a new living unit	Start-November 2025
Completed Projects During the Current Reporting Year	
Tar has been applied to some of the streets on campus to smooth them out.	

YRTC-Hastings Staffing

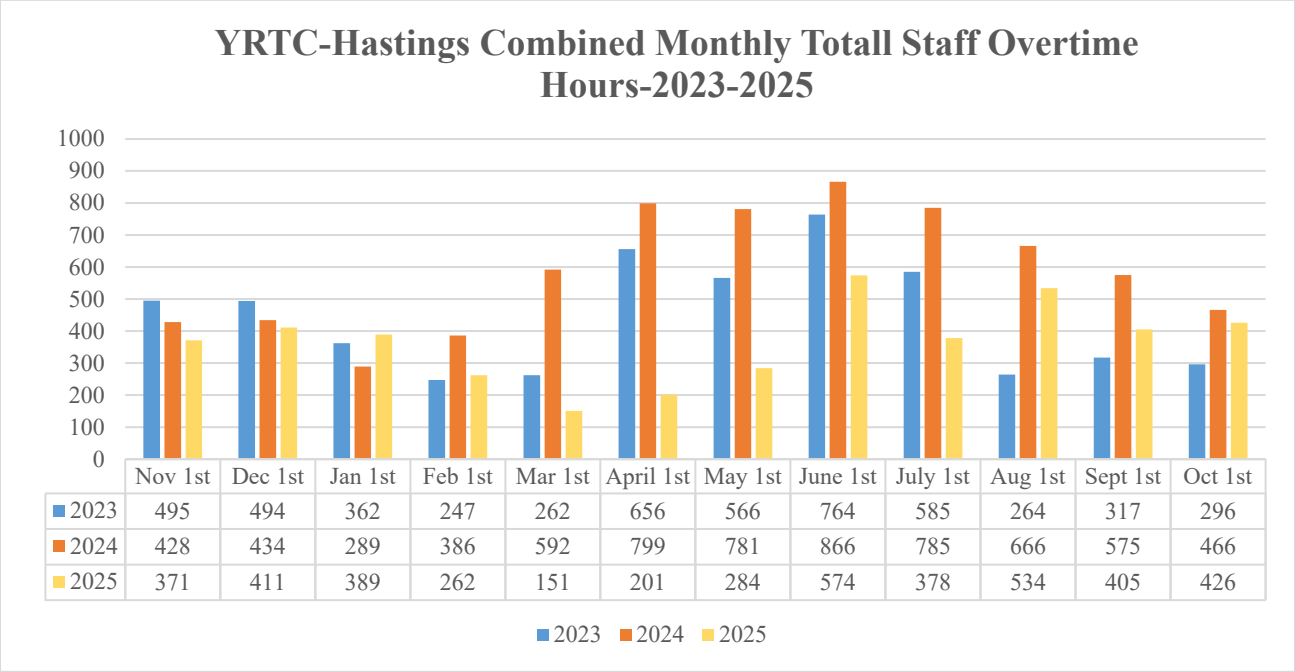
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See **Table 19**.)

Table 19

YRTC-Hastings Staffing – Permanent and Temporary Staff on October 31st of Each Respective Year						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions Needed in HR Staffing Plan for FY23	83 for **FY21**	116 for **FY22**	118 for **FY23**	112 for **FY24**	100 for **FY25**	104 for **FY25**
Number of Positions Filled	64	72	81	80 Perm 0 Temp	73	82 Perm 1 Temp
Number of Positions Vacant	19	39	37	32	27	21
Monthly Turnover Rate	N/A	3%	2.2%	4.2%	3.5%	3.0%
Aggregate Turnover Rate	23%	38%	24.4%	50%	42%	37%

Chart 23 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 23.)

Chart 23



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	495	494	362	247	262	656	566	764	585	264	317	296
2024	428	434	289	386	592	799	781	866	785	666	575	466
2025	371	411	389	262	151	201	284	574	378	534	405	426

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported was at an overall rate of 80%, as of October 31, 2025, as shown in the **Table 20**, compare to the 73% filled in the last reporting year.

Table 20

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACTIVITY SPECIALIST	**1**	1	100%
ADMINISTRATIVE NURSE	**1**	1	100%
ADMINISTRATIVE SPECIALIST	**1**	1	100%
ADMINISTRATIVE TECHNICIAN	**1**	1	100%
BARBER/BEAUTICIAN	**1**	1	100%
BEHAVIORAL HEALTH PRACTITIONER I	**1**	1	100%
BEHAVIORAL HEALTH PRACTITIONER II	**3**	1	33%
BEHAVIORAL HEALTH PRACTITIONER IV	**1**	1	100%
COMPLIANCE SPECIALIST	**1**	1	100%

DHHS FACILITY ADMINISTRATOR	**1**	1	100%
FACILITY OPERATING OFFICER	**1**	1	100%
FOOD SERVICE MANAGER	**1**	1	100%
FOOD SERVICE WORKER	**5**	4	80%
HR SPECIALIST MANAGER / HR BUSINESS PARTNER II	**1**	1	100%
HR SPECIALIST/GENERALIST	**1**	1	100%
MAINTENANCE TECHNICIAN	**2**	2	100%
NURSE PRACTITIONER	**2**	1	50%
OFFICE SPECIALIST	**2**	2	100%
OFFICE TECHNICIAN	**1**	1	100%
PROCUREMENT SPECIALIST	**1**	1	100%
PROCUREMENT SPECIALIST	**1**	1	100%
PSYCHOLOGIST/LICENSED	**1**	1	100%
RECREATION MANAGER	**1**	0	0%
RECREATION SPECIALIST	**2**	1	50%
REGISTERED NURSE	**1**	1	100%
RELIGIOUS COORDINATOR	**1**	1	100%
TEACHER (SCATA CONTRACT)	**11**	5	45%
TRAINING COORDINATOR	**1**	1	100%
YOUTH COUNSELOR	**2**	2	100%
YOUTH COUNSELOR SUPERVISOR	**3**	2	67%
YOUTH SECURITY SPECIALIST II	**37**	30	81%
YOUTH SECURITY SPECIALIST II (TEMP)	**1**	1	100%
YOUTH SECURITY SUPERVISOR	**13**	12	92%
Total	**104**	83	80%

Recent Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding YRTC-Hastings found are highlighted. The more significant concerns found include the following:

- The Nebraska State Fire Marshall noted that the "owner was to verify all heads in units are not painted, damaged, or obstructed in any way."
- The Commission on Accreditation for Corrections found that youth must knock on the bedroom door and request staff to open the bedroom door to access the toilet.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate.

YRTC- LINCOLN

YRTC-Lincoln serves high-acuity male and female youth who require more intensive and individualized interventions, such as targeted behavioral and trauma-based programming. Established in 2020, it is a newer facility. Youth enter the YRTC system through either YRTC-Hastings or YRTC-Kearney. YRTC-Lincoln provides a different, more secure physical structure than YRTC-Hastings or YRTC-Kearney.

At YRTC-Lincoln's start in 2020, DHHS entered into a 5-year contract with Lancaster County to lease space within the Lancaster County Youth Services Center (LCYSC). LCYSC provides for detention of youth being processed through the juvenile justice system or youth adjudicated or ordered by an adult criminal court to serve a specified time frame. Food and maintenance are also sourced through LCYSC. However, the youth populations of each facility do not mix.

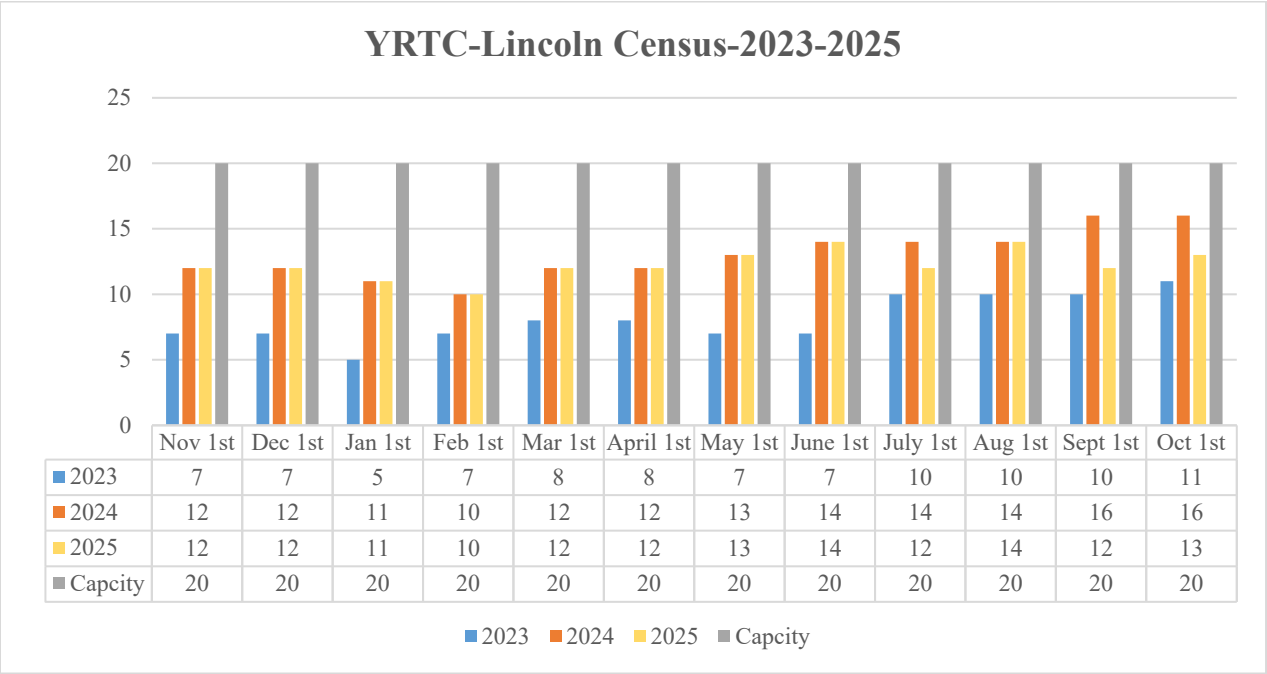
YRTC-Lincoln consists of one main building on a closed campus with a fence. This building is comprised of a secure living area for male youth, a secure living area for female youth, a day room, a school room, a library, a medical room, a group/kitchen room, a gym, a visitation room, and an outside fenced in, grassy area.

YRTC-Lincoln is accredited with the ACA and PREA.

Capacity and Census

The licensed capacity total for YRTC-Lincoln is 20. For the current reporting period, the average monthly census was 12, compared to 8 in 2022/23 and 13 in 2023/24. **Chart 24** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1 until October 31 of each respective year. (See Chart 24.)

Chart 24



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	7	7	5	7	8	8	7	7	10	10	10	11
2024	12	12	11	10	12	12	13	14	14	14	16	16
2025	12	12	11	10	12	12	13	14	12	14	12	13
Capcity	20	20	20	20	20	20	20	20	20	20	20	20

Complaints to OPC regarding YRTC-Lincoln

For the period of December 1, 2024 through November 30, 2025, the OPC received 14 complaints regarding YRTC-Lincoln. While there was not sufficient evidence to support findings in all complaints, the complaints received were in regard to child safety and the manner in which physical restraints were utilized, the amount of time youth spent in seclusion, unfair consequences, and the food quality.

Facility Inspection

The YRTC-Lincoln facility is housed in a leased space owned by Lancaster County and shared with the Lancaster County Youth Services Center. The facility is generally well kept and maintained. As mentioned in previous reports, it is worth considering the long-term goals of YRTC-Lincoln and whether the detention setting best serves the youth who reside there for a longer period of time. Detention-style space is built for very short and emergent stays.

YRTC-Lincoln reports that work-related injuries increased over the past year, but noted periods of increased census. YRTC-Lincoln also reported that none of the work-related injuries resulted in hospital admissions.

YRTC-Lincoln is currently piloting a collaborative transition program with the Administrative Office of the Courts and Probation-Juvenile Services Division. The program and partnerships with external service providers has been established to support the transition of youth as they return to the community through evaluation, therapy, family support, and outings.

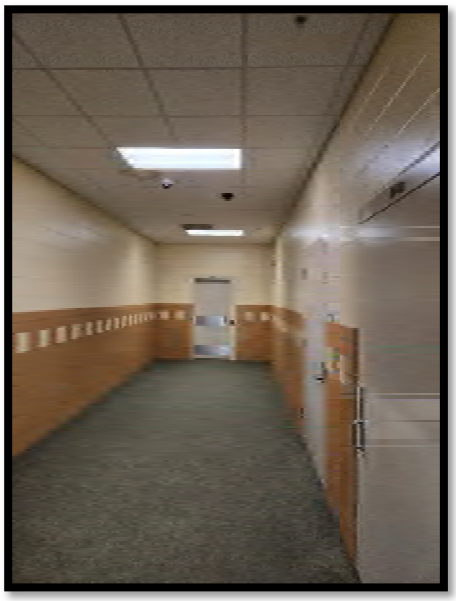
Youth who are in the transition stage of their commitment will have the opportunity beginning this year to go off campus for a variety of activities, including meals, shopping, sports, museums, and campus tours. The YRTC-Lincoln campus is also helping youth to obtain an identification card prior to leaving the facility.

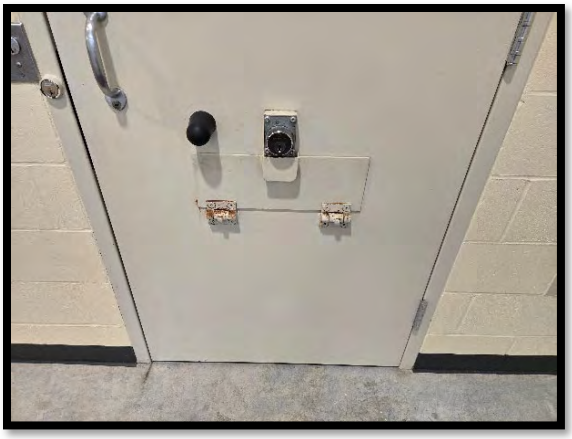
Table 21 provides any highlights observed by OPC staff during the facility inspection. (See Table 21.)

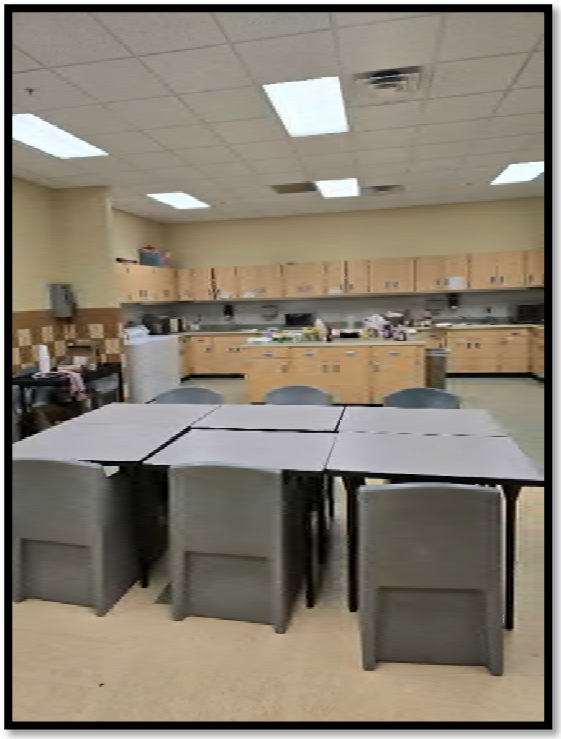
Table 21

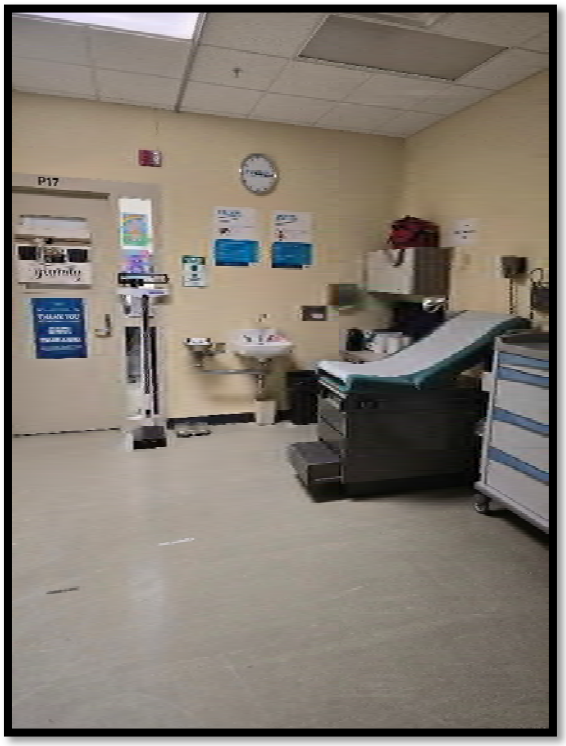
Facility Description	General Observations
Grounds	The facility is well-kept on the exterior, although OPC staff observed the back area designed for an outdoor space to be overgrown in the summer, making it difficult, if not impossible, for the youth to use. YRTC-Lincoln is a leased space shared with LCYSC. It is constructed as a traditional detention facility with locking doors at unit entrance and in the individual sleeping areas, limiting movement of the individuals served, as well as fenced yards outdoors.
Administration Office	No major destruction or structural issues identified. This is a shared space with the LCYSC Administrative Staff. The reception area is attractive with updated furniture. Staff offices seem to be of sufficient size and condition for their purpose.
Echo Pod	No major destruction or structural issues identified. The two pods one with 11 private cells, and the other with 9 private cells lining the exterior walls. One pod houses the female youth, and the other houses the male youth. The pods are joined by one common area. Mice have been found in the building on occasion.
Foxtrot Pod	The mattresses and pillows were selected to reduce potential hazards from self-harming behavior, the sleeping areas are constructed of a hard cement surface, and the mattresses do not extend to the full length of the slab. A larger youth may not fit well on the space provided.
J Pod	No major destruction or structural issues identified. This space is used for additional classroom and programming space. The exterior fence was recently expanded to include an exterior window in the space, which allows the YRTC to utilize this space again following a prior escape.

Gym	No major destruction or structural issues identified. The gym space is spacious and in good condition. This is a shared space with the LCYSC, although YRTC youth do not utilize the gym while LCYSC youth are present.
Classrooms	No major destruction or structural issues identified. Overall, classroom space is somewhat limited due to the space being shared with the LCYSC. This is a shared space with the LCYSC, although youth committed to the YRTC do not utilize while LCYSC youth are present.





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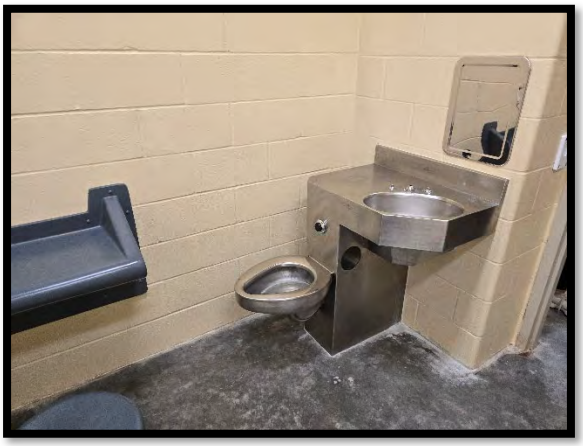


Major Projects/Improvements

In Progress Projects	Projected Completion Date
None known	
Pending	**Projected Completion Date**
None known	
Completed Projects During the Current Reporting Year	
Fence moved to include the windows north facing, located in JPod for increased security. Routine, preventative, and repair work is completed by Property Management. State contracts used for additional/specialized work (carpet cleaning, ceiling repair, cameras, etc.) Repair the JPod Unit to utilize for programming.	

YRTC-Lincoln Staffing

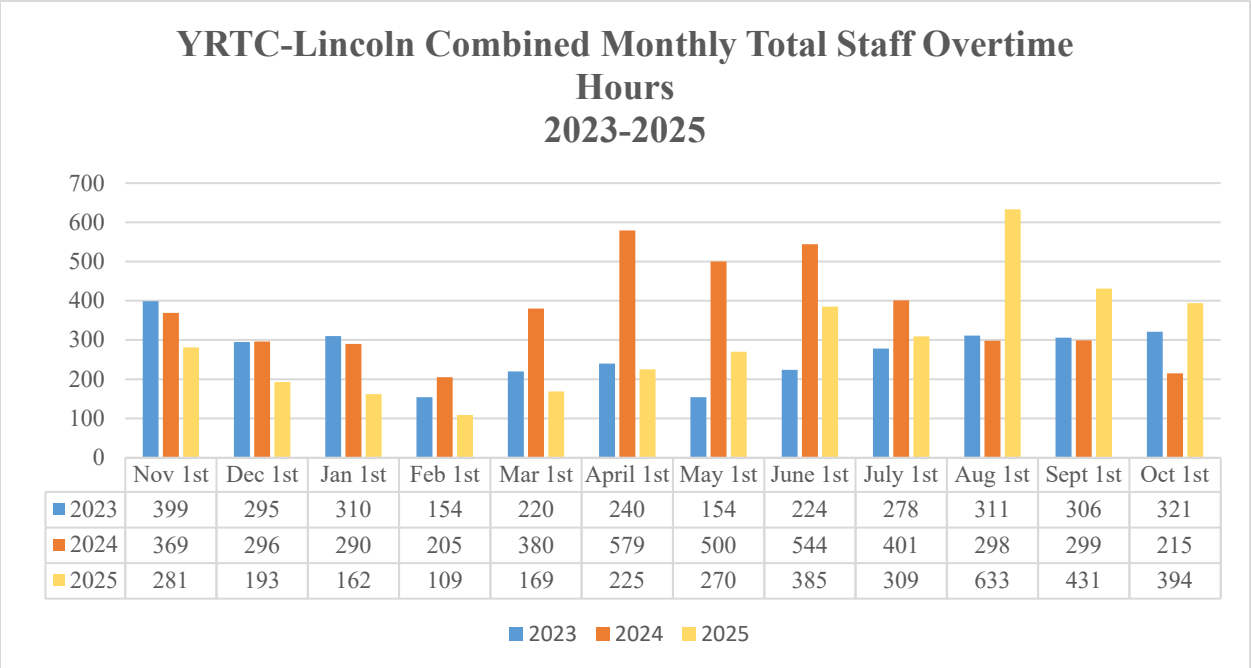
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See Table 22.)

Table 22

YRTC-Lincoln Staffing – Permanent and Temporary Staff						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions Needed in HR Staffing Plan for FY23	53 for **FY21**	56 for **FY22**	100 for **FY23**	101 for **FY24**	80 for **FY25**	**78** for **FY26**
Number of Positions Filled	47	50	52	53	63 Perm 1 Temp	53 Perm
Number of Positions Vacant	6	8	48	48	16	25
Monthly Turnover Rate	N/A	4%	2.8%	3.7%	3.6%	4.4%
Aggregate Turnover Rate	N/A	42%	31%	44%	43%	52%

Chart 25 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2024. (See Chart 25.)

Chart 25



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	399	295	310	154	220	240	154	224	278	311	306	321
2024	369	296	290	205	380	579	500	544	401	298	299	215
2025	281	193	162	109	169	225	270	385	309	633	431	394

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported were at an overall rate of 68%, on October 31, 2025. (See Table 23).

Table 23

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACTIVITY SPECIALIST	1	1	100%
ADMINISTRATIVE SPECIALIST	1	0	0%
BEHAVIOR SUPPORT SPECIALIST	2	2	100%
BEHAVIOR TECHNICIAN	44	28	64%
BEHAVIOR TECHNICIAN LEAD	13	10	77%
BEHAVIOR TECHNICIAN PROGRAMMING COORDINATOR	2	2	100%
BEHAVIOR TECHNICIAN SUPERVISOR	2	2	100%
BEHAVIORAL HEALTH PRACTITIONER II	1	0	0%
BEHAVIORAL HEALTH PRACTITIONER IV	2	1	50%
BOARD CERTIFIED BEHAVIOR ANALYST CLINICAL SUPERVISOR	1	0	0%
COMPLIANCE SPECIALIST	1	1	100%
CONSULTANT	1	0	0%
DHHS FACILITY ADMINISTRATOR	1	1	100%
PRINCIPAL	1	1	100%
REGISTERED NURSE	1	1	100%
TEACHER (SCATA CONTRACT)	4	3	75%
Total	**78**	**53**	**68%**

Recent Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding YRTC-Lincoln found are highlighted. There were no significant concerns identified in those reports.

WHITEHALL

Whitehall helps adolescents manage their mental health challenges through person-centered care. Until recently, Whitehall focused on treating male adolescents who have sexually offended. However, in the fall of 2020, the Hastings Juvenile Chemical Dependency Program was relocated from the former Hastings Regional Center (HRC) to Whitehall. There are now currently two distinct programming offerings on the Whitehall campus: treatment for youth who sexually harm and the substance use program.

Youth are referred to Whitehall by the Courts and Juvenile Probation, DHHS, or self-referred by a family member. An interdisciplinary team that includes mental health and medical practitioners, social workers, substance use counselors, and other professionals, diagnoses and plans treatment for the youth.

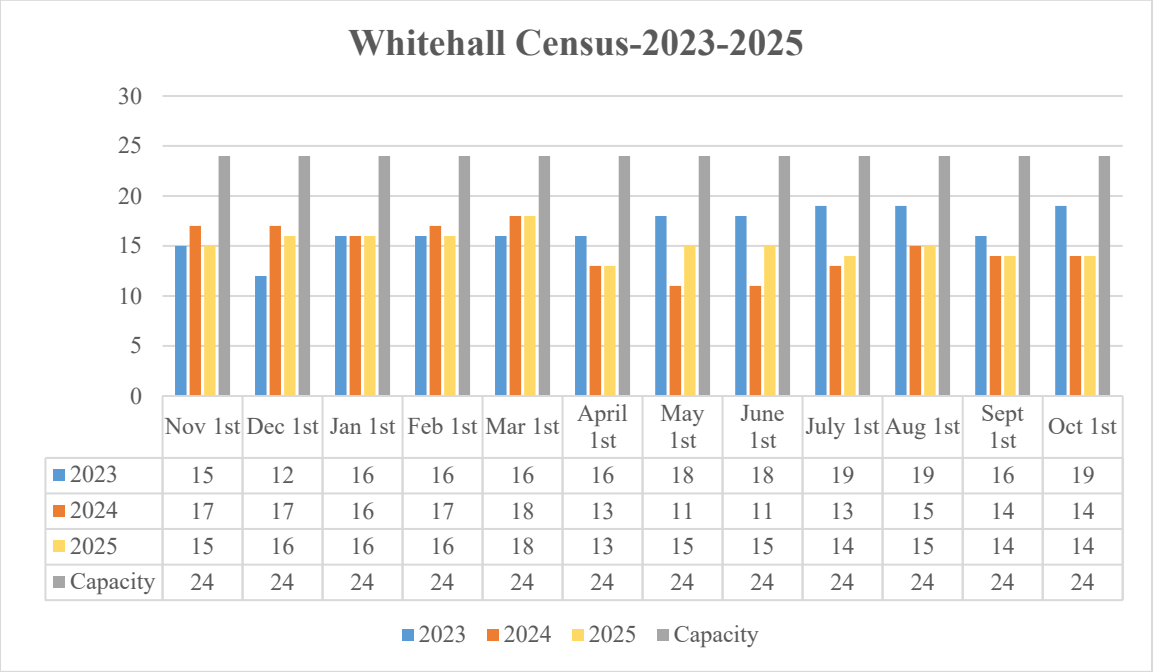
The Whitehall campus is comprised of several different buildings and areas to meet youth's housing, educational, recreation, and dining needs. Youth are housed according to the program in which they participate.

Whitehall is a PRTF licensed and accredited as part of LRC, and is considered an extension of LRC, which is a Joint Commission-accredited state psychiatric hospital. Whitehall meets statutory requirements as a MHSU Treatment Center, and is licensed by the DHHS Division of Public Health as a residential child-caring agency.

Capacity and Census

The licensed capacity total for Whitehall is 24. For the current reporting period, the average monthly census was 15, as compared to 17 in 2022/23 and 15 in 2023/24. **Chart 26** illustrates the licensed capacity and combined monthly census for all units during the periods of November 1 until October 31 of each respective year. (See Chart 26).

Chart 26



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	15	12	16	16	16	16	18	18	19	19	16	19
2024	17	17	16	17	18	13	11	11	13	15	14	14
2025	15	16	16	16	18	13	15	15	14	15	14	14
Capacity	24	24	24	24	24	24	24	24	24	24	24	24

Complaints to OPC regarding Whitehall

For the period of December 1, 2024 through November 30, 2025, the OPC received three complaints regarding Whitehall. The complaints were in regard to youth treatment by staff, and other general concerns.

Facility Inspection

This campus is very aged and appears to be difficult to maintain due to its age. In addition, there are concerns with the facilities not being Americans with Disabilities Act compliant, which will likely require a large amount of funding to update. New structures at this site, or another site, should be considered for this facility.

OPC staff noticed two additional concerns that need to be addressed with a sense of urgency. The first is that an odor similar to natural gas was noticed near the exterior door of one of the living cottages. The odor was the strongest while outside, but also detectable as OPC staff entered the unit. The facility administrator was present during our tour and stated that the natural gas company has been on-site on several occasions and have been unable to identify the source of the issue.

The second issue is the basements within the living cottages and the extreme water leaking that occurs each time the area receives precipitation. The basement fills with several inches of water and makes the space unusable and dangerous due to the slippery conditions of the floors and

potential for mold and mildew growth, even though the laundry facilities are housed in the basements of the living units.

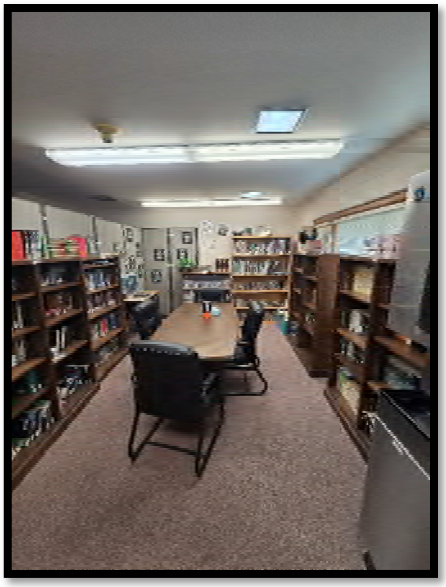
When OPC staff talked with youth on campus, the feedback regarding the programming and their experience with staff was generally very positive.

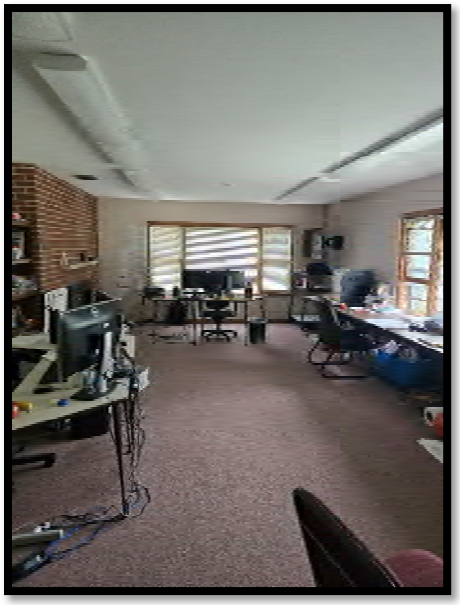
Table 24 provides any highlights observed by OPC staff during the facility inspection. (See Table 24.)

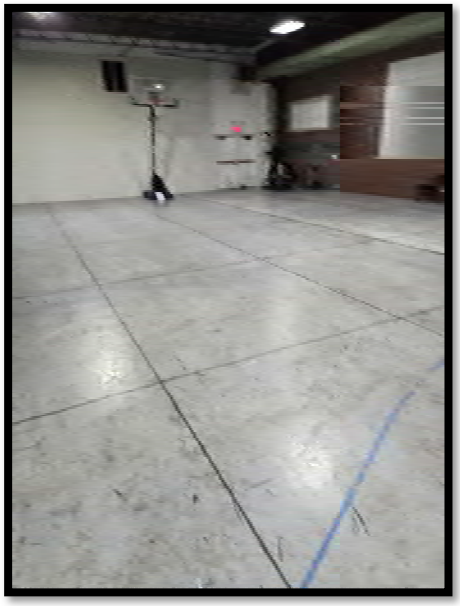
Table 24

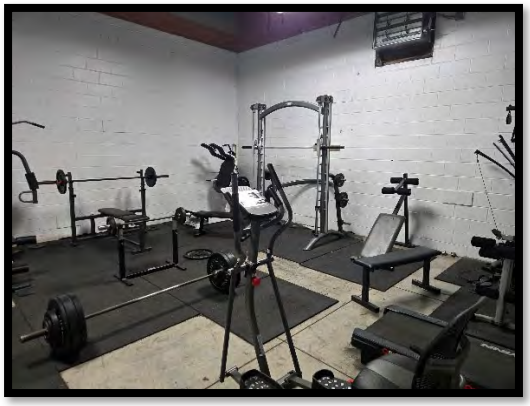
Facility Description	General Observations
Grounds	Campus is large, with expansive yard space and trees. Several buildings on campus are either abandoned due to age or utilized by other state agencies. Sidewalks leading to and from buildings are badly cracked. Some sidewalks have abrupt drops and steep grades that are not marked. A few sidewalks have small drainage ditches alongside, which are not separated by any safety features. While the grounds were all mowed and free of debris, they do not appear to be watered or manicured on a regular basis. The grounds lack dedicated recreation space for outdoor activities. The grounds are not set up with underground sprinklers, therefore the condition of the yards is contingent on the amount of precipitation received in the area.
Administration Building	No major destruction or structural issues identified.
Warner Cottage	The Whitehall Campus is generally outdated in terms of design, layout, and structure and not the most conducive for the care of youth. Unit basements are not in use because of leaking from exterior sources when it rains in the area. The leaking is significant, and will sometimes flood the basement several inches. This space is not usable due to the damage and runs a risk for mold and mildew development in the living units where youth sleep and spend a great deal of time. The carpet is old, worn, and stained in most buildings.
Community Life Center	

Family Life Center	Bathrooms smell very musty with an overtone of cleaning chemicals. Ventilation in some bathrooms is aging and does not appear to sufficiently help reduce mold and mildew growth. Some bedroom floors are bare and are only painted concrete. Others are tile with artificial wood grain, which looks nice but does not feel home-like. Wooden platforms for beds are old and worn, and even broken with jagged edges in some cases. Mattresses are thin and worn, and some have cracks. Bedrooms are not equal in size - those on the corner are larger. Unit kitchen areas are mostly unused and take up space that could be used for therapy rooms or other uses.
School	No major destruction or structural issues identified. This area is also old and not enough space to allow for learning.
Gym and Weight room	No major destruction or structural issues identified. The gym and weight room spaces have been adapted for the purposes they serve but have poor lighting, no air conditioning, and a painted concrete floor.

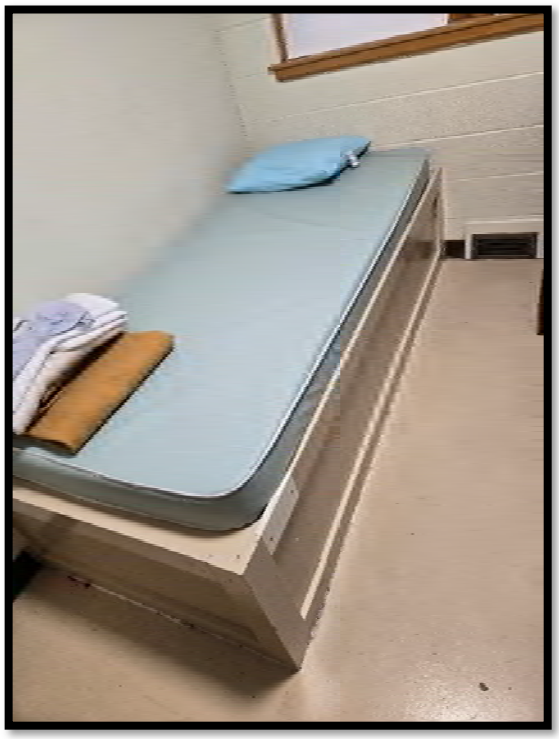


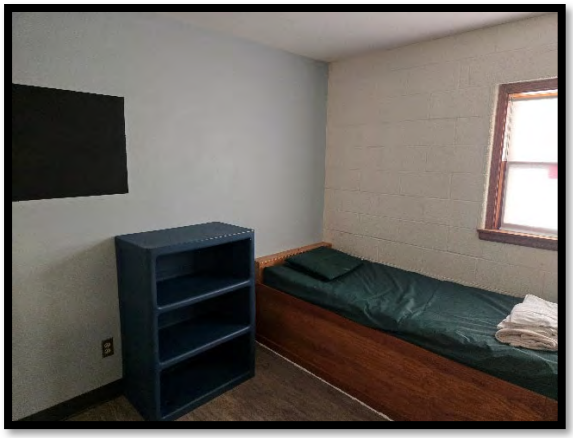


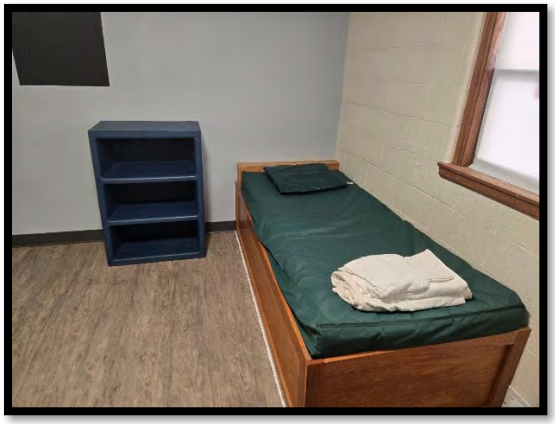




EXIT







Major Projects/Improvements

In Progress Projects	Projected Completion Date
None known	
Pending	**Projected Completion Date**
ADA campus improvement response project, which has involved an architect surveying the campus to assess what the needs are to bring campus within compliance with ADA regulations. An estimated completion date has not been given at this time.	Unknown
Concrete work and a ramp are planned to be completed outside the Administration Building to remove wooden stairs that are currently inoperable. The sidewalks around the Administration Building will be widened to fit ADA standards.	Spring 2026

Central A/C is being upgraded at NDCS, which will result in the gym space that Whitehall youth utilize becoming climate controlled.	2026
The basements in most cottages around campus have flooding issues when it rains, it is anticipated that these will be repaired.	Spring 2026
Completed Projects During the Current Reporting Year	
A wall A/C unit was added to the weight room in the gym. Several sidewalks around campus received new concrete where it was identified that new concrete needed to be poured. The hallway in the Administration Building was repainted. Community Life Center and Warner Cottages were repainted. The fire system in the Administration Building was identified by the Fire Marshal as being only audible and not visual, so a new alert system was installed in the Administration Building to meet Fire Marshall code.	

Whitehall Staffing

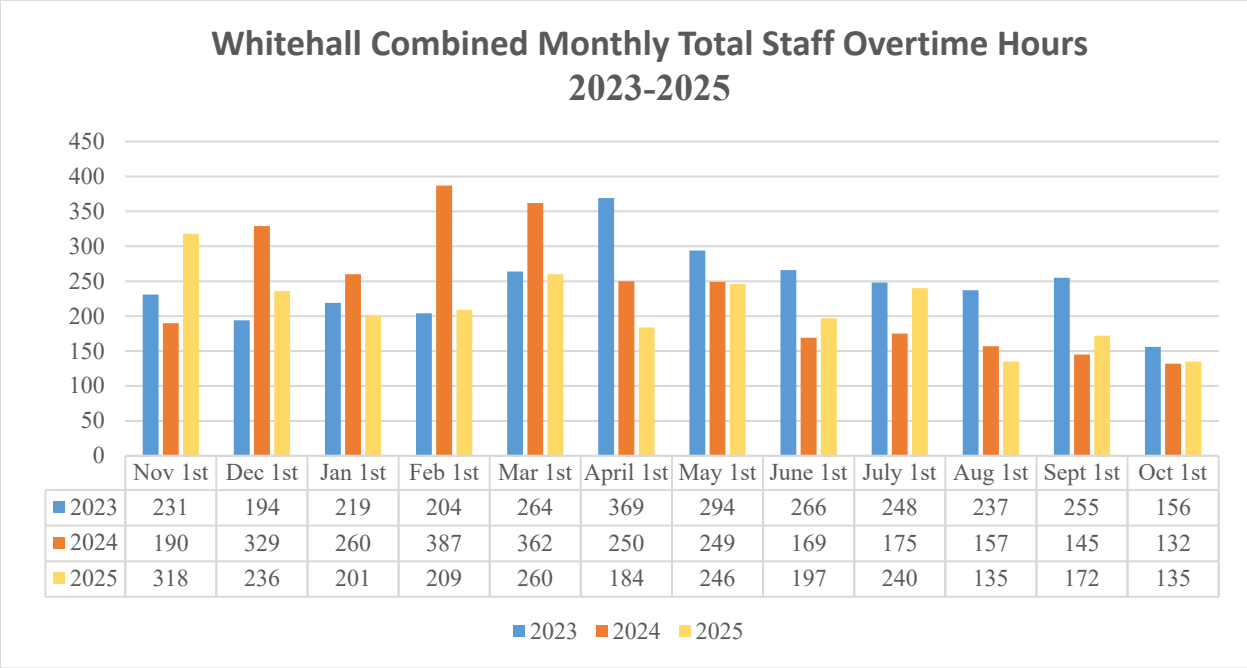
The table below shows the staffing numbers provided by DHHS for the past six reporting years. (See **Table 25**.)

Table 25

Whitehall Staffing – Permanent and Temporary Staff on October 31st of Each Respective Year						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Number of Positions Needed in HR Staffing Plan for FY23	58 for **FY21**	59 for **FY22**	47 for **FY23**	83 for **FY24**	71 for **FY25**	69 for **FY26**
Number of Positions Filled	57	46	36	63	60 Perm 1 Temp	66 Perm
Number of Positions Vacant	1	13	11	20	10	3
Monthly Turnover Rate	N/A	2%	1.4%	.9%	1.5%	.7%
Aggregate Turnover Rate	N/A	26%	15%	11%	18%	8%

Chart 27 illustrates the total combined monthly staff overtime for the periods of November 1, 2022 until October 31, 2025. (See Chart 27).

Chart 27



	Nov 1st	Dec 1st	Jan 1st	Feb 1st	Mar 1st	April 1st	May 1st	June 1st	July 1st	Aug 1st	Sept 1st	Oct 1st
2023	231	194	219	204	264	369	294	266	248	237	255	156
2024	190	329	260	387	362	250	249	169	175	157	145	132
2025	318	236	201	209	260	184	246	197	240	135	172	135

Vacancies by Position

The table below illustrates the positions in which vacancies exist and what percentage by position type were filled on October 31, 2025. The percentage of filled positions reported were at an overall rate of 96%, on October 31, 2025, as shown in the **Table 26**.

Table 26

POSITION TITLE	Number of Positions Allocated on October 31, 2025	Filled Permanent and/or Temp/PRN Staff on October 31, 2025	Percent Filled
ACTIVITY SPECIALIST	2	2	100%
ACTIVITY SUPERVISOR	1	0	0%
ADMINISTRATIVE NURSE	1	1	100%
ADMINISTRATIVE SPECIALIST	2	2	100%
ADMINISTRATIVE TECHNICIAN	2	2	100%
BEHAVIORAL HEALTH PRACTITIONER I	1	1	100%
BEHAVIORAL HEALTH PRACTITIONER II	1	1	100%
BEHAVIORAL HEALTH PRACTITIONER III	1	1	100%
BEHAVIORAL HEALTH PRACTITIONER IV	1	1	100%

CERTIFIED MASTER SOCIAL WORKER	1	1	100%
CLINICAL PROGRAM MANAGER	1	1	100%
COMPLIANCE SPECIALIST	1	1	100%
FACILITY OPERATING OFFICER	2	2	100%
HEALTH INFORMATION MANAGER	1	1	100%
HR SPECIALIST SENIOR / HR BUSINESS PARTNER I	1	1	100%
OFFICE TECHNICIAN	1	1	100%
PSYCHOLOGIST/LICENSED	1	1	100%
REGISTERED NURSE	2	2	100%
TEACHER (SCATA CONTRACT)	5	5	100%
YOUTH COUNSELOR	2	2	100%
YOUTH COUNSELOR SUPERVISOR	2	2	100%
YOUTH SECURITY SPECIALIST II	30	28	93%
YOUTH SECURITY SUPERVISOR	7	7	100%
Total	**69**	**66**	**96%**

Recent Licensure and Inspection Reports

The annual inspection reports provided by the facilities are attached to this report and any concerns regarding Whitehall found are highlighted. The more significant concerns found include the following:

- Midwest Alarm Services highly recommended new fire alarm panels, and added that the facility has been aware of the concern for a year. Ecolab also cited replacing old smoke detectors and pull stations, along with replacing all heat detectors with smoke detectors.
- Ecolab, a pest elimination company, cited findings of mice on the exterior of the buildings and concern with the gaps in the exterior doors larger than recommended. The recommendations included the installation or repair of door sweeps.
- Ecolab, a pest elimination company, cited findings of cockroaches in the lower floor of the school.
- DHHS Centers for Medicare and Medicaid Services found that the facility failed to document provided training on the facility's Emergency Preparedness Plan for staff. The Center added that this deficiency had the potential to affect the health and safety of all clients residing in the facility.
- DHHS Centers for Medicare and Medicaid Services found that the facility failed to have a written program description that is available to staff, clients, and members of the public that accurately explains the range of care and treatment activities that are provided at the facility.
- DHHS Centers for Medicare and Medicaid Services found that the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit at 1 of 10 faucet locations.

- DHHS Centers for Medicare and Medicaid Services found that the facility failed to ensure all parts of the facility, facility equipment and services are maintained in good working order, safe and free of potential harm.

Many of the findings have either been resolved, or have a plan in place to remedy the findings. More detail is provided within the attachments regarding the inspection reports, corrective action plans, and waivers when appropriate. The Whitehall Certification of Licensure is active at the time of this report. [9]

[9] Licensure information was found at this website link: https://www.nebraska.gov/LISSearch/search.cgi

Attachments

Bld # 5
Break Rm

SUMMIT FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Branch Office 1104 **Work Order** 043095593

Phone No.: 402-476-4646

NAME Lincoln Regional Center
ADDRESS 801 Prospector Place
CITY Lincoln, NE 68522
TELEPHONE 402-479-5453 STORE NO.
OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE

ANNUAL	SEMI-ANNUAL	RECHARGE	INSTALLATION	RENOVATION
	☑			

LOCATION OF SYSTEMS CYLINDERS: West side of Hood

MANUFACTURER	MODEL NUMBER	WET CHEMICAL	DRY CHEMICAL
Ansul	R-102	☑	

CYLINDER SIZE MASTER	CYLINDER SIZE SLAVE	CYLINDER SIZE SLAVE
3gal.		

MANIFOLDED ☐ YES ☑ NO
PIRANHA WATERFLOW PRESSURE:

FUSE LINKS 360°F	FUSE LINKS 450°F	FUSE LINKS 500°F	OTHER
3-360			

MECHANICAL GAS VALVE(S) & SIZE(S)	ELECTRICAL GAS VALVE(S) & SIZE(S)	MANUAL RESET RELAY
N/A	N/A	☐ YES ☑ NO

LAST HYDRO TEST DATE	ELECTRIC CONNECTED
2014	☑ YES ☐ NO

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

No Appliances at this time.							

	YES	NO	N/A
1. System interlocked with building fire alarm.	☑	☐	☐
2. Duct and plenum covered with correct nozzles.	☑	☐	☐
3. Check positioning of all nozzles.	☑	☐	☐
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A standards.	☑	☐	☐
5. Hood/duct penetrations sealed with weld or U.L. device	☑	☐	☐
6. Check if seals intact, evidence of tampering	☑	☐	☐
7. Pressure gauge in proper range (if gauged)	☐	☐	☑
8. Check cartridge weight (if applicable) 4302	☑	☐	☐
9. Dry system 6-year maintenance date Wet system 12-year hydro test date 2026	☑	☐	☐
10. Inspect cylinder and mount	☑	☐	☐
11. Operate system from terminal link	☑	☐	☐
12. Test for proper operation from remote	☑	☐	☐
13. Check operation of micro switch	☑	☐	☐
14. Check operation of gas valve	☐	☐	☑
15. Clean nozzles	☑	☐	☐
16. Proper nozzle covers in place	☑	☐	☐
17. Replaced fuse links x3	☑	☐	☐
18. Check travel of cable	☑	☐	☐
19. Piping and conduit securely bracketed	☑	☐	☐

	YES	NO	N/A
20. Proper separation between fryers and flame	☐	☐	☑
21. Proper clearance - flame to filters	☐	☐	☑
22. Exhaust fan in operating order	☑	☐	☐
23. All filters replaced	☑	☐	☐
24. Fuel shut-off in on position	☑	☐	☐
25. Manual and remote set/seals in place	☑	☐	☐
26. Replace system covers	☑	☐	☐
27. System operational and seals in place	☑	☐	☐
28. Slave system operational	☐	☐	☑
29. Clean cylinder and mount	☑	☐	☐
30. Fan warning sign on hood	☑	☐	☐
31. Proper signage and personnel instructed in manual operation of system	☑	☐	☐
32. Proper hand portable extinguishers	☑	☐	☐
33. K-Class fire extinguisher in cooking area	☐	☐	☑
34. Portable extinguishers are properly serviced	☑	☐	☐
35. Service & Certification tag on system	☑	☐	☐
36. Safety chains on all gas appliances attached and secured	☐	☐	☑

37. Status of grease build-up in the hood and duct opening
☑ CLEAN ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

COMMENTS Note - Hood Not in use at this time (No Appliances)

Note - testing In-Accordance with NFPA96 (2012 Edition)

SERVICE TECHNICIAN	PERMIT NO.	DATE	CUSTOMER'S AUTHORIZED AGENT
Doug Amerine	KM0117944	2/10/25	Ross Hoover

Bld # 14

SUMMIT FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Branch Office 1104 **Work Order** 04309593

Phone No.: 402-476-4646

NAME Lincoln Regional Center

ADDRESS 801 W. Prospector PL.

CITY Lincoln, NE. 68522

TELEPHONE 402-405-3635 STORE NO.

OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE

ANNUAL	SEMI-ANNUAL ✓	RECHARGE	INSTALLATION	RENOVATION
LOCATION OF SYSTEMS CYLINDERS: Hood enclosure				
MANUFACTURER: Ansul	MODEL NUMBER: R-102	WET CHEMICAL ✓	DRY CHEMICAL	
CYLINDER SIZE MASTER: 3gal	CYLINDER SIZE SLAVE: —	CYLINDER SIZE SLAVE: —		
MANIFOLDED ☐ YES ☑ NO	PIRANHA WATERFLOW PRESSURE: —			
FUSE LINKS 360°F: 2.360	FUSE LINKS 450°F: —	FUSE LINKS 500°F: —	OTHER: —	
MECHANICAL GAS VALVE(S) & SIZE(S): —	ELECTRICAL GAS VALVE(S) & SIZE(S): —	MANUAL RESET RELAY ☐ YES ☑ NO		
LAST HYDRO TEST DATE: 2020	ELECTRIC CONNECTED ☑ YES ☐ NO			

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

Oven							

	YES	NO	N/A
1. System interlocked with building fire alarm.	✓		
2. Duct and plenum covered with correct nozzles.	✓		
3. Check positioning of all nozzles.	✓		
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A standards.	✓		
5. Hood/duct penetrations sealed with weld or U.L. device	✓		
6. Check if seals intact, evidence of tampering	✓		
7. Pressure gauge in proper range (if gauged)			✓
8. Check cartridge weight (if applicable) 42¼ oz	✓		
9. Dry system 6-year maintenance date Wet system 12-year hydro test date 2032	✓		
10. Inspect cylinder and mount	✓		
11. Operate system from terminal link	✓		
12. Test for proper operation from remote	✓		
13. Check operation of micro switch	✓		
14. Check operation of gas valve			✓
15. Clean nozzles	✓		
16. Proper nozzle covers in place	✓		
17. Replaced fuse links + 2	✓		
18. Check travel of cable	✓		
19. Piping and conduit securely bracketed	✓		

	YES	NO	N/A
20. Proper separation between fryers and flame			✓
21. Proper clearance - flame to filters	✓		
22. Exhaust fan in operating order	✓		
23. All filters replaced	✓		
24. Fuel shut-off in on position	✓		
25. Manual and remote set/seals in place	✓		
26. Replace system covers	✓		
27. System operational and seals in place	✓		
28. Slave system operational			✓
29. Clean cylinder and mount	✓		
30. Fan warning sign on hood	✓		
31. Proper signage and personnel instructed in manual operation of system	✓		
32. Proper hand portable extinguishers	✓		
33. K-Class fire extinguisher in cooking area	✓		
34. Portable extinguishers are properly serviced	✓		
35. Service & Certification tag on system	✓		
36. Safety chains on all gas appliances attached and secured			✓

37. Status of grease build-up in the hood and duct opening
☑ CLEAN ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

COMMENTS — Testing In-Accordance with NFPA 96 (2012 Edition)

✗ Doug Ladmejdi — SERVICE TECHNICIAN

KM011794 — PERMIT NO.

2/10/25 — DATE

✗ Kris Hoard — CUSTOMER'S AUTHORIZED AGENT

Bld # 10 canteen

SUMMIT FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Branch Office 1104 **Work Order** 04309593

Phone No.: 402-476-4646

NAME Lincoln Regional Center

ADDRESS 801 Prospector Lane

CITY Lincoln, NE. 68522

TELEPHONE 402-479-5453 STORE NO.

OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE

ANNUAL	SEMI-ANNUAL	RECHARGE	INSTALLATION	RENOVATION
	✓			

LOCATION OF SYSTEMS CYLINDERS			
south side of Hood			
MANUFACTURER	**MODEL NUMBER**	**WET CHEMICAL**	**DRY CHEMICAL**
Ansul	R-102	✓	

CYLINDER SIZE MASTER	CYLINDER SIZE SLAVE	CYLINDER SIZE SLAVE
3 gal.		

MANIFOLDED	PIRANHA WATERFLOW PRESSURE
☐ YES ☑ NO	

FUSE LINKS 360°F	FUSE LINKS 450°F	FUSE LINKS 500°F	OTHER
	3-450		

MECHANICAL GAS VALVE(S) & SIZE(S)	ELECTRICAL GAS VALVE(S) & SIZE(S)	MANUAL RESET RELAY
3/4"		☐ YES ☑ NO

LAST HYDRO TEST DATE	ELECTRIC CONNECTED
2014	☑ YES ☐ NO

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

4 Burner Range	Flat grill	Fryer	2 Burner				

	YES	NO	N/A
1. System interlocked with building fire alarm.	✓		
2. Duct and plenum covered with correct nozzles.	✓		
3. Check positioning of all nozzles.	✓		
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A standards.	✓		
5. Hood/duct penetrations sealed with weld or U.L. device	✓		
6. Check if seals intact, evidence of tampering	✓		
7. Pressure gauge in proper range (if gauged)			✓
8. Check cartridge weight (if applicable) 4202	✓		
9. Dry system 6-year maintenance date Wet system 12-year hydro test date 2026	✓		
10. Inspect cylinder and mount	✓		
11. Operate system from terminal link	✓		
12. Test for proper operation from remote	✓		
13. Check operation of micro switch	✓		
14. Check operation of gas valve	✓		
15. Clean nozzles	✓		
16. Proper nozzle covers in place	✓		
17. Replaced fuse links x3	✓		
18. Check travel of cable	✓		
19. Piping and conduit securely bracketed	✓		

	YES	NO	N/A
20. Proper separation between fryers and flame	✓		
21. Proper clearance - flame to filters	✓		
22. Exhaust fan in operating order	✓		
23. All filters replaced	✓		
24. Fuel shut-off in on position	✓		
25. Manual and remote set/seals in place	✓		
26. Replace system covers	✓		
27. System operational and seals in place	✓		
28. Slave system operational			✓
29. Clean cylinder and mount	✓		
30. Fan warning sign on hood			✓
31. Proper signage and personnel instructed in manual operation of system	✓		
32. Proper hand portable extinguishers	✓		
33. K-Class fire extinguisher in cooking area	✓		
34. Portable extinguishers are properly serviced	✓		
35. Service & Certification tag on system	✓		
36. Safety chains on all gas appliances attached and secured			✓

37. Status of grease build-up in the hood and duct opening
☑ CLEAN ☑ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

COMMENTS Note - Hood Not in use at this time!
Tested In-Accordance with NFPA 96 2012 Edition

✗ Doug Smith	KM0117944	2/10/25	✗ Kris Hoyer
SERVICE TECHNICIAN	PERMIT NO.	DATE	CUSTOMER'S AUTHORIZED AGENT

AUTOMATIC FIRE SUPPRESSION SYSTEM INSPECTION REPORT

Bld. #10 main Kitchen

Date 2/10/25 Work Order No. 04309593 ☑ Semi-Annual ☐ Acceptance

SUMMIT
FIRE PROTECTION
2431 Fairfield Street, Lincoln, NE 68521 • (402) 476-4646 • (800) 228-4555

Customer Lincoln Regional Center Bld #10 (Main Kitchen)
Address 601 Prospector Pl Lincoln, NE 68522
Contact Andy Miller
Protected Area Kitchen Hoods Main Kitchen
Address Same
Panel Mfg. & Model Captive Aire (Core System) Agent Water
Monitored By Permar ☐ Directly ☑ VIA Fire Alarm System

Explanation of markings
☑ PASSED
☐ NOT APPLICABLE
☒ SEE COMMENTS

SIGNALING DEVICES

		QUANTITY
☐	Smoke Detectors	
	Ionization Type	
	Photoelectric Type	
☑	Heat Detectors	3
☐	Flame Detectors	
☑	Manual Stations	1

AUDIBLE ALARM DEVICES

		TYPE	
☐	1st Alarm		
☐	Pre-Discharge		
☑	Discharge	Core Panel	1

VISUAL ALARM DEVICES

☐	1st Alarm	
☐	Pre-Discharge	
☑	Discharge Core Panel	1

DISCHARGE FUNCTIONS

☐	Time Delay (Seconds)	
☑	Release Circuits	2
☑	Release Modules, Heads or Solenoids	3
☐	Abort Switches	

AUXILIARY RELAYS FUNCTION

☑	1st Alarm	FACP
☐	Pre-Discharge	
☑	Discharge	Gas/make-up Air/ electrical Shunt-trip
☑	Trouble	FACP

GENERAL SYSTEM AND AREA CHECKS

☑	System Operation on Batteries (Date Due)	2026
☑	Batteries Under One Amp Load (Volts)	27V
☐	Annunciators	
☑	Panel Lights	
☐	Auxiliary Power Supply (Volts)	
☑	Area Integrity and Design Unchanged	
☑	Piping and Nozzles Secure	
☐	Sub-Floor Clean	
☑	Portable Fire Extinguishers Current	
☑	Personnel Instructed on System Operation	DS
☐	Personnel Declined Operating Instructions	

VISUAL CONTAINER INSPECTION

☐	Cylinder Condition (Quantity)	
☑	Pressure Core domestic water	OK
☑	Level Readings surfactant	OK
☐	Hydro-Test Current (Date Due)	
☐	10-Year Initiator Replacement (Date Due)	

COMMENTS: Note- testing in Accordance with NFPA96 (2012 Edition)

INSPECTOR Doug Swigert LICENSE # KH0117944
CLIENT X Ken Hoover

I have been advised of the above problem(s), but DO NOT authorize repair at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	500004	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	801 W PROSPECTOR PLACE LINCOLN, NE 68522

(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 6/11/2025, DHHS Public Health representatives conducted an offsite revisit survey to determine compliance with the deficiency cited during the 1/28/2025 - 2/4/2025 survey. The facility was in compliance with these regulations at the time of survey.	{I 000}		

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

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	500004	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	801 W PROSPECTOR PLACE LINCOLN, NE 68522

(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 3/25/2024-3/28/2024, DHHS Public Health representatives conducted a licensure survey and complaint investigation to determine compliance with 175 NAC 9, Licensure Regulations for Hospitals. The facility was in compliance with the regulations at the time of survey.	I 000		

Licensure Unit

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

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

February 12, 2025

Mitchell Bruening, Administrator,
Lincoln Regional Center
801 W Prospector Place
Lincoln, NE 68522-4949

Dear Mr. Bruening:

An unannounced visit was conducted to Lincoln Regional Center on January 28 - February 4, 2025, by representatives of Health and Human Services division of Public Health. The purpose of the visit was to investigate complaints on non-compliance with regulatory requirements received by our office. To complete this investigation, a representative sample of patients was selected. The investigative process included review of medical records, review of policy and procedures, observations, staff interviews, tours, staff interviews, and administrative reviews.

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

ALLEGATIONS:

1. The facility failed to ensure the medical care and treatment needs of patients are met.
2. The facility failed to ensure the staff followed policies and procedures to provide care in a safe setting.
3. The facility failed to ensure the patient's rights were protected.
4. The facility failed to protect patients from unnecessary physical restraints.
5. The facility failed to protect the patients right to care in a safe setting.
6. The facility failed to implement policies and procedures to protect patients from staff abuse.

FINDINGS:

1. Based on policy review, and medical record review the facility ensured the patients were set up with a clinic appointment, seen by a provider, received lab, nursing assessments, provider exams and interventions as medical care and treatment needs presented.

2. Based on observations, record review, policy review, building tours, staff interviews and facility investigation. The facility staff intervened immediately and ensured patients and staff are protected.

3. Based on policy review, medical record review, observations, administrative review, building tours, and staff interviews the facility failed to ensure a seclusion order was placed to protect the rights of a patient.

4. Based on policy and procedure review, medical record review, observations, staff interviews, administrative review, and building tours, the facility ensured the rights of the patients were protected and utilized physical restraints per policy to protect the other patients from harm.

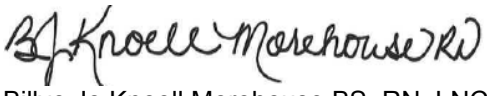
5. Based on policy and procedure review, medical record review, building tours, administrative review, staff interviews, special treatment plan review, observations, and administrative interview the facility failed to ensure the rights of the patients were protected by following policies to provide care in a safe setting.

6. Based on policy and procedure review, medical record review, administrative review, and staff interviews the facility ensured policies and procedures were in place to protect the patients.

Please see the email for instructions on completion and submission of the statement of compliance for the deficiency found during the complaint investigation. Please contact this office if you have questions.

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,



Billye Jo Knoell Morehouse BS, RN, LNC – Program Manager RN
DHHS Public Health – Licensure Unit
Acute Care Facilities
PO Box 94669, Lincoln, NE 68509-4669
Email: BJ.Morehouse@nebraska.gov

BKM/lc

SUMMIT
FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Bld. #10 Canteen

Branch Office: 11315

Work Order 04965971

Phone No.: 402-476-4646

NAME Lincoln Regional Center

ADDRESS 801 W. Prospector PL.

CITY Lincoln, NE. 68522

TELEPHONE 402-405-3635 STORE NO.

OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE.

ANNUAL	SEMI-ANNUAL	RECHARGE	INSTALLATION	RENOVATION
	X			

LOCATION OF SYSTEM CYLINDERS: Right side of Hood

MANUFACTURER	MODEL NUMBER	WET CHEMICAL	DRY CHEMICAL
Ansul	R-102	X	

CYLINDER SIZE MASTER	CYLINDER SIZE SLAVE	CYLINDER SIZE SLAVE
3 gal.	—	—

MANIFOLDED: ☐ YES ☑ NO

PIRANHA WATERFLOW PRESSURE: —

FUSE LINKS 360° F	FUSE LINKS 450° F	FUSE LINKS 500° F	OTHER
	3-450°F		

MECHANICAL GAS VALVE(S) & SIZE(S)	ELECTRICAL GAS VALVE(S) & SIZE(S)	MANUAL RESET RELAY
3/4"	—	☐ YES ☑ NO

LAST HYDRO TEST DATE	ELECTRIC CONNECTED
2014	☑ YES ☐ NO

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

4 Burner Range	Fryer	Flat grill	2 Burner Range				

	YES	NO	N/A
1. System interlocked with building fire alarm	☑	☐	☐
2. Duct and plenum covered with correct nozzles	☑	☐	☐
3. Check positioning of all nozzles	☑	☐	☐
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A. standards	☑	☐	☐
5. Hood/duct penetrations sealed with weld or U.L. device	☑	☐	☐
6. Check if seals intact, evidence of tampering	☑	☐	☐
7. Pressure gauge in proper range (if gauged)	☐	☐	☑
8. Check cartridge weight (if applicable) 4002	☑	☐	☐
9. Dry system 6-year maintenance date Wet system 12-year hydro test date 2026	☑	☐	☐
10. Inspect cylinder and mount	☑	☐	☐
11. Operate system from terminal link	☑	☐	☐
12. Test for proper operation from remote	☑	☐	☐
13. Check operation of micro switch	☑	☐	☐
14. Check operation of gas valve	☑	☐	☐
15. Clean nozzles	☑	☐	☐
16. Proper nozzle covers in place	☑	☐	☐
17. Replaced fuse links +3	☑	☐	☐
18. Check travel of cable	☑	☐	☐
19. Piping and conduit securely bracketed	☑	☐	☐

	YES	NO	N/A
20. Proper separation between fryers and flame	☑	☐	☐
21. Proper clearance – flame to filters	☑	☐	☐
22. Exhaust fan in operating order	☑	☐	☐
23. All filters replaced	☑	☐	☐
24. Fuel shut-off in on position	☑	☐	☐
25. Manual and remote set/seals in place	☑	☐	☐
26. Replace system covers	☑	☐	☐
27. System operational and seals in place	☑	☐	☐
28. Slave system operational	☐	☐	☑
29. Clean cylinder and mount	☑	☐	☐
30. Fan warning sign on hood	☐	☐	☑
31. Proper signage and personnel instructed in manual operation of system	☑	☐	☐
32. Proper hand portable extinguishers	☑	☐	☐
33. K-Class fire extinguisher in cooking area	☑	☐	☐
34. Portable extinguishers properly serviced	☑	☐	☐
35. Service & Certification tag on system	☑	☐	☐
36. Safety chains on all gas appliances attached and secured	☑	☐	☐

37. Status of grease build-up in the hood and duct opening
☐ CLEAN ☑ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

★ NOTE DISCREPANCIES OR DEFICIENCIES BELOW ★

COMMENTS Note- Testing In Accordance with NFPA 96 (2012 edition)
(Note- Kitchen not in use at this time)
(Note #9 System Due for 12yr-Hydro-test Next year 2026)

X Doug Dunphy — SERVICE TECHNICIAN

KM0117944 — PERMIT NO.

8/5/25 — DATE

X [illegible] — CUSTOMER'S AUTHORIZED AGENT

THE ABOVE SERVICE TECHNICIAN CERTIFIES THAT THE SYSTEM WAS PERSONALLY INSPECTED AND CONDITIONS WERE FOUND TO BE AS INDICATED ON THIS REPORT.

WHITE - CUSTOMER YELLOW - DISTRIBUTOR PINK - AUTHORITY HAVING JURISDICTION

SUMMIT
FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Bld. # 5 Break room

Branch Office: 1104

Work Order 04965971

Phone No.: 402-476-9611b

NAME Lincoln Regional Center

ADDRESS 801 Prospector Pl.

CITY Lincoln, NE. 68522

TELEPHONE 402-405-3635 STORE NO.

OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE.

ANNUAL	SEMI-ANNUAL	RECHARGE	INSTALLATION	RENOVATION
	X			

LOCATION OF SYSTEM CYLINDERS: Right side of Hood

MANUFACTURER	MODEL NUMBER	WET CHEMICAL	DRY CHEMICAL
Ansul	R-102	X	

CYLINDER SIZE MASTER	CYLINDER SIZE SLAVE	CYLINDER SIZE SLAVE
3gal.	—	—

MANIFOLDED ☐ YES ☑ NO

PIRANHA WATERFLOW PRESSURE: —

FUSE LINKS 360° F	FUSE LINKS 450° F	FUSE LINKS 500° F	OTHER
3-360	—	—	—

MECHANICAL GAS VALVE(S) & SIZE(S)	ELECTRICAL GAS VALVE(S) & SIZE(S)	MANUAL RESET RELAY
~~3/4"~~ N/A	—	☐ YES ☑ NO

LAST HYDRO TEST DATE	ELECTRIC CONNECTED
2014	☑ YES ☐ NO

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

NO	Appliances present at this time					

	YES	NO	N/A
1. System interlocked with building fire alarm	☑	☐	☐
2. Duct and plenum covered with correct nozzles	☑	☐	☐
3. Check positioning of all nozzles	☑	☐	☐
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A. standards	☑	☐	☐
5. Hood/duct penetrations sealed with weld or U.L. device	☑	☐	☐
6. Check if seals intact, evidence of tampering	☑	☐	☐
7. Pressure gauge in proper range (if gauged)	☐	☐	☑
8. Check cartridge weight (if applicable) 4 3oz	☑	☐	☐
9. Dry system 6-year maintenance date / Wet system 12-year hydro test date 2026	☑	☐	☐
10. Inspect cylinder and mount	☑	☐	☐
11. Operate system from terminal link	☑	☐	☐
12. Test for proper operation from remote	☑	☐	☐
13. Check operation of micro switch	☑	☐	☐
14. Check operation of gas valve	☐	☐	☑
15. Clean nozzles	☑	☐	☐
16. Proper nozzle covers in place	☑	☐	☐
17. Replaced fuse links x3	☑	☐	☐
18. Check travel of cable	☑	☐	☐
19. Piping and conduit securely bracketed	☑	☐	☐

	YES	NO	N/A
20. Proper separation between fryers and flame	☐	☐	☑
21. Proper clearance – flame to filters	☐	☐	☑
22. Exhaust fan in operating order	☑	☐	☐
23. All filters replaced	☑	☐	☐
24. Fuel shut-off in on position	☐	☐	☑
25. Manual and remote set/seals in place	☑	☐	☐
26. Replace system covers	☑	☐	☐
27. System operational and seals in place	☑	☐	☐
28. Slave system operational	☐	☐	☑
29. Clean cylinder and mount	☑	☐	☐
30. Fan warning sign on hood	☐	☐	☑
31. Proper signage and personnel instructed in manual operation of system	☑	☐	☐
32. Proper hand portable extinguishers	☑	☐	☐
33. K-Class fire extinguisher in cooking area	☑	☐	☐
34. Portable extinguishers properly serviced	☑	☐	☐
35. Service & Certification tag on system	☑	☐	☐
36. Safety chains on all gas appliances attached and secured	☐	☐	☑

37. Status of grease build-up in the hood and duct opening
☑ CLEAN ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

★ NOTE DISCREPANCIES OR DEFICIENCIES BELOW ★

COMMENTS Note- testing In-Accordance with NFPA96 (2012 edition)
(Note- Hood Not in use at this time)
(- Note #9 system Due for 12yr-Hydro-test Next year 2026!)

X Doug Dmejdl — SERVICE TECHNICIAN

KM011794 — PERMIT NO.

8/5/25 — DATE

Kim Hoover — CUSTOMER'S AUTHORIZED AGENT

THE ABOVE SERVICE TECHNICIAN CERTIFIES THAT THE SYSTEM WAS PERSONALLY INSPECTED AND CONDITIONS WERE FOUND TO BE AS INDICATED ON THIS REPORT.

WHITE - CUSTOMER YELLOW - DISTRIBUTOR PINK - AUTHORITY HAVING JURISDICTION

Bld. # 14

SUMMIT FIRE PROTECTION
SummitFire.com

PRE-ENGINEERED FIRE SYSTEM INSPECTION AND MAINTENANCE REPORT

Branch Office 1104 **Work Order** 24965971

Phone No.: 402-476-4646

NAME Lincoln Regional Center

ADDRESS 801 N. Prospect Pl.

CITY Lincoln, NE. 68522

TELEPHONE 402-405-3635 STORE NO.

OWNER OR MANAGER Andy Miller

NON-COMPLIANT SYSTEMS MAY FAIL TO EXTINGUISH/SUPPRESS A FIRE

ANNUAL	SEMI-ANNUAL X	RECHARGE	INSTALLATION	RENOVATION
LOCATION OF SYSTEMS CYLINDERS: Hood enclosure				
MANUFACTURER: Ansul	MODEL NUMBER: R-102	WET CHEMICAL: X	DRY CHEMICAL	
CYLINDER SIZE MASTER: 3 gal.	CYLINDER SIZE SLAVE: —	CYLINDER SIZE SLAVE: —		
MANIFOLDED ☐ YES ☑ NO	PIRANHA WATERFLOW PRESSURE: —			
FUSE LINKS 360°F: 2-360	FUSE LINKS 450°F: —	FUSE LINKS 500°F: —	OTHER: —	
MECHANICAL GAS VALVE(S) & SIZE(S): —	ELECTRICAL GAS VALVE(S) & SIZE(S): —	MANUAL RESET RELAY ☐ YES ☑ NO		
LAST HYDRO TEST DATE: 2020	ELECTRIC CONNECTED ☑ YES ☐ NO			

COOKING APPLIANCE LOCATIONS and SIZES *(LEFT TO RIGHT)*

Oven							

	YES	NO	N/A
1. System interlocked with building fire alarm.	☑	☐	☐
2. Duct and plenum covered with correct nozzles.	☑	☐	☐
3. Check positioning of all nozzles.	☑	☐	☐
4. Systems installed per U.L. 300 standards and meets manufacturer's U.L. listing and N.F.P.A standards.	☑	☐	☐
5. Hood/duct penetrations sealed with weld or U.L. device	☑	☐	☐
6. Check if seals intact, evidence of tampering	☑	☐	☐
7. Pressure gauge in proper range (if gauged)	☐	☐	☑
8. Check cartridge weight (if applicable) #2 1/4 oz	☑	☐	☐
9. Dry system 6-year maintenance date / Wet system 12-year hydro test date 2032 x 1	☑	☐	☐
10. Inspect cylinder and mount	☑	☐	☐
11. Operate system from terminal link	☑	☐	☐
12. Test for proper operation from remote	☑	☐	☐
13. Check operation of micro switch	☑	☐	☐
14. Check operation of gas valve	☐	☐	☑
15. Clean nozzles	☑	☐	☐
16. Proper nozzle covers in place	☑	☐	☐
17. Replaced fuse links x 1	☑	☐	☐
18. Check travel of cable	☑	☐	☐
19. Piping and conduit securely bracketed	☑	☐	☐

	YES	NO	N/A
20. Proper separation between fryers and flame	☐	☐	☑
21. Proper clearance - flame to filters	☐	☐	☑
22. Exhaust fan in operating order	☑	☐	☐
23. All filters replaced	☐	☐	☑
24. Fuel shut-off in on position	☑	☐	☐
25. Manual and remote set/seals in place	☑	☐	☐
26. Replace system covers	☑	☐	☐
27. System operational and seals in place	☑	☐	☐
28. Slave system operational	☐	☐	☑
29. Clean cylinder and mount	☑	☐	☐
30. Fan warning sign on hood	☑	☐	☐
31. Proper signage and personnel instructed in manual operation of system	☑	☐	☐
32. Proper hand portable extinguishers	☑	☐	☐
33. K-Class fire extinguisher in cooking area	☑	☑	☐
34. Portable extinguishers are properly serviced	☑	☐	☐
35. Service & Certification tag on system	☑	☐	☐
36. Safety chains on all gas appliances attached and secured	☐	☐	☑

37. Status of grease build-up in the hood and duct opening
☑ CLEAN ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ EXCESSIVE

COMMENTS Note - Tested In Accordance with NFPA 96 (2012 edition)

X Dave Amajedi	KM1179LL	8/5/25	Kim Howell
SERVICE TECHNICIAN	PERMIT NO.	DATE	CUSTOMER'S AUTHORIZED AGENT

AUTOMATIC FIRE SUPPRESSION SYSTEM INSPECTION REPORT

Bld # 10

Date 8/5/25 Work Order No. 04965971 ☑ Semi-Annual ☐ Acceptance

SUMMIT
FIRE PROTECTION
2431 Fairfield Street, Lincoln, NE 68521 · (402) 476-4646 · (800) 228-4555

Customer Lincoln Regional Center Bld # 10
Address 801 W. Prospector PL. Lincoln, NE. 68522
Contact Andy Millar 402-405-3635
Protected Area Kitchen Hoods (Main Kitchen)
Address Same
Panel Mfg. & Model Captiveaire (Core System) Agent Water
Monitored By Permar ☐ Directly ☑ VIA Fire Alarm System

Explanation of markings
☑ PASSED
☐ NOT APPLICABLE
☒ SEE COMMENTS

SIGNALING DEVICES

		QUANTITY
☐	Smoke Detectors	
	Ionization Type	
	Photoelectric Type	
☑	Heat Detectors	3
☐	Flame Detectors	
☑	Manual Stations	1

AUDIBLE ALARM DEVICES

		TYPE	
☐	1st Alarm		
☐	Pre-Discharge		
☑	Discharge	Core Panel	1

VISUAL ALARM DEVICES

☐	1st Alarm	
☐	Pre-Discharge	
☑	Discharge (Core Panel)	1

DISCHARGE FUNCTIONS

☐	Time Delay (Seconds)	
☑	Release Circuits	2
☑	Release Modules, Heads or Solenoids	3
☐	Abort Switches	

AUXILIARY RELAYS FUNCTION

☑	1st Alarm	FACP
☐	Pre-Discharge	
☑	Discharge	Gas/make-up Air/ electrical shunt-trip
☑	Trouble	FACP

GENERAL SYSTEM AND AREA CHECKS

☐	System Operation on Batteries (Date Due)	2025
☑	Batteries Under One Amp Load (Volts)	27V
☐	Annunciators	
☑	Panel Lights	
☐	Auxiliary Power Supply (Volts)	
☑	Area Integrity and Design Unchanged	
☑	Piping and Nozzles Secure	
☐	Sub-Floor Clean	
☑	Portable Fire Extinguishers Current	
☑	Personnel Instructed on System Operation	DA
☐	Personnel Declined Operating Instructions	

VISUAL CONTAINER INSPECTION

☐	Cylinder Condition (Quantity)	
☑	Pressure (Core Domestic Water)	OK
☑	Level Readings (Surfactant)	OK
☐	Hydro-Test Current (Date Due)	
☐	10-Year Initiator Replacement (Date Due)	

COMMENTS: Note- testing In-Accordance with NFPA 96 (2012 edition)

INSPECTOR Doug Dwight LICENSE # KA0117944

CLIENT X Kris Havel

I have been advised of the above problem(s), but DO NOT authorize repair at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	500004	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	801 W PROSPECTOR PLACE LINCOLN, NE 68522

(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
D 000	Initial Comments On 3/25/2024-3/28/2024, DHHS Public Health representatives conducted a licensure survey and complaint investigation to determine compliance with 175 NAC 1, Licensure Regulations for Hospitals. The facility was in compliance with the regulations at the time of survey.	D 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU030	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	FOLSOM & PROSPECTOR, BUILDING 14 LINCOLN, NE 68509

(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
D 050	005.04 Complaints and Grievances A licensee must establish, implement and revise as necessary, written policies and procedures to promptly address complaints or grievances filed verbally or in writing. The policies and procedures must include: (A) Information regarding how the consumer or designee may submit a complaint or grievance; (B) Timeframes for investigative review and for a response to the consumer or designee; (C) How the licensee will utilize information from complaints and grievances to improve the quality of care and treatment provided; and (D) How the licensee will maintain records of complaints and grievances received, actions taken and resolution. This Standard is not met as evidenced by: . Based on record review and interview the facility failed to follow their policy on Complaints and Grievances regarding timeframe's for investigative review and for a response to the consumer or designee. This had the potential to affect all clients at the facility. The facility census was 64 at the time of the complaint investigation survey. Findings: Record Review of the facility's 4/25/2025 Complaints and Grievance policy revealed that in each unit of the facility there is a complaint and grievance box, that is collected by staff daily. The responder is to respond to the complainant by listing the investigative steps taken on behalf of the complainant and the results of the compliant process and decision and the date they met with the complainant. The responder is responsible for providing the complainant with a copy of the "My	D 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU030	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	FOLSOM & PROSPECTOR, BUILDING 14 LINCOLN, NE 68509

(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
D 050	Continued From page 1 Voice Compliant Response Form" within 14 business days from the date it was submitted. If this time frame needs to be extended, the responder must inform the complainant in writing. This needs to be provided every time an extension is granted. Record Review on the facility's Complaints and Grievances Log from 2/20/2025 to 8/19/2025 revealed the following grievances were not responded to in a timely manner: Client 2 submitted a grievance on 2/20/2025 and the date it was responded to was 8/14/2025 Client 3 submitted a grievance on 2/23/2025 and the date it was responded to was 8/15/2025 Client 4 submitted a grievance on 5/15/2025, and another grievances on 5/16/2025 and the date responded to was 8/14/2025. Record Review of the "My Voice Complaint Response Form" for identified grievances revealed the following: Client 2 Date Received by Responder: Unknown Name of Responder: Unknown Complaint: Staff was rude, unknown when interaction occurred. Results to Complaint Processes and Decision: Patient Processed with individual therapist. Patient Signature: (marked with a 0) Client 3 Date Received by Responder: Unknown Name of Responder: Unknown Date Met with Patient: Unknown Complaint: Undiagnosed Tourette's Syndrome Results to Complaint Process and Decision: Doctor has ongoing sessions with patient. Patient contacted the Ombudsman office with concerns.	D 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU030	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	FOLSOM & PROSPECTOR, BUILDING 14 LINCOLN, NE 68509

(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
D 050	Continued From page 2	D 050		

Response to Ombudsman- Medical Director consulted with Treatment team, more information was being collected.
Patient Signature: Patient not available
Attached was an email from the Ombudsman office following up on the patients concerns dated 8/14/2025

Client 4
Date Complaint Received: 5/15/2025
Date and time Response was given to Compliance: 8/14/2025
Complaint: Heat Restriction due to staff shortages
Response: If all patients cant go outside, staff shouldn't allow just one. Ensure outside time during the summer.
Client 4 signed the response form and was satisfied with its resolution 8/14/2025

Date Complaint Received:5/16/2025
Date and time Response was given to Compliance: 8/14/2025
Complaint: Staff supervision issues and room searches
Response: Staff and Lead talked to. Allowed to walk away to calm down when needed.
Client 4 signed the response form and was satisfied with its resolution 8/14/2025

Interview on 8/19/2025 at 10:30 am with the Director of Social Work stated that they were in the process of improving the complaint and grievance system, and that they had recently updated the Complaint and Grievance Policy on 4/25/2025. The grievance and response tracking system is in place for all grievances following the new updated policy. Director of Social Work stated that in an attempt to catch up grievances prior to the grievance policy change, they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU030	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	FOLSOM & PROSPECTOR, BUILDING 14 LINCOLN, NE 68509

(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
D 050	Continued From page 3 went back and reviewed client records to see if clients had their concerns met around the time they had made the grievance. This information was used to fill out the "My Complaint Response Form" on 8/14/2025 and 8/15/2025. When asked why the clients did not sign the response form, the Director of Social Work stated that sometimes clients refuse to sign. The Director of Social Work acknowledged that there was no part on the form that identified that the clients refused to sign. Interview on 8/19/2025 at 11:00 am with the Compliance Administrator confirmed that the grievance responses to the identified grievances did not follow the current policy and were not completed in a timely manner.	D 050		

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

Jim Pillen, Governor

August 22, 2025

Mitchell Bruening, Administrator
Lincoln Regional Center
Folsom & Prospector, Building 14
Lincoln, NE 68509

Dear Mr. Bruening:

An unannounced visit was made to Lincoln Regional Center on August 14- 19, 2025, by representatives of this Department. The purpose of the visit was to investigate a complaint on non-compliance with regulatory requirements received by our office.

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

ALLEGATION:
1. The facility fails to ensure the clients are free from abuse and neglect.
2. The facility fails to provide ongoing training regarding management of resistive behaviors.
3. The facility fails to allow patients/families to participate in treatment and discharge plans.

FINDINGS:
1. Based on record reviews and interview the facility is in compliance with the regulations as they relate to the allegation. The facility had various policies and procedures in place to ensure that patients are protected from abuse. The facility conducted an internal investigation which included video footage. The facility took the appropriate steps to keep the clients safe and free from abuse.

2. Based on record reviews and interview the facility is in compliance with the regulations as they relate to the allegation. The facility had various policies and procedures in place to ensure staff is trained on resistive behaviors. The following polices are in place and a plan of action is in place to have trainings completed on the Abuse or Neglect Responsibilities, Fall Prevention, and Therapeutic Environment.

3. Based on observation, record review and interviews, the facility is compliance with the regulations as they relate to the allegation. The facility includes the client in all treatment plans and meets with them on a regular basis. The clinical team completes a monthly meeting with the client to review their requests and plans for discharge. The facility has a system in place to receive comments and concerns from family and visitors to the facility. The environmental tour of the facility revealed no safety concerns.

Please see the enclosed letter for instructions on completion and submission of the plan of correction for the deficiency(ies) found during the complaint investigation. Please contact this office if you have questions.

Sincerely,

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94669, Lincoln, NE 68509-4669
Email: mark.luger@nebraska.gov

Division of Public Health
(402) 471-4975
FAX: (402) 742-2326

EID:SNNH11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	500004	A. BUILDING: _____ B. WING _____	C 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN REGIONAL CENTER	801 W PROSPECTOR PLACE LINCOLN, NE 68522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments On 10/14/2025 - 10/20/2025, DHHS Public Health representatives conducted a complaint investigation to determine compliance with 175 NAC 9, Licensure 006.16 Patient Rights Regulations for Hospitals. The facility was in compliance with the regulations at the time of survey.	I 000		

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

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 27, 2025

Mitchell Bruening, Administrator
Lincoln Regional Center
801 W Prospector Place
Lincoln, NE 68522-4949

Dear Mr. Bruening:

An unannounced visit was conducted to Lincoln Regional Center on October 14 - 20, 2025, by representatives of the Department of Health and Human Services Division of Public Health. The purpose of the visit was to investigate complaints on non-compliance with regulatory requirements received by our office. To complete these investigations, a representative sample of patients was selected. The investigative process included review of medical records, observations completed, review of policy and procedures, and administrative and staff interviews.

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

ALLEGATION:

1. The facility failed to ensure that patient rights are protected.
2. The facility failed to ensure the staff followed policies and procedures to provide care in a safe setting.
3. The facility fails to monitor and treat patients for side effects of medications.

FINDINGS:

1. Based on medical record review, policy review, video review, observations, and administrative interviews, the facility did ensure patient rights were protected through safety precautions that are implemented and updated by the treatment team. The facility conducted an internal investigation of staff adherence to policies and procedures to keep the patients safe.
2. Based on medical record review, policy and procedure review, and administrative interviews, the facility did ensure staff follow policies and procedures through internal investigations, ongoing training and education to the staff to ensure compliance is maintained to provide care in a safe setting.
3. Based on medical record review, policy and procedure review, observations, and pharmacy staff interviews the facility ensured court ordered medication was therapeutically managed through the provider, pharmacist and nursing does monitor for side effects and reports to the provider.

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,

BJ Knoell Morehouse RN

Billye Jo Knoell Morehouse BS, RN, LNC – Program Manager RN
DHHS Public Health – Licensure Unit
Acute Care Facilities
PO Box 94669, Lincoln, NE 68509-4669
Email: BJ.Morehouse@nebraska.gov

BKM/lc

Enclosed: State Form 175 NAC 9

Department of Health and Human Services
Division of Public Health
Health Facilities Licensure Unit
301 Centennial Mall South, P O Box 94669
Lincoln, NE 68509-4669

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

Lincoln Regional Center

MEETS STATUTORY REQUIREMENTS AS
PSYCHIATRIC HOSPITAL
Lic # 500004

EXPIRES
12/31/2025

Cut on heavy line and place on license.

FACILITY NAME: Lincoln Regional Center
ADDRESS: 801 W PROSPECTOR PLACE, 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.

Backflow Preventer Test Form

402.441.5912 ● e-mail: Backflow@lincoln.ne.gov ● FAX: 402.441.8003

Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 3 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# Na e-mail: kris.hoover@nebraska.gov

Device Location South wall lower level

☑ Annual Test ☐ Repair ☐ New Installation

☑ DC ☐ RPP Serial #: U00792 Size: 4 Manufacturer: Wilkins Model#: 350a

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☑ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve		Pressure Vacuum Breaker	
Shut off #2	Held ☑ Yes ☐ No	Shut off #1	Held ☐ Yes ☐ No
Check Valve #1 2.8 PSID	Held ☑ Yes ☐ No	Shut off #2	Held ☐ Yes ☐ No
Check Valve #2 3.7 PSID	Held ☑ Yes ☐ No	Check Valve Held at ____ ____ PSID	
Relief Valve (RP only) Opened at ____ ____ PSID		Air vent opened at ____ ____ PSID	

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	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 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. **Must be returned to LWS within 30 days of performing test.**

Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

PLEASE TYPE OR PRINT LEGIBLY

White Copy - LWS Yellow Copy - Contractor Pink Copy - Business

Backflow Preventer Test Form

402.441.5912 ● e-mail: Backflow@lincoln.ne.gov ● FAX: 402.441.8003

Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 5 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-471-4444 e-mail: kris.hoover@nebraska.gov

Device Location Basement fire line

☑ Annual Test ☐ Repair ☐ New Installation

☑ DC ☐ RPP Serial #: H47912 Size: 4 Manufacturer: Ames Model#: Derringer 20

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☑ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 2.9 PSID Held ☑ Yes ☐ No

Check Valve #2 3.1 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at PSID

Air vent opened at PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	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 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. **Must be returned to LWS within 30 days of performing test.**

Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Backflow Preventer Test Form

402.441.5912 ● e-mail: Backflow@lincoln.ne.gov ● FAX: 402.441.8003

Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location Basement

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: 50718 Size: 1 Manufacturer: Watts Model#: 919qt

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☑ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 8.4 PSID Held ☑ Yes ☐ No

Check Valve #2 1.6 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at 2.3 PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at PSID

Air vent opened at PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Backflow Preventer Test Form

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Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location Basement chiller

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: Sy812 Size: 1 Manufacturer: Conbraco Model#: 40205t2

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☑ Other (Desc): Chiller

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 7.3 PSID Held ☑ Yes ☐ No

Check Valve #2 1.8 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at 2.3 PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at PSID

Air vent opened at PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Backflow Preventer Test Form

402.441.5912 ● e-mail: Backflow@lincoln.ne.gov ● FAX: 402.441.8003

Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 10 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# Na e-mail: kris.hoover@nebraska.gov

Device Location West side lower level

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: 328452 Size: 1/2 Manufacturer: Watts Model#: 009qt

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☑ Other (Desc): Dental chair

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 _____ 7.9 PSID Held ☑ Yes ☐ No

Check Valve #2 _____ 1.8 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at _____ 2.3 PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at _____ _____ PSID

Air vent opened at _____ _____ PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments: _____

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Backflow Preventer Test Form

402.441.5912 ● e-mail: Backflow@lincoln.ne.gov ● FAX: 402.441.8003

Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 10 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# Na e-mail: kris.hoover@nebraska.gov

Device Location West side lower level

☑ Annual Test ☐ Repair ☐ New Installation

☑ DC ☐ RPP Serial #: N0702010539 Size: 6 Manufacturer: Febco Model#: 850

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☑ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve		Pressure Vacuum Breaker	
Shut off #2	Held ☑ Yes ☐ No	Shut off #1	Held ☐ Yes ☐ No
Check Valve #1 1.5 PSID	Held ☑ Yes ☐ No	Shut off #2	Held ☐ Yes ☐ No
Check Valve #2 1.4 PSID	Held ☑ Yes ☐ No	Check Valve Held at ____ ____ PSID	
Relief Valve (RP only) Opened at ____ ____ PSID		Air vent opened at ____ ____ PSID	

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Backflow Preventer Test Form

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Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location North wall boiler plant

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: 124467 Size: 2 Manufacturer: Watts Model#: 009

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☑ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve		Pressure Vacuum Breaker	
Shut off #2	Held ☑ Yes ☐ No	Shut off #1	Held ☐ Yes ☐ No
Check Valve #1 7.9 PSID	Held ☑ Yes ☐ No	Shut off #2	Held ☐ Yes ☐ No
Check Valve #2 1.4 PSID	Held ☑ Yes ☐ No	Check Valve Held at	PSID
Relief Valve (RP only) Opened at 2.2 PSID		Air vent opened at	PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Backflow Preventer Test Form

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Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location East wall boiler plant

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☐ RPP Serial #: K10184 Size: 4 Manufacturer: Watts Model#: 757

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☑ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 1.7 PSID Held ☑ Yes ☐ No

Check Valve #2 1.5 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at PSID

Air vent opened at PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location East wall pump room

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: 00799t Size: 1 Manufacturer: Conbraco Model#: 402055t2

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☑ Other (Desc): Heat and cooling loop

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 _____ 7.9 PSID Held ☑ Yes ☐ No

Check Valve #2 _____ 1.4 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at _____ 2.2 PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at _____ _____ PSID

Air vent opened at _____ _____ PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments: _____

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Return to: Lincoln Water System Backflow 2021 North 27th Street, Lincoln, NE 68503

Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location East wall pump room

☑ Annual Test ☐ Repair ☐ New Installation

☐ DC ☑ RPP Serial #: 00799t Size: 1 Manufacturer: Conbraco Model#: 402055t2

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☐ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☑ Other (Desc): Heat and cooling loop

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 _____ 7.9 PSID Held ☑ Yes ☐ No

Check Valve #2 _____ 1.4 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at _____ 2.2 PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at _____ _____ PSID

Air vent opened at _____ _____ PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments: _____

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Business/Building Lincoln Regional Center B 14 Contact Person Kris Hoover

Service Address 801 West Prospector Suite#

Phone# 402-479-5452 e-mail: kris.hoover@nebraska.gov

Device Location Basement

☑ Annual Test ☐ Repair ☐ New Installation

☑ DC ☐ RPP Serial #: U28690 Size: 4 Manufacturer: Wilkins Model#: 350a

☐ Replacement

☐ DC ☐ RPP Serial #: Size: Manufacturer: Model#:

☐ Domestic Containment ☐ Irrigation ☑ Fire Service ☐ Boiler ☐ Carbonator

☐ Swimming Pool ☐ Cooling Tower ☐ Water Cooled Ice Maker ☐ Other (Desc):

Reduced Pressure-Double Check Valve

Shut off #2 Held ☑ Yes ☐ No

Check Valve #1 3.1 PSID Held ☑ Yes ☐ No

Check Valve #2 2.8 PSID Held ☑ Yes ☐ No

Relief Valve (RP only) Opened at PSID

Pressure Vacuum Breaker

Shut off #1 Held ☐ Yes ☐ No

Shut off #2 Held ☐ Yes ☐ No

Check Valve Held at PSID

Air vent opened at PSID

Final Test: Check Valve #1	Check Valve #2	Pressure Relief	PVB/SVB
	Closed Tight ☐ Yes ☐ No		Check Valve PSID
PSID	PSID	Replaced PSID	Air Inlet PSID

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Jerad Baxter	NIFCO Mechanical Systems	8699	531-220-1709
State Certified Technician (Please Print)	Company	Grade 6 Certificate#	Cell/Phone#
			03/12/2025
State Certified Technician (Signature)	Customer (Signature)		Date of Test
Midwest	11132661		10/14/2024
Test Gauge Manufacturer	Test Gauge Serial #		Date of Calibration

Comments:

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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

David Pleiss
Chief Boiler Inspector

Doug Hohbein
State Fire Marshal

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

06/23/2025

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.

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 **6505825**

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

Location **2136496**

Lincoln Regional Center
801 W Prospector Pl
Lincoln, NE 68522-1970

State ID Number: NE01388
Type: FTSM - FTS Marine Dry Back
Last External Inspection: 04/29/2025
Expiration Date: 09/30/2025
Inspected By: Michael Hamer
Inspecting Agency: BVI&I
Last Internal Inspection: 10/03/2023
National Board Number: 36603

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 100 PSI
Manufacturer: Kewanee
Year Built: 1982
Print Date: 06/23/2025
Next Internal Due Date: 10/03/2024
Serial Number: R4781
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

Dave Pleiss

David Pleiss

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

David Pleiss
Chief Boiler Inspector

Doug Hohbein
State Fire Marshal

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

06/23/2025

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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 **6505825**

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

Location **2136496**

Lincoln Regional Center
801 W Prospector Pl
Lincoln, NE 68522-1970

State ID Number: NE01389
Type: FTSM - FTS Marine Dry Back
Last External Inspection: 04/29/2025
Expiration Date: 01/31/2026
Inspected By: Michael Hamer
Inspecting Agency: BVI&I
Last Internal Inspection: 07/12/2023
National Board Number: 36658

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 100 PSI
Manufacturer: Kewanee
Year Built: 1982
Print Date: 06/23/2025
Next Internal Due Date: 07/12/2025
Serial Number: P4907
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

Dave Pleiss

David Pleiss

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

David Pleiss
Chief Boiler Inspector

Doug Hohbein
State Fire Marshal

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

06/23/2025

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.

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 **6505825**

Lincoln Regional Center
ATTN: Thom Marsh
801 W Prospector Pl
Lincoln, NE 68522-1970

Location **2136496**

Lincoln Regional Center
801 W Prospector Pl
Lincoln, NE 68522-1970

State ID Number: NE01390
Type: FTWB - FTS Marine Wet Back
Last External Inspection: 04/29/2025
Expiration Date: 01/31/2026
Inspected By: Michael Hamer
Inspecting Agency: BVI&I
Last Internal Inspection: 07/12/2023
National Board Number: 36582

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 100 PSI
Manufacturer: Kewanee
Year Built: 1982
Print Date: 06/23/2025
Next Internal Due Date: 07/12/2025
Serial Number: P4722
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

Dave Pleiss

David Pleiss

E-DOCKET

Maintenance

NO. e-docket :US557184

US serial number :	**USV1008514**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**4076 - T BLDG #5**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : CAT1 - HY

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	4076 - T BLDG #5	
Unit	USV1008514	
SAFETY TEST	☑	
REQUIRED DOCUMENTATION	☑	
Material Used/Spare Parts Used	4076 - T BLDG #5 USV1008514-Hydraulic:	

Technician's comments and recommendations :

Annual test. Pass

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US557184

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1				11-Mar-2025	07:45 AM	08:45 AM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 11-03-2025

Called customer

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 17073

Name of Facility:	**Lincoln Regional Center Bldg #3**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Pl, Lincoln**
Maximum Occupancy:	**50 Beds**
Date Issued:	**12/12/2024**

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.

NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

FUEL SYSTEM

EQUIP NUM: RE300216

CAT D300

SERIAL NUMBER: RE300216

E330-55220-5203

LABEL#: 5203

SHOP JOB NUM : 14112

SAMPLE SHIP TIME (days) : 18

NEBRASKA GENERATOR SERVICE-LAVISTA

RECEIVED DATE: 08-Aug-25

No Action Required

Interp By: Alvin Lingenfelter

Interpreted On: 16-Aug-25

ALL TEST ARE PERFORMED IN ACCORDANCE WITH ASTM D-975 SAMPLE IS CLEAR AND RED IN COLOR. ALL TESTS APPEAR NORMAL FOR #2 DIESEL FUEL. RESAMPLE AT NORMAL INTERVAL.

SAMPLE INFORMATION

Sampled Date	21-Jul-25	03-Jun-24
Sample Id	E330-55220-5203	E330-54193-5216
Lab Date	08-Aug-25	11-Jul-24
Meter [Hr]	171	106
Meter On Fluid		
Fluid Brand		
Fluid Weight		
Fluid Type		
Fluid Change	N	N
Filter Change	N	N
Total Fluid Added	0	0

ELEMENTAL ANALYSIS

		21-Jul-25	03-Jun-24
ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]			
Cu	Copper	0	0
Fe	Iron	0	0
Cr	Chromium	0	0
Al	Aluminum	0	0
Pb	Lead	0	0
Sn	Tin	0	0
Si	Silicon	0	0
Na	Sodium	0	0
K	Potassium	0	0
Mo	Molybdenum	0	0
Ni	Nickel	0	0
Ag	Silver	0	0
Ti	Titanium	0	0
V	Vanadium	0	0
Ca	Calcium	0	0
P	Phosphorus	0	0
Zn	Zinc	0	0
Mg	Magnesium	0	0
B	Boron	0	0

PREVIOUS SAMPLE

ALL TEST ARE PERFORMED IN ACCORDANCE WITH ASTM D-975 SAMPLE IS CLEAR AND RED IN COLOR. TRACE AMOUNT OF DEBRIS IN SAMPLE, ALL OTHER TEST APPEAR NORMAL FOR #2 DIESEL. RESAMPLE AT NORMAL INTERVAL.

For additional sample history, go to: S.O.S WEB

PROPERTIES / PHYSICALS

		21-Jul-25	03-Jun-24
SULFUR (PPM) ASTM D5453			
SULFU	SULFUR	7	4
BIODIESEL (%) EN 14078			
Biodi	Biodiesel	1.32	0.09
FLASH POINT (°C) ASTM D93			
FL Pt	Flash Point	62.0	56.0
PHYSICAL			
App	Appearance	RED	H2O
PAmt	Precip Amount	none	trace
PProp	Precip Property		non-mag

CLEANLINESS / CONTAMINATION

		21-Jul-25	03-Jun-24
PARTICLE COUNT - ISO 11171:1999 reported per ISO 4406			
ISO	ISO Code Rating	18/16/12	H2O
4µ	4µ	1937	
6µ	6µ	530	
10µ	10µ	99	
14µ	14µ	29	
21µ	21µ	5	
38µ	38µ	0	
WATER CONTENT (%) ASTM D6304			
H2O	Water	0.00369	0.00332
MICROBIOLOGY			
Bact	Bacteria	<LDL	<LDL
Fung	Fungus	<LDL	<LDL

Notice: This analysis is intended as an aid in predicting mechanical wear. No guarantee, expressed or implied, is made against failure of this piece of equipment or component thereof.

FUEL SYSTEM
SERIAL NUMBER: RE300216
EQUIP NUM: RE300216
CAT D300

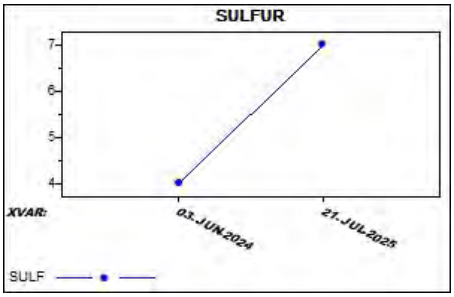
E330-55220-5203
No Action Required

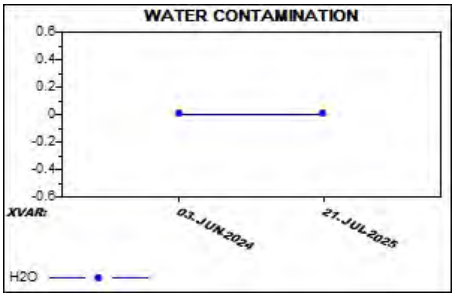
SAMPLE INFORMATION

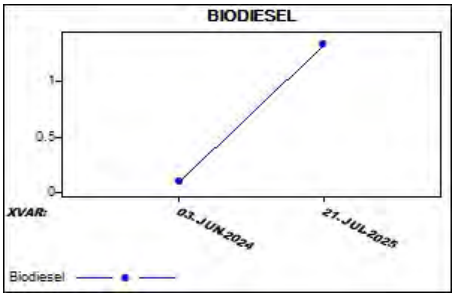
Sampled Date	21-Jul-25	03-Jun-24
Sample Id	E330-55220-5203	E330-54193-5216
Lab Date	08-Aug-25	11-Jul-24
Meter [Hr]	171	106
Meter On Fluid		
Fluid Brand		
Fluid Weight		
Fluid Type		
Fluid Change	N	N
Filter Change	N	N
Total Fluid Added	0	0

SEDIMENT

VOL	% Volume	0.000	0.000







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FUEL SYSTEM
SERIAL NUMBER: RE300216
EQUIP NUM: RE300216
CAT D300

E330-55220-5203

No Action Required

E330-55220-5203

E330-54193-5216

Report Comment

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FUEL SYSTEM

SERIAL NUMBER: RE300216

EQUIP NUM: RE300216

CAT D300

E330-55220-5203

No Action Required

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE | **EQUIP NUM: RE300216** | **SERIAL NUMBER: RE300216**

CAT D300

E330-55219-0073

LABEL#: 0073

SHOP JOB NUM : 14112

SAMPLE SHIP TIME (days) : 17

NEBRASKA GENERATOR SERVICE-LAVISTA

RECEIVED DATE: 07-Aug-25

No Action Required

NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. CONTINUE SAMPLING AT THE NORMAL INTERVAL.

Interp By: Mary E Churchill

Interpreted On: 10-Aug-25

SAMPLE INFORMATION

Sampled Date	21-Jul-25	03-Jul-24
Sample Id	E330-55219-0073	E330-54194-0112
Lab Date	07-Aug-25	12-Jul-24
Meter [Hr]	171.5	106
Meter On Fluid		
Fluid Brand	VALVOLINE	
Fluid Weight	15W-40	
Fluid Type		
Fluid Change	Y	N
Filter Change	Y	N
Kidney Loop	U	U
Total Fluid Added	0	0

WEAR LEVELS / ADDITIVES

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

		21-Jul-25	03-Jul-24
Cu	Copper	2	1
Fe	Iron	8	3
Cr	Chromium	0	0
Al	Aluminum	2	1
Pb	Lead	0	1
Sn	Tin	0	0
Si	Silicon	0	2
Na	Sodium	5	5
K	Potassium	11	5
Mo	Molybdenum	57	53
Ni	Nickel	0	0
Ag	Silver	0	0
Ti	Titanium	0	0
V	Vanadium	0	0
Cd	Cadmium	1	2
Ca	Calcium	1422	1216
P	Phosphorus	953	847
Zn	Zinc	1134	1004
Mg	Magnesium	959	788
Ba	Barium	0	0
B	Boron	44	42

PREVIOUS SAMPLE

NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. MORE SAMPLE HISTORY NEEDED TO ESTABLISH A NORMAL WEAR TREND. RESAMPLE AT THE NEXT SERVICE INTERVAL.

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

VISCOSITY (CENTISTOKES) ASTM D445

		21-Jul-25	03-Jul-24
V100	Viscosity at 100 C	12.30	12.80

INFRARED (UFM) ASTM E2412

ST	Soot	0	0
OXI	Oxidation	18	18
SUL	Sulfate By-Product	23	25
	Sulfur Products	23	25
NIT	Nitration	0	9

WATER

W	Water	N	N

ANTIFREEZE

A	Antifreeze	N	N

FUEL

F	Fuel	N	N

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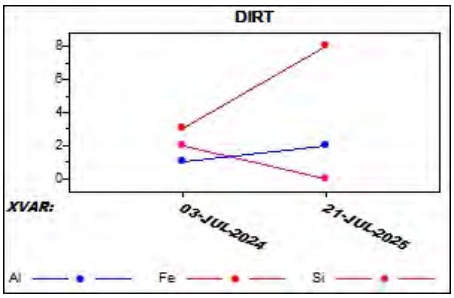
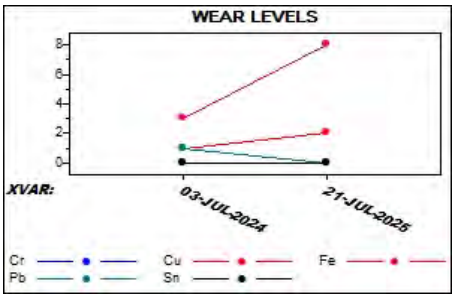
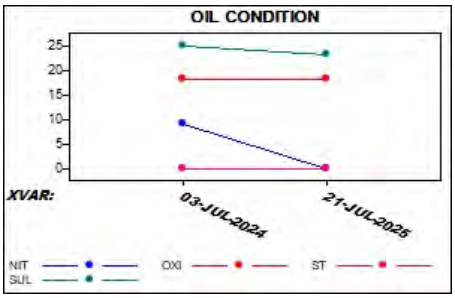
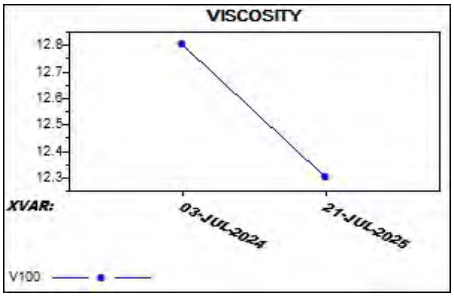
ENGINE
SERIAL NUMBER: RE300216
EQUIP NUM: RE300216
CAT D300

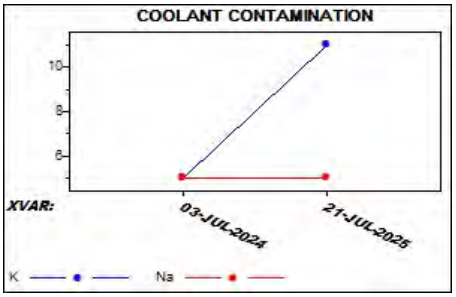
E330-55219-0073
No Action Required

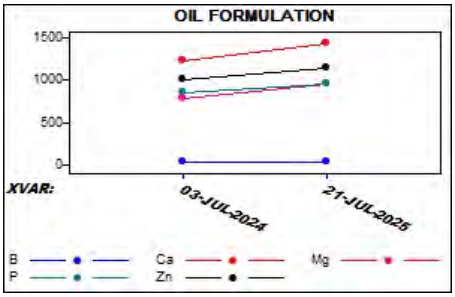












Report Comment

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E-DOCKET

Maintenance

NO. e-docket :US582856

US serial number :	**USV1008514**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**4076 - T BLDG #5**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	4076 - T BLDG #5	
Unit	USV1008514	
PERFORMED PREVENTATIVE MAINTENANCE	☑	
Material Used/Spare Parts Used	4076 - T BLDG #5 USV1008514-Hydraulic:	

Technician's comments and recommendations :

Pm

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US582856

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.75				02-Jun-2025	08:30 AM	09:15 AM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 02-06-2025

Called customer

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US557199

US serial number :	**USV1008559**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**4071 - #6**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : CAT1 - HY

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	4071 - #6
Unit	USV1008559
SAFETY TEST	☑
REQUIRED DOCUMENTATION	☑
Material Used/Spare Parts Used	4071 - #6 USV1008559-Hydraulic:

Technician's comments and recommendations :

Pm

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

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E-DOCKET

Maintenance

NO. e-docket :US557199

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1				11-Mar-2025	11:15 AM	12:15 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 11-03-2025

Customer not present

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

FUEL SYSTEM

EQUIP NUM: 7WG01892

CAT 3456

SERIAL NUMBER: 7WG01892

E330-55220-5205

LABEL#: 5205

SHOP JOB NUM : 14113

SAMPLE SHIP TIME (days) : 18

NEBRASKA GENERATOR SERVICE-KEARNEY

RECEIVED DATE: 08-Aug-25

No Action Required

Interp By: Alvin Lingenfelter

Interpreted On: 16-Aug-25

ALL TEST ARE PERFORMED IN ACCORDANCE WITH ASTM D-975 SAMPLE IS CLEAR AND RED IN COLOR. ALL TESTS APPEAR NORMAL FOR #2 DIESEL FUEL. RESAMPLE AT NORMAL INTERVAL.

SAMPLE INFORMATION

Sampled Date	21-Jul-25
Sample Id	E330-55220-5205
Lab Date	08-Aug-25
Meter [Hr]	851
Meter On Fluid	
Fluid Brand	
Fluid Weight	
Fluid Type	
Fluid Change	N
Filter Change	N
Total Fluid Added	0

ELEMENTAL ANALYSIS

21-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	0
Fe	Iron	0
Cr	Chromium	0
Al	Aluminum	0
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	0
K	Potassium	0
Mo	Molybdenum	0
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Ca	Calcium	0
P	Phosphorus	1
Zn	Zinc	1
Mg	Magnesium	0
B	Boron	0

For additional sample history, go to: S.O.S WEB

PROPERTIES / PHYSICALS

21-Jul-25

SULFUR (PPM) ASTM D5453

SULFU	SULFUR	11

BIODIESEL (%) EN 14078

Biodi	Biodiesel	1.07

FLASH POINT (°C) ASTM D93

FL Pt	Flash Point	62.0

PHYSICAL

App	Appearance	RED
PAmt	Precip Amount	none

CLEANLINESS / CONTAMINATION

21-Jul-25

PARTICLE COUNT - ISO 11171:1999 reported per ISO 4406

ISO	ISO Code Rating	16/14/10
4µ	4µ	550
6µ	6µ	126
10µ	10µ	21
14µ	14µ	6
21µ	21µ	1
38µ	38µ	0

WATER CONTENT (%) ASTM D6304

H2O	Water	0.00333

MICROBIOLOGY

Bact	Bacteria	<LDL
Fung	Fungus	<LDL

SEDIMENT

VOL	% Volume	0.000

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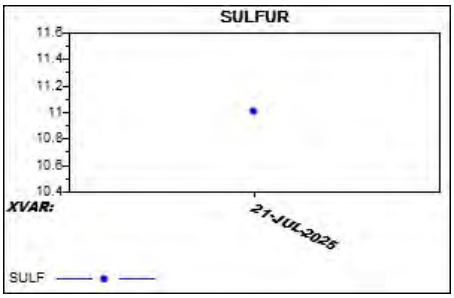
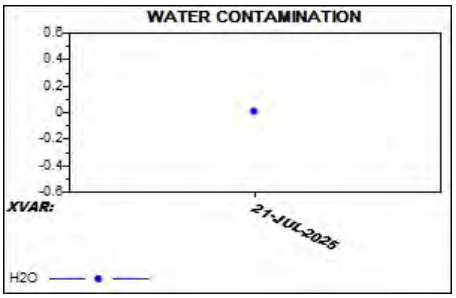
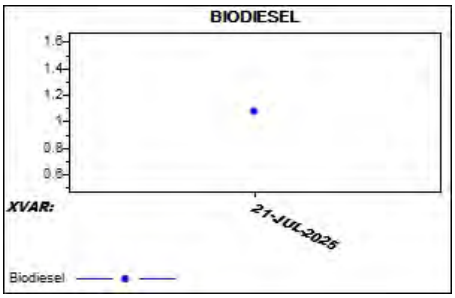
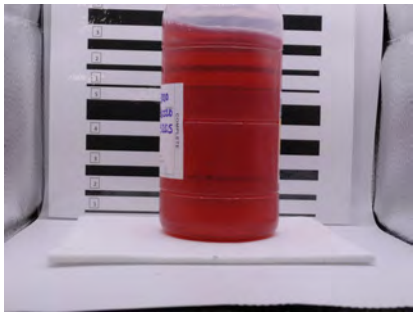
FUEL SYSTEM
SERIAL NUMBER: 7WG01892
EQUIP NUM: 7WG01892
CAT 3456

E330-55220-5205
No Action Required









E330-55220-5205

Report Comment

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PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE GENSET | **EQUIP NUM: 7WG01892** | **SERIAL NUMBER: 7WG01892**

CAT 3456

E330-55219-0069

LABEL#: 0069

SAMPLE SHIP TIME (days) : 17

NEBRASKA GENERATOR

SERVICE-KEARNEY

RECEIVED DATE: 07-Aug-25

No Action Required

Interp By: Mary E Churchill

Interpreted On: 10-Aug-25

UNKNOWN TIME ON OIL. THE OIL VISCOSITY @ 100C IS LOW FOR A 15W-40 BUT NORMAL FOR A 10W-30.OTHER ANALYSIS READINGS APPEAR TO BE ACCEPTABLE. MORE SAMPLE HISTORY NEEDED TO ESTABLISH A NORMAL WEAR TREND. RESAMPLE AT THE NEXT SERVICE INTERVAL.

SAMPLE INFORMATION

Sampled Date	21-Jul-25
Sample Id	E330-55219-0069
Lab Date	07-Aug-25
Meter [Hr]	
Meter On Fluid	
Fluid Brand	VALVOLINE
Fluid Weight	15W-40
Fluid Type	
Fluid Change	Y
Filter Change	Y
Make Up Fluid []	0
Kidney Loop	U
Total Fluid Added	0

WEAR LEVELS / ADDITIVES

21-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	26
Fe	Iron	3
Cr	Chromium	0
Al	Aluminum	2
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	4
K	Potassium	0
Mo	Molybdenum	60
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Cd	Cadmium	1
Ca	Calcium	1426
P	Phosphorus	972
Zn	Zinc	1171
Mg	Magnesium	931
Ba	Barium	0
B	Boron	44

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

21-Jul-25

VISCOSITY (CENTISTOKES) ASTM D445

V100	Viscosity at 100 C	11.70

INFRARED (UFM) ASTM E2412

ST	Soot	0
OXI	Oxidation	19
SUL	Sulfate By-Product	23
NIT	Nitration	0

WATER

W	Water	N

ANTIFREEZE

A	Antifreeze	N

FUEL

F	Fuel	N

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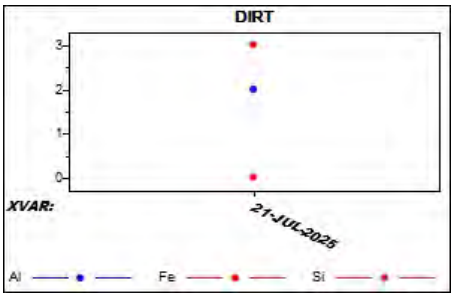
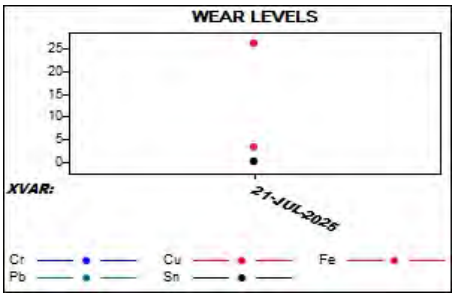
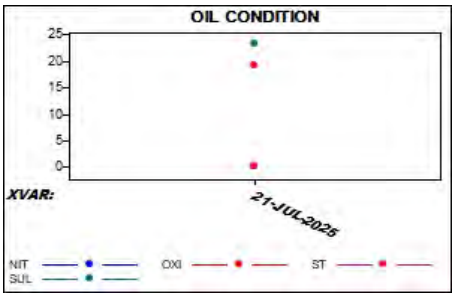
ENGINE GENSET
SERIAL NUMBER: 7WG01892
EQUIP NUM: 7WG01892
CAT 3456

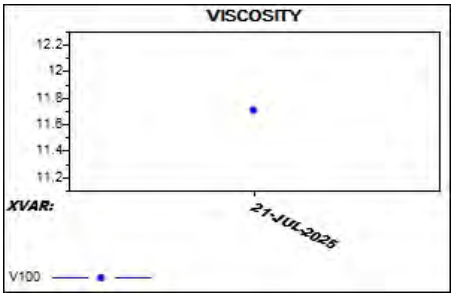
E330-55219-0069

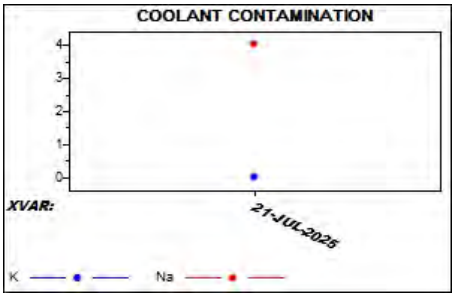
No Action Required

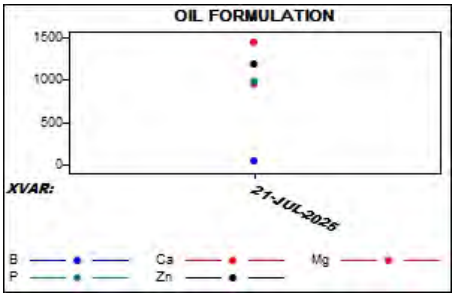












Report Comment

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E-DOCKET

Maintenance

NO. e-docket :US597212

US serial number :	**USV1008536**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**6403 - #1**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	6403 - #1
Unit	USV1008536
PERFORMED PREVENTATIVE MAINTENANCE	☑
Material Used/Spare Parts Used	6403 - #1 USV1008536-Hydraulic:

Technician's comments and recommendations :

Pm. Checked HWA. Working but flaky. Troubleshot and found a loose connection at key switch. Tightened and verified operation. Working as should.

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US597212

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.75				17-Jul-2025	01:30 PM	02:15 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 17-07-2025

Called customer

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E-DOCKET

Maintenance

NO. e-docket :US557527

US serial number :	**USV1008504**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7165 - K BLDG #3**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : CAT1 - HY

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	7165 - K BLDG #3
Unit	USV1008504
SAFETY TEST	☑
REQUIRED DOCUMENTATION	☑
Material Used/Spare Parts Used	7165 - K BLDG #3 USV1008504-Hydraulic:

Technician's comments and recommendations :

Annual test pass

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US557527

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1.5				12-Mar-2025	11:30 AM	01:00 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 12-03-2025

Called customer

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E-DOCKET

Maintenance

NO. e-docket :US557215

US serial number :	**USV1008088**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7182 - NORTH #1**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : CAT1 - HY

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	7182 - NORTH #1
Unit	USV1008088
SAFETY TEST	☑
REQUIRED DOCUMENTATION	☑
Material Used/Spare Parts Used	7182 - NORTH #1 USV1008088-Hydraulic:

Technician's comments and recommendations :

Annual test. Pass

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US557215

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1.25				11-Mar-2025	01:45 PM	03:00 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 11-03-2025

Called customer

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NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 16870

Name of Facility:	**Lincoln Regional Center Bldg #10 Psych Rehab**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Pl, Lincoln**
Maximum Occupancy:	**45 Beds**
Date Issued:	**10/1/2024**

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.

NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

FUEL SYSTEM

EQUIP NUM: FTE04110

CAT C15

SERIAL NUMBER: FTE04110

E330-55220-5208

LABEL#: 5208

SHOP JOB NUM : 14119

SAMPLE SHIP TIME (days) : 17

NEBRASKA GENERATOR SERVICE-KEARNEY

RECEIVED DATE: 08-Aug-25

No Action Required

Interp By: Alvin Lingenfelter

Interpreted On: 16-Aug-25

ALL TEST ARE PERFORMED IN ACCORDANCE WITH ASTM D-975 SAMPLE IS CLEAR AND RED IN COLOR. ALL TESTS APPEAR NORMAL FOR #2 DIESEL FUEL. RESAMPLE AT NORMAL INTERVAL.

SAMPLE INFORMATION

Sampled Date	22-Jul-25
Sample Id	E330-55220-5208
Lab Date	08-Aug-25
Meter [Hr]	175.7
Meter On Fluid	175.7
Fluid Brand	
Fluid Weight	
Fluid Type	
Fluid Change	N
Filter Change	N
Total Fluid Added	0

ELEMENTAL ANALYSIS

22-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	0
Fe	Iron	0
Cr	Chromium	0
Al	Aluminum	0
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	0
K	Potassium	0
Mo	Molybdenum	0
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Ca	Calcium	0
P	Phosphorus	1
Zn	Zinc	0
Mg	Magnesium	0
B	Boron	0

For additional sample history, go to: S.O.S WEB

PROPERTIES / PHYSICALS

22-Jul-25

SULFUR (PPM) ASTM D5453

SULFU	SULFUR	7

BIODIESEL (%) EN 14078

Biodi	Biodiesel	1.16

FLASH POINT (°C) ASTM D93

FL Pt	Flash Point	64.0

PHYSICAL

App	Appearance	RED
PAmt	Precip Amount	none

CLEANLINESS / CONTAMINATION

22-Jul-25

PARTICLE COUNT - ISO 11171:1999 reported per ISO 4406

ISO	ISO Code Rating	19/16/12
4µ	4µ	2642
6µ	6µ	592
10µ	10µ	119
14µ	14µ	37
21µ	21µ	9
38µ	38µ	0

WATER CONTENT (%) ASTM D6304

H2O	Water	0.00219

MICROBIOLOGY

Bact	Bacteria	<LDL
Fung	Fungus	<LDL

SEDIMENT

VOL	% Volume	0.000

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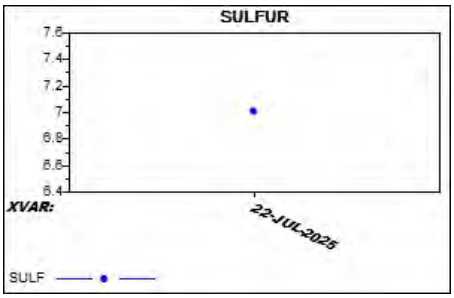
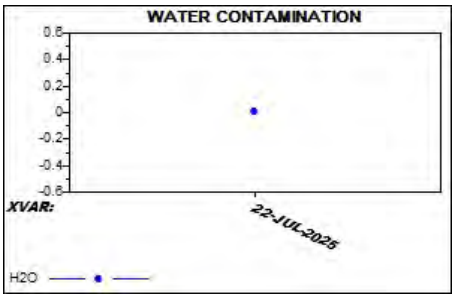
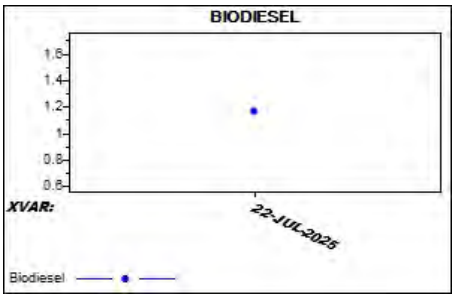
FUEL SYSTEM
SERIAL NUMBER: FTE04110
EQUIP NUM: FTE04110
CAT C15

E330-55220-5208
No Action Required







E330-55220-5208

Report Comment

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE GENSET | **EQUIP NUM: FTE04110** | **SERIAL NUMBER: FTE04110**

CAT C15

E330-55219-0071

LABEL#: 0071

SAMPLE SHIP TIME (days) : 16

NEBRASKA GENERATOR SERVICE-KEARNEY

RECEIVED DATE: 07-Aug-25

No Action Required

Interp By: Mary E Churchill

Interpreted On: 10-Aug-25

NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. MORE SAMPLE HISTORY NEEDED TO ESTABLISH A NORMAL WEAR TREND. RESAMPLE AT THE NEXT SERVICE INTERVAL.

SAMPLE INFORMATION

Sampled Date	22-Jul-25
Sample Id	E330-55219-0071
Lab Date	07-Aug-25
Meter [Hr]	175.7
Meter On Fluid	141.4
Fluid Brand	VALVOLINE
Fluid Weight	15W-40
Fluid Type	
Fluid Change	Y
Filter Change	Y
Make Up Fluid []	0
Kidney Loop	U
Total Fluid Added	0

WEAR LEVELS / ADDITIVES

22-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	2
Fe	Iron	6
Cr	Chromium	0
Al	Aluminum	2
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	4
K	Potassium	0
Mo	Molybdenum	53
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Cd	Cadmium	1
Ca	Calcium	1332
P	Phosphorus	947
Zn	Zinc	1113
Mg	Magnesium	928
Ba	Barium	0
B	Boron	38

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

22-Jul-25

VISCOSITY (CENTISTOKES) ASTM D445

V100	Viscosity at 100 C	12.60

INFRARED (UFM) ASTM E2412

ST	Soot	0
OXI	Oxidation	17
SUL	Sulfate By-Product	22
NIT	Nitration	0

WATER

W	Water	N

ANTIFREEZE

A	Antifreeze	N

FUEL

F	Fuel	N

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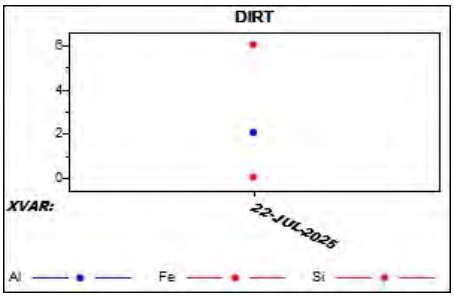
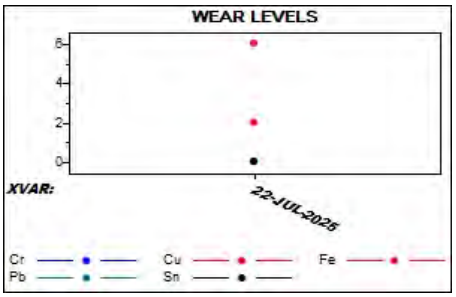
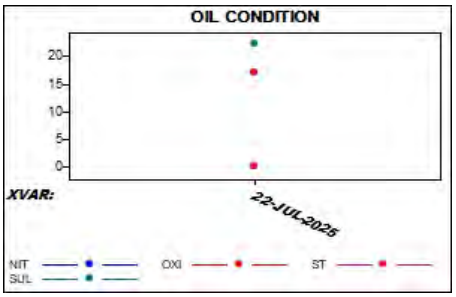
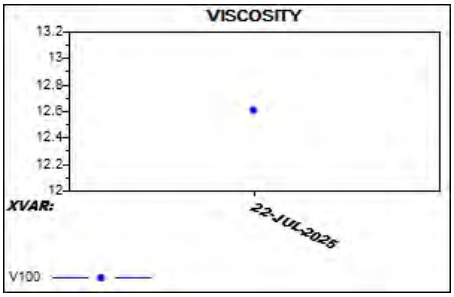
ENGINE GENSET
SERIAL NUMBER: FTE04110
EQUIP NUM: FTE04110
CAT C15

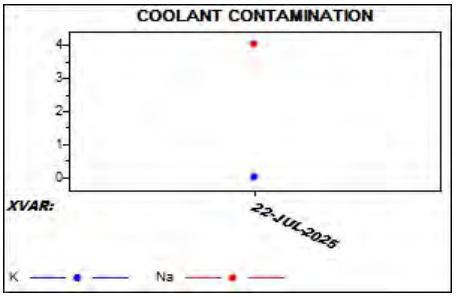
E330-55219-0071
No Action Required

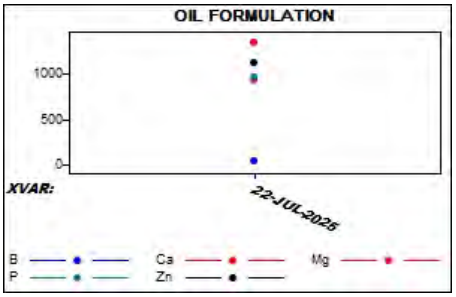












Report Comment

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E-DOCKET

Maintenance

NO. e-docket :US582858

US serial number :	**USV1008107**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7183 - SOUTH #2**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	7183 - SOUTH #2	
Unit	USV1008107	
PERFORMED PREVENTATIVE MAINTENANCE	☑	
Material Used/Spare Parts Used	7183 - SOUTH #2 USV1008107-Hydraulic:	

Technician's comments and recommendations :

Pm

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US582858

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.75				02-Jun-2025	07:45 AM	08:30 AM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 02-06-2025

Called customer

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E-DOCKET

Maintenance

NO. e-docket :US597203

US serial number :	**USV1008088**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7182 - NORTH #1**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	7182 - NORTH #1
Unit	USV1008088
PERFORMED PREVENTATIVE MAINTENANCE	☑
Material Used/Spare Parts Used	7182 - NORTH #1 USV1008088-Hydraulic:

Technician's comments and recommendations :

Pm. Tested phones on both elevators. Both tested good.

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US597203

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.75				17-Jul-2025	12:00 PM	12:45 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 17-07-2025

Called customer

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E-DOCKET

Billable Repair

NO. e-docket :US582859

Quote No. :	**077423**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Repair Type :	**Proactive Repair**	**Supervisor Name :**	**Brandon L Dunham**
US serial number :	**USV1008107**	**Branch Name :**	**OMAHA**
Lift Number :	**7183 - SOUTH #2**	**IVR WO Number :**	
Unit Type :	**Hydraulic**	**Building Address :**	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**

Repair

Operating Upon Departure the technician : Yes

Technician's comments and recommendations :

Stop switch does work and prevent car from running. Sounds alarm bell. Troubleshoot would need to continue, ran out of time. Talked with Andy onsite and elected to leave out for now and possibly look into during service visit if time permits. Closing ticket.

Material Used :

N/A

CLIENT COMMENTS

N/A

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E-DOCKET

Billable Repair

NO. e-docket :US582859

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	2.25				02-Jun-2025	10:45 AM	01:00 PM	

Field Complete : Yes

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 02-06-2025

Called customer

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE NATURAL GAS

EQUIP NUM: E850761977

ONAN 150KW_ONAN

SERIAL NUMBER: E850761977

E330-55219-0032

LABEL#: 0032

SHOP JOB NUM : 14117

SAMPLE SHIP TIME (days) : 15

LINCOLN REGIONAL CENTER

RECEIVED DATE: 07-Aug-25

No Action Required

NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. CONTINUE SAMPLING AT THE NORMAL INTERVAL.

Interp By: Mary E Churchill

Interpreted On: 10-Aug-25

SAMPLE INFORMATION

Sampled Date	23-Jul-25	02-Jul-24
Sample Id	E330-55219-0032	E330-54194-0051
Lab Date	07-Aug-25	12-Jul-24
Meter [Hr]	1414.2	1376.7
Meter On Fluid		
Fluid Brand	VALVOLINE	
Fluid Weight	15W-40	
Fluid Type		
Fluid Change	Y	N
Filter Change	Y	N
Kidney Loop	U	U
Total Fluid Added	0	0

WEAR LEVELS / ADDITIVES

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

		23-Jul-25	02-Jul-24
Cu	Copper	4	1
Fe	Iron	11	4
Cr	Chromium	1	0
Al	Aluminum	3	2
Pb	Lead	2	1
Sn	Tin	0	0
Si	Silicon	0	1
Na	Sodium	4	4
K	Potassium	4	1
Mo	Molybdenum	60	51
Ni	Nickel	0	0
Ag	Silver	0	0
Ti	Titanium	0	0
V	Vanadium	0	0
Cd	Cadmium	1	2
Ca	Calcium	1391	1200
P	Phosphorus	913	786
Zn	Zinc	1079	958
Mg	Magnesium	875	741
Ba	Barium	0	0
B	Boron	69	54

PREVIOUS SAMPLE

NOTE TIME BETWEEN SAMPLES. OTHER ANALYSIS READINGS APPEAR TO BE ACCEPTABLE. RESAMPLE AT THE NEXT SERVICE INTERVAL.

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

VISCOSITY (CENTISTOKES) ASTM D445

		23-Jul-25	02-Jul-24
V100	Viscosity at 100 C	12.80	13.60

INFRARED (UFM) ASTM E2412

ST	Soot	0	0
OXI	Oxidation	17	18
SUL	Sulfate By-Product	22	25
	Sulfur Products	22	25
NIT	Nitration	1	9

WATER

W	Water	N	N

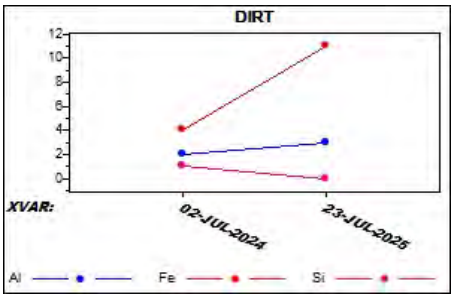
ANTIFREEZE

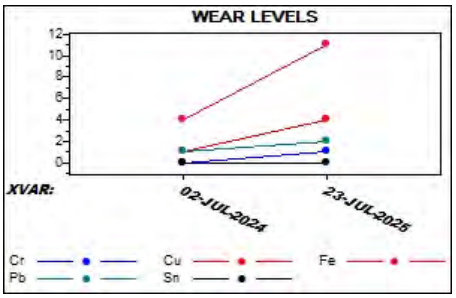
A	Antifreeze	N	N

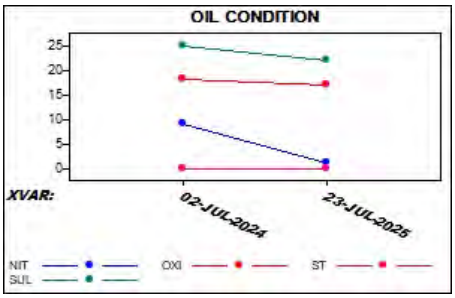
Notice: This analysis is intended as an aid in predicting mechanical wear. No guarantee, expressed or implied, is made against failure of this piece of equipment or component thereof.

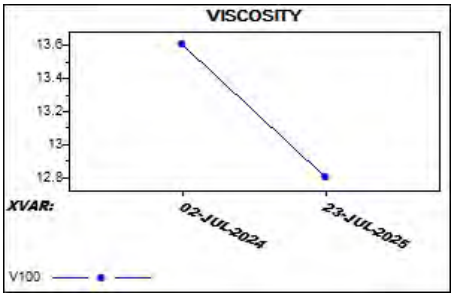
ENGINE NATURAL GAS
SERIAL NUMBER: E850761977
EQUIP NUM: E850761977
ONAN 150KW_ONAN

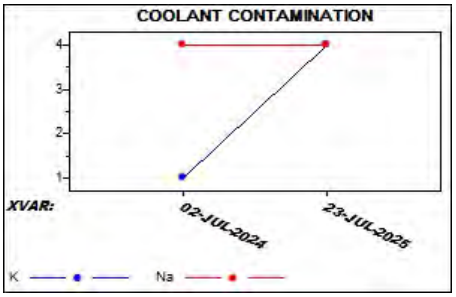
E330-55219-0032
No Action Required

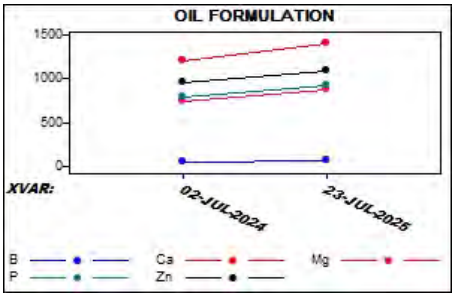












Report Comment

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E-DOCKET

Maintenance

NO. e-docket :US557525

US serial number :	**USV1008538**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**10054 - R BLDG #4**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : CAT1 - HY

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	10054 - R BLDG #4
Unit	USV1008538
SAFETY TEST	☑
REQUIRED DOCUMENTATION	☑
Material Used/Spare Parts Used	10054 - R BLDG #4 USV1008538-Hydraulic:

Technician's comments and recommendations :

Annual test. Pass

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US557525

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	2				12-Mar-2025	09:30 AM	11:30 AM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 12-03-2025

Called customer

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

FUEL SYSTEM

EQUIP NUM: 3FZ08400

CAT 3412C

SERIAL NUMBER: 3FZ08400

E330-55220-5201

LABEL#: 5201

SHOP JOB NUM : 14118

SAMPLE SHIP TIME (days) : 17

NEBRASKA GENERATOR SERVICE-KEARNEY

RECEIVED DATE: 08-Aug-25

No Action Required

Interp By: Alvin Lingenfelter

Interpreted On: 16-Aug-25

ALL TEST ARE PERFORMED IN ACCORDANCE WITH ASTM D-975 SAMPLE IS CLEAR AND RED IN COLOR. TRACE AMOUNT OF DEBRIS IN SAMPLE, ALL OTHER TEST APPEAR NORMAL FOR #2 DIESEL. RESAMPLE AT NORMAL INTERVAL.

SAMPLE INFORMATION

Sampled Date	22-Jul-25
Sample Id	E330-55220-5201
Lab Date	08-Aug-25
Meter [Hr]	810
Meter On Fluid	
Fluid Brand	
Fluid Weight	
Fluid Type	
Fluid Change	N
Filter Change	N
Total Fluid Added	0

For additional sample history, go to: S.O.S WEB

PROPERTIES / PHYSICALS

22-Jul-25

SULFUR (PPM) ASTM D5453

SULFU	SULFUR	6

BIODIESEL (%) EN 14078

Biodi	Biodiesel	0.17

FLASH POINT (°C) ASTM D93

FL Pt	Flash Point	61.0

ELEMENTAL ANALYSIS

22-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	0
Fe	Iron	0
Cr	Chromium	0
Al	Aluminum	0
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	0
K	Potassium	0
Mo	Molybdenum	0
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Ca	Calcium	0
P	Phosphorus	0
Zn	Zinc	0
Mg	Magnesium	0
B	Boron	0

PHYSICAL

App	Appearance	DEBRIS
PAmt	Precip Amount	trace
PProp	Precip Property	non-mag

CLEANLINESS / CONTAMINATION

22-Jul-25

PARTICLE COUNT - ISO 11171:1999 reported per ISO 4406

ISO	ISO Code Rating	DEBRIS

WATER CONTENT (%) ASTM D6304

H2O	Water	0.00321

MICROBIOLOGY

Bact	Bacteria	<LDL
Fung	Fungus	<LDL

SEDIMENT

VOL	% Volume	0.000

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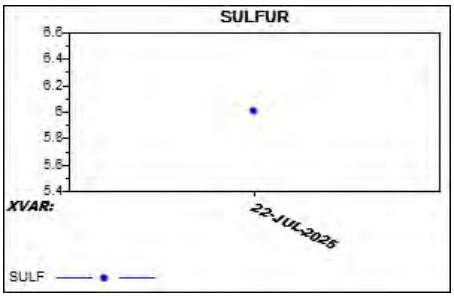
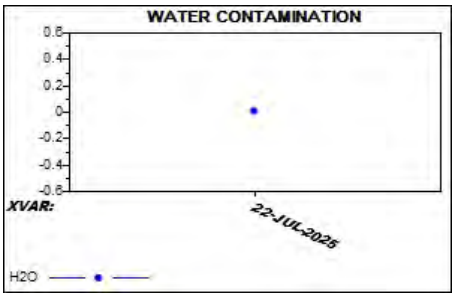
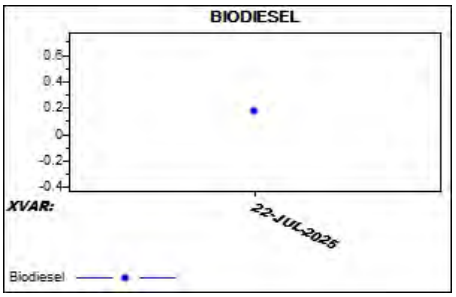
FUEL SYSTEM
SERIAL NUMBER: 3FZ08400
EQUIP NUM: 3FZ08400
CAT 3412C

E330-55220-5201
No Action Required







E330-55220-5201

Report Comment

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NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE GENSET | **EQUIP NUM: 3FZ08400** | **SERIAL NUMBER: 3FZ08400**

CAT 3412C

E330-55219-0068

LABEL#: 0068

SAMPLE SHIP TIME (days) : 16

NEBRASKA GENERATOR SERVICE-KEARNEY

RECEIVED DATE: 07-Aug-25

No Action Required

UNKNOWN TIME ON OIL. NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. MORE SAMPLE HISTORY NEEDED TO ESTABLISH A NORMAL WEAR TREND. RESAMPLE AT THE NEXT SERVICE INTERVAL.

Interp By: Mary E Churchill

Interpreted On: 10-Aug-25

SAMPLE INFORMATION

Sampled Date	22-Jul-25
Sample Id	E330-55219-0068
Lab Date	07-Aug-25
Meter [Hr]	810
Meter On Fluid	
Fluid Brand	VALVOLINE
Fluid Weight	15W-40
Fluid Type	
Fluid Change	Y
Filter Change	Y
Make Up Fluid [Gal]	0
Kidney Loop	U
Total Fluid Added	0

WEAR LEVELS / ADDITIVES

22-Jul-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	1
Fe	Iron	3
Cr	Chromium	0
Al	Aluminum	2
Pb	Lead	0
Sn	Tin	0
Si	Silicon	0
Na	Sodium	3
K	Potassium	0
Mo	Molybdenum	61
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Cd	Cadmium	1
Ca	Calcium	1355
P	Phosphorus	1052
Zn	Zinc	1218
Mg	Magnesium	982
Ba	Barium	0
B	Boron	39

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

22-Jul-25

VISCOSITY (CENTISTOKES) ASTM D445

V100	Viscosity at 100 C	13.30

INFRARED (UFM) ASTM E2412

ST	Soot	0
OXI	Oxidation	18
SUL	Sulfate By-Product	22
NIT	Nitration	0

WATER

W	Water	N

ANTIFREEZE

A	Antifreeze	N

FUEL

F	Fuel	N

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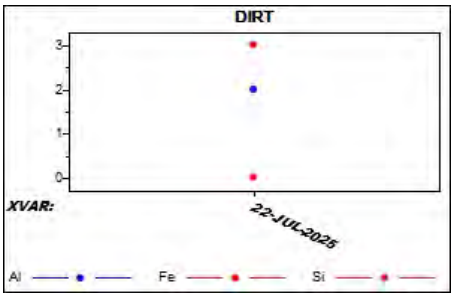
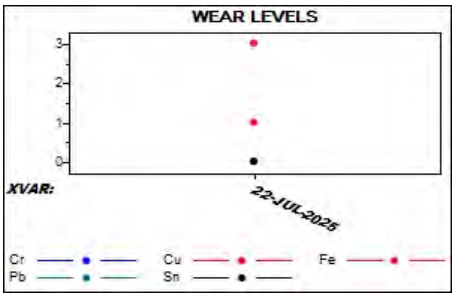
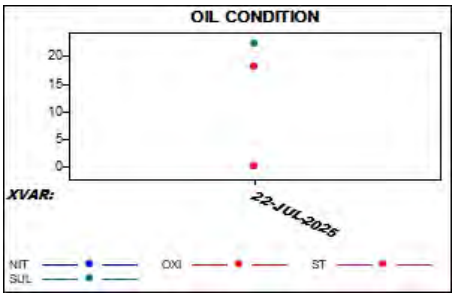
ENGINE GENSET
SERIAL NUMBER: 3FZ08400
EQUIP NUM: 3FZ08400
CAT 3412C

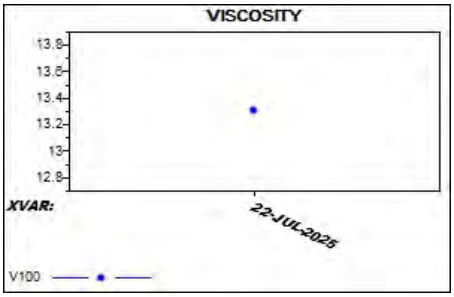
E330-55219-0068

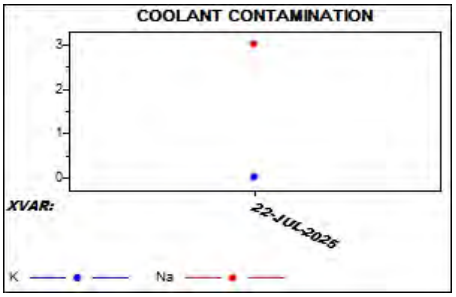
No Action Required

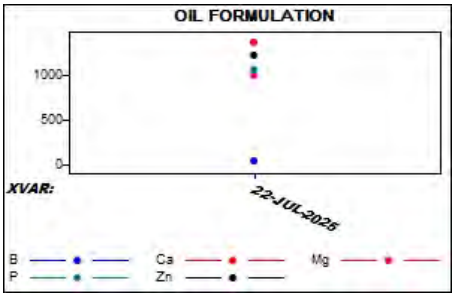












Report Comment

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E-DOCKET

Maintenance

NO. e-docket :US597198

US serial number :	**USV1008538**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**10054 - R BLDG #4**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	10054 - R BLDG #4	
Unit	USV1008538	
PERFORMED PREVENTATIVE MAINTENANCE	☑	
Material Used/Spare Parts Used	10054 - R BLDG #4 USV1008538-Hydraulic:	

Technician's comments and recommendations :

Pm

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US597198

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.5				17-Jul-2025	11:30 AM	12:00 PM	

TECHNICIAN SIGNATURE

Technician : Matthew Gordon Wright

CLIENT SIGNATURE

For the client :

Date : 17-07-2025

Customer not present

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NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: State of Nebraska, Lincoln Regional Cente **Generator Model: D300GC**

Address: 801 W prospect PL, Lincoln Ne **Generator Serial: CAT0D300HRE300216**

4 HOUR LOADBANK TEST **Generator kW: 300**

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
4/8/25	7:45 AM	208	208	208	284	285	284	60	102	34%	1800	101	96	27	156.2
	8:00 AM	208	209	208	284	285	284	60	103	34%	1800	111	90	27	156.4
	8:15 AM	208	209	208	284	285	284	60	103	34%	1800	111	90	27	156.7
	8:30 AM	208	208	208	462	462	462	60	166	55%	1800	183	60	27	156.9
	8:45 AM	208	208	208	462	462	462	60	166	55%	1800	183	60	27	157.2
	9:00 AM	208	208	208	695	694	698	60	251	84%	1800	190	53	27	157.4
	9:15 AM	208	208	208	695	694	698	60	251	84%	1800	190	53	27	157.7
	9:30 AM	208	208	208	699	698	701	60	252	84%	1800	190	52	27	157.9
	9:45 AM	208	208	208	699	698	701	60	252	84%	1800	190	52	27	158.2
	10:00 AM	208	208	208	699	700	703	60	252	84%	1800	186	51	27	158.4
	10:15 AM	208	208	208	699	700	703	60	252	84%	1800	186	51	27	158.7
	10:30 AM	208	208	208	700	701	700	60	252	84%	1800	188	51	27	158.9
	10:45 AM	208	208	208	700	701	700	60	252	84%	1800	188	51	27	159.2
	11:00 AM	208	208	208	699	700	698	60	252	84%	1800	187	51	27	159.4
	11:15 AM	208	208	208	699	700	698	60	252	84%	1800	187	51	27	159.7
	11:30 AM	208	208	208	698	699	699	60	252	84%	1800	187	51	27	159.9
	11:45 AM	208	208	208	698	699	699	60	252	84%	1800	187	51	27	160.2

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska	**DATE:** 4/8/25
ADDRESS: 801 W. Prospector Pl. #3, Lincoln, NE 68522	**JOB ID:** 12925
SITE NAME: Building 3	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS	
GEN MAKE Caterpillar	**GEN MODEL:** D300GC
GEN SERIAL: CAT0D300HRE300216	**GEN HOURS:** 160

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	209	B-C	208	C-A	208	A-B	208	B-C	208	C-A	208
A-N	121	B-N	120	C-B	120	A-N	120	B-N	120	C-B	120
A-Amps		B-Amps		C-Amps		A-Amps	698	B-Amps	699	C-Amps	699
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	99	Battery Charging voltage	27.2				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	187	W/ or W/O Load	W/Load
✓			CONTROL DISPLAY	Oil Pressure	51	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Weknesday
✓			SWITCH/CONTROLS	Battery Voltage	27.6	Week	weekly
			CB OPERATION	Frequency Rate	60	Start Time	130PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	3/4	
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

4/8/25 Nick

Arrive on site, gain access to generator. Inspect generator and equipment. Set up load bank and run generator to temp. Ran a 4 hour load bank test and recorded all generator data. No issues found during run time. Generator is in automatic, breaker closed, block heater is on and battery charger is operational. Clean up and move on to next generator.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center Building 5	**DATE:** 4/22/2025
ADDRESS: 801 W. Prospector Pl. #5 Lincoln, NE, 68522	**JOB ID:** 12972
SITE NAME: Site 5	**TECHNICIAN:** Nick, Austin
CONTACT NAME: Jeff	**CONTACT TEL:** 402-405-3651

PRODUCT DETAILS	
GEN MAKE Caterpillar	**GEN MODEL:** SR4B
GEN SERIAL: CER00941	**GEN HOURS:** 838

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
Mod#CTS SER# TSG01404 MOD# CTS SER# TSG01407	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	491	B-C	489	C-A	491	A-B	481	B-C	480	C-A	481
A-N	284	B-N	282	C-B	283	A-N	278	B-N	278	C-B	278
A-Amps	79	B-Amps	75	C-Amps	77	A-Amps	128	B-Amps	127	C-Amps	128
A-Temp	62	B-Temp	62	C-Temp	62	A-Temp	62	B-Temp	62	C-Temp	62
PRE OPERATION CHECKS				Coolant temp	96	Battery Charging voltage	27				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	208	W/ or W/O Load	w/o
✓			CONTROL DISPLAY	Oil Pressure	70	Exercise Duration	30 min
✓			EMERGENCY STOP	Oil Temp	192	Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	27	Week	Every
✓			CB OPERATION	Frequency Rate	60	Start Time	1:30PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	Full
✓			ENCLOSURE CONDITION				
		✓	BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes: 4/22/2025 Nick, Austin
Arrived on site and gained access to generator. Conducted visual inspection and took initial readings for 4 hour load bank. Batteries could use replaced due to age, waiting on confirmation. Completed 4 hour load bank, allowed for 15 minute cool down. Packed up and moved on to next generator.

NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: State of Nebraska Lincoln Regional Center BLDG 5 **Generator Model: 3456**

Address: 801 W Prospector Place Lincoln Ne, 68522 **Generator Serial: CER00941**

4 HOUR LOADBANK TEST **Generator kW: 500**

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
4/22/25										0%	1800				
	8:00 AM	481	480	481	128	127	128	60	100	20%	1800	96	83	27	838.0
	8:15 AM	481	480	481	128	127	128	60	100	20%	1800	96	83	27	838.3
	8:30 AM	481	480	481	502	501	502	60	415	83%	1800	201	70	27	838.5
	8:45 AM	481	480	481	502	501	502	60	415	83%	1800	201	70	27	838.8
	9:00 AM	481	480	481	499	499	500	60	415	83%	1800	208	70	27	839.0
	9:15 AM	481	480	481	499	499	500	60	415	83%	1800	208	70	27	839.3
	9:30 AM	481	480	481	499	499	500	60	415	83%	1800	208	69	27	839.5
	9:45 AM	481	480	481	499	499	500	60	415	83%	1800	208	69	27	839.8
	10:00 AM	481	480	482	499	499	500	60	415	83%	1800	208	68	27	840.0
	10:15 AM	481	480	482	499	499	500	60	415	83%	1800	208	68	27	840.3
	10:30 AM	481	480	481	499	499	500	60	415	83%	1800	208	69	27	840.5
	10:45 AM	481	480	481	499	499	500	60	415	83%	1800	208	69	27	840.8
	11:00 AM	481	480	482	499	499	500	60	415	83%	1800	208	69	27	841.0
	11:15 AM	481	480	428	499	499	500	60	415	83%	1800	208	69	27	841.3
	11:30 AM	481	480	481	499	498	500	60	415	83%	1800	208	67	27	841.5
	11:45 AM	481	480	481	499	498	500	60	415	83%	1800	208	67	27	841.8
	12:00 PM	481	481	482	499	499	500	60.00	415.00	83%	1800.00	208.00	68.00	27.00	842.00

NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: State of Nebraska, Lincoln Regional Cente **Generator Model: D500GC**

Address: 801 W prospect PL, Lincoln Ne **Generator Serial: CAT0D500TRK500126**

4 HOUR LOADBANK TEST **Generator kW: 500**

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
4/8/25	12:00 PM	480	480	480	249	248	249	60	207	41%	1800	89	79	27	159.1
	12:15 PM	480	480	480	249	248	249	60	207	41%	1800	99	79	27	159.3
	12:30 PM	480	480	480	492	492	492	60	409	82%	1800	186	65	27	159.6
	12:45 PM	480	480	480	492	492	492	60	409	82%	1800	186	65	27	159.8
	1:00 PM	480	480	480	492	490	491	60	408	82%	1800	188	62	27	160.1
	1:15 PM	480	480	480	492	490	491	60	408	82%	1800	188	62	27	160.3
	1:30 PM	480	480	480	491	490	492	60	408	82%	1800	188	62	27	160.6
	1:45 PM	480	480	480	491	490	492	60	408	82%	1800	188	62	27	160.8
	2:00 PM	480	480	480	492	490	491	60	408	82%	1800	188	62	27	161.1
	2:15 PM	480	480	480	491	490	491	60	408	82%	1800	188	62	27	161.3
	2:30 PM	480	480	480	491	490	491	60	408	82%	1800	188	62	27	161.6
	2:45 PM	480	480	480	491	490	491	60	408	82%	1800	188	62	27	161.8
	3:00 PM	480	480	480	491	490	491	60	408	82%	1800	188	62	27	162.1
	3:15 PM	480	480	480	491	490	491	60	408	82%	1800	188	62	27	162.3
	3:30 PM	480	480	480	490	490	490	60	407	81%	1800	188	62	27	162.6
	3:45 PM	480	480	480	490	490	490	60	407	81%	1800	188	62	27	162.8
	4:00 PM	480	480	480	490	490	490	60	407	81%	1800	188	62	27	163.1

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska	**DATE:** 4/8/25
ADDRESS: 801 W. Prospector Pl. #10, Lincoln, NE 68522	**JOB ID:** 12928
SITE NAME: Building 10	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS	
GEN MAKE Caterpillar	**GEN MODEL:** D300GC
GEN SERIAL: CAT0D300HRE300216	**GEN HOURS:** 160

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B		B-C		C-A		A-B	480	B-C	480	C-A	480
A-N		B-N		C-B		A-N	277	B-N	277	C-B	277
A-Amps		B-Amps		C-Amps		A-Amps	490	B-Amps	491	C-Amps	490
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	93	Battery Charging voltage	26.9				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	188	W/ or W/O Load	W/Load
✓			CONTROL DISPLAY	Oil Pressure	62	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Weknesday
✓			SWITCH/CONTROLS	Battery Voltage	27.2	Week	weekly
			CB OPERATION	Frequency Rate	60	Start Time	130PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	3/4	
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

4/8/25 Nick

Arrive on site, gain access to generator. Inspect generator and equipment. Set up load bank and run generator to temp. Ran a 4 hour load bank test and recorded all generator data. No issues found during run time. Generator is in automatic, breaker closed, block heater is on and battery charger is operational. Clean up and leave site.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center Building 11	**DATE:** 4/22/2025
ADDRESS: 801 W. Prospector Pl. #11 Lincoln, NE, 68522	**JOB ID:** 12929
SITE NAME: Site 11	**TECHNICIAN:** Nick, Austin
CONTACT NAME: Jeff	**CONTACT TEL:** 402-405-3651
PRODUCT DETAILS	
GEN MAKE Onan	**GEN MODEL:** 115.OWA-15R/25122L
GEN SERIAL: E850761977	**GEN HOURS:** 1402.8

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
Mod#OTBCA400-5DU/3103 SER# A830647440	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	245	B-C	245	C-A	244	A-B	233	B-C	233	C-A	233
A-N	122	B-N	212	C-B	122	A-N	115	B-N	115	C-B	206
A-Amps	54	B-Amps	43	C-Amps	49	A-Amps	123	B-Amps	123	C-Amps	123
A-Temp	62	B-Temp	62	C-Temp	62	A-Temp	62	B-Temp	62	C-Temp	62
PRE OPERATION CHECKS				Coolant temp	120	Battery Charging voltage	12.6				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	180	W/ or W/O Load	W / O
✓			CONTROL DISPLAY	Oil Pressure	40	Exercise Duration	30
✓			EMERGENCY STOP	Oil Temp	NA	Day	WEDNESDAY
✓			SWITCH/CONTROLS	Battery Voltage	12.8	Week	EVERY
✓			CB OPERATION	Frequency Rate	60	Start Time	7:00
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
		✓	ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	N/G
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes: 4/22/2025 Nick, Austin
Arrived on site and gained access to generator. Conducted visual inspection and connected load bank. During load bank there was excessive blowby coming out of the breathers under load. Under load there is also lifter tick and bearing noise. Finished 4 hour load bank and returned generator in auto. Packed up and left site

NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: Lincoln Regional Bldg 11

Address: 801 W. Prospector Pl. #11 Lincoln Ne, 68522

Generator Model: ONAN

Generator Serial: E850761911

4 HOUR LOADBANK TEST

Generator kW: 115

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
									0	0%					
	12:15 PM	231	231	231	127	127	127	60	51	44%	1800	105	60	14	1403.1
	12:30 PM	231	231	231	127	127	127	60	51	44%	1800	160	50	14	1403.3
	12:45 PM	231	231	231	185	184	184	60	74	64%	1800	180	45	14	1403.5
	1:00 PM	231	231	231	185	184	184	60	74	64%	1800	180	45	14	1403.7
	1:15 PM	233	233	233	226	225	226	60	91	79%	1800	180	45	14	1403.9
	1:30 PM	233	233	233	226	225	226	60	91	79%	1800	180	45	14	1404.1
	1:45 PM	233	233	233	226	225	226	60	91	79%	1800	180	45	14	1404.3
	2:00 PM	233	233	233	226	225	226	60	91	79%	1800	180	40	14	1404.5
	2:15 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1404.7
	2:30 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1404.9
	2:45 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1405.1
	3:00 PM	231	231	232	225	225	226	60	90	79%	1800	180	40	14	1405.3
	3:15 PM	231	231	232	225	225	226	60	90	79%	1800	180	40	14	1405.5
	3:30 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1405.7
	3:45 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1405.7
	4:00 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1405.9
	4:15 PM	231	231	232	226	225	226	60	90	79%	1800	180	40	14	1406.1

NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: State of Nebraska, Lincoln Regional Cente **Generator Model: D500GC**

Address: 801 W prospect PL, Lincoln Ne **Generator Serial: CAT0D500TRK500126**

4 HOUR LOADBANK TEST **Generator kW: 600**

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
4/9/25	7:30 AM	482	480	481	113	117	69	60	83	14%	1800	91	77	27	797.0
	7:45 AM	482	480	481	113	117	69	60	83	14%	1800	91	77	27	797.3
	8:00 AM	480	473	483	456	454	410	60	365	61%	1800	189	77	27	797.6
	8:15 AM	478	473	483	571	570	525	60	460	77%	1800	194	72	27	797.8
	8:30 AM	478	473	480	684	681	636	60	551	92%	1800	196	71	27	798.1
	8:45 AM	478	473	480	678	677	633	60	547	91%	1800	185	70	27	798.3
	9:00 AM	478	473	480	678	677	633	60	547	91%	1800	185	70	27	798.6
	9:15 AM	478	473	480	678	677	633	60	547	91%	1800	186	70	27	798.8
	9:30 AM	478	473	480	678	677	633	60	547	91%	1800	186	70	27	799.1
	9:45 AM	478	473	480	678	677	633	60	547	91%	1800	186	70	27	799.3
	10:00 AM	480	475	485	678	677	632	60	551	92%	1800	187	70	27	799.6
	10:15 AM	480	475	485	687	677	632	60	553	92%	1800	187	70	27	799.8
	10:30 AM	480	475	483	677	676	632	60	549	92%	1800	187	69	27	800.1
	10:45 AM	480	475	483	677	676	632	60	549	92%	1800	187	69	27	800.3
	11:00 AM	480	475	485	677	676	632	60	550	92%	1800	187	69	27	800.6
	11:15 AM	480	475	485	677	676	632	60	550	92%	1800	187	69	27	800.8
	11:30 AM	480	475	485	677	676	632	60	550	92%	1800	187	69	27	801.1

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska Lincoln Regional Center BLDG 14	**DATE:** 4/9/25
ADDRESS: 801 W Prospector Place Lincoln Ne, 68522	**JOB ID:** 12930
SITE NAME: BLDG 14	**TECHNICIAN:** Nick, Austin
CONTACT NAME: Andy	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS	
GEN MAKE Catipillar	**GEN MODEL:** 3412
GEN SERIAL: AER00540	**GEN HOURS:** 797

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	485	B-C	490	C-A	493	A-B	482	B-C	480	C-A	481
A-N		B-N		C-B		A-N		B-N		C-B	473
A-Amps		B-Amps		C-Amps		A-Amps	113	B-Amps	117	C-Amps	69
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	184	Battery Charging voltage	27				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	171	W/ or W/O Load	W/Load
✓			CONTROL DISPLAY	Oil Pressure	54	Exercise Duration	30 MIN
✓			EMERGENCY STOP	Oil Temp	82	Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	27	Week	Weekly
✓			CB OPERATION	Frequency Rate	60	Start Time	1pm
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
✓			FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	FULL
✓			ENCLOSURE CONDITION				
		✓	BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes: 4/9/2025 Nick, Austin
Arrived on site and gained access to generator. Inspected generator as directed and found batteries were 4 years old. Started 4 hour load bank test to simulate outage. Completed load bank, let generator and load bank run cool down. Returned generator to auto. Packed up site and moved on to the next generator

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 1/3/25
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 11995
SITE NAME: Building 3	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)405-3635

PRODUCT DETAILS	
GEN MAKE CAT	**GEN MODEL:** D300GC
GEN SERIAL: CAT0D300HRE300216	**GEN HOURS:** 149

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ATS- 1 Model: CTS Serial: TSG05467 ATS- 2 Model: CTS Serial: TSG05351	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	210	B-C	210	C-A	210	A-B	208	B-C	208	C-A	208
A-N	121	B-N	121	C-B	121	A-N	120	B-N	120	C-B	120
A-Amps		B-Amps		C-Amps		A-Amps	281	B-Amps	281	C-Amps	281
A-Temp	63	B-Temp	63	C-Temp	63	A-Temp	60	B-Temp	60	C-Temp	60
PRE OPERATION CHECKS				Coolant temp	113	Battery Charging voltage	26.8				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	178	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	63	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	27.5	Week	Weekly
			CB OPERATION	Frequency Rate	60hz	Start Time	1:00PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	1/2
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

1.3.25 Nick

Arrive on site and gain access to generator. Inspect gen and equipment. No issues found. Run to temp. Common alarm for low fuel, customer is having tank filled.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 1/3/25
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 11996
SITE NAME: Building 5	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)405-3635

PRODUCT DETAILS	
GEN MAKE CAT	**GEN MODEL:** 3456
GEN SERIAL: CER00941	**GEN HOURS:** 824

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ATS- AC Model: CTS Serial: TSG01404 ATS- Building Model: CTS Serial: TSG01407 ATS- C Model: CTS Serial: TSG03540 ATS- LS Model: CTS Serial: TSG03541	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	484	B-C	484	C-A	484	A-B	480	B-C	480	C-A	480
A-N	279	B-N	279	C-B	279	A-N	277	B-N	277	C-B	277
A-Amps		B-Amps		C-Amps		A-Amps		B-Amps		C-Amps	
A-Temp	55	B-Temp	55	C-Temp	55	A-Temp	55	B-Temp	55	C-Temp	55
PRE OPERATION CHECKS				Coolant temp	81	Battery Charging voltage	28				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	138	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	81	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	28	Week	Weekly
			CB OPERATION	Frequency Rate	60hz	Start Time	1:00PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	3/4	
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

1.3.25 Nick
Arrive on site and gain access to generator. Inspect gen and equipment. No issues found. Run to temp. No leaks.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 1/3/25
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 11997
SITE NAME: Building 10	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)405-3635

PRODUCT DETAILS	
GEN MAKE CAT	**GEN MODEL:** D500GC
GEN SERIAL: CAT0D500TRK500126	**GEN HOURS:** 149

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	484	B-C	484	C-A	484	A-B	480	B-C	480	C-A	480
A-N	279	B-N	279	C-B	279	A-N	277	B-N	277	C-B	277
A-Amps		B-Amps		C-Amps		A-Amps	245	B-Amps	245	C-Amps	246
A-Temp	63	B-Temp	63	C-Temp	63	A-Temp	60	B-Temp	60	C-Temp	60
PRE OPERATION CHECKS				Coolant temp	93	Battery Charging voltage	26.9				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	182	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	67	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	27.8	Week	Weekly
			CB OPERATION	Frequency Rate	60hz	Start Time	1:00PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	3/4	
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

1.3.25 Nick
Arrive on site and gain access to generator. Inspect gen and equipment. No issues found. Run to temp.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 1/3/25
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 11998
SITE NAME: Building 11	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)405-3635

PRODUCT DETAILS	
GEN MAKE ONAN	**GEN MODEL:** 115.0WA-15R/25122L
GEN SERIAL: E850761977	**GEN HOURS:** 1393

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ATS- Main Model: OTBCA Serial: A830647440	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	122	B-C	212	C-A	122	A-B	121	B-C	210	C-A	121
A-N	242	B-N	242	C-B	242	A-N	240	B-N	240	C-B	240
A-Amps		B-Amps		C-Amps		A-Amps		B-Amps		C-Amps	
A-Temp	78	B-Temp	78	C-Temp	78	A-Temp	76	B-Temp	76	C-Temp	76
PRE OPERATION CHECKS				Coolant temp	98	Battery Charging voltage	13.3				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	178	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	45	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp		Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	14	Week	Weekly
			CB OPERATION	Frequency Rate	60hz	Start Time	1:00PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	NG
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

1.3.25 Nick

Arrive on site and gain access to generator. Inspect gen and equipment. No issues found. Run to temp. Coolant leaks have been observed but they are not bad and radiator is still full. Customer is aware of leaks and the possible worstening of leaks if a repair attempt is made.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 1/3/25
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 11999
SITE NAME: Building 14	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)405-3635

PRODUCT DETAILS	
GEN MAKE CAT	**GEN MODEL:** 3412
GEN SERIAL: AER00540	**GEN HOURS:** 789

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ATS- L Model: CTS Serial: TSG01724 ATS- Chiller Model: CTS Serial: TSG01714 ATS- Main Model: CTS Serial: TSG01713	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	489	B-C	490	C-A	499	A-B	483	B-C	481	C-A	481
A-N	283	B-N	282	C-B	284	A-N	278	B-N	280	C-B	277
A-Amps		B-Amps		C-Amps		A-Amps		B-Amps		C-Amps	
A-Temp	68	B-Temp	68	C-Temp	68	A-Temp	68	B-Temp	68	C-Temp	68
PRE OPERATION CHECKS				Coolant temp	95	Battery Charging voltage	26				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	176	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	79	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp	187	Day	Wednesday
✓			SWITCH/CONTROLS	Battery Voltage	27	Week	Weekly
			CB OPERATION	Frequency Rate	60hz	Start Time	1:30PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	7/8	
✓			ENCLOSURE CONDITION				
	✓		BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

1/3/25 Nick

Arrive on site. Gain access to generator. Inspect unit. Added 1 gallon coolant. No leaks found. Run gen to temp.

Recommend batteries at next visit. Batteries dated 2/21.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: Lincoln Regional Center	**DATE:** 7/21/25
ADDRESS: 801 W Prospector Place, #3 Lincoln NE	**JOB ID:** 14112
SITE-NAME: Building #3	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** (402)

PRODUCT DETAILS		
GEN MAKE CAT	**GEN MODEL:** D300GC	**GEN SPEC:**
GEN SERIAL: CAT0D300HRE300216	**GEN HOURS:** 171.6	**ENGINE S/N:** S9P02680

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B		B-C		C-A		A-B	208	B-C	208	C-A	208
A-N		B-N		C-B		A-N	120	B-N	120	C-B	120
A-Amps		B-Amps		C-Amps		A-Amps	279	B-Amps	280	C-Amps	281
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	111	Battery voltage	29	Battery Date	7/21/25	Size	31

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	186	W/ or W/O Load	W/LOAD
✓			CONTROL DISPLAY	Oil Pressure	60	Exercise Duration	30MIN
✓			EMERGENCY STOP	Oil Temp		Day	WEDNESDAY
✓			SWITCH/CONTROLS	Battery Voltage	28.7	Week	WEEKLY
✓			CB OPERATION	Frequency Rate	60	Start Time	1:30PM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
	✓		ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
✓			FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	3/4
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION	GOOD			
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

7/21/2025 Nick, Austin

Arrived on site and gained access to generator. Conducted visual inspection and took initial readings. During inspection we found that a section of charge piping going to the turbo is torn and needs replaced. Changed oil and filters. Started generator to bring it to operational temperature. Took final readings. Shut generator off. Put generator in auto and closed CB. Packed up and moved on to next generator.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska- Building Division	**DATE:** 7/21/2025
ADDRESS: Lincoln Regional Center #5, 801 W. Prospector Pl. #5, Lincoln, NE 68522	**JOB ID:** 14113
SITE-NAME: Building 5	**TECHNICIAN:** Nick, Austin
CONTACT NAME: Andy	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS		
GEN MAKE CAT	**GEN MODEL:** 3456	**GEN SPEC:**
GEN SERIAL: CER00941	**GEN HOURS:** 851	**ENGINE S/N:** 7WG01892

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B		B-C		C-A		A-B	483	B-C	482	C-A	483
A-N		B-N		C-B		A-N	279	B-N	279	C-B	279
A-Amps		B-Amps		C-Amps		A-Amps	0	B-Amps	0	C-Amps	0
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	97	Battery voltage	26	Battery Date	7/1/25	Size	4D

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	163	W/ or W/O Load	NO LOAD
✓			CONTROL DISPLAY	Oil Pressure	82	Exercise Duration	30MIN
✓			EMERGENCY STOP	Oil Temp	156	Day	WEDNESDAY
✓			SWITCH/CONTROLS	Battery Voltage	27	Week	WEEKLY
✓			CB OPERATION	Frequency Rate	60	Start Time	4AM
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
✓			FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	3/4
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION	GOOD			
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

7/21/2025 Nick, Austin

Arrived on site and gained access to generator. Conducted visual inspection and took initial readings. Changed oil and filters. Started generator to bring it to operational temperature. Took final readings. Shut generator off. Put generator in auto and closed CB. Packed up and left site.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska- Building Division	**DATE:** 7/22/2025
ADDRESS: 801 W. Prospector Pl. #10, Lincoln, NE 68522	**JOB ID:** 14114
SITE-NAME: Building 10	**TECHNICIAN:** Austin
CONTACT NAME: ANDY	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS		
GEN MAKE CAT	**GEN MODEL:** D500GC	**GEN SPEC:**
GEN SERIAL: CAT0D500TRK500126	**GEN HOURS:** 175.7	**ENGINE S/N:** FTE04110

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ATS-Main Model: OTBCA Serial: A830647440	**Quarterly**	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B		**B-C**		**C-A**		**A-B**	479	**B-C**	480	**C-A**	482
A-N		**B-N**		**C-B**		**A-N**	277	**B-N**	278	**C-B**	277
A-Amps		**B-Amps**		**C-Amps**		**A-Amps**	244	**B-Amps**	244	**C-Amps**	244
A-Temp		**B-Temp**		**C-Temp**		**A-Temp**		**B-Temp**		**C-Temp**	
PRE OPERATION CHECKS				**Coolant temp**	95	**Battery voltage**	26.9	**Battery Date**	7/22/25	**Size**	31

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			**CONTROL LIGHTS**	**Engine Run temp**	188	**W/ or W/O Load**	W/OUT LOAD
✓			**CONTROL DISPLAY**	**Oil Pressure**	65	**Exercise Duration**	30MIN
✓			**EMERGENCY STOP**	**Oil Temp**		**Day**	WEDNESDAY
✓			**SWITCH/CONTROLS**	**Battery Voltage**	27.2	**Week**	WEEKLY
✓			**CB OPERATION**	**Frequency Rate**	60	**Start Time**	1PM
✓			**AUTO OPERATION**	**RPM**	1800		
✓			**COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses**				
✓			**EXHAUST SYSTEMS CONDITION**				
✓			**ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather**				
✓			**ALTERNATOR CONDITION**				
✓			**FULL SERVICE PERFORMED**				
✓			**FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition** **Fuel Level** 3/4				
✓			**ENCLOSURE CONDITION**				
✓			**BATTERY CONDITION** GOOD				
✓			**ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger**				
✓			**OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM**				
✓			**Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs**				

Notes:

7/22/2025 Nick Austin

Arrived on site and gained access to the generator. Conducted visual inspection and took initial reading. During the inspection we noticed the air filter needs changed. Recommend replacing next inspection. Changed out batteries due to customer request. Changed oil and filters. Started generator to bring it to operational temperature. Took final readings. Shut off generator. Put generator in auto and closed CB. Packed up and left site.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska- Building Division	**DATE:** 7/23/25
ADDRESS: Lincoln Regional Center #11, 801 W. Prospector Pl. #5, Lincoln, NE 68522	**JOB ID:** 14117
SITE-NAME: Building 11	**TECHNICIAN:** Nick
CONTACT NAME: Andy	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS		
GEN MAKE Onan	**GEN MODEL:** 115.0WA-15R/25122L	**GEN SPEC:**
GEN SERIAL: E850761977	**GEN HOURS:** 1414.2	**ENGINE S/N:** 388078

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
ONAN Model: OTBCA400-5DU73103 Serial: A830647440	**Quarterly**	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	242	**B-C**	242	**C-A**	242	**A-B**	240	**B-C**	240	**C-A**	240
A-N	122	**B-N**	212	**C-B**	122	**A-N**	120	**B-N**	120	**C-B**	120
A-Amps		**B-Amps**		**C-Amps**		**A-Amps**		**B-Amps**		**C-Amps**	
A-Temp		**B-Temp**		**C-Temp**		**A-Temp**		**B-Temp**		**C-Temp**	
PRE OPERATION CHECKS				**Coolant temp**	94	**Battery voltage**	13.6	**Battery Date**	5/24	**Size**	31P

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			**CONTROL LIGHTS**	**Engine Run temp**	165	**W/ or W/O Load**	NO LOAD
✓			**CONTROL DISPLAY**	**Oil Pressure**	42	**Exercise Duration**	30MIN
	✓		**EMERGENCY STOP**	**Oil Temp**		**Day**	WEDNESDAY
✓			**SWITCH/CONTROLS**	**Battery Voltage**	14	**Week**	WEEKLY
✓			**CB OPERATION**	**Frequency Rate**	60	**Start Time**	Morning
✓			**AUTO OPERATION**	**RPM**	1800		
✓			**COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses**				
✓			**EXHAUST SYSTEMS CONDITION**				
✓			**ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather**				
✓			**ALTERNATOR CONDITION**				
✓			**FULL SERVICE PERFORMED**				
✓			**FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition** **Fuel Level** NG				
✓			**ENCLOSURE CONDITION**				
✓			**BATTERY CONDITION** GOOD				
✓			**ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger**				
✓			**OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM**				
✓			**Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs**				

Notes: 7/23/2025 Nick

Arrived on site and gained access to generator. Inspect generator and equipment. Generator Took initial readings. Changed oil and filters. Started generator and ran to temp. Took final readings. Shut generator off. Put generator in auto, breaker closed, block heater on, battery charger on. Clean up and leave site. Customer is aware of coolant leading from head. Does not want to repair due to possibly making it worse and cost.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska- Building Division	**DATE:** 7/22/2025
ADDRESS: 801 W. Prospector Pl. #14, Lincoln, NE 68522	**JOB ID:** 14118
SITE-NAME: BUILDING 14	**TECHNICIAN:** Austin
CONTACT NAME: ANDY	**CONTACT TEL:** 402-405-3635

PRODUCT DETAILS		
GEN MAKE CAT	**GEN MODEL:** 3412	**GEN SPEC:**
GEN SERIAL: AER00540	**GEN HOURS:** 810	**ENGINE S/N:** 3FZ08400

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	495	B-C	500	C-A	503	A-B	480	B-C	478	C-A	477
A-N		B-N		C-B		A-N	277	B-N	277	C-B	276
A-Amps		B-Amps		C-Amps		A-Amps	0	B-Amps	0	C-Amps	0
A-Temp		B-Temp		C-Temp		A-Temp		B-Temp		C-Temp	
PRE OPERATION CHECKS				Coolant temp	84	Battery voltage	26	Battery Date	6/27/2025	Size	4D

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	178	W/ or W/O Load	w/load
✓			CONTROL DISPLAY	Oil Pressure	78	Exercise Duration	30min
✓			EMERGENCY STOP	Oil Temp	188	Day	wedensday
✓			SWITCH/CONTROLS	Battery Voltage	27	Week	weekly
✓			CB OPERATION	Frequency Rate	60	Start Time	1pm
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
✓			FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition		Fuel Level	1/2	
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION	GOOD			
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

7/22/2025 Nick, Austin

Arrived on site and gained access to generator. Conducted visual inspection and took initial readings. Changed oil and filters. Started generator to bring it to operational temperature. Took final readings. Shut off generator. Put generator back in auto and closed CB. Packed up and moved on to the next generator.

NEBRASKA STATE FIRE MARSHAL

OCCUPANCY PERMIT

Certificate Number: 17733

Name of Facility:	**Lincoln Regional Center Bldg #14**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Pl, Lincoln**
Maximum Occupancy:	**85 Beds**
Date Issued:	**7/16/2025**

Inspected By: **Monica Ellis**
Deputy State Fire Marshal

Approved By:
Interim 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: 17734

Name of Facility:	**Lincoln Regional Center Bldg #5 Forensic**
Type of Facility:	**Hospital**
Location:	**801 W Prospector Pl, Lincoln**
Maximum Occupancy:	**109 Beds**
Date Issued:	**7/16/2025**

Inspected By: **Monica Ellis**
Deputy State Fire Marshal

Approved By:
Interim State Fire Marshal

POST IN PROMINENT PLACE

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

MEDICAL DIRECTOR, LINCOLN REGIONAL CENTER
801 W PROSPECTOR PL
LINCOLN, NE 68522

CLIA ID NUMBER

28D0670944

EFFECTIVE DATE

09/01/2024

LABORATORY DIRECTOR

DR. ROGER DONOVICK

EXPIRATION DATE

08/31/2026

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.
This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Gregg Brandush, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.

PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.
FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA.

Summit Fire Protection
2431 Fairfield Street Suite A
Lincoln, NE 68521-1308
Tel: (402) 476-4646
Fax:

Invoice

Bill to: LRC Maintenance Department
PO BOX 94949
LINCOLN, NE 68509-4949

Date: 09/25/2025
Invoice No: 3541664
WO#: 05121356

Service at: LINCOLN REGIONAL CENTER
801 W Prospector Pl
Bldgs 5 7 10 14
Lincoln, NE 68522-1970

Terms: Net 30
WO Completed: 09/25/2025

Customer ID: 40630144

Reference WO#:

PO Number:

Description	Quantity	Unit Price	Amount	
Annual Inspection - Fire Extinguisher	1.0	$791.00	$791.00	
Fire Extinguisher Inspection - Annual Inspections	113.0		$0.00	
K-Class Extinguisher Service - 5 Year Class-K Hydro - Parts included	1.0	$205.00	$205.00	T
5 LB Dry Chemical Ext. Low Pressure Hydro Test Hydrotests	9.0	$30.00	$270.00	T
5 LB Dry Chemical Extinguisher Recharge Recharges	9.0	$32.00	$288.00	T
5 LB Dry Chemical Extinguisher 6-Yr Maintenance 6-Year Services	14.0	$32.00	$448.00	T
10 LB Dry Chemical Ext. Low Pressure Hydro Test Hydrotests	2.0	$30.00	$60.00	T
10 LB Dry Chemical Extinguisher Recharge Recharges	2.0	$42.00	$84.00	T
10 LB Dry Chemical Extinguisher 6-Yr Maintenance 6-Year Services	6.0	$42.00	$252.00	T
20 LB Dry Chemical Extinguisher Recharge Recharge	1.0	$58.00	$58.00	T
GENERIC TAMPER SEAL FLAG STYLE	113.0	$0.75	$84.75	T
COLLAR VC VERF	1.0	$2.10	$2.10	T
ANSUL 79694 1.5 GALLON ANSULEX CHEMICAL	1.0	$325.00	$325.00	
COLLAR VC VERF	32.0	$2.10	$67.20	T
GAUGE DRY CHEM 195#	1.0	$16.80	$16.80	T
STRAP UNIV 2 24''	2.0	$1.50	$3.00	T
CLIP HCM UNIV	2.0	$2.50	$5.00	T
DOT Compliance Fee	2.0	$4.00	$8.00	T
Truck Charge	1.0	$68.00	$68.00	
VALVE STEM DRY/WET CHEM	1.0	$22.00	$22.00	T
O-RING DRY/WET CHEM	1.0	$4.50	$4.50	T
VALVE STEM DRY/WET CHEM	32.0	$22.00	$704.00	T
O-RING DRY/WET CHEM	32.0	$4.50	$144.00	T

PLEASE NOTE NEW BANK DETAILS

ACH Payments:
Beneficiary: Summit Fire Protection
Bank: Wells Fargo Bank
ABA Number: 121000248
Account Number: 4226038909

Please send inquiries / remittance to:
ar@summitcompanies.com

PLEASE NOTE NEW REMITTANCE ADDRESS

To Pay by Check or Credit Card
(651) 272-3251

Check Payments:
Summit Fire Protection
PO Box 851675
Minneapolis, MN 55485-1675

PAY ONLINE:
https://summitfire.com/

Subtotal:	**$3,910.35**
Sales Tax:	$197.70
Total Invoice:	**$4,108.05**
Collected Onsite:	
Balance Due:	**$4,108.05**

Cust: 40630144 Inv: 3541664

Please reference the above noted Customer ID and Invoice Number on your remittance.

Fire Alarm Supplementary Form

Location Code: VWJJISK

Contact: Kris Hoover

Contact Address: 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Annex 5
(Detention/Correctional)
801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (EP5 EQUIPMENT)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Annex 5	Property Type: Detention/Correctional	Location Code: VWJJISK
Service Address: 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
AMP	1	1	0	1	0
DVC	1	1	0	1	0
PWS	1	1	0	1	0

Type	Total	Tested	Not Tested	Passed	Failed
BATT	1	1	0	1	0
FACP	1	1	0	1	0

Zone: EQUIPMENT

Zone: EQUIPMENT							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
FACP	1	ENTRY	NFS2-640	Semi-Annual	9/15/2025	Pass	
AMP	4	FACP	DAX-3525 PCA	Semi-Annual	9/15/2025	Pass	
BATT	2	FACP	12V 35AMP X 2	Semi-Annual	9/15/2025	Pass	
DVC	3	FACP		Semi-Annual	9/15/2025	Pass	
PWS	5	FACP	AMPS 24	Semi-Annual	9/15/2025	Pass	

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Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.
Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By	Keith Allen Benne
Inspector License:	J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector	
Date	9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name	
Owner or Owner's Representative Signature	No Signature Available
Date	9/12/2025

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: VWJJISK

Contact: Kris Hoover

Contact Address: 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Annex 5
(Detention/Correctional)
801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (FORM)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes, No, or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5453

Owner's Address:
801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Annex 5 (Detention/Correctional)

Property Address:
801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (FORM)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	PERMAR
Address:	
Phone:	
Fax:	
Email:	
Account number:	
Phone line 1:	
Phone line 2:	
Means of transmission:	
Entity to which alarms are retransmitted:	
Phone:	

4. System Information

4.1 Control Unit:

Manufacturer:	NOTIFIER
Model number:	NFS2-640
4.2 Software and Firmware Revision number:	26

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120 VAC
Amps:	NA
Location:	ENTRY
Overcurrent protection type:	BREAKER
Amps:	NA
Disconnecting means location:	ELECTRICAL

4.3.2 Secondary Power:

Type:	BATTERIES
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	15

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Local annunciator	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Remote power panels	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Fire Alarm Supplementary Form

Location Code: URVENHG

Contact: Kris Hoover

Contact Address: Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5451

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 3
(Detention/Correctional)
Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP2 Tampers/ Waterflows)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 3	Property Type: Detention/Correctional	Location Code: URVENHG
Service Address: Building 3 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5451
Owner's Address: Building 3 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
MM	3	3	0	3	0
WF	4	4	0	4	0

Type	Total	Tested	Not Tested	Passed	Failed
TS	3	3	0	3	0

Zone: Tampers/ Water Flows

Zone: Tampers/ Water Flows							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
WF	L1M33	1st Floor Custodial		Annual	9/15/2025	Pass	
TS	L1M32	1st Flr Custodial		Annual	9/15/2025	Pass	
TS	L2M01	2nd Floor Custodial		Annual	9/15/2025	Pass	
WF	L2M02	2nd Floor Custodial		Annual	9/15/2025	Pass	
MM	L1M14	BackFlow		Annual	9/15/2025	Pass	
TS	L1M17	BSMT Tamper		Annual	9/15/2025	Pass	
WF	L1M11	BSMT Waterflow		Annual	9/15/2025	Pass	

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Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: Tampers/ Water Flows							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
MM	L1M15	PIV		Annual	9/15/2025	Pass	
MM	L1M16	Riser 1 and 2		Annual	9/15/2025	Pass	
WF	L1M12	Riser 1 and 2 Waterflow		Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.
Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector:

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name:
Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Fire Alarm Supplementary Form

Location Code: URVENHG

Contact: Kris Hoover

Contact Address: Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5451

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 3 (Detention/Correctional)
Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP5 FA Equipment Signals)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 3	Property Type: Detention/Correctional	Location Code: URVENHG
Service Address: Building 3 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5451
Owner's Address: Building 3 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
Amplifer	1	1	0	1	0
FACP FACP	1	1	0	1	0

Type	Total	Tested	Not Tested	Passed	Failed
BATT	5	5	0	5	0
PWS PWS	4	4	0	4	0

Zone: Panels

Zone: Panels							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
PWS PWS	5	1ST FLR ELECTRICAL	PSE-6	Annual	9/15/2025	Pass	
BATT	6	1ST FLR ELECTRICAL PWS		Annual	9/15/2025	Pass	
PWS PWS	7	2ND FLR ELECTRICAL	PSE-6	Annual	9/15/2025	Pass	
BATT	8	2ND FLR ELECTRICAL PWS	12V 7 AMP HR X 2	Annual	9/15/2025	Pass	
BATT	1	BATTERY BOX	12V 55 AMP X2 FOR FACP AND AMP	Annual	9/15/2025	Pass	

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Zone: Panels							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
BATT	2	BSMT ELECTRICAL CLOSET	12V 7 AMP HR X 2	Annual	9/15/2025	Pass	
PWS	NA	BSMT ELECTRICAL CLOSET		Annual	9/15/2025	Pass	
PWS	3	BSMT STORAGE FOR SUPP.	PSE-6	Annual	9/15/2025	Pass	
BATT	4	BSMT STORAGE PWS	12V 7 AMP X 2	Annual	9/15/2025	Pass	
FACP	NA	Front Entrance		Annual	9/15/2025	Pass	
Amplifer	NA	IN FACP Cabinet		Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector:

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name:

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: URVENHG

Contact: Kris Hoover

Contact Address: Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5451

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 3
(Detention/Correctional)
Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (TJC - Fire Alarm)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes*, *No*, *or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5451

Owner's Address:
Building 3 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 3 (Detention/Correctional)

Property Address:
Building 3 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (TJC - Fire Alarm)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	Per Mar
Address:	
Phone:	
Fax:	
Email:	
Account number:	
Phone line 1:	
Phone line 2:	
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	
Phone:	

4. System Information

4.1 Control Unit:

Manufacturer:	Notifier
Model number:	3030
4.2 Software and Firmware Revision number:	27

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120v
Amps:	NA
Location:	FACP
Overcurrent protection type:	NA
Amps:	NA
Disconnecting means location:	Breaker

4.3.2 Secondary Power:

Type:	BATTERY
Location:	IN FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	15

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Local annunciator	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote power panels	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Alarm restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Location Code: URVENHG

Contact: Kris Hoover

Contact Address: Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5451

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 3 (Detention/Correctional)
Building 3 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Suppression (Generator Suppression System)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Frequency Of Testing

Frequency: ☐ Quarterly ☑ Semi-Annual ☐ Annual
Date 9/12/2025

Account Information

Account Information		
Facility Name: Lincoln Regional Center - Building 3	Property Type: Fire Suppression (Generator Suppression System)	Location Code: URVENHG
Service Address: 6775 South 118th Street		
Owner: Omaha Office		Owner Phone: (402) 479-5451
Owner's Address: Building 3 - 801 West Prospector Place, Lincoln, NE, 68522		

Panel Information

Type	Location	Manufacturer	Model:	Result
☑ Releasing Panel ☐ Power Supply ☐ Annunciator	FACP Front Entrance	Notifier	3030	☑ Pass ☐ Fail

Batteries

Type	Location	Install Date:	Voltage/Amphere Reading	Result
☑ 12vdc/7ah ☐ 12vdc/12ah ☐ 12vdc/18ah ☐ 12vdc/26ah ☐ 12vdc/35ah ☐ 12vdc/55ah	PWS IN BASEMENT STORAGE	2021	13.7	☑ Pass ☐ Fail ☐ N/A

Cylinder/Tank

Location	Serial Number:	Manufacture Date:	Manufacturer	Gross/Agent/PSI	Liquid Level
Gemerator	Na	NA	Stat-X	NA	NA

Devices

Legend		
Abort - Abort Station	AirPressSw - Air Pressure Switch	BATT - Batteries
BOTTDIS - Bottom Discharge	CntrlMod - Control Module	Combo Detector - Combo Detector
DAMP - Damper	H/S - Horn-Strobes	HD - Heat Detector
HOSE - Hose	Initiator - Initiator	Low Air - Low Air
MAINT - Maintenance Switch	MM - Monitor Module (Ansul, temp, CO, etc)	ManRel - Manual Release
NOZZ - Nozzle	Other - Other	PWS - Power Supply
Relay Module - Relay Module	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector
SOL - Solenoid	STROBE - Strobes	TOPDIS - Top Discharge
TS - Tamper Switch	VES - VESDA	WF - Waterflow

Asset Type	Total	Tested	Not Tested	Passed	Failed
Abort	2	2	0	2	0
HD	2	2	0	2	0

Asset Type	Total	Tested	Not Tested	Passed	Failed
H/S	2	2	0	2	0
ManRel	1	1	0	1	0

Zone: NA

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: NA						
Asset Type	**Address**	**Location**	**Notes**	**Frequency**	**Test Results**	**Comments**
H/S		Gen Wall Outside		Annual	Pass	
H/S		Gen Wall Outside		Annual	Pass	
Abort		IN Generator		Annual	Pass	
Abort		IN Generator		Annual	Pass	
HD		IN Generator		Annual	Pass	
HD		IN Generator		Annual	Pass	
ManRel		IN Generator		Annual	Pass	

Notification Devices

Suppression Questionnaire

Is system connected to Main Fire Alarm System?	☑ Yes ☐ No ☐ N/A
Is the protected room properly sealed?	☑ Yes ☐ No ☐ N/A
Is there a door sweep?	☑ Yes ☐ No ☐ N/A
Do the trouble signals operate correctly from releasing panel and sub panels (if any)?	☑ Yes ☐ No ☐ N/A
Did alarm signals operate correctly for releasing panel and associated devices when tested?	☑ Yes ☐ No ☐ N/A
Is all wiring installed correctly, terminated and in a serviceable working order?	☑ Yes ☐ No ☐ N/A
Are all switches, indicators, meters, and gauges in good working order both physically and functionally?	☑ Pass ☐ Fail ☐ N/A
Do all shutdown function relays and devices work as intended? Air handlers, fans, dampers, computer systems.	☑ Yes ☐ No ☐ N/A
Will system operate on batteries for 24 hours in standby and 5 minutes in alarm?	☑ Yes ☐ No ☐ N/A
Date of Work	9/12/2025
Inspected By:	Keith Allen Benne
Inspector License:	J13
Signature of Inspector:	

Fire Alarm Supplementary Form

Location Code: IGEKQEV

Contact: Kris Hoover

Contact Address: Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 5
(Detention/Correctional)
Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP2 SPRINKLER)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 5	Property Type: Detention/Correctional	Location Code: IGEKQEV
Service Address: Building 5 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 5 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
TS	7	7	0	7	0

Type	Total	Tested	Not Tested	Passed	Failed
WF	5	5	0	5	0

Zone: EP2

Zone: EP2							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L1M31	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L1M33	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L1M36	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L2M3	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L3M22	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L3M24	BLDG 5		Semi-Annual	9/15/2025	Pass	
WF	L1M23	BLDG 5		Semi-Annual	9/15/2025	Pass	
WF	L1M30	BLDG 5		Semi-Annual	9/15/2025	Pass	

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Zone: EP2							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
WF	L2M02	BLDG 5		Semi-Annual	9/15/2025	Pass	
WF	L3M21	BLDG 5		Semi-Annual	9/15/2025	Pass	
WF	L3M23	BLDG 5		Semi-Annual	9/15/2025	Pass	
TS	L1M35	PIV		Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Fire Alarm Supplementary Form

Location Code: IGEKQEV

Contact: Kris Hoover

Contact Address: Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 5
(Detention/Correctional)
Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP5 EQUIPMENT)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 5	Property Type: Detention/Correctional	Location Code: IGEKQEV
Service Address: Building 5 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 5 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
BATT	6	6	0	6	0
PWS	4	4	0	4	0

Type	Total	Tested	Not Tested	Passed	Failed
FACP	1	1	0	1	0

Zone: EP5

Zone: EP5							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
PWS	5	2ND FLR STROBES	PSE-10	Semi-Annual	9/15/2025	Pass	
BATT	9	2ND FLR STROBES FCPS	12V 7 AMP X 2	Semi-Annual	9/15/2025	Pass	
PWS	3	ABOVE FACP	PSE-10	Semi-Annual	9/15/2025	Pass	
BATT	11	AMP 1 AND 2	12V 26AMP HR X 2	Semi-Annual	9/15/2025	Pass	
BATT	12	AMP 3 AND 4	12V 26 AMP X 2	Semi-Annual	9/15/2025	Pass	
FACP	1	CONTROL RM	NFS2-3030	Semi-Annual	9/15/2025	Pass	
BATT	10	FACP	12V 55 AMP X 2	Semi-Annual	9/15/2025	Pass	

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Phone: 402-592-8225

Zone: EP5							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
PWS	2	FACP	AMPS-24	Semi-Annual	9/15/2025	Pass	
BATT	7	PWS ABOVE FACP	12V 7 AMP HR X2	Semi-Annual	9/15/2025	Pass	
PWS	4	S1 STORAGE	PSE-10	Semi-Annual	9/15/2025	Pass	
BATT	8	S1 STORAGE FCPS	12V 7 AMP X 2	Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: IGEKQEV

Contact: Kris Hoover

Contact Address: Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 5
(Detention/Correctional)
Building 5 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (Panel/Batteries)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes, No, or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5453

Owner's Address:
Building 5 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 5 (Detention/Correctional)

Property Address:
Building 5 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (Panel/Batteries)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	PERMAR
Address:	
Phone:	
Fax:	
Email:	
Account number:	
Phone line 1:	
Phone line 2:	
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	
Phone:	

4. System Information

4.1 Control Unit:

Manufacturer:	NOTIFER
Model number:	NFS2-3030
4.2 Software and Firmware Revision number:	26

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120VAC
Amps:	NA
Location:	CONTROL RM
Overcurrent protection type:	BREAKER
Amps:	NA
Disconnecting means location:	ELECTRICAL

4.3.2 Secondary Power:

Type:	BATTERIES
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	5

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☐ Pass ☐ Fail ☑ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Local annunciator	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote power panels	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Alarm restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Fire Alarm Supplementary Form

Location Code: BFBKVTY

Contact: Kris Hoover

Contact Address: Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 9
(Detention/Correctional)
Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP5 FA Equipment Signals)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 9	Property Type: Detention/Correctional	Location Code: BFBKVTY
Service Address: Building 9 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 9 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
BATT	1	1	0	1	0
FACP	1	1	0	1	0

Type	Total	Tested	Not Tested	Passed	Failed
DVC	1	0	1	0	0

Zone: FACP

Zone: FACP							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
BATT	NA	In FACP	12v 55 ampX2	Semi-Annual	9/15/2025	Pass	
FACP	Notifier NFS-320	Main Hallway		Semi-Annual	9/15/2025	Pass	
DVC	1	MAIN PANEL			2/25/2025	N/A	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.
Please see the summary section at the top of the form for the comments.

Inspector's Information

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Omaha, NE 68137
Phone: 402-592-8225

Inspected By	Keith Allen Benne
Inspector License:	J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector	
Date	9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name	
Owner or Owner's Representative Signature	No Signature Available
Date	9/12/2025

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Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: BFBKVTY

Contact: Kris Hoover

Contact Address: Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 9
(Detention/Correctional)
Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (TJC - Fire Alarm)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes*, *No*, *or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5453

Owner's Address:
Building 9 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 9 (Detention/Correctional)

Property Address:
Building 9 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (TJC - Fire Alarm)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	Per Mar
Address:	NA
Phone:	NA
Fax:	NA
Email:	NA
Account number:	NA
Phone line 1:	NA
Phone line 2:	NA
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	NA
Phone:	NA

4. System Information

4.1 Control Unit:

Manufacturer:	Notifier
Model number:	NFS2-640
4.2 Software and Firmware Revision number:	27
4.3 System Power:	
4.3.1 Primary (Main) Power:	
Nominal voltage:	120v
Amps:	NA
Location:	FACP
Overcurrent protection type:	NA
Amps:	NA
Disconnecting means location:	Breaker
4.3.2 Secondary Power:	
Type:	BATTERY
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	15

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Local annunciator	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote power panels	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Alarm restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Location Code: BFBKVTY

Contact: Kris Hoover

Contact Address: Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 9 (Detention/Correctional)
Building 9 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Suppression (FS Inspection)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Frequency Of Testing

Frequency: ☐ Quarterly ☑ Semi-Annual ☐ Annual
Date 9/12/2025

Account Information

Account Information		
Facility Name: Lincoln Regional Center - Building 9	Property Type: Fire Suppression (FS Inspection)	Location Code: BFBKVTY
Service Address: 6775 South 118th Street		
Owner: Omaha Office		Owner Phone: (402) 479-5453
Owner's Address: Building 9 - 801 West Prospector Place, Lincoln, NE, 68522		

Panel Information

Type	Location	Manufacturer	Model:	Result
☑ Releasing Panel ☐ Power Supply ☐ Annunciator	Telephone Rm	PYROCHEM	Na	☑ Pass ☐ Fail

Batteries

Type				
☑ 12vdc/7ah ☐ 12vdc/12ah ☐ 12vdc/18ah ☐ 12vdc/26ah ☐ 12vdc/35ah ☐ 12vdc/55ah	Location In releasing panel	Install Date: 8/2022	Voltage/Amphere Reading 13.2	Result ☑ Pass ☐ Fail ☐ N/A
☑ 12vdc/7ah ☐ 12vdc/12ah ☐ 12vdc/18ah ☐ 12vdc/26ah ☐ 12vdc/35ah ☐ 12vdc/55ah	Location In releasing panel	Install Date: 8/2022	Voltage/Amphere Reading 13.2	Result ☑ Pass ☐ Fail ☐ N/A

Cylinder/Tank

Location	Serial Number:	Manufacture Date:	Manufacturer	Gross/Agent/PSI	Liquid Level
Telephone Rm	Na	Na	PYROCHEM	180/69/350	Na

Devices

Legend		
Abort - Abort Station	AirPressSw - Air Pressure Switch	BATT - Batteries
BOTTDIS - Bottom Discharge	CntrlMod - Control Module	Combo Detector - Combo Detector
DAMP - Damper	H/S - Horn-Strobes	HD - Heat Detector
HOSE - Hose	Initiator - Initiator	Low Air - Low Air
MAINT - Maintenance Switch	MM - Monitor Module (Ansul, temp, CO, etc)	ManRel - Manual Release
NOZZ - Nozzle	Other - Other	PWS - Power Supply
Relay Module - Relay Module	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector
SOL - Solenoid	STROBE - Strobes	TOPDIS - Top Discharge
TS - Tamper Switch	VES - VESDA	WF - Waterflow

Asset Type	Total	Tested	Not Tested	Passed	Failed
Abort	1	1	0	1	0
SD-Photo	2	2	0	2	0

Asset Type	Total	Tested	Not Tested	Passed	Failed
ManRel	1	1	0	1	0

Zone: 1

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: 1						
Asset Type	**Address**	**Location**	**Notes**	**Frequency**	**Test Results**	**Comments**
Abort		Telephone Rm		Semi-Annual	Pass	
ManRel		Telephone Rm		Semi-Annual	Pass	
SD-Photo		Telephone Rm		Semi-Annual	Pass	
SD-Photo		Telephone Rm		Semi-Annual	Pass	

Notification Devices

Device Type ☐ Horn Strobe ☐ Bell ☐ Strobe ☑ Exterior Strobe	Location HALLWAY OF TELEPHONE ROOM	Result ☑ Pass ☐ Fail ☐ N/A
Device Type ☐ Horn Strobe ☑ Bell ☐ Strobe ☐ Exterior Strobe	Location TELEPHONE ROOM	Result ☑ Pass ☐ Fail ☐ N/A
Device Type ☐ Horn Strobe ☐ Bell ☑ Strobe ☐ Exterior Strobe	Location TELEPHONE ROOM	Result ☑ Pass ☐ Fail ☐ N/A

Suppression Questionnaire

Is system connected to Main Fire Alarm System?	☑ Yes ☐ No ☐ N/A
Is the protected room properly sealed?	☑ Yes ☐ No ☐ N/A
Is there a door sweep?	☑ Yes ☐ No ☐ N/A
Do the trouble signals operate correctly from releasing panel and sub panels (if any)?	☑ Yes ☐ No ☐ N/A
Did alarm signals operate correctly for releasing panel and associated devices when tested?	☑ Yes ☐ No ☐ N/A
Is all wiring installed correctly, terminated and in a serviceable working order?	☑ Yes ☐ No ☐ N/A
Are all switches, indicators, meters, and gauges in good working order both physically and functionally?	☑ Pass ☐ Fail ☐ N/A
Do all shutdown function relays and devices work as intended? Air handlers, fans, dampers, computer systems.	☑ Yes ☐ No ☐ N/A
Will system operate on batteries for 24 hours in standby and 5 minutes in alarm?	☑ Yes ☐ No ☐ N/A
Date of Work	9/12/2025
Inspected By:	Keith Allen Benne
Inspector License:	J13
Signature of Inspector:	

Fire Alarm Supplementary Form

Location Code: FOPQBAH

Contact: Kris Hoover

Contact Address: Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 309-3231

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 10
(Detention/Correctional)
Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP2 Tampers Waterflows)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 10	Property Type: Detention/Correctional	Location Code: FOPQBAH
Service Address: Building 10 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 309-3231
Owner's Address: Building 10 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
MM	1	1	0	1	0
WF	3	2	1	2	0

Type	Total	Tested	Not Tested	Passed	Failed
TS	9	8	1	8	0

Zone: Loop 1Tampers/ Waterflows

Zone: Loop 1Tampers/ Waterflows							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L1M27	1st and 2nd ISO		Semi-Annual	9/15/2025	Pass	
TS	L1M33	1st Floor North		Semi-Annual	9/15/2025	Pass	
WF	L1M32	1st Floor North		Semi-Annual	9/15/2025	Pass	
TS	L1M34	BSMT South Sprinkler		Semi-Annual	9/15/2025	Pass	
TS	L1M29	BSMT Valve Tamper		Semi-Annual	9/15/2025	Pass	
TS	L1M35	Corridor 024		Semi-Annual	9/15/2025	Pass	
MM	L1M23	PIV		Semi-Annual	9/15/2025	Pass	

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Phone: 402-592-8225

Zone: Loop 1Tampers/ Waterflows							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L1M31	Sprinkler Backflow		Semi-Annual	9/15/2025	Pass	
TS	L1M26	Sprinkler Drain		Semi-Annual	9/15/2025	Pass	
TS	L1M20	Sprinkler Volunteer Shop		Semi-Annual	9/15/2025	Pass	
WF	L1M28	Water Entry		Semi-Annual	9/15/2025	Pass	

Zone: Loop 2 Tampers/ Waterflows

Zone: Loop 2 Tampers/ Waterflows							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L2M21	2nd Floor North				N/A	
WF	L2M20	2nd Floor North				N/A	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Fire Alarm Supplementary Form

Location Code: FOPQBAH

Contact: Kris Hoover

Contact Address: Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 309-3231

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 10
(Detention/Correctional)
Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP5 FA Equipment Signals)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 10	Property Type: Detention/Correctional	Location Code: FOPQBAH
Service Address: Building 10 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 309-3231
Owner's Address: Building 10 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
Amplifier	2	2	0	2	0
FACP FACP	1	1	0	1	0

Type	Total	Tested	Not Tested	Passed	Failed
BATT	6	6	0	6	0
PWS PWS	4	4	0	4	0

Zone: FA Equipment Signal Batteries

Zone: FA Equipment Signal Batteries							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
BATT	Amplifier	1ST FLR ELECTRICAL AMP 1 AND 2	12v 26amp Left Right	Semi-Annual	9/15/2025	Pass	
BATT	2	BSMT STORAGE PWS	12V 7 AMP X2	Semi-Annual	9/15/2025	Pass	
PWS PWS	1	BSMT STORAGE RM FOR SUPP.		Semi-Annual	9/15/2025	Pass	
BATT	FACP	FACP Cabinet	12v 26amp Left Right	Semi-Annual	9/15/2025	Pass	

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: FA Equipment Signal Batteries							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
BATT	Power Supply	PWS 1st Floor Bottom	12v 8amp Left Right	Semi-Annual	9/15/2025	Pass	
BATT	Power Supply	PWS 1st Floor Top	12v 8amp Left Right	Semi-Annual	9/15/2025	Pass	
BATT	Power Supply	PWS BSMT CLOSET	12v 8amp Left Right	Semi-Annual	9/15/2025	Pass	

Zone: FA Equipment Signals

Zone: FA Equipment Signals							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
PWS PWS	FCPS	1st Floor FCPS Bottom		Semi-Annual	9/15/2025	Pass	
PWS PWS	FCPS	1st Floor FCPS Top		Semi-Annual	9/15/2025	Pass	
Amplifier	NA	BSMT Amplifier		Semi-Annual	9/15/2025	Pass	
PWS PWS	FCPS	BSMT FCPS		Semi-Annual	9/15/2025	Pass	
Amplifier	NA	FACP Cabinet		Semi-Annual	9/15/2025	Pass	
FACP FACP	NFS-3030	Front Entrance		Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: FOPQBAH

Contact: Kris Hoover

Contact Address: Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 309-3231

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 10 (Detention/Correctional)
Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (TJC - Fire Alarm)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes*, *No*, *or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 309-3231

Owner's Address:
Building 10 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 10 (Detention/Correctional)

Property Address:
Building 10 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (TJC - Fire Alarm)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	Per Mar
Address:	NA
Phone:	NA
Fax:	NA
Email:	NA
Account number:	NA
Phone line 1:	NA
Phone line 2:	NA
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	NA
Phone:	NA

4. System Information

4.1 Control Unit:

Manufacturer:	Notifier
Model number:	NFS2-3030
4.2 Software and Firmware Revision number:	27

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120v
Amps:	NA
Location:	FACP
Overcurrent protection type:	NA
Amps:	NA
Disconnecting means location:	Breaker

4.3.2 Secondary Power:

Type:	BATTERY
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	15

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Local annunciator	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote power panels	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Alarm restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Location Code: FOPQBAH

Contact: Kris Hoover

Contact Address: Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 309-3231

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 10 (Detention/Correctional)
Building 10 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Suppression (Generator Suppression System)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Frequency Of Testing

Frequency: ☐ Quarterly ☑ Semi-Annual ☐ Annual
Date 9/12/2025

Account Information

Account Information		
Facility Name: Lincoln Regional Center - Building 10	Property Type: Fire Suppression (Generator Suppression System)	Location Code: FOPQBAH
Service Address: 6775 South 118th Street		
Owner: Omaha Office		Owner Phone: (402) 309-3231
Owner's Address: Building 10 - 801 West Prospector Place, Lincoln, NE, 68522		

Panel Information

Type	Location	Manufacturer	Model:	Result
☑ Releasing Panel ☐ Power Supply ☐ Annunciator	FACP Front Entrance	Notifier	3030	☑ Pass ☐ Fail

Batteries

Type	Location	Install Date:	Voltage/Amphere Reading	Result
☐ 12vdc/7ah ☐ 12vdc/12ah ☑ 12vdc/18ah ☐ 12vdc/26ah ☐ 12vdc/35ah ☐ 12vdc/55ah	Power supply basement storage	2021	13.7	☑ Pass ☐ Fail ☐ N/A

Cylinder/Tank

Location	Serial Number:	Manufacture Date:	Manufacturer	Gross/Agent/PSI	Liquid Level
Generator	NA	NA	Stat-X	NA	NA

Devices

Legend		
Abort - Abort Station	AirPressSw - Air Pressure Switch	BATT - Batteries
BOTTDIS - Bottom Discharge	CntrlMod - Control Module	Combo Detector - Combo Detector
DAMP - Damper	H/S - Horn-Strobes	HD - Heat Detector
HOSE - Hose	Initiator - Initiator	Low Air - Low Air
MAINT - Maintenance Switch	MM - Monitor Module (Ansul, temp, CO, etc)	ManRel - Manual Release
NOZZ - Nozzle	Other - Other	PWS - Power Supply
Relay Module - Relay Module	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector
SOL - Solenoid	STROBE - Strobes	TOPDIS - Top Discharge
TS - Tamper Switch	VES - VESDA	WF - Waterflow

Asset Type	Total	Tested	Not Tested	Passed	Failed
Abort	2	2	0	2	0
HD	2	2	0	2	0

Asset Type	Total	Tested	Not Tested	Passed	Failed
H/S	2	2	0	2	0
ManRel	1	1	0	1	0

Zone: NA

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: NA						
Asset Type	**Address**	**Location**	**Notes**	**Frequency**	**Test Results**	**Comments**
Abort		Generator		Annual	Pass	
Abort		Generator		Annual	Pass	
HD		Generator		Annual	Pass	
HD		Generator		Annual	Pass	
ManRel		Generator		Annual	Pass	
H/S		Gen Wall Outside		Annual	Pass	
H/S		Gen Wall Outside		Annual	Pass	

Notification Devices

Suppression Questionnaire

Is system connected to Main Fire Alarm System?	☑ Yes ☐ No ☐ N/A
Is the protected room properly sealed?	☑ Yes ☐ No ☐ N/A
Is there a door sweep?	☑ Yes ☐ No ☐ N/A
Do the trouble signals operate correctly from releasing panel and sub panels (if any)?	☑ Yes ☐ No ☐ N/A
Did alarm signals operate correctly for releasing panel and associated devices when tested?	☑ Yes ☐ No ☐ N/A
Is all wiring installed correctly, terminated and in a serviceable working order?	☑ Yes ☐ No ☐ N/A
Are all switches, indicators, meters, and gauges in good working order both physically and functionally?	☑ Pass ☐ Fail ☐ N/A
Do all shutdown function relays and devices work as intended? Air handlers, fans, dampers, computer systems.	☑ Yes ☐ No ☐ N/A
Will system operate on batteries for 24 hours in standby and 5 minutes in alarm?	☑ Yes ☐ No ☐ N/A
Date of Work	9/12/2025
Inspected By:	Keith Allen Benne
Inspector License:	J13
Signature of Inspector:	

Fire Alarm Supplementary Form

Location Code: WPVMKMS

Contact: Kris Hoover

Contact Address: Building 11 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 11
(Detention/Correctional)
Building 11 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (TJC EP5 EQUIPMENT)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 11	Property Type: Detention/Correctional	Location Code: WPVMKMS
Service Address: Building 11 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 11 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
AMP	1	1	0	1	0
BATT	1	1	0	1	0
FACP FACP	1	1	0	1	0

Type	Total	Tested	Not Tested	Passed	Failed
ANNUNCIATOR	1	1	0	1	0
DVC	1	1	0	1	0
PWS PWS	1	1	0	1	0

Zone: EQUIPMENT

Zone: EQUIPMENT							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
ANNUNCIATOR	3	BOILER OFFICE	NCA-1	Semi-Annual	9/15/2025	Pass	
AMP	5	FACP	DAA2-5025 PCA	Semi-Annual	9/15/2025	Pass	
BATT	2	FACP	12V 35 AMP X 2	Semi-Annual	9/15/2025	Pass	
DVC	4	FACP	DVC	Semi-Annual	9/15/2025	Pass	
PWS PWS	6	FACP	AMPS-24	Semi-Annual	9/15/2025	Pass	

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Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: EQUIPMENT							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
FACP FACP	1	GROUNDS OFFICE	NFS2-640	Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: WPVMKMS

Contact: Kris Hoover

Contact Address: Building 11 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 11
(Detention/Correctional)
Building 11 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (FORM)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes, No, or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5453

Owner's Address:
Building 11 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 11 (Detention/Correctional)

Property Address:
Building 11 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (FORM)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	PERMAR
Address:	
Phone:	
Fax:	
Email:	
Account number:	
Phone line 1:	
Phone line 2:	
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	
Phone:	

4. System Information

4.1 Control Unit:

Manufacturer:	NOTIFIER
Model number:	NFS2-640
4.2 Software and Firmware Revision number:	27

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120VAC
Amps:	NA
Location:	OFFICE
Overcurrent protection type:	BREAKER
Amps:	NA
Disconnecting means location:	ELECTRICAL

4.3.2 Secondary Power:

Type:	BATTERIES
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	5

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Local annunciator	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Remote power panels	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

Fire Alarm Supplementary Form

Location Code: HOLOAIZ

Contact: Kris Hoover

Contact Address: Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 14
(Detention/Correctional)
Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (EP2 SPRINKLER)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 14	Property Type: Detention/Correctional	Location Code: HOLOAIZ
Service Address: Building 14 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 14 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
TS	10	10	0	10	0

Type	Total	Tested	Not Tested	Passed	Failed
WF	6	6	0	6	0

Zone: EP2

Zone: EP2							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L2M2	1ST FLR TAMPER		Semi-Annual	9/15/2025	Pass	
WF	L2M1	1ST FLR WF		Semi-Annual	9/15/2025	Pass	
TS	L3M12	2ND FLR HALL BY VENDING		Semi-Annual	9/15/2025	Pass	
WF	L3M21	2ND FLR HALL BY VENDING		Semi-Annual	9/15/2025	Pass	
WF	L4M6	3RD FLR FLOW		Semi-Annual	9/15/2025	Pass	
TS	L4M7	3RD FLR TAMPER		Semi-Annual	9/15/2025	Pass	
WF	L4M	4TH FLR FLOW		Semi-Annual	9/15/2025	Pass	

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Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Zone: EP2							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
TS	L4M16	4TH FLR TAMPER		Semi-Annual	9/15/2025	Pass	
TS	L1M17	MECH 042		Semi-Annual	9/15/2025	Pass	
TS	L1M18	MECH 042		Semi-Annual	9/15/2025	Pass	
TS	L1M19	MECH 042		Semi-Annual	9/15/2025	Pass	
TS	L1M20	MECH 042		Semi-Annual	9/15/2025	Pass	
WF	L1M23	MECH 042	BLDG 14 WF	Semi-Annual	9/15/2025	Pass	
WF	L4M8	PENTHOUSE FLOW		Semi-Annual	9/15/2025	Pass	
TS	L4M9	PENTHOUSE TAMPER		Semi-Annual	9/15/2025	Pass	
TS	L1M21	PIV		Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.
Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector:

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name:
Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Fire Alarm Supplementary Form

Location Code: HOLOAIZ

Contact: Kris Hoover

Contact Address: Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 14
(Detention/Correctional)
Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm Supplement (EP5 EQUIPMENT)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

There are no reported deficiencies for this submission

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Fire Alarm Supplementary Form

Account Information		
Facility Name: Lincoln Regional Center - Building 14	Property Type: Detention/Correctional	Location Code: HOLOAIZ
Service Address: Building 14 - 801 West Prospector Place, Lincoln, NE, 68522		
Owner: Kris Hoover		Owner's Phone: (402) 479-5453
Owner's Address: Building 14 - 801 West Prospector Place, Lincoln, NE, 68522		

Legend				
AS - Abort Station	BATT - Batteries	CoD - Carbon Monoxide Detector	CM - Control Module	DA - Damper
DD - Duct Detector	DH - Door Holder	EL - Emergency/Exit Light	FACP - Fire Alarm Control Panel	HD - Heat Detector
HORN - Horns	H/S - Horn-Strobes	LA - Low Air	MM - Monitor Module (Ansul, temp, CO, etc)	
MR - Manual Release	Other	PR - Phase Reversal	PS - Pull Station	PWS - Power Supply
SC - Signal/Sounder Control	SD - Smoke Detector	SD-Ion - Ion Smoke Detector	SD-Photo - Photo Smoke Detector	SPKR - Speakers
S/S - Speaker-Strobes	STROBE - Strobes	TS - Tamper Switch	WF - Waterflow	

Type	Total	Tested	Not Tested	Passed	Failed
AMPLIFIER	8	8	0	8	0
DVC/KD	1	1	0	1	0
LCD-160,,ACM,REM MIC	1	1	0	1	0
PWS	6	6	0	6	0

Type	Total	Tested	Not Tested	Passed	Failed
BATT	12	12	0	12	0
FACP	1	1	0	1	0
LCD-160,ACM,REM MIC	8	8	0	8	0

Zone: EP5

Zone: EP5							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
LCD-160,ACM,REM MIC	3	1ST FLR CENTER		Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	4	1ST FLR EAST		Semi-Annual	9/15/2025	Pass	

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Omaha, NE 68137
Phone: 402-592-8225

Zone: EP5							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
LCD-160,ACM,REM MIC	5	1ST FLR WEST		Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	6	2ND FLR CENTER		Semi-Annual	9/15/2025	Pass	
LCD-160,,ACM,REM MIC	7	2ND FLR EAST		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 4	2ND FLR ELEC.		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 5	2ND FLR ELEC.		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 6	2ND FLR ELEC.		Semi-Annual	9/15/2025	Pass	
BATT	004	2ND FLR ELEC. AMP 3	12V 12 AMP X2	Semi-Annual	9/15/2025	Pass	
BATT	006	2ND FLR ELEC. AMP 5 AND 6	12V 26 AMP X 2	Semi-Annual	9/15/2025	Pass	
BATT	005	2ND FLR ELEC AMP 4	12V 12AMP X 2	Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 2	2ND FLR ELECTRICAL		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP3	2ND FLR ELECTRICAL		Semi-Annual	9/15/2025	Pass	
BATT	003	2ND FLR ELECTRICAL AMP 2	12V 12 AMP X2	Semi-Annual	9/15/2025	Pass	
BATT	PWS 3	2ND FLR STROBES	12V 8 AMP X 2	Semi-Annual	9/15/2025	Pass	
PWS PWS	PWS 3	2ND FLR STROBES		Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	8	2ND FLR WEST		Semi-Annual	9/15/2025	Pass	
BATT	PWS 4	3RD FLR	12V 8 AMP X 2	Semi-Annual	9/15/2025	Pass	
BATT	PWS 5	3RD FLR	12V 8 X 2	Semi-Annual	9/15/2025	Pass	
PWS PWS	PWS 4	3RD FLR		Semi-Annual	9/15/2025	Pass	
PWS PWS	PWS 5	3RD FLR		Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	9	3RD FLR CENTER		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 7	3RD FLR STORAGE		Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 8	3RD FLR STORAGE		Semi-Annual	9/15/2025	Pass	
BATT	AMP 7-8	3RD FLR STORAGE	12V 26AMP X 2	Semi-Annual	9/15/2025	Pass	

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Omaha, NE 68137
Phone: 402-592-8225

Zone: EP5							
Type	**Address**	**Location**	**Notes**	**Frequency**	**Last Tested**	**Test Results**	**Comments**
BATT	PWS 1	BSMT ELECTRICAL	12V 8 X 2	Semi-Annual	9/15/2025	Pass	
FACP	NFS2-3030	BSMT ELECTRICAL		Semi-Annual	9/15/2025	Pass	
PWS	PWS 1	BSMT ELECTRICAL		Semi-Annual	9/15/2025	Pass	
PWS	001	BSMT ELECTRICAL ACROSS FROM FACP	PSE-10	Semi-Annual	9/15/2025	Pass	
BATT	002	BSMT ELECTRICAL PWS	12V 7 AMP X 2	Semi-Annual	9/15/2025	Pass	
AMPLIFIER	AMP 1	FACP		Semi-Annual	9/15/2025	Pass	
BATT	12V 55 AMP X 2	FACP		Semi-Annual	9/15/2025	Pass	
DVC/KD	DVC	FACP		Semi-Annual	9/15/2025	Pass	
PWS	AMPS24	FACP		Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	1	MAINTENANCE ENTRANCE	BSMT	Semi-Annual	9/15/2025	Pass	
BATT	PWS 2	PWS 2	12V 12 AMP X 2	Semi-Annual	9/15/2025	Pass	
LCD-160,ACM,REM MIC	2	STREET LEVEL ENTRANCE		Semi-Annual	9/15/2025	Pass	

Comments

Any deficiencies or other problems found with the devices must be explained using the comment specific for each device. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

Inspector's Information

Inspected By: Keith Allen Benne

Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*.

Signature of Inspector:

Date: 9/12/2025

Owner or Owner's Representative

Owner or Owner's Representative Name:

Owner or Owner's Representative Signature: No Signature Available

Date: 9/12/2025

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Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Location Code: HOLOAIZ

Contact: Kris Hoover

Contact Address: Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Phone: (402) 479-5453

Email: kris.hoover@nebraska.gov

Property Evaluated: Lincoln Regional Center - Building 14
(Detention/Correctional)
Building 14 - 801 West Prospector Place
Lincoln, NE 68522

Description: Fire Alarm (FORM)

Company: Omaha Office

Address: 6775 South 118th Street
Omaha, NE 68137

Company Phone: 402-592-8225

Inspector: Keith Allen Benne
J13

Date of Work: 9/12/2025

Frequency: Semi-Annual

Deficiency Summary

Please refer to the Deficiency Summary located on applicable Fire Alarm Supplementary Forms for additional deficiency details.

General Comments

There are no general comments for this submission

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Form for Inspection, Testing and Maintenance of Fire Alarms and Signaling Systems

Separate forms are available for inspection, testing, and maintenance of the rest of the fire protection system of which the fire alarms and signaling systems are a part. More frequent inspection, testing, and maintenance may be necessary depending on the conditions of the occupancy and the water supply.

Notes:

1. All questions are to be answered *Yes*, *No*, *or Not Applicable*. All "No" answers are to be explained in the *Comments* for this form.
2. Refer to NFPA-72 for specific inspection frequency requirements for the different components.

1. Property Information

Owner:
Kris Hoover

Owner's Phone Number:
(402) 479-5453

Owner's Address:
Building 14 - 801 West Prospector Place, Lincoln, NE, 68522

Property Being Evaluated:
Lincoln Regional Center - Building 14 (Detention/Correctional)

Property Address:
Building 14 - 801 West Prospector Place, Lincoln, NE, 68522

Assembly Description:
Fire Alarm (FORM)

2. Owner's Section

A. Are the fire alarms and signaling systems in service?	☑ Yes ☐ No
B. Have fire alarms and signaling systems remained in service since the last inspection?	☑ Yes ☐ No
C. Was the system (of which the fire alarm and signaling systems are a part) free of actuation of devices or alarms since the last inspection?	☑ Yes ☐ No
D. The required record documents are available and include the current revisions of all fire alarm software and the revisions of software of any systems with which the fire alarm software interfaces?	☑ Yes ☐ No

3. Monitoring Information

Monitoring organization:	PERMAR
Address:	
Phone:	
Fax:	
Email:	
Account number:	
Phone line 1:	
Phone line 2:	
Means of transmission:	RADIO
Entity to which alarms are retransmitted:	
Phone:	

4. System Information

4.1 Control Unit:

Manufacturer:	NOTIFIER
Model number:	NFS2-3030
4.2 Software and Firmware Revision number:	26

4.3 System Power:

4.3.1 Primary (Main) Power:

Nominal voltage:	120VAC
Amps:	NA
Location:	BSMT ELECTRICAL
Overcurrent protection type:	BREAKER
Amps:	NA
Disconnecting means location:	BSMT ELECTRICAL

4.3.2 Secondary Power:

Type:	BATTERIES
Location:	FACP
Battery type (if applicable):	☐ Lead-acid ☐ Nickel-cadmium ☐ Primary (dry cell) ☑ Sealed lead-acid

Calculated capacity of batteries to drive the system:

In standby mode (hours):	24
In alarm mode (minutes):	15

5. Notifications Made Prior To Testing

	Contact	Time
Monitoring organization:	PER MAR	8AM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

6. Testing Results

6.1 Control Unit and Related Equipment

Description	Visual Inspection	Functional Test	Results
Control unit	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Lamps/LEDs/LCDs	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Fuses	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Trouble signals	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Disconnect switches	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Ground-fault monitoring	☐ Yes ☑ No	☐ Yes ☑ No	☐ Pass ☐ Fail ☑ N/A
Supervision	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Local annunciator	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote annunciators	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Remote power panels	☑ Yes ☐ No	☐ Yes ☑ No	☑ Pass ☐ Fail ☐ N/A
Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Pass ☐ Fail ☐ N/A

6.2 Secondary Power

Description	Visual Inspection	Functional Test	Results
Battery condition	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Load voltage	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Discharge test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Charger test	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A
Remote panel batteries	☐ Yes ☑ No	☑ Yes ☐ No	☑ Pass ☐ Fail ☐ N/A

6.3 Alarm and Supervisory Alarm Initiating Device

Complete supplementary device test form for all initiating devices.

6.4 Notification Appliances

Complete supplementary appliance test form for all notification appliances.

6.5 Interface Equipment

Complete supplementary interface component test form for all interface components.
Circuit Interface / Signaling Line Circuit Interface / Fire Alarm Control Interface

6.6 Supervising Station Monitoring

Description	Yes/No	Time (sec)	Results
Alarm signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Alarm restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Trouble restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory signal	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A
Supervisory restoration	☑ Yes ☐ No		☑ Pass ☐ Fail ☐ N/A

6.7 Public Emergency Alarm Reporting System

Description	Yes/No	Time (seconds)	Results
Alarm signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Alarm restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Trouble restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory signal	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A
Supervisory restoration	☐ Yes ☐ No		☐ Pass ☐ Fail ☑ N/A

7. Notifications That Testing Is Complete

	Contact	Time
Monitoring organization:	PER MAR	3PM
Building management:	NA	NA
Building occupants:	NA	NA
Authority Having Jurisdiction:	NA	NA
Other, if required:		

8. System Restored To Normal Operation

Date: 9/12/2025
Time: 3PM

9. Comments

Any "No" answers, test failures or other problems found with the fire alarm system must be explained using the comment specific for each question. Additional comments can be added here.

Please see the summary section at the top of the form for the comments.

10. Inspector's Information

Inspected By: Keith Allen Benne
Inspector License: J13

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 operating condition upon completion of this inspection except as noted in the *Comments*. This system as specified herein has been inspected and tested according to NFPA 72, 2013 edition, Chapter 14.

Omaha Office
6775 South 118th Street
Omaha, NE 68137
Phone: 402-592-8225

Signature of Inspector

Date 9/12/2025

11. Owner or Owner's Representative

Owner or Owner's Representative Name

Owner or Owner's Representative Signature No Signature Available

Date 9/12/2025

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
Dec 18, 2024

Building: Lincoln Regional Center B 3
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 3	**Contact:** Kris Hoover
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Address:	**Fax:**
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Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Dec 18, 2024

Building: Lincoln Regional Center B 3

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Supervisory Signal	5	5	0	5	5

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Piping	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 (2024)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 20

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 3
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Supervisory Signal	5	5	0	5	5

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Supervisory Signal	Basement Center room 008	59342400	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center room 008	30561923	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center room 008	30561920	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	1st Center rom 116	59342403	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd Center rom 216	59342408	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P

Device Total: 5

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Tamper Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Tamper Switch	Basement Center room 008	30561922	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 008	30561921	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 008	59342398	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 008	59342401	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	1st Center rom 116	59342404	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 5								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Waterflow Switch	Basement Center room 008	59342402	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	Basement Center room 008	30561918	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Center rom 116	59342405	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd Center rom 216	59342406	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Drain	Basement Center room 008	59342396	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

Fire department connections shall be inspected quarterly to verify the following: Connections are visible and accessible, couplings or swivels are not damaged and rotate smoothly, plugs or caps are in place and undamaged, gaskets are in place and in good condition, identification signs are in place, the check valve is not leaking, the automatic drain valve is in place and operating properly and the clapper is in place and operating properly. (2011 ed.) (NFPA 25 13.7.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Fire Dep't Connection	In yard, south of main entrance	68041242	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Piping		68040263	0		03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Control Valve	2nd Center rom 216	59342407	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Gauge		68040262	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Post Indicator Valve	Garden Center outside Sw side	59342397	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

Service Summary

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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
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	4
Total		**20**
Grand Total		**20**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 3

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040262

Location	Service Date	Static psi	Min. Range	Max. Range
	01/27/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4 and 1	Normal	☑	68040263

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron	N/A	Normal	01/27/2023

Building: Lincoln Regional Center B 3 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden Center outside Sw side			☑	59342397

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard, south of main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041242

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
Control Valve	LS 02.01.35 EP 14	5.00%	1
Drain	EC 02.03.05 EP 09	5.00%	1
Fire Dep't Connection	EC 02.03.05 EP 10	5.00%	1
Gauge	LS 02.01.35 EP 14	5.00%	1
Piping	LS 02.01.35 EP 03/EP 04	5.00%	1
Post Indicator Valve	LS 02.01.35 EP 14	5.00%	1
Supervisory Signal	EC 02.03.05 EP 01	25.00%	5
Tamper Switch	EC 02.03.05 EP 02	25.00%	5
Waterflow Switch	EC 02.03.05 EP 02	20.00%	4

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 3 Years to 5 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	5		Pressure		03/02/2020
Tamper Switch	5		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 5
801 West Prospector
Lincoln, NE 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 18, 2024

Building: Lincoln Regional Center B 5
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 5	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-471-4444
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Dec 18, 2024

Building: Lincoln Regional Center B 5

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Supervisory Signal	7	7	0	7	7

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Piping	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 (2024)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 27

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 5
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

Inspection & Testing

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Building: Lincoln Regional Center B 5

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EC 02.03.05 EP 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Supervisory Signal	7	7	0	7	7

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Supervisory Signal	Basement Boiler	59342376	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Boiler	59342379	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	1st Closet closet by reception center	59342381	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Tamper Switch	Basement Boiler	59342377	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Boiler	59342378	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	1st 1st closet by reception desk	59342382	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	1st Closet room 133a	59342386	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342388	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342390	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	2nd Closet s5 west stairwell	59342395	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Waterflow Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Waterflow Switch	Basement Boiler	59342380	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Closet room 133a	59342384	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Closet room 133a S2	68605364	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Drain	Basement Boiler	59342375	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

Fire department connections shall be inspected quarterly to verify the following: Connections are visible and accessible, couplings or swivels are not damaged and rotate smoothly, plugs or caps are in place and undamaged, gaskets are in place and in good condition, identification signs are in place, the check valve is not leaking, the automatic drain valve is in place and operating properly and the clapper is in place and operating properly. (2011 ed.) (NFPA 25 13.7.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Fire Dep't Connection	Garden outside ne of entrance	68041241	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Piping		68040264	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Control Valve	1st Closet room 133a S2	68605365	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Gauge	1st 1st closet by reception desk	68040265	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Post Indicator Valve	Garden outside ne of entrance	59342356	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	7
Tamper Switch	Annual	7
Waterflow Switch	Annual	7
Total		**27**
Grand Total		**27**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 5

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040265

Location	Service Date	Static psi	Min. Range	Max. Range
1st 1st closet by reception desk	01/27/2023		3	3

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4"	Normal	☑	68040264

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	06/07/2022

Building: Lincoln Regional Center B 5 — Basement, Building-

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.

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	64		☑	59342375

Previous Inspections

September 25, 2024

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	63		☑	59342375

June 26, 2024

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	63		☑	59342375

Building: Lincoln Regional Center B 5 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden outside ne of entrance			☑	59342356

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Garden outside ne of entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041241

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
Control Valve	LS 02.01.35 EP 14	3.70%	1
Drain	EC 02.03.05 EP 09	3.70%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.70%	1
Gauge	LS 02.01.35 EP 14	3.70%	1
Piping	LS 02.01.35 EP 03/EP 04	3.70%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.70%	1
Supervisory Signal	EC 02.03.05 EP 01	25.93%	7
Tamper Switch	EC 02.03.05 EP 02	25.93%	7
Waterflow Switch	EC 02.03.05 EP 02	25.93%	7

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 3 Years to 5 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Supervisory Signal	3				03/02/2020
Supervisory Signal	3		Pressure		03/02/2020
Supervisory Signal	1		Valve Sup. Switch		03/02/2020
Tamper Switch	7		Control Valve	Supervisory	03/02/2020
Waterflow Switch	7		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Basement Wet Pipe, Building-					
Drain	1		Main		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				
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 10
801 West Prospector
Lincoln, NE 68522

This inspection was performed in accordance with NFPA 101, EDITION 2012, LIFE SAFETY CODE, NFPA 72, EDITION 2010, FIRE ALARM SYSTEMS, NFPA 25, EDITION 2011,WATER-BASED FIRE PROTECTION SYSTEMS and other regulatory standards applicable to this inspection.

This Inspection was performed in accordance with applicable NFPA Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

Quarterly Inspection
Inspection Completion Date
Dec 18, 2024

Building: Lincoln Regional Center B 10
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** Na
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Dec 18, 2024

Building: Lincoln Regional Center B 10

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Supervisory Signal	6	6	0	6	6

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Piping	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 (2024)	Total Quantity
Gauge	1	1	0	1	1
Inspector's Test	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 22

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 10
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Supervisory Signal	Basement Center room 013	59342346	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center room 013	59342342	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center room 013	59342351	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center room 013	59342348	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	1st Center room 147	59342410	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd East room 234	59342341	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P

Device Total: 6

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Tamper Switch	Basement Center room 013	59342345	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 013	59342343	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 013	59342344	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 013	59342350	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center room 013	59342349	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	1st Center room 147	59342409	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	2nd East room 234	59342340	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 7								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Waterflow Switch	Basement Center room 013	59342347	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Center room 147	59342411	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd East room 234	59342339	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Drain	Basement Center room 013	59342353	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

Fire department connections shall be inspected quarterly to verify the following: Connections are visible and accessible, couplings or swivels are not damaged and rotate smoothly, plugs or caps are in place and undamaged, gaskets are in place and in good condition, identification signs are in place, the check valve is not leaking, the automatic drain valve is in place and operating properly and the clapper is in place and operating properly. (2011 ed.) (NFPA 25 13.7.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Fire Dep't Connection	In yard by main entrance	68041243	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Piping		68040250	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Gauge	Basement Center room 013	68040251	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
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 Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Inspector's Test	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Inspector's Test	2nd East room 234	Y89971	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Post Indicator Valve	Basement Center room 013	59342352	0	12/21-P	03/27-P	06/26-P		12/18-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
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Inspector's Test	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	6
Tamper Switch	Annual	7
Waterflow Switch	Annual	3
Total		**22**
Grand Total		**22**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 10

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040251

Location	Service Date	Static psi	Min. Range	Max. Range
Basement Center room 013	01/25/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		6"	Normal	☑	68040250

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 10 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Basement Center room 013			☑	59342352

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard by main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041243

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
Drain	EC 02.03.05 EP 09	4.55%	1
Fire Dep't Connection	EC 02.03.05 EP 10	4.55%	1
Gauge	LS 02.01.35 EP 14	4.55%	1
Inspector's Test	LS 02.01.35 EP 14	4.55%	1
Piping	LS 02.01.35 EP 03/EP 04	4.55%	1
Post Indicator Valve	LS 02.01.35 EP 14	4.55%	1
Supervisory Signal	EC 02.03.05 EP 01	27.27%	6
Tamper Switch	EC 02.03.05 EP 02	31.82%	7
Waterflow Switch	EC 02.03.05 EP 02	13.64%	3

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 3 Years to 5 Years					
Drain	1		Main		03/02/2020
Inspector's Test	1				03/02/2020
Supervisory Signal	4				03/02/2020
Supervisory Signal	2		Pressure		03/02/2020
Tamper Switch	6		Control Valve	Supervisory	03/02/2020
Tamper Switch	1		OS&Y	Supervisory	03/02/2020
Waterflow Switch	3		Vane	Alarm	03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
In Service - 15 Years to 25 Years					
Wet Pipe					
Gauge	1		City Pressure		03/02/2008
Piping	1		Steel		03/02/2008

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
Dec 18, 2024

Building: Lincoln Regional Center B 14
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Dec 18, 2024

Building: Lincoln Regional Center B 14

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Supervisory Signal	11	11	0	11	11

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2024)	Total Quantity
Piping	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 (2024)	Total Quantity
Check Valve	1	1	0	1	1
Control Valve	2	2	0	2	2
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 33

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 14
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Alarm conditions shall be simulated by activating alarm circuits at alarm sensor locations and all such local or remote alarm indicating devices (visual and audible) shall be observed for operation. (2011 ed.) (NFPA 25 8.3.3.5)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Supervisory Signal	11	11	0	11	11

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Supervisory Signal	Basement Room 42	59342429	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Room 42	59342431	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Room 42	59342436	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Room 42	59342439	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center Room 039	59342336	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Basement Center Room 039	59342337	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	3rd Center Room 340	59342418	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Supervisory Signal	Penthouse Elevator room	59342424	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P

Device Total: 11

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - Valve shall be operated and signal receipt shall be verified to be within the first two revolutions of the hand wheel or within one-fifth of the travel distance, or per the manufacturer's published instructions. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14i.1))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Tamper Switch	9	9	0	9	9

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Tamper Switch	Basement Room 42	59342430	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Room 42	59342432	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Room 42	59342437	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Room 42	59342438	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center Room 039	59342335	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	Basement Center Room 039	59342338	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	1st Center Room 135 above ceiling	59342412	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	3rd Center Room 340	59342419	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Tamper Switch	3rd Center Room 340	59342421	1-3rd floor	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 9								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/pressure-type water-flow devices. Quarterly testing of mechanical water-flow devices. NFPA 72-2010 Table 14.4.5; NFPA 25-2011 Table 5.1.1.2.

Vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. Per NFPA 25, Section 5.3.3.1, mechanical waterflow alarm devices shall be tested quarterly. Water shall be flowed through an inspector's test connection indicating the flow of water equal to that from a single sprinkler of the smallest orifice size installed in the system for wet-pipe systems, or an alarm test bypass connection for dry-pipe, pre-action, or deluge systems. (2010 ed.) (NFPA 72 Table 14.4.2.2 (14j))

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Waterflow Switch	Basement Room 42	59342427	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Waterflow Switch	3rd Center Room 340	59342423	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Drain	Basement Room 42	59342426	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

Fire department connections shall be inspected quarterly to verify the following: Connections are visible and accessible, couplings or swivels are not damaged and rotate smoothly, plugs or caps are in place and undamaged, gaskets are in place and in good condition, identification signs are in place, the check valve is not leaking, the automatic drain valve is in place and operating properly and the clapper is in place and operating properly. (2011 ed.) (NFPA 25 13.7.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Fire Dep't Connection	Basement Room 42	59342433	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Piping	Throughout building	68040252	0			06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Check Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Check Valve	Basement Room 42	59342434	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Control Valve	2nd Center Room 247 above ceiling	59342416	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-P
Control Valve	Penthouse Elevator room	59342425	1	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Gauge	Basement mech room	68040253	0			06/26-P	09/25-P	12/18-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q4/24	Pass Q4/24	Fail Q4/24	Tested YTD (2024)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q4/23	Q1/24	Q2/24	Q3/24	Q4/24
Post Indicator Valve	Garden South In yard south of building	59342435	0	12/21-P	03/27-P	06/26-P	09/25-P	12/18-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
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	11
Tamper Switch	Annual	9
Waterflow Switch	Annual	5
Total		**33**
Grand Total		**33**

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			43	4	1	☑	59342417

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Basement Room 42	Wall	4"	2	Yes	Yes	01/25/2023	☑	59342433

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure	wika		1/4	Air/Water	☑	68040253

Location	Service Date	Static psi	Min. Range	Max. Range
Basement mech room	03/02/2020			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel	Throughout building	1"	Normal	☑	68040252

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 14 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden South In yard south of building			☑	59342435

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

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
Check Valve	LS 02.01.35 EP 14	3.03%	1
Control Valve	LS 02.01.35 EP 14	6.06%	2
Drain	EC 02.03.05 EP 09	3.03%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.03%	1
Gauge	LS 02.01.35 EP 14	3.03%	1
Piping	LS 02.01.35 EP 03/EP 04	3.03%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.03%	1
Supervisory Signal	EC 02.03.05 EP 01	33.33%	11
Tamper Switch	EC 02.03.05 EP 02	27.27%	9
Waterflow Switch	EC 02.03.05 EP 02	15.15%	5

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 3 Years to 5 Years					
Check Valve	1		Grooved		03/02/2020
Control Valve	2		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	11		Pressure		03/02/2020
Tamper Switch	9		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Fire Dep't Connection	1		Wall		03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Gauge	1		City Pressure		03/02/2020
Wet Pipe, Building-					
Post Indicator Valve	1		Ground		03/02/2020
In Service - 25 Years or Older					
Wet Pipe					
Piping	1		Steel		10/02/1982

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

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.

Annual Inspection
Inspection Completion Date
Mar 11, 2025

Building: Lincoln Regional Center B 3
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 3	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** Na
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Mar 11, 2025

Building: Lincoln Regional Center B 3

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	5	5	0	5	5

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	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 (2025)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 20

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 3
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Supervisory Signal	Basement Center room 008	30561920	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center room 008	30561923	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center room 008	59342400	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	1st Center rom 116	59342403	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd Center rom 216	59342408	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P

Device Total: 5

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Tamper Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Tamper Switch	Basement Center room 008	30561921	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 008	30561922	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 008	59342398	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 008	59342401	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	1st Center rom 116	59342404	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 5								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Waterflow Switch	Basement Center room 008	30561918	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	Basement Center room 008	59342402	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Center rom 116	59342405	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd Center rom 216	59342406	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Drain	Basement Center room 008	59342396	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Fire Dep't Connection	In yard, south of main entrance	68041242	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Piping		68040263	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Control Valve	2nd Center rom 216	59342407	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Gauge		68040262	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Post Indicator Valve	Garden Center outside Sw side	59342397	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	4
Total		**20**
Grand Total		**20**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 3

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040262

Location	Service Date	Static psi	Min. Range	Max. Range
	01/27/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4 and 1	Normal	☑	68040263

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron	N/A	Normal	01/27/2023

Building: Lincoln Regional Center B 3 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden Center outside Sw side			☑	59342397

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard, south of main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041242

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
Control Valve	LS 02.01.35 EP 14	5.00%	1
Drain	EC 02.03.05 EP 09	5.00%	1
Fire Dep't Connection	EC 02.03.05 EP 10	5.00%	1
Gauge	LS 02.01.35 EP 14	5.00%	1
Piping	LS 02.01.35 EP 03/EP 04	5.00%	1
Post Indicator Valve	LS 02.01.35 EP 14	5.00%	1
Supervisory Signal	EC 02.03.05 EP 01	25.00%	5
Tamper Switch	EC 02.03.05 EP 02	25.00%	5
Waterflow Switch	EC 02.03.05 EP 02	20.00%	4

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	5		Pressure		03/02/2020
Tamper Switch	5		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 5
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.

Annual Inspection
Inspection Completion Date
Mar 11, 2025

Building: Lincoln Regional Center B 5
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 5	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-471-4444
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Mar 11, 2025

Building: Lincoln Regional Center B 5

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	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 (2025)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 27

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 5
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Supervisory Signal	Basement Boiler	59342376	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Boiler	59342379	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	1st Closet closet by reception center	59342381	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - 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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Tamper Switch	Basement Boiler	59342377	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Boiler	59342378	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	1st 1st closet by reception desk	59342382	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	1st Closet room 133a	59342386	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342388	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342390	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	2nd Closet s5 west stairwell	59342395	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Waterflow Switch	Basement Boiler	59342380	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Closet room 133a	59342384	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Closet room 133a S2	68605364	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Drain	Basement Boiler	59342375	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Fire Dep't Connection	Garden outside ne of entrance	68041241	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Piping		68040264	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Control Valve	1st Closet room 133a S2	68605365	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Gauge	1st 1st closet by reception desk	68040265	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Post Indicator Valve	Garden outside ne of entrance	59342356	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	7
Tamper Switch	Annual	7
Waterflow Switch	Annual	7
Total		**27**
Grand Total		**27**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 5

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040265

Location	Service Date	Static psi	Min. Range	Max. Range
1st 1st closet by reception desk	01/27/2023		3	3

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4"	Normal	☑	68040264

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	06/07/2022

Building: Lincoln Regional Center B 5 — Basement, Building-

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.

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	61		☑	59342375

Previous Inspections

December 18, 2024

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	64		☑	59342375

September 25, 2024

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	63		☑	59342375

Building: Lincoln Regional Center B 5 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden outside ne of entrance			☑	59342356

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Garden outside ne of entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041241

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
Control Valve	LS 02.01.35 EP 14	3.70%	1
Drain	EC 02.03.05 EP 09	3.70%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.70%	1
Gauge	LS 02.01.35 EP 14	3.70%	1
Piping	LS 02.01.35 EP 03/EP 04	3.70%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.70%	1
Supervisory Signal	EC 02.03.05 EP 01	25.93%	7
Tamper Switch	EC 02.03.05 EP 02	25.93%	7
Waterflow Switch	EC 02.03.05 EP 02	25.93%	7

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Supervisory Signal	3				03/02/2020
Supervisory Signal	3		Pressure		03/02/2020
Supervisory Signal	1		Valve Sup. Switch		03/02/2020
Tamper Switch	7		Control Valve	Supervisory	03/02/2020
Waterflow Switch	7		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Basement Wet Pipe, Building-					
Drain	1		Main		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				
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 10
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.

Annual Inspection
Inspection Completion Date
Mar 11, 2025

Building: Lincoln Regional Center B 10
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** Na
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Mar 11, 2025

Building: Lincoln Regional Center B 10

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	0	0	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 (2025)	Total Quantity
Gauge	1	1	0	1	1
Inspector's Test	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 22

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 10
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Supervisory Signal	Basement Center room 013	59342351	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center room 013	59342348	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center room 013	59342346	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center room 013	59342342	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	1st Center room 147	59342410	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd East room 234	59342341	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P

Device Total: 6

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - 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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Tamper Switch	Basement Center room 013	59342350	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 013	59342349	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 013	59342345	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 013	59342344	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center room 013	59342343	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	1st Center room 147	59342409	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	2nd East room 234	59342340	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 7								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Waterflow Switch	Basement Center room 013	59342347	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Center room 147	59342411	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd East room 234	59342339	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Drain	Basement Center room 013	59342353	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Fire Dep't Connection	In yard by main entrance	68041243	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	0	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Piping		68040250	0	03/27-P	06/26-P	09/25-P	12/18-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Gauge	Basement Center room 013	68040251	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Inspector's Test	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Inspector's Test	2nd East room 234	Y89971	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Post Indicator Valve	Basement Center room 013	59342352	0	03/27-P	06/26-P		12/18-P	03/11-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
Fire Dep't Connection	Annual	1
Gauge	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		**21**
	Untested	
Piping		1
Total		**1**
Grand Total		**22**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 10

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040251

Location	Service Date	Static psi	Min. Range	Max. Range
Basement Center room 013	01/25/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		6"	Normal	☐	68040250

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 10 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Basement Center room 013			☑	59342352

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard by main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041243

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
Drain	EC 02.03.05 EP 09	4.55%	1
Fire Dep't Connection	EC 02.03.05 EP 10	4.55%	1
Gauge	LS 02.01.35 EP 14	4.55%	1
Inspector's Test	LS 02.01.35 EP 14	4.55%	1
Piping	LS 02.01.35 EP 03/EP 04	4.55%	1
Post Indicator Valve	LS 02.01.35 EP 14	4.55%	1
Supervisory Signal	EC 02.03.05 EP 01	27.27%	6
Tamper Switch	EC 02.03.05 EP 02	31.82%	7
Waterflow Switch	EC 02.03.05 EP 02	13.64%	3

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Drain	1		Main		03/02/2020
Inspector's Test	1				03/02/2020
Supervisory Signal	4				03/02/2020
Supervisory Signal	2		Pressure		03/02/2020
Tamper Switch	6		Control Valve	Supervisory	03/02/2020
Tamper Switch	1		OS&Y	Supervisory	03/02/2020
Waterflow Switch	3		Vane	Alarm	03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
In Service - 15 Years to 25 Years					
Wet Pipe					
Gauge	1		City Pressure		03/02/2008
Piping	1		Steel		03/02/2008

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.

Annual Inspection
Inspection Completion Date
Mar 11, 2025

Building: Lincoln Regional Center B 14
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: Mar 11, 2025

Building: Lincoln Regional Center B 14

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	11	11	0	11	11

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	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 (2025)	Total Quantity
Check Valve	1	1	0	1	1
Control Valve	2	2	0	2	2
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 33

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 14
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	11	11	0	11	11

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Supervisory Signal	Basement Room 42	59342439	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Room 42	59342436	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Room 42	59342431	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Room 42	59342429	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center Room 039	59342337	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Basement Center Room 039	59342336	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	3rd Center Room 340	59342418	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Supervisory Signal	Penthouse Elevator room	59342424	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P

Device Total: 11

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Tamper Switch	9	9	0	9	9

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Tamper Switch	Basement Room 42	59342438	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Room 42	59342437	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Room 42	59342432	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Room 42	59342430	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center Room 039	59342338	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	Basement Center Room 039	59342335	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	1st Center Room 135 above ceiling	59342412	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	3rd Center Room 340	59342421	1-3rd floor	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Tamper Switch	3rd Center Room 340	59342419	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 9								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Waterflow Switch	Basement Room 42	59342427	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Waterflow Switch	3rd Center Room 340	59342423	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Drain	Basement Room 42	59342426	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Fire Dep't Connection	Basement Room 42	59342433	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Piping	Throughout building	68040252	0		06/26-P	09/25-P	12/18-P	03/11-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)	

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Check Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Check Valve	Basement Room 42	59342434	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Control Valve	2nd Center Room 247 above ceiling	59342416	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-P
Control Valve	Penthouse Elevator room	59342425	1	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Gauge	Basement mech room	68040253	0		06/26-P	09/25-P	12/18-P	03/11-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 Q1/25	Pass Q1/25	Fail Q1/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q1/24	Q2/24	Q3/24	Q4/24	Q1/25
Post Indicator Valve	Garden South In yard south of building	59342435	0	03/27-P	06/26-P	09/25-P	12/18-P	03/11-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
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	11
Tamper Switch	Annual	9
Waterflow Switch	Annual	5
Total		**33**
Grand Total		**33**

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			48	4	1	☑	59342417

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Basement Room 42	Wall	4"	2	Yes	Yes	01/25/2023	☑	59342433

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure	wika		1/4	Air/Water	☑	68040253

Location	Service Date	Static psi	Min. Range	Max. Range
Basement mech room	03/02/2020			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel	Throughout building	1"	Normal	☑	68040252

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 14 Building-

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.

Components

Post Indicator Valve

Location		Manufacturer	Model #	OK	ScanID
Garden South In yard south of building				☑	59342435
Type	**Size**	**Position**	**Status**	**# of Turns**	
Ground	4"	Open	Locked & Supervised		

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
Check Valve	LS 02.01.35 EP 14	3.03%	1
Control Valve	LS 02.01.35 EP 14	6.06%	2
Drain	EC 02.03.05 EP 09	3.03%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.03%	1
Gauge	LS 02.01.35 EP 14	3.03%	1
Piping	LS 02.01.35 EP 03/EP 04	3.03%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.03%	1
Supervisory Signal	EC 02.03.05 EP 01	33.33%	11
Tamper Switch	EC 02.03.05 EP 02	27.27%	9
Waterflow Switch	EC 02.03.05 EP 02	15.15%	5

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Check Valve	1		Grooved		03/02/2020
Control Valve	2		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	11		Pressure		03/02/2020
Tamper Switch	9		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Fire Dep't Connection	1		Wall		03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Gauge	1		City Pressure		03/02/2020
Wet Pipe, Building-					
Post Indicator Valve	1		Ground		03/02/2020
In Service - 25 Years or Older					
Wet Pipe					
Piping	1		Steel		10/02/1982

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

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
May 7, 2025

Building: Lincoln Regional Center B 3
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 3	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** Na
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: May 7, 2025

Building: Lincoln Regional Center B 3

EC 02.03.05 EP 01

The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	5	5	0	5	5

EC 02.03.05 EP 02

Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04

Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	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 (2025)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 20

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 3
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	5	5	0	5	5

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Supervisory Signal	Basement Center room 008	59342400	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center room 008	30561920	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center room 008	30561923	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	1st Center rom 116	59342403	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	2nd Center rom 216	59342408	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 5

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Tamper Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Tamper Switch	Basement Center room 008	30561921	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 008	59342401	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 008	59342398	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 008	30561922	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	1st Center rom 116	59342404	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 5								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Waterflow Switch	Basement Center room 008	59342402	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	Basement Center room 008	30561918	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	1st Center rom 116	59342405	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	2nd Center rom 216	59342406	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 4

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Drain	Basement Center room 008	59342396	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Fire Dep't Connection	In yard, south of main entrance	68041242	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Piping		68040263	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Control Valve	2nd Center rom 216	59342407	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Gauge		68040262	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Post Indicator Valve	Garden Center outside Sw side	59342397	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 3

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Annual	1
Drain	Annual	1
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	5
Tamper Switch	Annual	5
Waterflow Switch	Annual	4
Total		**20**
Grand Total		**20**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 3

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040262

Location	Service Date	Static psi	Min. Range	Max. Range
	01/27/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4 and 1	Normal	☑	68040263

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron	N/A	Normal	01/27/2023

Building: Lincoln Regional Center B 3 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden Center outside Sw side			☑	59342397

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard, south of main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041242

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
Control Valve	LS 02.01.35 EP 14	5.00%	1
Drain	EC 02.03.05 EP 09	5.00%	1
Fire Dep't Connection	EC 02.03.05 EP 10	5.00%	1
Gauge	LS 02.01.35 EP 14	5.00%	1
Piping	LS 02.01.35 EP 03/EP 04	5.00%	1
Post Indicator Valve	LS 02.01.35 EP 14	5.00%	1
Supervisory Signal	EC 02.03.05 EP 01	25.00%	5
Tamper Switch	EC 02.03.05 EP 02	25.00%	5
Waterflow Switch	EC 02.03.05 EP 02	20.00%	4

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	5		Pressure		03/02/2020
Tamper Switch	5		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 10
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
May 7, 2025

Building: Lincoln Regional Center B 10
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** Na
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: May 7, 2025

Building: Lincoln Regional Center B 10

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	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 (2025)	Total Quantity
Gauge	1	1	0	1	1
Inspector's Test	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 22

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 10
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Supervisory Signal	Basement Center room 013	59342348	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center room 013	59342351	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center room 013	59342346	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center room 013	59342342	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	1st Center room 147	59342410	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	2nd East room 234	59342341	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 6

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Tamper Switch	Basement Center room 013	59342349	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 013	59342344	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 013	59342350	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 013	59342345	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center room 013	59342343	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	1st Center room 147	59342409	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	2nd East room 234	59342340	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 7								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Waterflow Switch	Basement Center room 013	59342347	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	1st Center room 147	59342411	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	2nd East room 234	59342339	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 3								

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Drain	Basement Center room 013	59342353	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Fire Dep't Connection	In yard by main entrance	68041243	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Piping	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Piping		68040250	0	06/26-P	09/25-P	12/18-P		05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Gauge	Basement Center room 013	68040251	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Inspector's Test	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Inspector's Test	2nd East room 234	Y89971	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Post Indicator Valve	Basement Center room 013	59342352	0	06/26-P		12/18-P	03/11-P	05/07-P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 10

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Drain	Annual	1
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Inspector's Test	Annual	1
Piping	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	6
Tamper Switch	Annual	7
Waterflow Switch	Annual	3
Total		**22**
Grand Total		**22**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 10

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040251

Location	Service Date	Static psi	Min. Range	Max. Range
Basement Center room 013	01/25/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		6"	Normal	☑	68040250

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 10 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Basement Center room 013			☑	59342352

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
In yard by main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041243

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
Drain	EC 02.03.05 EP 09	4.55%	1
Fire Dep't Connection	EC 02.03.05 EP 10	4.55%	1
Gauge	LS 02.01.35 EP 14	4.55%	1
Inspector's Test	LS 02.01.35 EP 14	4.55%	1
Piping	LS 02.01.35 EP 03/EP 04	4.55%	1
Post Indicator Valve	LS 02.01.35 EP 14	4.55%	1
Supervisory Signal	EC 02.03.05 EP 01	27.27%	6
Tamper Switch	EC 02.03.05 EP 02	31.82%	7
Waterflow Switch	EC 02.03.05 EP 02	13.64%	3

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Drain	1		Main		03/02/2020
Inspector's Test	1				03/02/2020
Supervisory Signal	4				03/02/2020
Supervisory Signal	2		Pressure		03/02/2020
Tamper Switch	6		Control Valve	Supervisory	03/02/2020
Tamper Switch	1		OS&Y	Supervisory	03/02/2020
Waterflow Switch	3		Vane	Alarm	03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
In Service - 15 Years to 25 Years					
Wet Pipe					
Gauge	1		City Pressure		03/02/2008
Piping	1		Steel		03/02/2008

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
May 7, 2025

Building: Lincoln Regional Center B 14
Contact: Kris Hoover
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:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Jerad Baxter
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-220-1709
Country: United States of America	**Email:** jbaxter@nifcomechanical.com

Inspection Completion Date: May 7, 2025

Building: Lincoln Regional Center B 14

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	11	11	0	11	11

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Check Valve	1	1	0	1	1
Control Valve	2	2	0	2	2
Gauge	0	0	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 33

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 14
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	11	11	0	11	11

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Supervisory Signal	Basement Room 42	59342439	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Room 42	59342436	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Room 42	59342431	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Room 42	59342429	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center Room 039	59342337	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Basement Center Room 039	59342336	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	3rd Center Room 340	59342418	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Supervisory Signal	Penthouse Elevator room	59342424	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 11

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - 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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Tamper Switch	9	9	0	9	9

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Tamper Switch	Basement Room 42	59342438	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Room 42	59342437	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Room 42	59342432	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Room 42	59342430	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center Room 039	59342338	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	Basement Center Room 039	59342335	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	1st Center Room 135 above ceiling	59342412	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	3rd Center Room 340	59342419	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Tamper Switch	3rd Center Room 340	59342421	1-3rd floor	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 9								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Waterflow Switch	Basement Room 42	59342427	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Waterflow Switch	3rd Center Room 340	59342423	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 5

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Drain	Basement Room 42	59342426	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Fire Dep't Connection	Basement Room 42	59342433	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Piping	Throughout building	68040252	0	06/26-P	09/25-P	12/18-P	03/11-P	
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Check Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Check Valve	Basement Room 42	59342434	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Control Valve	2	2	0	2	2

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Control Valve	2nd Center Room 247 above ceiling	59342416	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Control Valve	Penthouse Elevator room	59342425	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 2								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Gauge	0	0	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Gauge	Basement mech room	68040253	0	06/26-P	09/25-P	12/18-P	03/11-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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Post Indicator Valve	Garden South In yard south of building	59342435	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 14

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Check Valve	Annual	1
Control Valve	Annual	2
Drain	Annual	1
Fire Dep't Connection	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	11
Tamper Switch	Annual	9
Waterflow Switch	Annual	5
Total		**31**
	Untested	
Gauge		1
Piping		1
Total		**2**
Grand Total		**33**

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			45	4	1	☑	59342417

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Basement Room 42	Wall	4"	2	Yes	Yes	01/25/2023	☑	59342433

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure	wika		1/4	Air/Water	☐	68040253

Location	Service Date	Static psi	Min. Range	Max. Range
Basement mech room	03/02/2020			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel	Throughout building	1"	Normal	☐	68040252

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 14 Building-

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.

Components

Post Indicator Valve

Location		Manufacturer	Model #	OK	ScanID
Garden South In yard south of building				☑	59342435
Type	**Size**	**Position**	**Status**	**# of Turns**	
Ground	4"	Open	Locked & Supervised		

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
Check Valve	LS 02.01.35 EP 14	3.03%	1
Control Valve	LS 02.01.35 EP 14	6.06%	2
Drain	EC 02.03.05 EP 09	3.03%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.03%	1
Gauge	LS 02.01.35 EP 14	3.03%	1
Piping	LS 02.01.35 EP 03/EP 04	3.03%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.03%	1
Supervisory Signal	EC 02.03.05 EP 01	33.33%	11
Tamper Switch	EC 02.03.05 EP 02	27.27%	9
Waterflow Switch	EC 02.03.05 EP 02	15.15%	5

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Check Valve	1		Grooved		03/02/2020
Control Valve	2		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	11		Pressure		03/02/2020
Tamper Switch	9		Control Valve	Supervisory	03/02/2020
Waterflow Switch	4		Vane	Alarm	03/02/2020
Wet Pipe					
Fire Dep't Connection	1		Wall		03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Gauge	1		City Pressure		03/02/2020
Wet Pipe, Building-					
Post Indicator Valve	1		Ground		03/02/2020
In Service - 25 Years or Older					
Wet Pipe					
Piping	1		Steel		10/02/1982

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

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 5
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
May 8, 2025

Building: Lincoln Regional Center B 5
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Jerad Baxter
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 5
Address: 801 West Prospector
Address:
City/State/ZIP Code: Lincoln, NE 68522
Country: United States of America

Contact: Kris Hoover
Phone: 402-471-4444
Fax:
Mobile:
Email: kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems
Address: 500 Blue Heron Dr
Address:
City/State/ZIP Code: Lincoln, NE 68522-1701
Country: United States of America

Inspector: Jerad Baxter
Phone: 402-477-0666
Fax:
Mobile: 531-220-1709
Email: jbaxter@nifcomechanical.com

Inspection Completion Date: May 8, 2025

Building: Lincoln Regional Center B 5

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	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

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Control Valve	1	1	0	1	1
Gauge	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 27

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 5
Inspector: Jerad Baxter
Contact: Kris Hoover

Jerad Baxter Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	
Nebraska Grade VI Water Operator	8699

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Supervisory Signal	Basement Boiler	59342376	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	Basement Boiler	59342379	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	1st Closet closet by reception center	59342381	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.

Semi-Annually - 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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Tamper Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Tamper Switch	Basement Boiler	59342377	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	Basement Boiler	59342378	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	1st 1st closet by reception desk	59342382	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	1st Closet room 133a	59342386	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342388	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	2nd Closet s4 housekeeping cliset	59342390	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Tamper Switch	2nd Closet s5 west stairwell	59342395	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Waterflow Switch	Basement Boiler	59342380	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	1st Closet room 133a	59342384	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	1st Closet room 133a S2	68605364	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P

Device Total: 7

EC 02.03.05 EP 09 Annual test of main drains at system low point or at all system risers. NFPA 25-2011: 13.2.5

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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Drain	Basement Boiler	59342375	0	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Device Total: 1								

EC 02.03.05 EP 10 Quarterly inspection of all fire department water supply connections. NFPA 25-2011: 13.7

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Fire Dep't Connection	Garden outside ne of entrance	68041241	0	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Piping		68040264	0	06/26-P	09/25-P	12/18-P	03/11-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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Control Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Control Valve	1st Closet room 133a S2	68605365	1	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Gauge	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Gauge	1st 1st closet by reception desk	68040265	0	06/26-P	09/25-P	12/18-P	03/11-P	05/08-P
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

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 Q2/25	Pass Q2/25	Fail Q2/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q2/24	Q3/24	Q4/24	Q1/25	Q2/25
Post Indicator Valve	Garden outside ne of entrance	59342356	0	06/26-P	09/25-P	12/18-P	03/11-P	05/07-P
Device Total: 1								

Service Summary

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 5

The Service Summary section provides an overview of the services performed in this report.

Device Type	Service	Quantity
	Passed	
Control Valve	Annual	1
Drain	Annual	1
Fire Dep't Connection	Annual	1
Gauge	Annual	1
Post Indicator Valve	Annual	1
Supervisory Signal	Tested	7
Tamper Switch	Annual	7
Waterflow Switch	Annual	7
Total		**26**
	Untested	
Piping		1
Total		**1**
Grand Total		**27**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 5

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☑	68040265

Location	Service Date	Static psi	Min. Range	Max. Range
1st 1st closet by reception desk	01/27/2023		3	3

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4"	Normal	☐	68040264

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	06/07/2022

Building: Lincoln Regional Center B 5 — Basement, Building-

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.

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	61		☑	59342375

Previous Inspections

March 11, 2025

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	61		☑	59342375

December 18, 2024

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	64		☑	59342375

Building: Lincoln Regional Center B 5 Building-

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.

Components

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden outside ne of entrance			☑	59342356

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Garden outside ne of entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041241

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
Control Valve	LS 02.01.35 EP 14	3.70%	1
Drain	EC 02.03.05 EP 09	3.70%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.70%	1
Gauge	LS 02.01.35 EP 14	3.70%	1
Piping	LS 02.01.35 EP 03/EP 04	3.70%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.70%	1
Supervisory Signal	EC 02.03.05 EP 01	25.93%	7
Tamper Switch	EC 02.03.05 EP 02	25.93%	7
Waterflow Switch	EC 02.03.05 EP 02	25.93%	7

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Control Valve	1		Butterfly	Main Control	03/02/2020
Supervisory Signal	3				03/02/2020
Supervisory Signal	3		Pressure		03/02/2020
Supervisory Signal	1		Valve Sup. Switch		03/02/2020
Tamper Switch	7		Control Valve	Supervisory	03/02/2020
Waterflow Switch	7		Vane	Alarm	03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Basement Wet Pipe, Building-					
Drain	1		Main		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				
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

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.

Semi-Annual Inspection
Inspection Completion Date
Sep 24, 2025

Building: Lincoln Regional Center B 3
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Brian Egger
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 3	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Brian Egger
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-2201688
Country: United States of America	**Email:** begger@nifcomechanical.com

Inspection Completion Date: Sep 24, 2025

Building: Lincoln Regional Center B 3

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	Total Quantity
Tamper Switch	1	1	0	1	1
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 (2025)	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 (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Control Valve	5	5	0	5	5
Gauge	0	0	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 21

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 3
Inspector: Brian Egger
Contact: Kris Hoover

Brian Egger Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8951

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Supervisory Signal	Basement Center room 008	30561920	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center room 008	59342400	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center room 008	59342399	1					09/24-P
Supervisory Signal	Basement Center room 008	30561923	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	1st Center rom 116	59342403	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	2nd Center rom 216	59342408	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 6								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Tamper Switch	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Tamper Switch	Basement Center room 008	59342398	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	4	4	0	4	4

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Waterflow Switch	Basement Center room 008	30561918	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	Basement Center room 008	59342402	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	1st Center rom 116	59342405	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	2nd Center rom 216	59342406	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Drain	Basement Center room 008	59342396	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Fire Dep't Connection	Outside South In yard, south of main entrance	68041242	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Piping		68040263	0	09/25-P	12/18-P	03/11-P	05/07-P	
Device Total: 1								

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Control Valve	5	5	0	5	5

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Control Valve	Basement Center room 008	59342401	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center room 008	30561921	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center room 008	30561922	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	1st Center rom 116	59342404	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	2nd Center rom 216	59342407	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Gauge	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Gauge		68040262	0	09/25-P	12/18-P	03/11-P	05/07-P	
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. Post indicating and outside screw and yoke valves shall be backed a one-quarter turn from the fully open position to prevent jamming. (2011 ed.) (NFPA 25 13.3.3.2/13.3.3.3)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Post Indicator Valve	Outside South	59342397	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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	Semi-Annual	5
Drain	Semi-Annual	1
Fire Dep't Connection	Semi-Annual	1
Post Indicator Valve	Semi-Annual	1
Supervisory Signal	Semi-Annual	6
Tamper Switch	Semi-Annual	1
Waterflow Switch	Semi-Annual	4
Total		**19**
Untested		
Gauge		1
Piping		1
Total		**2**
Grand Total		**21**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 3

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☐	68040262

Location	Service Date	Static psi	Min. Range	Max. Range
	01/27/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		4 and 1	Normal	☐	68040263

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron	N/A	Normal	01/27/2023

Building: Lincoln Regional Center B 3 Building-

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

Supervisory Signal

Type	Location	Zone/Address	OK	ScanID
Valve Sup. Switch	Basement Center room 008	1	☑	59342399

Tamper Switch

Type	Description	Location	# of Turns	Zone/Address	OK	ScanID
Control Valve	Supervisory	Basement Center room 008		1	☑	59342398

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center room 008			☑	30561922

Position	Size	Status	Description
Open	4"	Supervised	Main Control

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Outside South			☑	59342397

Type	Size	Position	Status	# of Turns
Ground	6"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Outside South In yard, south of main entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041242

Building: Lincoln Regional Center B 3 — Floors- 1 & 2

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			40.266	3	1	☑	30561918

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center room 008			☑	59342401
Position	**Size**	**Status**	**Description**		
Open	3"	Supervised	Isolation		

Building: Lincoln Regional Center B 3 — Floors-1

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			39.243	2.5	1	☑	59342405

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st Center rom 116			☑	59342404
Position	**Size**	**Status**	**Description**		
Open	2.5"	Supervised	Isolation		

Building: Lincoln Regional Center B 3 — Floors-2

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			19.524	2.5	1	☑	59342406

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	2nd Center rom 216			☑	59342407
Position	**Size**	**Status**	**Description**		
Open	2.5"	Supervised	Isolation		

Building: Lincoln Regional Center B 3 — Floors-LL

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			53.963	3	1	☑	59342402

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center room 008			☑	30561921
Position	**Size**	**Status**	**Description**		
Open	3"	Supervised	Isolation		

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
Control Valve	LS 02.01.35 EP 14	23.81%	5
Drain	EC 02.03.05 EP 09	4.76%	1
Fire Dep't Connection	EC 02.03.05 EP 10	4.76%	1
Gauge	LS 02.01.35 EP 14	4.76%	1
Piping	LS 02.01.35 EP 03/EP 04	4.76%	1
Post Indicator Valve	LS 02.01.35 EP 14	4.76%	1
Supervisory Signal	EC 02.03.05 EP 01	28.57%	6
Tamper Switch	EC 02.03.05 EP 02	4.76%	1
Waterflow Switch	EC 02.03.05 EP 02	19.05%	4

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Drain	1		Main		03/02/2020
Supervisory Signal	5		Valve Sup. Switch		03/02/2020
Wet Pipe					
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Wet Pipe, Building-					
Control Valve	1		Butterfly	Main Control	03/02/2020
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Supervisory Signal	1		Valve Sup. Switch		03/02/2020
Tamper Switch	1		Control Valve	Supervisory	03/02/2020
Wet Pipe, Floors- 1 & 2					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-1					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-2					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-LL					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 5
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.

Semi-Annual Inspection
Inspection Completion Date
Sep 24, 2025

Building: Lincoln Regional Center B 5
Contact: Kris Hoover
Title: Maintenance

Company: NIFCO Mechanical Systems
Contact: Brian Egger
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 5	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-471-4444
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Brian Egger
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-2201688
Country: United States of America	**Email:** begger@nifcomechanical.com

Inspection Completion Date: Sep 24, 2025

Building: Lincoln Regional Center B 5

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	Total Quantity
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 (2025)	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 (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Control Valve	8	8	0	8	8
Gauge	0	0	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 27

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 5
Inspector: Brian Egger
Contact: Kris Hoover

Brian Egger Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8951

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Supervisory Signal	Basement Boiler	59342376	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	Basement Boiler	59342379	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	1st Closet closet by reception center	59342381	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	1st Closet room 133a	59342385	1-s-2	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342387	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	2nd Closet s4 housekeeping cliset	59342389	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Supervisory Signal	2nd Closet s5 west stairwell	59342394	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P

Device Total: 7

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	7	7	0	7	7

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Waterflow Switch	Basement Boiler	59342380	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	1st Closet closet by reception center	59342383	1-s-2	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	1st Closet room 133a	59342384	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	1st Closet room 133a S2	68605364	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342391	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	2nd Closet s4 housekeeping cliset	59342392	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Waterflow Switch	2nd Closet s5 west stairwell	59342393	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Drain	Basement Boiler	59342375	0	09/25-P	12/18-P	03/11-P	05/08-P	09/24-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Fire Dep't Connection	Garden outside ne of entrance	68041241	0	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Piping		68040264	0	09/25-P	12/18-P	03/11-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Control Valve	8	8	0	8	8

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Control Valve	Basement Boiler	59342377	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	Basement Boiler	59342378	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	1st 1st closet by reception desk	59342382	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	1st Closet room 133a	59342386	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	1st Closet room 133a S2	68605365	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	2nd Closet s4 housekeeping cliset	59342388	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	2nd Closet s4 housekeeping cliset	59342390	1	09/25-P	12/18-P	03/11-P	05/08-P	09/24-P
Control Valve	2nd Closet s5 west stairwell	59342395	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P

Device Total: 8

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Gauge	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Gauge	1st 1st closet by reception desk	68040265	0	09/25-P	12/18-P	03/11-P	05/08-P	
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Post Indicator Valve	Garden outside ne of entrance	59342356	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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	Semi-Annual	8
Drain	Semi-Annual	1
Fire Dep't Connection	Semi-Annual	1
Post Indicator Valve	Semi-Annual	1
Supervisory Signal	Semi-Annual	7
Waterflow Switch	Semi-Annual	7
Total		**25**
Untested		
Gauge		1
Piping		1
Total		**2**
Grand Total		**27**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 5

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			55.025	2	1	☑	68605364
Vane			42.448	2	1-s-2	☑	59342383

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st Closet room 133a S2			☑	68605365
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Main Control		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st 1st closet by reception desk			☑	59342382
Position	**Size**	**Status**	**Description**		
Open	2.5"	Supervised	Isolation		

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☐	68040265
Location		**Service Date**	**Static psi**	**Min. Range**	**Max. Range**	
1st 1st closet by reception desk		01/27/2023		3	3	

Piping

Type	Location		Size	Braces	OK	ScanID
Steel			4"	Normal	☐	68040264
Identified	**Fittings**	**Antifreeze**	**Hangers**		**Internal Date**	
	Cast Iron		Normal		06/07/2022	

Building: Lincoln Regional Center B 5 — Area-s3

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			51.826	2	1	☑	59342392

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	2nd Closet s4 housekeeping cliset			☑	59342390

Position	Size	Status	Description
Open	2"	Supervised	Isolation

Building: Lincoln Regional Center B 5 — Area-s4

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

Supervisory Signal

Type	Location	Zone/Address	OK	ScanID
Valve Sup. Switch	2nd Closet s4 housekeeping cliset	1	☑	59342387

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane			44.172	2	1	☑	59342391

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	2nd Closet s4 housekeeping cliset			☑	59342388

Position	Size	Status	Description
Open	2"	Supervised	Isolation

Building: Lincoln Regional Center B 5 — Area-s5

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			21.434	2	1	☑	59342393

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	2nd Closet s5 west stairwell			☑	59342395
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Isolation		

Building: Lincoln Regional Center B 5 — Basement, Building-

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.

Devices

Drain

Current Inspection

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		83	55	2	☑	59342375

Previous Inspections

May 8, 2025

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	61		☑	59342375

March 11, 2025

Type	Location	Size	Supply psi	Static psi	Residual psi	Sec	OK	ScanID
Main	Basement Boiler	2"		79	61		☑	59342375

Building: Lincoln Regional Center B 5 — Building-

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.

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Boiler			☑	59342377

Position	Size	Status	Description
Open	4"	Supervised	Main Control

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Boiler			☑	59342378

Position	Size	Status	Description
Open	4"	Supervised	Isolation

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Garden outside ne of entrance			☑	59342356

Type	Size	Position	Status	# of Turns
Ground	4"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Garden outside ne of entrance	Freestanding	4"	2	Yes	Yes	12/31/1969	☑	68041241

Building: Lincoln Regional Center B 5 — Floors-1

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			22.008	2	1	☑	59342384

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st Closet room 133a			☑	59342386
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Isolation		

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
Control Valve	LS 02.01.35 EP 14	29.63%	8
Drain	EC 02.03.05 EP 09	3.70%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.70%	1
Gauge	LS 02.01.35 EP 14	3.70%	1
Piping	LS 02.01.35 EP 03/EP 04	3.70%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.70%	1
Supervisory Signal	EC 02.03.05 EP 01	25.93%	7
Waterflow Switch	EC 02.03.05 EP 02	25.93%	7

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Supervisory Signal	6		Valve Sup. Switch		03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe					
Control Valve	1		Butterfly	Isolation	03/02/2020
Control Valve	1		Butterfly	Main Control	03/02/2020
Gauge	1		City Pressure		03/02/2020
Piping	1		Steel		03/02/2020
Waterflow Switch	2		Vane	Alarm	03/02/2020
Wet Pipe, Area-s3					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Area-s4					
Control Valve	1		Butterfly	Isolation	03/02/2020
Supervisory Signal	1		Valve Sup. Switch		03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Area-s5					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Building-					
Control Valve	1		Butterfly	Isolation	03/02/2020
Control Valve	1		Butterfly	Main Control	03/02/2020
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Wet Pipe, Floors-1					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020

Basement Wet Pipe, Building-			
Drain	1	Main	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				
	Waterflow Switch	1st Closet closet by reception center	Vane	59342383

Sprinkler Inspection, Testing and/or Maintenance Certificate

For

Lincoln Regional Center B 10
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.

Semi-Annual Inspection
Inspection Completion Date
Sep 24, 2025

Building: Lincoln Regional Center B 10
Contact: Kris Hoover
Title: Maintance Manager

Company: NIFCO Mechanical Systems
Contact: Brian Egger
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 10	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
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Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Brian Egger
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-2201688
Country: United States of America	**Email:** begger@nifcomechanical.com

Inspection Completion Date: Sep 24, 2025

Building: Lincoln Regional Center B 10

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	Total Quantity
Tamper Switch	1	1	0	1	1
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 (2025)	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 (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Control Valve	6	6	0	6	6
Gauge	0	0	0	1	1
Inspector's Test	1	1	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 22

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 10
Inspector: Brian Egger
Contact: Kris Hoover

Brian Egger Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8951

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	6	6	0	6	6

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Supervisory Signal	Basement Center room 013	59342346	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center room 013	59342342	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center room 013	59342351	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center room 013	59342348	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	1st Center room 147	59342410	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	2nd East room 234	59342341	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P

Device Total: 6

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Tamper Switch	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Tamper Switch	Basement Center room 013	59342344	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	3	3	0	3	3

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Waterflow Switch	Basement Center room 013	59342347	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	1st Center room 147	59342411	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	2nd East room 234	59342339	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Drain	Basement Center room 013	59342353	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Fire Dep't Connection	Outside West	68041243	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Piping		68040250	0	09/25-P	12/18-P		05/07-P	
Device Total: 1								

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Control Valve	6	6	0	6	6

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Control Valve	Basement Center room 013	59342345	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center room 013	59342343	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center room 013	59342350	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center room 013	59342349	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	1st Center room 147	59342409	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	2nd East room 234	59342340	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Gauge	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Gauge	Basement Center room 013	68040251	0	09/25-P	12/18-P	03/11-P	05/07-P	
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Inspector's Test	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Inspector's Test	2nd East room 234	Y89971	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Post Indicator Valve	Outside West	59342352	0		12/18-P	03/11-P	05/07-P	09/24-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		
Control Valve	Semi-Annual	6
Drain	Semi-Annual	1
Fire Dep't Connection	Semi-Annual	1
Inspector's Test	Semi-Annual	1
Post Indicator Valve	Semi-Annual	1
Supervisory Signal	Semi-Annual	6
Tamper Switch	Semi-Annual	1
Waterflow Switch	Semi-Annual	3
Total		**20**
Untested		
Gauge		1
Piping		1
Total		**2**
Grand Total		**22**

Wet Pipe Fire Sprinkler Systems

Generated by: BuildingReports.com

Building: Lincoln Regional Center B 10

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.

Devices

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure			1/4	Air/Water	☐	68040251

Location	Service Date	Static psi	Min. Range	Max. Range
Basement Center room 013	01/25/2023			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel		6"	Normal	☐	68040250

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 10 Building-

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.

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
OS&Y	Basement Center room 013			☑	59342345

Position	Size	Status	Description
Open	6"	Supervised	Main Control

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
OS&Y	Basement Center room 013			☑	59342343

Position	Size	Status	Description
Open	6"	Supervised	Main Control

Post Indicator Valve

Location	Manufacturer	Model #	OK	ScanID
Outside West			☑	59342352

Type	Size	Position	Status	# of Turns
Ground	6"	Open	Locked & Supervised	

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Outside West	Freestanding	4"	1	Yes	Yes	12/31/1969	☑	68041243

Building: Lincoln Regional Center B 10 — Floors-1

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			34.666	2.5	1	☑	59342411

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st Center room 147			☑	59342409
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Isolation		

Building: Lincoln Regional Center B 10 Floors-1& 2

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.

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center room 013			☑	59342350
Position	**Size**	**Status**	**Description**		
Open	2.5"	Supervised	Isolation		

Building: Lincoln Regional Center B 10 — Floors-2

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			37.314	2	1	☑	59342339

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	2nd East room 234			☑	59342340
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Isolation		

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			26.443	6	1	☑	59342347

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center room 013			☑	59342349
Position	**Size**	**Status**	**Description**		
Open	6"	Supervised	Isolation		

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
Control Valve	LS 02.01.35 EP 14	27.27%	6
Drain	EC 02.03.05 EP 09	4.55%	1
Fire Dep't Connection	EC 02.03.05 EP 10	4.55%	1
Gauge	LS 02.01.35 EP 14	4.55%	1
Inspector's Test	LS 02.01.35 EP 14	4.55%	1
Piping	LS 02.01.35 EP 03/EP 04	4.55%	1
Post Indicator Valve	LS 02.01.35 EP 14	4.55%	1
Supervisory Signal	EC 02.03.05 EP 01	27.27%	6
Tamper Switch	EC 02.03.05 EP 02	4.55%	1
Waterflow Switch	EC 02.03.05 EP 02	13.64%	3

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Drain	1		Main		03/02/2020
Inspector's Test	1				03/02/2020
Supervisory Signal	6		Valve Sup. Switch		03/02/2020
Tamper Switch	1		Control Valve	Supervisory	03/02/2020
Wet Pipe, Building-					
Control Valve	2		OS&Y	Main Control	03/02/2020
Fire Dep't Connection	1		Freestanding		03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Wet Pipe, Floors-1					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-1& 2					
Control Valve	1		Butterfly	Isolation	03/02/2020
Wet Pipe, Floors-2					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-Basement					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
In Service - 15 Years to 25 Years					
Wet Pipe					
Gauge	1		City Pressure		03/02/2008
Piping	1		Steel		03/02/2008

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.

Semi-Annual Inspection
Inspection Completion Date
Sep 24, 2025

Building: Lincoln Regional Center B 14
Contact: Kris Hoover
Title: Maintance Manager

Company: NIFCO Mechanical Systems
Contact: Brian Egger
Title: Inspector

Executive Summary

Generated by: BuildingReports.com

Building Information

Building: Lincoln Regional Center B 14	**Contact:** Kris Hoover
Address: 801 West Prospector	**Phone:** 402-479-5452
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522	**Mobile:**
Country: United States of America	**Email:** kris.hoover@nebraska.gov

Inspection Performed By

Company: NIFCO Mechanical Systems	**Inspector:** Brian Egger
Address: 500 Blue Heron Dr	**Phone:** 402-477-0666
Address:	**Fax:**
City/State/ZIP Code: Lincoln, NE 68522-1701	**Mobile:** 531-2201688
Country: United States of America	**Email:** begger@nifcomechanical.com

Inspection Completion Date: Sep 24, 2025

Building: Lincoln Regional Center B 14

EC 02.03.05 EP 01 — The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Supervisory Signal	10	10	0	10	10

EC 02.03.05 EP 02 — Six-month testing of tamper switches; vane-type/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 (2025)	Total Quantity
Tamper Switch	1	1	0	1	1
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 (2025)	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 (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

LS 02.01.35 EP 03/EP 04 — Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Devices	Tested This Quarter	Pass	Fail	Tested YTD (2025)	Total Quantity
Piping	0	0	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 (2025)	Total Quantity
Check Valve	0	0	0	1	1
Control Valve	11	11	0	11	11
Gauge	0	0	0	1	1
Post Indicator Valve	1	1	0	1	1

Total Device Count: 33

Certification

Company: NIFCO Mechanical Systems
Building: Lincoln Regional Center B 14
Inspector: Brian Egger
Contact: Kris Hoover

Brian Egger Certifications

Certification Type	Number
Nebraska Grade VI Water Operator	8951

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 01	The organization tests supervisory signal devices on the inventory with the following time frames: Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices. Semiannually for valve supervisory switches. Annually for other supervisory initiating devices. NFPA 72-2010 Table 14.4.5

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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Supervisory Signal	10	10	0	10	10

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Supervisory Signal	Basement Room 42	59342431	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Room 42	59342439	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Room 42	59342436	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center Room 039	59342336	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Basement Center Room 039	59342337	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	1st Center Room 135 above ceiling	59342413	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	2nd Center Room 247 above ceiling	59342415	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	3rd Center Room 340	59342420	1-3rd floor	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	3rd Center Room 340	59342418	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Supervisory Signal	Penthouse Elevator room	59342424	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P

Device Total: 10

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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.
Semi-Annually - 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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Tamper Switch	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Tamper Switch	Basement Room 42	59342430	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

EC 02.03.05 EP 02	Six-month testing of tamper switches; vane-type/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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Waterflow Switch	5	5	0	5	5

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Waterflow Switch	Basement Room 42	59342427	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	1st Center Room 135 above ceiling	59342414	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	2nd Center Room 247 above ceiling	59342417	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	3rd Center Room 340	59342422	1-3rd floor	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Waterflow Switch	3rd Center Room 340	59342423	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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. In systems where the sole water supply is through a backflow preventer, and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. When there is a 10 percent reduction in full flow pressure when compared to the original acceptance test or previously performed tests, the cause of the reduction shall be identified and corrected if necessary. 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; 13.2.5.1; 13.25.2; 13.4.4.3.2)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Drain	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Drain	Basement Room 42	59342426	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Fire Dep't Connection	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Fire Dep't Connection	Basement Room 42	59342433	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Device Total: 1								

LS 02.01.35 EP 03/EP 04	Piping supports are not damaged or loose. Piping not used to support any other item. NFPA 101-2012 18/19.3.5

Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, and corrosion. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. An inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. (2011 ed.) (NFPA 25 5.2.2 through 5.2.2.2; 14.2.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Piping	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Piping	Throughout building	68040252	0	09/25-P	12/18-P	03/11-P		
Device Total: 1								

LS 02.01.35 EP 14	All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5
Monthly: Alarm valves and system riser check valves shall be externally inspected monthly. Periodically: Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. (2011 ed.) (NFPA 25 13.4.1.1)	

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Check Valve	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Check Valve	Basement Room 42	59342434	1	09/25-P	12/18-P	03/11-P	05/07-P	
Device Total: 1								

LS 02.01.35 EP 14

All other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012 18/19.3.5

Monthly: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Periodically: Each control valve shall be operated annually through its full range and returned to its normal position. (2011 ed.) (NFPA 25 13.3.2.1.1; 13.3.3.1)

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Control Valve	11	11	0	11	11

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Control Valve	Basement Room 42	59342429	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Room 42	59342432	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Room 42	59342437	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Room 42	59342438	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center Room 039	59342335	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Basement Center Room 039	59342338	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	1st Center Room 135 above ceiling	59342412	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	2nd Center Room 247 above ceiling	59342416	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	3rd Center Room 340	59342421	1-3rd floor	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	3rd Center Room 340	59342419	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-P
Control Valve	Penthouse Elevator room	59342425	1	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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
Gauges are in good condition and normal pressure is being maintained. [Inspection frequency will depend on type of system gauge]; Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. (2011 ed.) (NFPA 25 13.2.7.1; 5.3.2.1)	

Devices	Tested Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Gauge	0	0	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Gauge	Basement mech room	68040253	0	09/25-P	12/18-P	03/11-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 Q3/25	Pass Q3/25	Fail Q3/25	Tested YTD (2025)	Total Quantity
Post Indicator Valve	1	1	0	1	1

Device Type	Location	ScanID	Address	Q3/24	Q4/24	Q1/25	Q2/25	Q3/25
Post Indicator Valve	Garden South In yard south of building	59342435	0	09/25-P	12/18-P	03/11-P	05/07-P	09/24-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		
Control Valve	Semi-Annual	11
Drain	Semi-Annual	1
Fire Dep't Connection	Semi-Annual	1
Post Indicator Valve	Semi-Annual	1
Supervisory Signal	Semi-Annual	10
Tamper Switch	Semi-Annual	1
Waterflow Switch	Semi-Annual	5
Total		**30**
Untested		
Check Valve		1
Gauge		1
Piping		1
Total		**3**
Grand Total		**33**

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.

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	3rd Center Room 340			☑	59342419

Position	Size	Status	Description
Open	2"	Supervised	Isolation

Devices

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Basement Room 42	Wall	4"	2	Yes	Yes	01/25/2023	☑	59342433

Gauge

Type	Manufacturer	Model #	Size	Fill Type	OK	ScanID
City Pressure	wika		1/4	Air/Water	☐	68040253

Location	Service Date	Static psi	Min. Range	Max. Range
Basement mech room	03/02/2020			

Piping

Type	Location	Size	Braces	OK	ScanID
Steel	Throughout building	1"	Normal	☐	68040252

Identified	Fittings	Antifreeze	Hangers	Internal Date
	Cast Iron		Normal	01/25/2023

Building: Lincoln Regional Center B 14 Building-

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.

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Room 42			☑	59342429
Position	**Size**	**Status**	**Description**		
Open	4"	Supervised	Main Control		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Room 42			☑	59342432
Position	**Size**	**Status**	**Description**		
Open	4"	Supervised	Main Control		

Post Indicator Valve

Location		Manufacturer	Model #	OK	ScanID
Garden South In yard south of building				☑	59342435
Type	**Size**	**Position**	**Status**	**# of Turns**	
Ground	4"	Open	Locked & Supervised		

Building: Lincoln Regional Center B 14 — Elevator

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.

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center Room 039			☑	59342335
Position	**Size**	**Status**	**Description**		
Open	1"	Supervised	Isolation		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Center Room 039			☑	59342338
Position	**Size**	**Status**	**Description**		
Open	1"	Supervised	Isolation		

Building: Lincoln Regional Center B 14 Floors-1,2,3

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.

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Room 42			☑	59342437
Position	**Size**	**Status**	**Description**		
Open	4"	Supervised	Main Control		

Building: Lincoln Regional Center B 14 — Floors-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			55.415	4	1	☑	59342414

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	1st Center Room 135 above ceiling			☑	59342412

Position	Size	Status	Description
Open	4"	Supervised	Isolation

Building: Lincoln Regional Center B 14 — Floors-2nd

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			53.979	4	1	☑	59342417

Building: Lincoln Regional Center B 14 — Floors-3rd

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.

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	3rd Center Room 340			☑	59342421

Position	Size	Status	Description
Open	4"	Supervised	Isolation

Building: Lincoln Regional Center B 14 — Floors-LL

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			23.589	3	1	☑	59342427

Components

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement Room 42			☑	59342438
Position	**Size**	**Status**	**Description**		
Open	3"	Supervised	Isolation		

Building: Lincoln Regional Center B 14 — Floors-Penthouse

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.

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Penthouse Elevator room			☑	59342425

Position	Size	Status	Description
Open	1.5"	Supervised	Isolation

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
Check Valve	LS 02.01.35 EP 14	3.03%	1
Control Valve	LS 02.01.35 EP 14	33.33%	11
Drain	EC 02.03.05 EP 09	3.03%	1
Fire Dep't Connection	EC 02.03.05 EP 10	3.03%	1
Gauge	LS 02.01.35 EP 14	3.03%	1
Piping	LS 02.01.35 EP 03/EP 04	3.03%	1
Post Indicator Valve	LS 02.01.35 EP 14	3.03%	1
Supervisory Signal	EC 02.03.05 EP 01	30.30%	10
Tamper Switch	EC 02.03.05 EP 02	3.03%	1
Waterflow Switch	EC 02.03.05 EP 02	15.15%	5

Device Type	Qty	Model #	Type	Description	Install Date
In Service - 5 Years to 10 Years					
Check Valve	1		Grooved		03/02/2020
Control Valve	1		Butterfly	Isolation	03/02/2020
Drain	1		Main		03/02/2020
Supervisory Signal	10		Valve Sup. Switch		03/02/2020
Tamper Switch	1		Control Valve	Supervisory	03/02/2020
Waterflow Switch	2		Vane	Alarm	03/02/2020
Wet Pipe					
Control Valve	1		Butterfly	Isolation	03/02/2020
Fire Dep't Connection	1		Wall		03/02/2020
Gauge	1		City Pressure		03/02/2020
Wet Pipe, Building-					
Control Valve	2		Butterfly	Main Control	03/02/2020
Post Indicator Valve	1		Ground		03/02/2020
Wet Pipe, Elevator					
Control Valve	2		Butterfly	Isolation	03/02/2020
Wet Pipe, Floors-1,2,3					
Control Valve	1		Butterfly	Main Control	03/02/2020
Wet Pipe, Floors-1st					
Control Valve	1		Butterfly	Isolation	03/02/2020
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-2nd					
Waterflow Switch	1		Vane	Alarm	03/02/2020
Wet Pipe, Floors-3rd					
Control Valve	1		Butterfly	Isolation	03/02/2020

Wet Pipe, Floors-LL				
Control Valve	1	Butterfly	Isolation	03/02/2020
Waterflow Switch	1	Vane	Alarm	03/02/2020
Wet Pipe, Floors-Penthouse				
Control Valve	1	Butterfly	Isolation	03/02/2020
In Service - 25 Years or Older				
Wet Pipe				
Piping	1	Steel		10/02/1982

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				
	Control Valve	3rd Center Room 340	Butterfly	59342421
	Waterflow Switch	3rd Center Room 340	Vane	59342422

Department of Health and Human Services
Division of Public Health
Health Facilities Licensure Unit
301 Centennial Mall South, P O Box 94669
Lincoln, NE 68509-4669

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
9/30/2026

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.

E-DOCKET

Maintenance

NO. e-docket :US515091

US serial number :	**USV1008514**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**4076 - T BLDG #5**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	4076 - T BLDG #5
Unit	USV1008514
PERFORMED PREVENTATIVE MAINTENANCE	☑
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐
Material Used/Spare Parts Used	4076 - T BLDG #5 USV1008514-Hydraulic:

Technician's comments and recommendations :

Met with maintenance inspected doors, cleaned interlocks clean car top, clean pit vacuum sills check fire service emptied oil container in the pit updated MCP's fire log and oil log looked into phone issue

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US515091

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	3				22-Oct-2024	07:00 AM	10:00 AM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 22-10-2024

Collect signature at a later time

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US515096

US serial number :	**USV1008088**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7182 - NORTH #1**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	7182 - NORTH #1
Unit	USV1008088
PERFORMED PREVENTATIVE MAINTENANCE	☑
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐
Material Used/Spare Parts Used	7182 - NORTH #1 USV1008088-Hydraulic:

Technician's comments and recommendations :

Met with building 10 maintenance supervisor got north elevator running interlocks weren't making up clean car top clean dinner locks emptied pit jug put down oil pads for spill oil out of jug went through fault law found magnets were moved reset magnets and inspected

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US515096

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1.5				22-Oct-2024	10:00 AM	11:30 AM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 22-10-2024

Called customer

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E-DOCKET

Maintenance

NO. e-docket :US515101

US serial number :	**USV1008107**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7183 - SOUTH #2**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	7183 - SOUTH #2
Unit	USV1008107
PERFORMED PREVENTATIVE MAINTENANCE	☑
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐
Material Used/Spare Parts Used	7183 - SOUTH #2 USV1008107-Hydraulic:

Technician's comments and recommendations :

Went through and cleaned interlocks, inspected fire, service, oil, logs, and MCP and checked in with maintenance before leaving to troublecall

Material Used :

CLIENT COMMENTS

N/A

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Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US515101

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	1.75				22-Oct-2024	11:30 AM	01:15 PM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 22-10-2024

Called customer

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US520927

US serial number :	**USV1008538**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**10054 - R BLDG #4**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	10054 - R BLDG #4	
Unit	USV1008538	
PERFORMED PREVENTATIVE MAINTENANCE	☑	
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐	
Material Used/Spare Parts Used	10054 - R BLDG #4 USV1008538-Hydraulic:	

Technician's comments and recommendations :

Arrived on site checked in waited for escort did cat one safety test also clean the pit, clean door tracks, interlock, and car

Material Used :

CLIENT COMMENTS

N/A

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Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US520927

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	2.5				08-Nov-2024	07:00 AM	09:30 AM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 08-11-2024

Collect signature at a later time

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US521010

US serial number :	**USV1008559**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**4071 - #6**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic
Unit Nickname	4071 - #6
Unit	USV1008559
PERFORMED PREVENTATIVE MAINTENANCE	☑
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐
Material Used/Spare Parts Used	4071 - #6 USV1008559-Hydraulic:

Technician's comments and recommendations :

Perform p.m. check fire service, access switches, clean car and hoist sales and car and hoistway door tracks and interlocks updated fire logs and MCP

Material Used :

CLIENT COMMENTS

N/A

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E-DOCKET

Maintenance

NO. e-docket :US521010

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.25				08-Nov-2024	11:15 AM	11:30 AM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 08-11-2024

Collect signature at a later time

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US521069

US serial number :	**USV1008504**	**Customer Name :**	**LINCOLN REGIONAL CENTER**
Lift Number :	**7165 - K BLDG #3**	**Supervisor Name :**	**Brandon L Dunham**
Unit Type :	**Hydraulic**	**Branch Name :**	**OMAHA**
Building Address :	**801 W PROSPECTOR PLC** **LANCASTER** **68509 LINCOLN**		
IVR WO Number :			

MAINTENANCE

Task Set : PREVENTATIVE MAINTENANCE

Operating Upon Departure the technician : Yes

Elevator

Unit Type	Hydraulic	
Unit Nickname	7165 - K BLDG #3	
Unit	USV1008504	
PERFORMED PREVENTATIVE MAINTENANCE	☑	
COMPLETED TKE BRAKE MAINTENANCE PROCEDURES	☐	
Material Used/Spare Parts Used	7165 - K BLDG #3 USV1008504-Hydraulic:	

Technician's comments and recommendations :

Preformed pm and updated logs

Material Used :

CLIENT COMMENTS

N/A

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

E-DOCKET

Maintenance

NO. e-docket :US521069

Time And Expense Detail

Line Type	Labor Type				Date	Start Time	End Time	Expense Amount
		1.5	1.7	2				
Labor	0.75				08-Nov-2024	11:30 AM	12:15 PM	

TECHNICIAN SIGNATURE

Technician : James Joseph Linhart

CLIENT SIGNATURE

For the client :

Date : 08-11-2024

Called customer

This document contains preliminary information regarding the work performed, and the time allotted for such work. Upon review, final adjustments may be made

Access any information about your equipments.maintenance at https://us.tkeview.com/webportal/public or contact your local Branch Office.

Midwest Automatic Fire Sprinkler Company

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Regional Plant Number: DW25-035

Location: 1700 No. Victory Lane Date: 1-22-25

Bill to: Norfolk, Ne. 68701 Travel Expense: _____

Address: _____ Equipment Used: _____

Kevin Cell # 402-649-1376

Description of Work / Comments: Jan Annual

Is work completed? _____ System in Service? _____

Contract with: Owner _____ Tenant _____ Contractor _____

Man hours - Straight time: _____ Overtime: _____

Quoted: $ NO - Cost plus/T & M: _____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# _____

BFP# _____

FIREPUMP# _____

Customer: _____

Foreman: _____

Date Signed: 1-22-25

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
FAX (402) 733-7810

1821-1823 Raccoon Street
DES MOINES, IOWA 50317
(515) 262-9311
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 Recreation Center
1700 No. Victory Lane
Norfolk, Ne. 68701

NAME OF PERSON/COMPANY PERFORMING INSPECTION

MIDWEST AUTOMATIC FIRE SPRINKLER CO.
4910 F STREET SUITE 400
OMAHA NE 68117

DW8891 DW25-035

TYPE OF SYSTEM
[ ] WET
[ ] DRY
[ ] OTHER

DATE OF INSPECTION 1-22-25

TYPE OF OCCUPANCY

SIGNATURE OF OWNERS REPRESENTATIVE

SIGNATURE OF SPRINKLER INSPECTOR

LICENSE# 18004

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 # 27545

BFP # 31319

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. 891 Inspection Contract No. DW25-035

Conferred With _____ Phone No. _____

REPORT TO Norfolk Reg Hospital BUILDING OR LOCATION _____

STREET 1700 N Victory Drive INSPECTOR Bryant

CITY & STATE Norfolk, Ne DATE 1-22-25

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? 2022

E. When was the dry-piping system last checked for proper pitch? _____

F. Are dry valves adequately protected from freezing? _____

Signature _____ Title _____ Date 1-22-25

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 53 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

SHEET 2 OF 2 - Use separate sheet for each system inspection

System No. or Description if multiple systems DW25-035

Inspection Report No. 041

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) _____ *(See Trip Test Table which follows.)*
13. Date quick-opening device tested _____ *(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	Yes	Yes	No	Yes	
Tank Control Valves							
Pump Control Valves							
Sectional Control Valves							
System Control Valves	2	Bfly	Yes	Yes	No	Yes	DCVA
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	1-31-24	Riser	2"	65	55
This Water Flow Test					

17. Explain any "No" answers and comments: N/A

18. Adjustments or corrections made during this inspection: N/A

19. Although these comments are not the result of an engineering review, the following desirable improvements are recommended:
N/A

Signature: _____ Date: 1-22-25

Midwest Automatic Fire Sprinkler Company

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Regional Center Number: D225-036

Location: 1700 No. Victory Lane Date: 1-22-25

Bill to: P.O. Box 1209 Travel Expense: _____

Address: Norfolk, Ne. 68701 Equipment Used: Code# 300

Kevin 402-649-1376

Description of Work / Comments: Annual

Is work completed? Yes System in Service? Yes

Contract with: Owner X Tenant _____ Contractor _____

Man hours - Straight time: _____ Overtime: _____

Quoted: $ Yes Cost plus/T & M: _____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# _____

BFP# _____

FIREPUMP# _____

Customer: _____

Foreman: _____

Date Signed: 1-22-25

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
FAX (402) 733-7810

1821-1823 Raccoon Street
DES MOINES, IOWA 50317
(515) 262-9311
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 Reg Center
1100 No Victory Lane
Norfolk Ne. 68701

NAME OF PERSON/COMPANY PERFORMING INSPECTION

MIDWEST AUTOMATIC FIRE SPRINKLER CO.
4910 F STREET SUITE 400
OMAHA NE 68117

DW25-036 MWO-237

*TYPE OF SYSTEM
*[X] WET
*[ ] DRY
*[ ] OTHER

DATE OF INSPECTION 1-22-25

TYPE OF OCCUPANCY

*SIGNATURE OF OWNERS REPRESENTATIVE

*SIGNATURE OF SPRINKLER INSPECTOR

*LICENSE# 9807

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. DW25-036

Conferred With _____ Phone No. _____

REPORT TO Norfolk Reg Center BUILDING OR LOCATION _____

STREET 1700 No. Victory Lane INSPECTOR Brent

CITY & STATE Norfolk, Ne DATE 1-22-25

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? 2022

E. When was the dry-piping system last checked for proper pitch? _____

F. Are dry valves adequately protected from freezing? _____

Signature _____ Title _____ Date 1-22-25

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

3W - 46
3E - 41
2W - 59
2E - 45
1W - 48
1E - 53
W - 46
Kit - 32
Main 25

SHEET 2 OF 2 - Use separate sheet for each system inspection

System No. or Description if multiple systems 5025-036

Inspection Report No. 237

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) _____ *(See Trip Test Table which follows.)*
13. Date quick-opening device tested _____ *(See Trip Test Table which follows.)*

TRIP TEST TABLE

DRY VALVE

MAKE	MODEL	SERIAL NO.

C.O.D.

MAKE	MODEL	SERIAL NO.

DRY PIPE OPERATING TEST

	Time to Trip Thru Test Pipe		Water Pressure	Air Pressure	Trip Point Air Pressure	Time Water Reached Test Outlet		Alarm Operated Properly	
	MIN.	SEC.	PSI	PSI	PSI	MIN.	SEC.	YES	NO
Without Q.O.D.									
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		Does each circuit operate valve release		Maximum time to operate release	
		YES	NO	YES	NO	YES	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	Yes	Yes	No	Yes	
Tank Control Valves							
Pump Control Valves							
Sectional Control Valves	18	BFly	Yes	Yes	No	Yes	
System Control Valves	2	BFly	Yes	Yes	No	Yes	DCVA
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	1-31-24	Riser	2"	80	70
This Water Flow Test	1-22-25	Riser	2"	80	70

17. Explain any "No" answers and comments: None

18. Adjustments or corrections made during this inspection: None

19. Although these comments are not the result of an engineering review, the following desirable improvements are recommended:
None

Signature: _____ Date: 1-22-25

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Quarterly Report of Inspection, Testing and Maintenance of Fire Sprinkler Systems

MUO-790 DW25-299

Name of Inspected Property: Norfolk Regional Center Date: 4-24-25

Inspector Name: Bmer.t 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	75			psi
13. Gauge reading during stable flow (residual)	65			psi
14. Time for supply pressure to return to normal	Imed			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				

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Quarterly Report of Inspection, Testing and Maintenance of Fire Sprinkler Systems

MCO-892 DU25-298

Name of Inspected Property: Norfolk Regional Heating Plant Date: 4-24-25

Inspector Name: BMerit 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	70			psi
13.	Gauge reading during stable flow (residual)	60			psi
14.	Time for supply pressure to return to normal	Imed			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				

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Davenport, Iowa 52807
(563) 388-6647
FAX (563) 388-6648

BACKFLOW DEVICE TEST REPORT

Customer or Business Name	Contct Person	Phone Number
Norfolk Regional Center		

Mailing address: 1700 No. Victory Lane Norfolk, Ne

Service Address - if different:

Isolation / Containment — Device Protects Backflow from: Fire Spk

Date of Test	Time	Supply Pressure
4-24-25	AM / PM	PSI

Type of Assembly	Manufacturer	Model	Size	Serial No.
DCVA	Watts	757	4"	HC-0763

Height off Floor: 3' Feet

Protection from: Freezing [X] Yes [ ] No; Flooding [X] Yes [ ] No

New Installation [ ] Yes [X] No

Is device installed according to plumbing code requirements? Yes / No

Does branch piping exist prior to the meter or containment device? Yes / No

DEVICE LOCATION:

REUCED PRESSURE PRINCIPAL ASSEMBLY — Initial Test	Passed	Failed
1st Check held in direction of flow _____PSID		
Relief Valve opened at _____PSID		
Difference (1st check-relief) _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

Failure of any above items require repair

REUCED PRESSURE PRINCIPAL ASSEMBLY — Final Test After Repair	Passed	Failed
1st Check held in direction of flow _____PSID		
Relief Valve opened at _____PSID		
Difference (1st check-relief) _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

REUCED PRESSURE PRINCIPAL ASSEMBLY — Initial Test	Passed	Failed
1st Check held in direction of flow 2.0 PSID	X	
2nd Check held back pressure	X	
2nd Check held in direction of flow 3.2 PSID	X	
No. 2 Shut-off Valve leak tight		

Failure of any above items require repair

REUCED PRESSURE PRINCIPAL ASSEMBLY — Final Test After Repair	Passed	Failed
1st Check held in direction of flow _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

Repair Comments:

THE ABOVE REPORT IS CERTIFIED TO BE TRUE, ACCURATE AND COMPLETE

Tested by: Brian Merit
Print Name Signature

Company Name: MIDWEST FIRE SPRINKLER CO.
4910 "F" St. Suite #400
Omaha, NE 68117

Registration No.: 9131 Registration Expiration Date: 12-25

Repaired By:
Print Name Signature

Final Test By:
Print Name Signiture

Date:

Test gauge manufacturer	Test gauge serial #	Date calibration verified	Accuracy verified by
Watts	133324	5-30-24	TT

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(563) 388-6647
FAX (563) 388-6648

BACKFLOW DEVICE TEST REPORT

Customer or Business Name	Contct Person	Phone Number
Norfolk Regional Heating plant		

Mailing address: 1700 No. Victory Ln Norfolk Ne.

Service Address - if different:

Device Protects Backflow from: (Isolation) Containment

Date of Test	Time	Supply Pressure	
4-24-25	AM / PM	PSI	Fire Spk

Type of Assembly	Manufacturer	Model	Size	Serial No.	
DCVA	WATTS	757	4"	KJ-1277	

Height off Floor	Protection from:		New Installation
Vert Feet	Freezing: [X] Yes [ ] No	Flooding: [X] Yes [ ] No	[ ] Yes [X] No

Is device installed according to plumbing code requirements? (Yes) / No

Does branch piping exist prior to the meter or containment device? Yes / (No)

DEVICE LOCATION:

REUCED PRESSURE PRINCIPAL ASSEMBLY — Initial Test	Passed	Failed
1st Check held in direction of flow _____PSID		
Relief Valve opened at _____PSID		
Difference (1st check-relief) _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

Failure of any above items require repair

REUCED PRESSURE PRINCIPAL ASSEMBLY — Final Test After Repair	Passed	Failed
1st Check held in direction of flow _____PSID		
Relief Valve opened at _____PSID		
Difference (1st check-relief) _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

REUCED PRESSURE PRINCIPAL ASSEMBLY — Initial Test	Passed	Failed
1st Check held in direction of flow 1.6 PSID	X	
2nd Check held back pressure	X	
2nd Check held in direction of flow 1.6 PSID	X	
No. 2 Shut-off Valve leak tight		

Failure of any above items require repair

REUCED PRESSURE PRINCIPAL ASSEMBLY — Final Test After Repair	Passed	Failed
1st Check held in direction of flow _____PSID		
2nd Check held back pressure		
2nd Check held in direction of flow _____PSID		
No. 2 Shut-off Valve leak tight		

Repair Comments:

THE ABOVE REPORT IS CERIFIED TO BE TRUE, ACCURATE AND COMPLETE

Tested by: Brian Merl
Print Name Signature

Company Name: MIDWEST FIRE SPRINKLER CO.
4910 "F" St. Suite #400
Omaha, NE 68117

Registration No.: 9131 Registration Expiration Date: 12-25

Repaired By:
Print Name Signature

Final Test By:
Print Name Signature

Date:

Watts	133324	5-30-24	TT
Test gauge manufacturer	Test gauge serial #	Date calibration verified	Accuracy verified by

Midwest Automatic Fire Sprinkler Company

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Prog Center Number: DW25-299

Location: 1700 No. Lane Date: _____

Bill to: P.O. Box 1209 Travel Expense: _____

Address: Norfolk, Ne. 68701 Equipment Used: Code # 100

Craig · 402·640-1125 _____

Description of Work / Comments: April @ Italy ·

_____

_____

Is work completed? Yes System in Service? Yes

Contract with: Owner X Tenant _____ Contractor _____

Man hours - Straight time: _____ Overtime: _____

Quoted: $ Yes - Cost plus/T & M: _____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# _____

BFP# _____

FIREPUMP# _____

Customer: [signature]

Foreman: [signature]

Date Signed: 4-24-25

Midwest Automatic Fire Sprinkler Company

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Recycling Plant Number: Dw25-298

Location: 1700 No. Victory Lane Date: 4-24-25

Bill to: P.O. Box 1209 Travel Expense:

Address: Norfolk, Ne 68701 Equipment Used:

Craig 402-640-1175

Description of Work / Comments: Install @ Duly.

Is work completed? Yes System in Service? Yes

Contract with: Owner X Tenant ____ Contractor ____

Man hours - Straight time: ____ Overtime: ____

Quoted: $NO Cost plus/T & M: ____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# ____

BFP# ____

FIREPUMP# ____

Customer: [signature]

Foreman: [signature]

Date Signed: 4-24-25

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Quarterly Report of Inspection, Testing and Maintenance of Fire Sprinkler Systems

MWD-769 D1025-701

Name of Inspected Property: Norfolk Regional Center Date: 7-9-25

Inspector Name: Bmerit 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	35	/		
12.	Supply water gauge reading befor flow	85			psi
13.	Gauge reading during stable flow (residual)	70			psi
14.	Time for supply pressure to return to normal	Imm			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

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Reg Center Number: D025 - 701

Location: 1700 No Victory Rd. Date: 7-9-25

Bill to: P.O. Box 1209 Travel Expense: _____

Address: Norfolk, Ne. 68701 Equipment Used: Code #100

402-370-3220

Description of Work / Comments: July Qtrly.

Is work completed? Yes System in Service? Yes

Contract with: Owner X Tenant _____ Contractor _____

Man hours - Straight time: _____ Overtime: _____

Quoted: $ Yes - Cost plus/T & M: _____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# _____

BFP# _____

FIREPUMP# _____

Customer: _____

Foreman: _____

Date Signed: 7-9-25

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
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

MWD-893 DW25-702

Name of Inspected Property: Norfolk Reg Heating Plant Date: 7-9-25

Inspector Name: Bmerit 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	95			psi
13. Gauge reading during stable flow (residual)	70			psi
14. Time for supply pressure to return to normal	Imed			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

4910 'F' Street, Suite #400
Omaha, Nebraska 68117
402-558-7080 Fax: 402-733-7810

Project Name: Norfolk Reg Heating Plant Number: DW25-702

Location: 1700 No. Victory Lane Norfolk Ne. Date: 7-9-25

Bill to: Norfolk Regional Center Travel Expense:

Address: 1700 No Victory Lane PO Box 1209 Equipment Used:

Norfolk, Ne. 68701

Description of Work / Comments: July Qtrly.

Is work completed? Yes System in Service? Yes

Contract with: Owner X Tenant ____ Contractor ____

Man hours - Straight time: ____ Overtime: ____

Quoted: $ NO - Cost plus/T & M: ____

Quantity	Item	Quantity	Item

I find the above items to be correct and agree to pay for same on presentation of an invoice.

NEBRASKA INSPECTION TAG#

SPIGOT# ____

BFP# ____

FIREPUMP# ____

Customer: [signature]

Foreman: [signature]

Date Signed: 7-9-25

MIDWEST
AUTOMATIC FIRE SPRINKLER COMPANY

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
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

MWO-791 DW25-967

Name of Inspected Property: Norfolk Regional Center Date: 10-8-25

Inspector Name: BMerit 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 78			psi
13.	Gauge reading during stable flow (residual) 76			psi
14.	Time for supply pressure to return to normal LMFC			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

4910 "F" Street Suite 400
Omaha, Nebraska 68117
(402) 558-7080
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

MWD: 894 DW25-968

Name of Inspected Property: Norfolk Regional Heating Plant Date: 10-8-25

Inspector Name: BMerit 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	75		psi
13.	Gauge reading during stable flow (residual)	65		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 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				

NEBRASKA STATE FIRE MARSHAL

DATE: 01/29/25

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: REGIONAL CENTER		
ADDRESS: 1700 N. VICTORY RD		NORFOLK, NE 68701
PREMISES PROTECTED: BUILDING 16		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	MODEL#: MXL	STANDBYE POWER TYPE: SLA
MANUFACTURER: PYROTRONICS	SERIAL#:	TROUBLE BATTERY TYPE: CELL

SYSTEM REMOTELY MONITORED BY: JCI	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	40	40
HEAT DETECTORS		
FIXED TEMP.NON RESTORABLE LINE		
FIXED TEMP.NON RESTORABLE SPOT		
FIXED TEMP.RATE OF RISE/RESTORE	44	44
RESTORABLE LINE TYPE		
SMOKE DETECTORS		
FUNCTIONAL	198	198
CALIBRATED		
DUCT DETECTORS	5	5
WATERFLOW DEVICES (TIME TO ACTIVATE)		
SUPERVISORY SWITCHES		
AUDIBLE DEVICES	49	49
VISUAL DEVICES	116	116
ANNUNCIATORS	8	8
CONTROL UNIT		
LAMPS AND LED'S	29	29
FUSES		
PRIMARY POWER SUPPLY	1	1
SECONDARY POWER SUPPLY	1	1
MAGNETIC HOLD-OPEN DEVICES	30	30
FAN RELAYS	22	22
VOICE ALARM AND 2-WAY PHONE		
TROUBLE SIGNALS		
ALARM CIRCUIT	10	10
ZONE INITIATING CIRCUIT	304	304
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? YES
DID ALARM SIGNAL OPERATE? YES

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD
EMERGENCY POWER BATTERY TYPE – SLA TEST VOLTS – 26.4
MAIN OPERATING POWER TYPE – PS TEST VOLTS – 120VAC
PAD – 25.8 PAD – 26.2

WHAT CODE IS SYSTEM INSTALLED UNDER? NFPA 72
IS SYSTEM OPERATING TO CODE? AS INSTALLED UNDER
COMMENTS: (NOTE ANY DEFICIANCIES) –

DIALER TESTED

LIST CURRENT REPAIRS TO SYSTEM AND DATE OF REPAIRS –

INSPECTOR: Austin Timmerman	LICENSE#: L05
AUSTIN TIMMERMAN	EXPIRATION DATE: 7-16-28
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

NEBRASKA STATE FIRE MARSHAL

DATE: 01-29-25

ACCEPTANCE ☐

FIRE ALARM TEST REPORT

RE-ACCEPTANCE ☐

PERIODIC 1 ■ 2 ☐

ELECTRONIC SYSTEMS, INC

P.O BOX 1260 HASTINGS, NEBRASKA 68902-1260

TELEPHONE (402) 463-0200

CUSTOMER: REGIONAL CENTER		
ADDRESS: 1700 N. VICTORY ROAD		NORFOLK, NE 68701
PREMISES PROTECTED: MAINTENANCE SHOP		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	MODEL#: XLS	STANDBYE POWER TYPE: SLA
MANUFACTURER: SIEMENS	SERIAL#:	TROUBLE BATTERY TYPE: CELL

SYSTEM REMOTELY MONITORED BY: JCI	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	5	5
HEAT DETECTORS		
FIXED TEMP.NON RESTORABLE LINE		
FIXED TEMP.NON RESTORABLE SPOT		
FIXED TEMP.RATE OF RISE/RESTORE		
RESTORABLE LINE TYPE		
SMOKE DETECTORS		
FUNCTIONAL	2	2
CALIBRATED		
DUCT DETECTORS	1	1
WATERFLOW DEVICES (TIME TO ACTIVATE)	3	3
SUPERVISORY SWITCHES	10	10
AUDIBLE DEVICES	11	11
VISUAL DEVICES	11	11
ANNUNCIATORS		
CONTROL UNIT		
LAMPS AND LED'S	156	156
FUSES	3	3
PRIMARY POWER SUPPLY	1	1
SECONDARY POWER SUPPLY	1	1
MAGNETIC HOLD-OPEN DEVICES		
FAN RELAYS		
VOICE ALARM AND 2-WAY PHONE		
TROUBLE SIGNALS		
ALARM CIRCUIT	4	4
ZONE INITIATING CIRCUIT	4	4
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? YES
DID ALARM SIGNAL OPERATE? YES

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD
EMERGENCY POWER BATTERY TYPE – SLA TEST VOLTS – 26.2
MAIN OPERATING POWER TYPE – PS TEST VOLTS – 120VAC

WHAT CODE IS SYSTEM INSTALLED UNDER? NFPA 72
IS SYSTEM OPERATING TO CODE? AS INSTALLED UNDER
COMMENTS: (NOTE ANY DEFICIANCIES) –

LIST CURRENT REPAIRS TO SYSTEM AND DATE OF REPAIRS –

INSPECTOR: [signature]	LICENSE#: L05
AUSTIN TIMMERMAN	EXPIRATION DATE: 7-16-28
SUBSCRIBER:	

STATE FIRE MARSHAL

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:_____

NEBRASKA STATE FIRE MARSHAL

DATE: 07/16/2025

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: REGIONAL CENTER		
ADDRESS: 1700 N. VICTORY RD		NORFOLK, NE 68701
PREMISES PROTECTED: BUILDING 16		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	MODEL#: MXL	STANDBYE POWER TYPE: SLA
MANUFACTURER: PYROTRONICS	SERIAL#:	TROUBLE BATTERY TYPE: CELL

SYSTEM REMOTELY MONITORED BY: JCI	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	40	40
HEAT DETECTORS		
FIXED TEMP.NON RESTORABLE LINE		
FIXED TEMP.NON RESTORABLE SPOT		
FIXED TEMP.RATE OF RISE/RESTORE	44	44
RESTORABLE LINE TYPE		
SMOKE DETECTORS		
FUNCTIONAL	198	198
CALIBRATED		
DUCT DETECTORS	5	5
WATERFLOW DEVICES (TIME TO ACTIVATE)		
SUPERVISORY SWITCHES		
AUDIBLE DEVICES	49	49
VISUAL DEVICES	116	116
ANNUNCIATORS	8	8
CONTROL UNIT		
LAMPS AND LED'S	29	29
FUSES		
PRIMARY POWER SUPPLY	1	1
SECONDARY POWER SUPPLY	1	1
MAGNETIC HOLD-OPEN DEVICES	30	30
FAN RELAYS	22	22
VOICE ALARM AND 2-WAY PHONE		
TROUBLE SIGNALS		
ALARM CIRCUIT	10	10
ZONE INITIATING CIRCUIT	304	304
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? YES
DID ALARM SIGNAL OPERATE? YES

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD
EMERGENCY POWER BATTERY TYPE – SLA TEST VOLTS – 26.3
MAIN OPERATING POWER TYPE – PS TEST VOLTS – 120VAC
PAD – 25.9 PAD – 26.2

WHAT CODE IS SYSTEM INSTALLED UNDER? NFPA 72
IS SYSTEM OPERATING TO CODE? AS INSTALLED UNDER
COMMENTS: (NOTE ANY DEFICIANCIES) –

DIALER TESTED

LIST CURRENT REPAIRS TO SYSTEM AND DATE OF REPAIRS –

INSPECTOR: Austin Timmerman	LICENSE#: L05
AUSTIN TIMMERMAN	EXPIRATION DATE: 7-16-28
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

NEBRASKA STATE FIRE MARSHAL

DATE: 07/16/2025

ACCEPTANCE ☐

FIRE ALARM TEST REPORT

RE-ACCEPTANCE ☐

PERIODIC 1☐ 2■

ELECTRONIC SYSTEMS, INC

P.O BOX 1260 HASTINGS, NEBRASKA 68902-1260

TELEPHONE (402) 463-0200

CUSTOMER: REGIONAL CENTER		
ADDRESS: 1700 N. VICTORY ROAD		NORFOLK, NE 68701
PREMISES PROTECTED: MAINTENANCE SHOP		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	MODEL#: XLS	STANDBYE POWER TYPE: SLA
MANUFACTURER: SIEMENS	SERIAL#:	TROUBLE BATTERY TYPE: CELL

SYSTEM REMOTELY MONITORED BY: JCI	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	5	5
HEAT DETECTORS		
FIXED TEMP.NON RESTORABLE LINE		
FIXED TEMP.NON RESTORABLE SPOT		
FIXED TEMP.RATE OF RISE/RESTORE		
RESTORABLE LINE TYPE		
SMOKE DETECTORS		
FUNCTIONAL	2	2
CALIBRATED		
DUCT DETECTORS	1	1
WATERFLOW DEVICES (TIME TO ACTIVATE)	3	3
SUPERVISORY SWITCHES	10	10
AUDIBLE DEVICES	11	11
VISUAL DEVICES	11	11
ANNUNCIATORS		
CONTROL UNIT		
LAMPS AND LED'S	156	156
FUSES	3	3
PRIMARY POWER SUPPLY	1	1
SECONDARY POWER SUPPLY	1	1
MAGNETIC HOLD-OPEN DEVICES		
FAN RELAYS		
VOICE ALARM AND 2-WAY PHONE		
TROUBLE SIGNALS		
ALARM CIRCUIT	4	4
ZONE INITIATING CIRCUIT	4	4
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? YES
DID ALARM SIGNAL OPERATE? YES

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD
EMERGENCY POWER BATTERY TYPE – SLA TEST VOLTS – 26.1
MAIN OPERATING POWER TYPE – PS TEST VOLTS – 120VAC

WHAT CODE IS SYSTEM INSTALLED UNDER? NFPA 72
IS SYSTEM OPERATING TO CODE? AS INSTALLED UNDER
COMMENTS: (NOTE ANY DEFICIANCIES) –

LIST CURRENT REPAIRS TO SYSTEM AND DATE OF REPAIRS –

INSPECTOR: austin timmerman	LICENSE#: L05
AUSTIN TIMMERMAN	EXPIRATION DATE: 7-16-28
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

NRC GENERATOR TESTING

Date 10-23-25 Start 800am. End 830 am.

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch SB. There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS____ EQ3____ CB1____ EQ4____ SB ✓ LS2____ ATS1____ ATS5____

3. Time test started 843am Transfer time in seconds 7.8

4. Time transfer switch transfers back to normal power 8.44am

5. Total time the generator and switches were tested on emergency power 30mins

6.Time generator shuts down after cooling —.

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 479 AC Amps PH. A 277
B-C 480 B 278
A-C 480 C 278

9. Hertz 60.1 Oil Pressure 74 Water Temperature 145

10. Exhaust temperature (right before retransfer) —

11.Did outside air and exhaust louvers return to normal position. yes

12. Is there evidence of wet stacking (continuous black smoke during running)? no

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time — Stop time — Total time —

15. Diesel Fuel level 3/4 Check belts ✓ Check for leaks ✓

Signature Alan Wright

q

NRC GENERATOR TESTING

Date 9-16-25 Start 8:30 am End 9:30 am

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch EQ4. There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS____ EQ3____ CB1____ EQ4 X SB____ LS2____ ATS1____ ATS5____

3. Time test started 8:45 Transfer time in seconds 7.8

4. Time transfer switch transfers back to normal power Yes.

5. Total time the generator and switches were tested on emergency power 30 min.

6.Time generator shuts down after cooling Yes.

7. Did outside air and exhaust louvers open? Yes

8. AC Volts PH. A-B 480 AC Amps PH. A 307
B-C 479 B 307
A-C 480 C 308

9. Hertz 60.1 Oil Pressure 79 psi Water Temperature 151°

10. Exhaust temperature (right before retransfer) 285

11.Did outside air and exhaust louvers return to normal position. Yes

12. Is there evidence of wet stacking (continuous black smoke during running)? NO

13. Check oil level ok Check coolant level ok Check charger voltage OK.

14. Load bank test. Start time 9:15 Stop time 9:25 Total time 40 min

15. Diesel Fuel level 3/4 Check belts ok Check for leaks ok

Signature Rocky Claussen

NRC GENERATOR TESTING

Date 8-22-25 Start 9:30 am. End 10:00 am.

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch CB1.There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS____EQ3____CB1 X EQ4____SB____LS2____ATS1____ATS5____

3. Time test started 9:15 Transfer time in seconds 7.9.

4. Time transfer switch transfers back to normal power 9:16.

5. Total time the generator and switches were tested on emergency power 30 mins.

6.Time generator shuts down after cooling X.

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 479 AC Amps PH. A 277
B-C 480 B 276
A-C 481 C 278

9. Hertz 60.1 Oil Pressure 74 Water Temperature 154

10. Exhaust temperature (right before retransfer) 278

11.Did outside air and exhaust louvers return to normal position. yes

12. Is there evidence of wet stacking (continuous black smoke during running)? no

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time X Stop time X Total time X

15. Diesel Fuel level 3/4 Check belts ✓ Check for leaks ✓

Signature Rena Mungo

NRC GENERATOR TESTING

Date 7-25-25 Start 800 am. End 8.38 am.

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch EQ3 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS_____EQ3__✓__CB1_____EQ4____SB_____LS2____ATS1____ATS5_____

3. Time test started 843 Transfer time in seconds 7.8

4. Time transfer switch transfers back to normal power 844.

5. Total time the generator and switches were tested on emergency power 25 mins.

6.Time generator shuts down after cooling 5 mins

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 480 AC Amps PH. A 72
B-C 480 B 73
A-C 480 C 72

9. Hertz 60.1 Oil Pressure 73 Water Temperature 149

10. Exhaust temperature (right before retransfer) 410

11.Did outside air and exhaust louvers return to normal position. yes

12. Is there evidence of wet stacking (continuous black smoke during running)? no

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time 800 Stop time 825 Total time 25 mins

15. Diesel Fuel level OK Check belts ✓ Check for leaks ✓

Signature Gloria Mungo

NRC GENERATOR TESTING

Date 6-23-25 Start 130 PM. End 204PM

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch LS .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS ✓ EQ3 ____ CB1 ____ EQ4 ____ SB ____ LS2 ____ ATS1 ____ ATS5 ____

3. Time test started 204PM Transfer time in seconds 7.94 seconds

4. Time transfer switch transfers back to normal power 200PM.

5. Total time the generator and switches were tested on emergency power 34 mins.

6.Time generator shuts down after cooling 3 mins

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 479 AC Amps PH. A 188
B-C 480 B 190
A-C 481 C 190

9. Hertz 60.1 Oil Pressure 72 Water Temperature 163

10. Exhaust temperature (right before retransfer) 480

11.Did outside air and exhaust louvers return to normal position. yes

12. Is there evidence of wet stacking (continuous black smoke during running)? no

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time 130 PM Stop time 200 PM Total time 30 mins

15. Diesel Fuel level 3/4 Check belts ✓ Check for leaks ✓

Signature [signature]

NRC GENERATOR TESTING

Date 5-20-25 Start 1:00 pm End 1:40 pm

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch ATS5 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:

LS_____ EQ3_____ CB1_____ EQ4_____ SB_____ LS2_____ ATS1_____ ATS5 ✓

3. Time test started 1:00 pm Transfer time in seconds 8.2

4. Time transfer switch transfers back to normal power 1:40 p.m.

5. Total time the generator and switches were tested on emergency power 30 min.

6.Time generator shuts down after cooling 1:40 pm.

7. Did outside air and exhaust louvers open? Yes

8. AC Volts PH. A-B 479 AC Amps PH. A 306
   B-C 480 B 308
   A-C 480 C 307

9. Hertz 60.1 Oil Pressure 72 Water Temperature 158°

10. Exhaust temperature (right before retransfer) 590

11.Did outside air and exhaust louvers return to normal position. Yes

12. Is there evidence of wet stacking (continuous black smoke during running)? NO

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time 1:00 Stop time 1:30 Total time 30 min

15. Diesel Fuel level 3/4 Check belts OK Check for leaks check minor leak

Signature [signature]

NRC GENERATOR TESTING

Date 4-24-25 Start 100PM End 133PM

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch ATS1 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:

LS____ EQ3____ CB1____ EQ4____ SB____ LS2____ ATS1 ✓ ATS5____

3. Time test started 149PM Transfer time in seconds 7.90 seconds

4. Time transfer switch transfers back to normal power 133PM

5. Total time the generator and switches were tested on emergency power 33 mins

6.Time generator shuts down after cooling 180 seconds

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 480 AC Amps PH. A 307

B-C 480 B 368

A-C 480 C 308

9. Hertz 60.1 Oil Pressure 71 Water Temperature 160

10. Exhaust temperature (right before retransfer) 580

11.Did outside air and exhaust louvers return to normal position. yes

12. Is there evidence of wet stacking (continuous black smoke during running)? NO

13. Check oil level OK Check coolant level OK Check charger voltage 28V

14. Load bank test. Start time 100PM Stop time 133PM Total time 33 mins

15. Diesel Fuel level 3/4 Check belts OK Check for leaks OK

Signature Kevin Wing

NRC GENERATOR TESTING

Date March 17 Start 1:30 pm End 2:02 pm

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch LS2 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS_____EQ3_____CB1_____EQ4____SB_____LS2 ✓ ATS1____ATS5_____

3. Time test started 230PM Transfer time in seconds 8.70

4. Time transfer switch transfers back to normal power 240PM.

5. Total time the generator and switches were tested on emergency power 32 mins.

6.Time generator shuts down after cooling 3 mins.

7. Did outside air and exhaust louvers open? Yes

8. AC Volts PH. A-B 480 AC Amps PH. A 420
B-C 479 B 422
A-C 480 C 422

9. Hertz 60.1 Oil Pressure 70 Water Temperature 171

10. Exhaust temperature (right before retransfer) 681

11.Did outside air and exhaust louvers return to normal position. Yes

12. Is there evidence of wet stacking (continuous black smoke during running)? NO

13. Check oil level ✓ Check coolant level ✓ Check charger voltage OK

14. Load bank test. Start time 130PM Stop time 200PM Total time 30 mins

15. Diesel Fuel level 3/4 Check belts ✓ Check for leaks OK

Signature [signature]

NRC GENERATOR TESTING

Date 2-14-25 Start 105 PM End 144 p.m.

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch SB .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS ____ EQ3 ____ CB1 ____ EQ4 ____ SB ✓ LS2 ____ ATS1 ____ ATS5 ____

3. Time test started 150PM Transfer time in seconds 8.75

4. Time transfer switch transfers back to normal power 155PM

5. Total time the generator and switches were tested on emergency power 33 minutes

6.Time generator shuts down after cooling 144.PM.

7. Did outside air and exhaust louvers open? ✓

8. AC Volts PH. A-B 479 AC Amps PH. A 307
B-C 479 B 308
A-C 479 C 308

9. Hertz 60.1 Oil Pressure 70 Water Temperature 162

10. Exhaust temperature (right before retransfer) 530

11.Did outside air and exhaust louvers return to normal position. yes.

12. Is there evidence of wet stacking (continuous black smoke during running)? no

13. Check oil level ✓ Check coolant level ✓ Check charger voltage 29

14. Load bank test. Start time 105PM Stop time 138 PM Total time 33 minutes

15. Diesel Fuel level 3/4 Check belts O/C Check for leaks O/K.

Signature Steven Wing

NRC GENERATOR TESTING

Date 1-15-2025 Start 2:45 PM End 2:50

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch EQ4 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS____EQ3____CB1____EQ4 ✓ SB____LS2____ATS1____ATS5____

3. Time test started 2:45 PM Transfer time in seconds 8.73

4. Time transfer switch transfers back to normal power 2:50 .

5. Total time the generator and switches were tested on emergency power 34 Minutes

6.Time generator shuts down after cooling 2:34 PM

7. Did outside air and exhaust louvers open? Yes

8. AC Volts PH. A-B 480 AC Amps PH. A 423
B-C 479 B 425
A-C 480 C 424

9. Hertz 60.1 Oil Pressure 69 Water Temperature 172°

10. Exhaust temperature (right before retransfer) 643°

11.Did outside air and exhaust louvers return to normal position. Yes

12. Is there evidence of wet stacking (continuous black smoke during running)? No

13. Check oil level OK Check coolant level OK Check charger voltage OK

14. Load bank test. Start time 1:55 PM Stop time 2:29 PM Total time 34 Minutes

15. Diesel Fuel level 3/4 Check belts OK Check for leaks OK.

Signature Rich Kluender

NRC GENERATOR TESTING

Date 12-26-24 Start 117 PM End 155 PM

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch CB1 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:
LS_____EQ3_____CB1 V EQ4___SB_____LS2___ATS1___ATS5_____

3. *Time test started* 2:17 *Transfer time in seconds* 5.40

4. Time transfer switch transfers back to normal power 2:28PM

5. Total time the generator and switches were tested on emergency power 38 minutes

6.Time generator shuts down after cooling 155 PM.

7. Did outside air and exhaust louvers open? yes

8. AC Volts PH. A-B 480 AC Amps PH. A 307
B-C 479 B 308
A-C 480 C 308

9. Hertz 60.1 Oil Pressure 69 Water Temperature 154°

10. Exhaust temperature (right before retransfer) 548

11.Did outside air and exhaust louvers return to normal position. yes.

12. Is there evidence of wet stacking (continuous black smoke during running)? NO

13. Check oil level OK Check coolant level OK. Check charger voltage 28 v

14. Load bank test. Start time 117 PM Stop time 150 PM Total time 38 minutes

15. Diesel Fuel level 3/4

Signature Kevin Lavergne

Cat 9L 664 DF

NRC GENERATOR TESTING

Date 11-19-2024 Start 2:19 PM End 2:24 PM

1.Generator should operate at least 30 minutes minimum under operating temperature.

2.Initiating transfer switch EQ 3 .There's (8) transfer switches at NRC . Each month rotate (1) transfer switch.

Transfer switch exercised:

LS_____ EQ3 ✓ CB1_____ EQ4____ SB_____ LS2____ ATS1____ ATS5_____

3. *Time test started* 2:19 *Transfer time in seconds* 7.63

4. Time transfer switch transfers back to normal power 2:24 PM

5. Total time the generator and switches were tested on emergency power 38 Minutes

6.Time generator shuts down after cooling 2:11 PM

7. Did outside air and exhaust louvers open? Yes

8. AC Volts PH. A-B 480 AC Amps PH. A 422

B-C 479 B 424

A-C 481 C 423

9. Hertz 60.1 Oil Pressure 68 Water Temperature 156°

10. Exhaust temperature (right before retransfer) 655

11.Did outside air and exhaust louvers return to normal position. Yes

12. Is there evidence of wet stacking (continuous black smoke during running)? No

13. Check oil level ✓ Check coolant level ✓ Check charger voltage ✓

14. Load bank test. Start time 1:26 PM Stop time 2:04 PM Total time 38 Minutes

15. Diesel Fuel level 3/4

Signature Neil Klunk

East
4098

Elevator and Amusement Ride Division
1313 Farnam, Rm. 233 Omaha, NE 68102 Office: 402-595-3184 Fax:
402-595-1360
SFM.Conveyances@nebraska.gov

Hydraulic Elevator Safety Test and Inspector Witness Report

(Revised 8/24/2018)

General Information

Building Name:	Norfolk Regional Center	Manufacturer:	Kone			State ID #:	4098
Address:	1200 N. Victory Rd	City:	Norfolk	ZIP:	68701-6859	Building ID #:	
Responsible Party Name:			Phone:			Email:	
Install Date:		Stops: Front 4	Rear 0	Capacity:	4000 lbs	Job/Contract #:	
Rated Speed:	fpm	Duty:	☒ Passenger ☐ Freight	Freight Class:	☐ A ☐ B ☐ C1 ☐ C2 ☐ C3		
Test Date:	1-16-25	Test Type:	☐ Acceptance & Witness Inspection	☒ Category 1	☐ 5-year Inspection		
Inspector Present?	☐ Yes	☒ No	*If Yes, Inspector Signs Report*				

Testing and Inspection Components

TCO = TCO in lieu of shutdown can be recommended (Category 1 & 5-year tests or inspection; NOT allowed at acceptance)

Relief Valve

OK	N/A		
Working Pressure – No Load 140		Relief Valve Set (≤ 150% of WP) 340	
OK	N/A	Acceptance only:	
☐	☐	Working Pressure – Load	
☐	☒	Plunger Gripper	
☐	☒	Valve adjustment needed	
☒	☐	Valve adjustment sealed	
☐	☒	Over-Speed Valve	

Doors

OK	N/A	
☒	☐	Closing force (max 30) TCO
☒	☐	Elec edge/safety edge
☒	☐	Interlocks - gate switches
☒	☐	Guides (gibs)
☐	☒	Retainers TCO
☒	☐	Restrictors TCO

Power-Down Static Test

Time Started:		Time Ended:	
Elapsed Time:	15 minutes		
Change in Car position? Distance:		inches	

Emergency Operations

☒ ☐ Phase I Recall TCO	☒ ☐ Phase II Operation TCO
☒ ☐ Signage – Phase I and II	☒ ☐ Alarm Bell
☒ ☐ 2-way communication TCO	☒ ☐ Emergency Lights
☐ ☐ Standby/E-Power (100% rated load - acceptance only)	

Safety Devices

☒ ☐ Stop Switches: car-pit-cartop-MR-control space	
☒ ☐ Escape hatch contact	☐ ☒ Low-oil pressure switch
☒ ☐ E-limits – terminal stop	☒ ☐ Low-oil protection
☒ ☐ Dir & final limits: up & down	☒ ☐ Re-level during man lowering

Other Items

☒ ☐ Test tags installed	☒ ☐ Keys available TCO
☒ ☐ MCP complete TCO	☒ ☐ Maint. logs updated
☐ ☐ Proper fuses used	☒ ☐ Wire connections tight
☒ ☐ MR-cartop-controller clean	☒ ☐ Jumpers removed

Inspector's Violation Description and/or Mechanic's Test Result Comment	Shut-Down	TCO (60 days)	Correction Date (Inspector only)
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Certifications

By signing below, I certify that all statements are true to the best of my knowledge and that all testing and test witnessing was performed according to current Conveyance Regulations and the appropriate edition of ASME A17.1 Sections 8.6, 8.10 and 8.11.

Mechanic Name:	Allan Gibbs	Contractor Company Name:		TKE	
Mechanic Signature:	Allan Gibbs	Date:	1-16-25	State License #:	11109
Inspector Name:		Inspection Company Name:		NA	
Inspector Signature:		Date:		QEI #:	

West
4095

Elevator and Amusement Ride Division
1313 Farnam, Rm. 233 Omaha, NE 68102 Office: 402-595-3184 Fax:
402-595-1360
SFM.Conveyances@nebraska.gov

Hydraulic Elevator Safety Test and Inspector Witness Report

(Revised 8/24/2018)

General Information

Building Name:	Norfolk Regional Center	Manufacturer:	Kone		State ID #:	4095	
Address:	1700 N. Victory Rd	City:	Norfolk	ZIP:	68701-6859	Building ID #:	
Responsible Party Name:		Phone:			Email:		
Install Date:		Stops: Front 4	Rear 0	Capacity:	4,000 lbs	Job/Contract #:	
Rated Speed:	fpm	Duty:	☒ Passenger ☐ Freight	Freight Class:	☐ A ☐ B ☐ C1 ☐ C2 ☐ C3		
Test Date:	1-16-25	Test Type:	☐ Acceptance & Witness Inspection	☒ Category 1	☐ 5-year Inspection		
Inspector Present?	☐ Yes	☒ No	*If Yes, Inspector Signs Report*				

Testing and Inspection Components

TCO = TCO in lieu of shutdown can be recommended (Category 1 & 5-year tests or inspection; NOT allowed at acceptance)

Relief Valve

OK	N/A		
Working Pressure – No Load 140		Relief Valve Set (≤ 150% of WP) 410	
OK	N/A	Acceptance only:	
☐	☐	Working Pressure – Load	☐ Valve adjustment needed
☐	☒	Plunger Gripper	☐ Valve adjustment sealed
			☐ Over-Speed Valve

Doors

OK	N/A		OK	N/A	
☒	☐	Closing force (max 30) TCO	☒	☐	Guides (gibs)
☒	☐	Elec edge/safety edge	☐	☒	Retainers TCO
☒	☐	Interlocks - gate switches	☐	☒	Restrictors TCO

Power-Down Static Test

Time Started:		Time Ended:	
Elapsed Time:	15 minutes		
Change in Car position? Distance:	0 inches		

Emergency Operations

OK	N/A		OK	N/A	
☒	☐	Phase I Recall TCO	☒	☐	Phase II Operation TCO
☒	☐	Signage – Phase I and II	☒	☐	Alarm Bell
☒	☐	2-way communication TCO	☒	☐	Emergency Lights
☐	☐	Standby/E-Power (100% rated load - acceptance only)			

Safety Devices

OK	N/A		OK	N/A	
☒	☐	Stop Switches: car-pit-cartop-MR-control space			
☐	☒	Escape hatch contact	☒	☐	Low-oil pressure switch
☒	☐	E-limits – terminal stop	☒	☐	Low-oil protection
☒	☐	Dir & final limits: up & down	☒	☐	Re-level during man lowering

Other Items

OK	N/A		OK	N/A	
☒	☐	Test tags installed	☒	☐	Keys available TCO
☒	☐	MCP complete TCO	☐	☐	Maint. logs updated
☐	☐	Proper fuses used	☒	☐	Wire connections tight
☒	☐	MR-cartop-controller clean	☒	☐	Jumpers removed

Inspector's Violation Description and/or Mechanic's Test Result Comment	Shut-Down	TCO (60 days)	Correction Date (Inspector only)
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Certifications

By signing below, I certify that all statements are true to the best of my knowledge and that all testing and test witnessing was performed according to current Conveyance Regulations and the appropriate edition of ASME A17.1 Sections 8.6, 8.10 and 8.11.

Mechanic Name:	Allan Gibb	Contractor Company Name:		TKE	
Mechanic Signature:	Allan Gibb	Date:	1-16-25	State License #:	11109
Inspector Name:		Inspection Company Name:		NA	
Inspector Signature:		Date:		QEI #:	

NRC Environmental Inspection Form

Date: 1/3/25 **Area** OT

Safety/Security	Yes	No	NA	Comments
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.			✓	
Showers/Bathrooms free of mold/mildew.	✓ mc			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	✓			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓ mc			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)			✓	
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			Can't tell if decor. is sprayed/tagged
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓ mc		✓	
Exterior doors are locked and working properly	✓ mc		✓	
Exterior lights are working (Fire Escape lights)		✓	✓	Outside light on the building, just above the garden is not working.

Additional Comments/Concerns: Did not notice any inconsistencies

Staff Signature/Date

Michelle Clark 1/31/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 1/29/2024 **Area** 3 West

Safety/Security	Yes	No	NA	Comments
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.		X		54, 58, 59. dirty clothes everywhere 1/2 hole in wall, right side, N10, grass, my clothes
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				Unit office doorframe torn like Hosp. Nurses office ceiling, wall S. alcove wall, trash wall next to W-8 in Back N hallway, left wall (behind Patt bed)
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date 1/29/25

Unit Supervisor/Team Lead Signature/Date 01-29-25

NRC Environmental Inspection Form

Date: _____ **Area** _____

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				front of building
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				front of building
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

_____

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 1-15-24 **Area** 2E/ SSC

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		North Shaver Paint peeling, Kitchen, laundry room, S-338 S-15
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out		X		RN office light, S-9
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Bathrooms need extra cleanings to stay mold free

1-15-25
Staff Signature/Date

1-15-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: **Area**

Safety/Security	Yes	No	NA	Comments
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.	X			S-10 S-9 S-16 N-7 N-6 N-9 paint chipping
Showers/Bathrooms free of mold/mildew.	X			paint chipping Shower curtain falls off Rail. Sinks drain slow. North shower paint chipping
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			Paint in Kitchen chipping. N-19 paint chipping
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			RN office 3. entrance needs lights. 1 light in tech office
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2 west. **Area** 1-15-25

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			N-1 Paint clipping. N-3 will not finished. W-2 Paint chipping. West hall wall paint chip. Laundry room. Paint chipping. N-14 Paint chipping
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			S-13 light out.
Outlet covers are intact.	X			
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			door sticks main door
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			Main door sticks
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date 1-15-25

Unit Supervisor/Team Lead Signature/Date 1/15/25

NRC Environmental Inspection Form

Date: 1-16-2025 **Area** RT/PDE

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		✓				
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/locked	✓					
Window Integrity checked	✓					
Badge Readers are working properly	✓					
Sensitive areas are maintained secure/No unusual activity	✓					
Code Green Buttons Accessible	✓					
Observation computer is working correctly(Logged in and on correct cameras)	✓					
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.		✓		The PS4s and TVs		
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.	✓		✓	Can't tell about the green things wrapped around the pipes		
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	✓					
Decorations are sprayed and tagged	✓		✓	~~String lights, Green wrapping around pipes not sure~~		
Facility Safety						
Gates are operable and no issues with perimeter fence.	✓					
Exterior doors are locked and working properly	✓					
Exterior lights are working (Fire Escape lights)	✓					
Other issues noted	✓					

Additional Comments:
When you come out of Library and turn left right around the corner there a pipe that there wood by that may be a fire hazzard.

Pool Room heaters leak oil-like Substance

Staff Signature/Date

RT 4/27/25

NRC Environmental Inspection Form

Date: 2-24-25 **Area** 3 East

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		N-6 peeling tiny ~~hole~~ hole by north shower
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out		✓		missing bulb in staff office - twirl bulb multiple ballast bulbs out down S hallway
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			✓	
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

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[signature] RT/MHS 2-24-25
Staff Signature/Date

[signature] 2-24-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: **Area**

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2-20-25 **Area** OT

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		Pt. Services ceiling, large storage room water damage ceiling.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Pt. Services ceiling paint chipping, Large storage room water damage ceiling.

Staff Signature/Date RT 2-20-25

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2/11/25 **Area** 3 West

Safety/Security	Yes	No	NA	Comments
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.	Y			
Showers/Bathrooms free of mold/mildew.				South bathroom sink close to the shower doesn't drain properly
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				North side day hall - paint missing & plaster coming off on door entry. both phone areas missing paint
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out				5-65-9 light out...
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Cleaning room Needs Cleaned..

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2/26/25 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.			X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.		X		Someone forgot Ice is slippery.
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Callie Bessemer 2/26/25
Staff Signature/Date

Michelle Clark AS. 2/26/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2/24/25 **Area** Cafeteria / Dietary

Safety/Security	Yes	No	NA	Comments
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.			✓	
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	✓			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.				Not sure where they are in cafeteria
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.			✓	Give to Drew.
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)			✓	
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged			✓	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.			✓	
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)			✓	
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			✓	
Exterior doors are locked and working properly			✓	
Exterior lights are working (Fire Escape lights)			✓	

Additional Comments/Concerns: nothing out of the ordinary to my knowledge

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2-2-25 **Area** 2East / SSC

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			✓	E-5 paint peeling. E-3 paint peeling, 5-18 Bath with shower paint peeling. Kitchen paint peeling.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out			✓	E-2 light out. Tech office light out. CM office light out.
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

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						
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/locked						
Window Integrity checked						
Badge Readers are working properly						
Sensitive areas are maintained secure/No unusual activity						
Code Green Buttons Accessible						
Observation computer is working correctly(Logged in and on correct cameras)						
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.						
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						
Decorations are sprayed and tagged						
Facility Safety						
Gates are operable and no issues with perimeter fence.						
Exterior doors are locked and working properly						
Exterior lights are working (Fire Escape lights)						
Other issues noted						

Additional Comments:

Staff Signature/Date

NRC Environmental Inspection Form

Date: 3-20-25 **Area** 3 West

Safety/Security	Yes	No	NA	Comments
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.	X			Some patients have bad hygiene practices and don't follow the paper limit standards.
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.		X		
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Josh Deiterman 3/20/25

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 3-25-25 **Area** 3 East

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			✓	North shower paint peeling; South bathroom paint chipping; South shower paint peeling S-11, S-9, N-1 N-3, N-7, N-9, N-14, E-5, E-6
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out			✓	N-14, N-10
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓		✓	Front gate not working.
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

James R PT 3-25-25
Staff Signature/Date

[signature] 3.25.25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 3-26-2025 **Area** 2 West

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		North ~~day~~ Hallway wall
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

N/A

[signature] RT 3-26-2025
Staff Signature/Date

[signature] 3/27/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 3/26/25 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)			X	

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2/31/2025 **Area** PDW/OT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.			X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	5 in office
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?				Doesn't help on W.C. and leaving OT
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.		X		

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	Y			
Magnetic doors are latching correctly	Y			
Electrical Panel in staff office is not blocked	Y			
No objects blocking sprinklers	Y			
Decorations are sprayed and tagged	Y			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	Y			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	Y			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			Sally port works
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Carlos Bassullen 3/31/2025
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 3-26-25 Area Cafeteria

Safety/Security	Yes	No	NA	Comments
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.			✓	
Showers/Bathrooms free of mold/mildew.			✓	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	✓			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.			✓	
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

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_____

_____

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_____

RT 3-26-25
Staff Signature/Date

_____
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 04/01/2025 **Area** Dietary

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.			X	
5 Radios on the unit.				
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly			X	
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.			X	
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				Sally port works
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Carlos Bassullo 4/1/2025
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: **Area**

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

_____

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_____
Staff Signature/Date

_____
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 4-26-2025 **Area** 2E / SSC

Safety/Security	Yes	No	NA	Comments
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.	✓ LB			Room 56 Dirty Laundry, N-9 Pile of Clothes. N8 - pile of Clothes.
Showers/Bathrooms free of mold/mildew.		✓		North Showers have Mildew Ceiling Paint Peeling N showers South Shower is Clean
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		SSC room walls Paint Patches, South hallway Paint Patches, North hallway Paint Patches. Obs area Paint Patches.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			Pillar by Obs table Needs Paint
Area well-lit/no lights out	✓			Corner of wall access from Shower Needs Paint.
Outlet covers are intact.	✓			Corner Top in Laundry room Need Plaster and Paint.
Unit Restraints accounted for.	✓			N bathroom toilets need re-caulked
All employees are wearing ID badge in plain sight.	✓			Paint needed around door trim in Kitchen.
5 Radios on the unit.	✓	✓ LB		4 in office, 1 in med office
All doors secured/locked	✓			Corner Piles are gray, need Paint
Windows are not tampered with, not functioning, or damaged?	✓			Plaster Flaking off near freezer in Kitchen
Badge Readers working properly?	✓			South Terrace area needs Plaster and Paint.
Code Green Buttons Accessible	✓			need Paint around doorway E-6
Observation computer is working correctly (Logged in and on correct cameras)	✓			Tiles Sagging inside SSC
Fire Safety				
No "daisy-chaining" of electrical items.	✓			Panels Kicked in hallway SSC
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.		✓		Staff Sticky hung from Ceiling

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns: Paint touch up.

Landon Beaver RT 04-26-2025

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 4-23-25 **Area** 3 South

Safety/Security	Yes	No	NA	Comments
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.			✓	~~RN Office~~ S-8 ~~S-11~~ 11-3
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			✓	RN office, ~~S-2~~ Small Storage, S-2, S-5, S-7, N-3 Nurses Station, North Hallway, South Alcove, N-1 S-13, S-16, S-11, Kitchen, N-2, N-4, N-6, N-10
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out			✓	RN office, S-6
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

South asphalt ceiling tile broken. Hand sanitizer in north asphalt broken. Corner protector coming off North hallway.

Staff Signature/Date

04/28/25

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 4-23-25 **Area** 2 West

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			✓	[illegible]
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out			✓	[illegible]
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

[signature] 4-23-25
Staff Signature/Date

[signature] 4/23/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 4-23-25 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.			X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			* Lighting Dim in the POE area
Outlet covers are intact.	X			
Unit Restraints accounted for.			X	[illegible]
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	We have Radios.
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			* Workspace exit Door don't Beep.
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.		X		
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			Microphone cord

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)			X	
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.		X		gate broken
Exterior doors are locked and working properly		X		
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

pts report sharp pieces on corner of pool table specifically first on to the right,

- Check hardhead cover on the top South west corner.
- Non-slip head (Fire door leading into the Kids Room.

Josh Peters 4-23-25
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 4-25-25 **Area** 1st floor exterior

Safety/Security	Yes	No	NA	Comments
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.			✓	
Showers/Bathrooms free of mold/mildew.			✓	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		mildew around windows
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)			✓	
Area well-lit/no lights out	✓			
Outlet covers are intact.			✓	
Unit Restraints accounted for.			✓	
All employees are wearing ID badge in plain sight.			✓	
5 Radios on the unit.			✓	
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)			✓	
Fire Safety				
No "daisy-chaining" of electrical items.			✓	
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.			✓	

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged			✓	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.			✓	
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)			✓	
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.		✓		Front gate is still down, Sally Port is Good
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Zachary Cochner/BZ
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: _____ **Area**

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 5-4-25 **Area** 2 West

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		Paint chipping N. Hallway
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.		✓		Front gate still broke
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Water slow to drain in unit bathroom, hot water always dripping.

RT
Staff Signature/Date

5/14/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 9 MAY 2022 **Area** 3 WEST

Safety/Security	Yes	No	NA	Comments
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.				CEILING TILE AROUND DESK TABLE HAS HOLE IN IT.
Showers/Bathrooms free of mold/mildew.		X		SHOWER MISSING BELL HANG BY SOUTH WALL CLOSET DOOR.
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		NEED ANY OF PAINT SOUTH WEST BY SOUTH PHONE
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			SMALL HOLE UNDER TABLE OF SOUTH PHONE.
Area well-lit/no lights out	X			FLOOR TRIM MISSING BY CHAPLAINS EXIT DOOR ON SOUTH HALLWAY
Outlet covers are intact.	X			DOOR STOP BROKEN BY 5-H DOOR STOP REMOVED BY 5-10
Unit Restraints accounted for.	X			CEILING TILE BY 5-5 ON SOUTH DAYROOM BY LIGHT HAS A HOLE
All employees are wearing ID badge in plain sight.	X			SCRATCH WINDOWS ON SOUTH DAYROOM AND RUBBER SEAL FOR 1 DOOR
5 Radios on the unit.	X			CHARGER UNDER TABLE BY TV IN SOUTH DAYROOM FLOOR DAMAGE
All doors secured/locked	X			PORTABLE CONSULT ABOVE SINK IN SOUTH BATHROOM
Windows are not tampered with, not functioning, or damaged?		X		CLOSET LATCH ON SMALL DOOR IN SOUTH DAYROOM IS MISSING
Badge Readers working properly?	X			CHARGER IN SOUTH DAYROOM NOT FUNCTIONING
Code Green Buttons Accessible	X			HAND RAIL BY DOOR MISSING SCREWS
Observation computer is working correctly (Logged in and on correct cameras)	X			FAN LIGHT IN SMOKING LIGHT COVER IN THE BATHROOM
Fire Safety				
No "daisy-chaining" of electrical items.	X			SMALL SCRATCH AND DENT ON DOOR NEAR DOOR LOCK FRONT
Corridors and exits are clear and unobstructed.	X			WATER DAMAGE AND PAINT ON WALL BY 5-6
Exit signs functioning and pointed in correct direction.	X			NORTH WALL UNDER WINDOW MISSING PLASTER AND PAINT
No items are hung from ceiling or in hallways.	X			PAINT AND PLASTER OUT BY DOOR BY 5-4

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			BROKEN SANITIZER BY CEO DESK. CRACKED/BROKEN TILE IN SHOWER ENTRY ON NORTH SHOWER. MOLD IN TILES ON MIDDLE NORTH SHOWER.
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			PAINT PEELING AROUND DOOR ON INSIDE DOOR OF NORTH SHOWER.
No objects blocking sprinklers	X			HANDLE MISSING ON BACK OF THE NORTH SHOWERS.
Decorations are sprayed and tagged			X	PAINT MISSING ON BACK TILE OF TOILET IN NORTH BATHROOM.
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			VENTS IN SHOWER/BATHROOM - NEED CLEANING.
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			PAINT PEELING BY SINK DISPENSER IN NORTH BATHROOM.
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	DOOR FRAME AROUND INSIDE OF KITCHEN DOOR STARTING AND PAINT. MISSING 2 CUPBOARD DOOR IN KITCHEN
Exterior doors are locked and working properly	X			PLASTER FLAKING OFF BY WINDOW IN KITCHEN
Exterior lights are working (Fire Escape lights)	X			BROKEN TILES IN KITCHEN, BY THE DOOR.

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date 05/09/25

NRC Environmental Inspection Form

Date: 9-5-25 **Area** OT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		Storage room ceiling falling Wood room chipping/ceiling paint
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?		X		Entry door has no beep
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)		X		
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.		X		Blankets on [illegible]

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			✓	
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

[redacted]

[redacted]

Staff Signature/Date

[redacted]

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 5/6/25 **Area** 2 East

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			X	water damage N bathroom ceiling water damage laundry room ceiling paint peeling 3 alcove, paint peeling E2E4
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				N-7 light out S-5 light out S-9 light out
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

5-6-25
Staff Signature/Date

5-6-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 5-6-25 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)			X	Pool Room. Kitchen. Paint peeling.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓		X	Vending room in RT light out.
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
S Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:
AC's need cleaned.

JBPA 5-6-25
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 5-6-25 **Area** Kitchen

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.			X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 6/23/25 **Area** 3E

Safety/Security	Yes	No	NA	Comments
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.				N4, 52, 512, 516, 57
Showers/Bathrooms free of mold/mildew.		X		North shower ceiling paint peeling/water damage
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		obs area wall paint peeling
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out				nurses office 1 bulb out, supply closet light
Outlet covers are intact.		X		south alcove outlet cover lose, North bathroom west outlet cover lose
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Cathe Matthews RN 6.25.25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: [illegible] **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			X	HALL WAY IN ENTRANCE NEED TOUCH UP PAINT.
Showers/Bathrooms free of mold/mildew.	X			PATIENT BATHROOM AROUND DOOR FRAME NEEDS PAINT.
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			FLOOR TRIM MISSING ON SIDE OF DOUBLE DOORS BY DOOR FRAME.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			CORNER CEILING BY INNER KITCHEN DOOR BY WINDOW PEELING PAINT.
Area well-lit/no lights out	X			SMALL HOLE IN WALL ABOVE FIRE PANEL.
Outlet covers are intact.	X			SMALL HOLE IN WALL BELOW DART BOARD.
Unit Restraints accounted for.			X	SEVERAL SMALL HOLES IN WALL BY A/C UNIT OUTSIDE LIBRARY DOOR.
All employees are wearing ID badge in plain sight.	X			HOLE BY [illegible]
5 Radios on the unit.			X	[illegible]
All doors secured/locked	X			[illegible]
Windows are not tampered with, not functioning, or damaged?	X			[illegible]
Badge Readers working properly?	X			[illegible]
Code Green Buttons Accessible	X			[illegible]
Observation computer is working correctly (Logged in and on correct cameras)	X			[illegible]
Fire Safety				
No "daisy-chaining" of electrical items.	X			LARGE HOLE ABOVE FIRE ALARM PULL
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	Y			
Magnetic doors are latching correctly	Y			
Electrical Panel in staff office is not blocked	Y			
No objects blocking sprinklers	Y			
Decorations are sprayed and tagged			Y	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	Y			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	Y			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			Y	
Exterior doors are locked and working properly	Y			
Exterior lights are working (Fire Escape lights)			Y	

Additional Comments/Concerns:

RT 2E

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 6/20/25 **Area** 2 West

Safety/Security	Yes	No	NA	Comments
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.	✓	✓		N11, N13, N12, N6, N2, S4, S8, S15, S1 need paint
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		Staff office, N hallway, S hallway, Laundry Room Ceiling + Walls
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged				Don't see tags, unsure if sprayed. Some don't seem safe to me. —TB
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Colton Bossuyt 06/20/2025
Staff Signature/Date

T Bussey
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: _____ **Area** _____

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				Touch up paint done
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out		X		
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Expect request to touch up paint around doorframes

L. L. Patterson BF 6-4-2025
Staff Signature/Date

Diane Charles 6-4-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 6-25-2025 **Area** 2East / SSC

Safety/Security	Yes	No	NA	Comments
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.		✓		Paint chipping on multiple rooms
Showers/Bathrooms free of mold/mildew.		✓		N Bathroom paint is bad, wall is flaking
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		paint peeling both bathroom, multiple rooms and some in hallways
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?		✓		Room E4 door window has scratches
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

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AT - 6-28-2025
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 6-26-26 **Area** OT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		Storage room needs new paint
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	according to staff, still all accounted for
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?		X		badge reader to leave area still doesn't give audible beep
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	observed from the MCC
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

James Beaver 6-26-26

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 6-26-26 **Area** First Floor/Outside Exterior

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		Sleep rooms and rooms maintenance
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.			X	Completed when no 1st floor staff in offices
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	observed from the MCC
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Christoper Tracy 6-26-26

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 7/31/2025 **Area** 2 East ISSC

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Cathie Ramelow 7/31/25

Staff Signature/Date

7-31-25

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 7-22-2025 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			✓	
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	✓			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.			✓	
All employees are wearing ID badge in plain sight.			✓	
5 Radios on the unit.	✓		✓	
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?		✓		
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.		✓	✓	
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)			✓	
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			✓	
Exterior doors are locked and working properly			✓	
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 13 July 2025 **Area** O.T.

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X mc		X	Handcuffs are in Main Bathroom Inside white Metal Cabinet mc
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			Kiln Door ? mc
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Michelle Clark A.S. 7/22/25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 7-13-2029 **Area** 3-East

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		Unit office by Code green button, by South alcove, across from kitchen, outside office door, multiple pt. rooms
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out		✓		North Dayhall, one dim bulb
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

Staff Signature/Date

7.13.25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 7-31-25 **Area** Dietary

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

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7-31-25

Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 7-31-25 **Area** 1st Flr / Exterior

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X		X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		[illegible] outside H1M - Green (Gen. Rec.) [illegible]
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out		X		Check H1 has lights [illegible]
Outlet covers are intact.	X			
Unit Restraints accounted for.			X	
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			master control monitors struggle and turn off from time to time.
Fire Safety				
No "daisy-chaining" of electrical items.		X	X	
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.			X	

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Normal Building Issues

Kris B [signature] RT/MHS 7-31-25

Staff Signature/Date

Kris Boe Simmons

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: _____ **Area** _____

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 08/29/2025 **Area** 3 West

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				W6- hole in wall by door.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out				W1 has light going out. Lights stay on when turned off
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns: Refer to Andrew ~~English~~ Engle report.

Carla Rosario 08/29/2025
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

08/29/2025

NRC Environmental Inspection Form

Date ~~08/29/25~~ **Area** 2 East / SSC

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			South Alcove walls chipped by office. South AC area staining.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date 08/29/2025

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 08/29/2025 **Area** 3 East

Safety/Security	Yes	No	NA	Comments
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.	X			
Showers/Bathrooms free of mold/mildew.		X		N. Shower, 1st one in to left, corners look moldy. N bathroom, under sinks, sediment build up. S. both good.
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out		X		1 light in office
Outlet covers are intact.	X			
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X		X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged			X	
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 8-30-25 **Area** 1st floor

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	✓			
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out		✓		Front building light flickering. South hall way East side light out.
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

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James Beaver PT 8-30-25

Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: **Area**

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: **Area**

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

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Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 2-5-25 **Area** West NRC

Safety/Security	Yes	No	NA	Comments
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.		X		Rm [illegible] multiple pts with excess linens in room
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		Hole in wall still chipped paint throughout unit
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

8-5-25
Staff Signature/Date

8-5-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 30 Aug 2025 **Area** RT

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X		X	
Are walls in good condition? (i.e., no peeling paint, holes, or patches)	X			Hole under dart board
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.	X			
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.			X	
5 Radios on the unit.			X	
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)			X	
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	X			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.			X	
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

30 Aug 2025
Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 19 Sept 25 **Area** PDW

Safety/Security	Yes	No	NA	Comments
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.			X	
Showers/Bathrooms free of mold/mildew.	X			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		ceiling in pottery room peeling paint
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	X			
Area well-lit/no lights out	X			
Outlet covers are intact.		X		Outlet in office coming off wall
Unit Restraints accounted for.	X			
All employees are wearing ID badge in plain sight.	X			
5 Radios on the unit.	X			
All doors secured/locked	X			
Windows are not tampered with, not functioning, or damaged?	X			
Badge Readers working properly?	X			
Code Green Buttons Accessible	X			
Observation computer is working correctly (Logged in and on correct cameras)	X			
Fire Safety				
No "daisy-chaining" of electrical items.	X			
Corridors and exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
No items are hung from ceiling or in hallways.	X			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	X			
Magnetic doors are latching correctly	X			
Electrical Panel in staff office is not blocked	X			
No objects blocking sprinklers	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	X			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	~~X~~	X		bottle label "what is this?"
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	X			
Exterior doors are locked and working properly	X			
Exterior lights are working (Fire Escape lights)	X			

Additional Comments/Concerns:

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form-PHARMACY

Date: 9.16.25 Area Pharmacy

Safety/Security	Yes	No	NA	Comments
Are rooms free of clutter, debris, and excess linens? (i.e., no boxes on floor, papers not piled on desks).		X		Tony's office Air vent in Expired med room
Medications not outside of packaging on counters	X			New cabinet meds/vials
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		X		paint peeling in expired med room
Area well-lit/no lights out. Outlet Covers intact.	X			
Medications are not expired. Medications being disposed of properly.	X			All pharm from license pharm rem - New Expired on counter Lodge
Refrigerator working? No food in the medication refrigerators.	X			Moved to new fridge Sensor wire on order
All doors secured/locked. No access to individuals that do not work in Pharmacy.	X			
Fire Safety				
No "daisy-chaining" of electrical items.	~~X~~		X	Power pole near desk?
Walk Path to exits are clear and unobstructed.	X			
Exit signs functioning and pointed in correct direction.	X			
Fire extinguisher pin in place. No objects blocking sprinklers.	X			
Decorations are sprayed and tagged	X			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
Gloves are available.	X			
Chemical containers and medications have appropriate labeling. (i.e., no labels faded or missing)	X			

Additional Comments/Concerns:

9.16.25

Staff Signature/Date

Pharmacy Staff/Date

NRC Environmental Inspection Form

Date: _____ **Area** _____

Safety/Security	Yes	No	NA	Comments
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.				
Showers/Bathrooms free of mold/mildew.				
Are walls in good condition? (i.e., no peeling paint, holes, or patches)				
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)				
Area well-lit/no lights out				
Outlet covers are intact.				
Unit Restraints accounted for.				
All employees are wearing ID badge in plain sight.				
5 Radios on the unit.				
All doors secured/locked				
Windows are not tampered with, not functioning, or damaged?				
Badge Readers working properly?				
Code Green Buttons Accessible				
Observation computer is working correctly (Logged in and on correct cameras)				
Fire Safety				
No "daisy-chaining" of electrical items.				
Corridors and exits are clear and unobstructed.				
Exit signs functioning and pointed in correct direction.				
No items are hung from ceiling or in hallways.				

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place				
Magnetic doors are latching correctly				
Electrical Panel in staff office is not blocked				
No objects blocking sprinklers				
Decorations are sprayed and tagged				
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.				
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)				
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.				
Exterior doors are locked and working properly				
Exterior lights are working (Fire Escape lights)				

Additional Comments/Concerns:

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Staff Signature/Date

_____

Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 9-3-2025 **Area** 2East/SSC

Safety/Security	Yes	No	NA	Comments
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.	✓			
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		A few places see Back
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out		✓		Possible 5-9 / 5-9 needs a light
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

E3 Toilet Needs stainless steel cleaner, E5 outside Rm light fixture needs cleaning Brown chipping paint on fire door window, E6 Bathroom still incomplete, E6 Back Room Needs finished painting Some faint water spots in SSC Hallway No phone Book in SSC, missing Baseboard in S13, S9 looks like just 1 light N shower ceiling paint needs touchup/peeling

9-3-25
Staff Signature/Date

9-9-25
Unit Supervisor/Team Lead Signature/Date

NRC Environmental Inspection Form

Date: 9-10-25 **Area** 2west

Safety/Security	Yes	No	NA	Comments
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.		✓		N-11, N-5
Showers/Bathrooms free of mold/mildew.	✓			
Are walls in good condition? (i.e., no peeling paint, holes, or patches)		✓		Laundry Room Paint peeling; S-7, S-11, S-13, S-15, S-16, S-14, S-12, S-10, S-8, S-4, N-1, N-2, N-4, N-6, N-10, N-12, N-11, N-9, W-1, W-2, Unit office bathroom.
Is furniture arranged so area is free from tripping and falling and in good working condition? (No loose screws, torn, etc.)	✓			
Area well-lit/no lights out	✓			
Outlet covers are intact.	✓			
Unit Restraints accounted for.	✓			
All employees are wearing ID badge in plain sight.	✓			
5 Radios on the unit.	✓			
All doors secured/locked	✓			
Windows are not tampered with, not functioning, or damaged?	✓			
Badge Readers working properly?	✓			
Code Green Buttons Accessible	✓			
Observation computer is working correctly (Logged in and on correct cameras)	✓			
Fire Safety				
No "daisy-chaining" of electrical items.	✓			
Corridors and exits are clear and unobstructed.	✓			
Exit signs functioning and pointed in correct direction.	✓			
No items are hung from ceiling or in hallways.	✓			

NRC Environmental Inspection Form

Fire Safety	Yes	No	NA	Comments
Fire extinguisher pin in place	✓			
Magnetic doors are latching correctly	✓			
Electrical Panel in staff office is not blocked	✓			
No objects blocking sprinklers	✓			
Decorations are sprayed and tagged	✓			
Hazardous Mat.	**Yes**	**No**	**NA**	**Comments**
EVS utility rooms locked.	✓			
Chemical containers have appropriate labeling. (i.e., no labels faded or missing)	✓			
Facility Safety	**Yes**	**No**	**NA**	**Comments**
Gates are operable and no issues with perimeter fence.	✓			
Exterior doors are locked and working properly	✓			
Exterior lights are working (Fire Escape lights)	✓			

Additional Comments/Concerns:

S-4 window curtain broken.

Staff Signature/Date

Unit Supervisor/Team Lead Signature/Date

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 2W

Date: 8.8.25

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)		
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)		
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)		
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)		
5	All employees are wearing ID badge in plain sight and carrying radios.		
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)		
7	Confidential papers are secure and protected.		
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.		
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.		
10.	Units are free of excess staples?		
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)		
12.	Windows are not tampered with, not functioning, or damaged?		

Section Score: ___ / 12 **Percentage:** ___ %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms		
2	Refrigerator logs maintained and up to date (refrigerator temps are stored on the S drive, temperature folder.		
3	Food is not present in medication refrigerator other then what is used in giving medication.		

Section Score: 3 / 3 **Percentage:** ___ %

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

7	Is fire/smoke doors free of being propped/held wedged open?		
8	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.		
9	Means of egress are free of furniture, laundry carts, etc. Halls must have 8' clearance and no items can be hanging from ceiling.		
	Section Score: /9	**Percentage:** _____ %	

Hazardous Material Waste and Communication		**Score**	**Comment**
1	Chemicals stored in appropriate cabinets (i.e. metal)		
2	EVS closet is locked when not in use.		
3	Chemical containers have appropriate labeling. (i.e. no labels faded or missing)		
4	Product labels are not altered or defaced.		
5	Personal Protective Equipment is readily available (i.e. gloves)		
	Section Score: / 5	**Percentage:** _____ %	

Emergency Management/Utility Systems		**Score**	
1	Flash lights work---extra batteries available		
2	Two way radios charged and working properly?		
3	Weather radio plugged in and alerts when activated?		
4	Code Green buttons easily accessible and not blocked.		
5	Emergency blankets easily accessible.		
6	Red Emergency Management Manual is readily available and up to date?		
7	Panel box is not block and is locked?		
8	Toilets, faucets and drains working properly? No apparent leaks.		
	Section Score: / 8	**Percentage:** _____ %	

Medical Equipment Management Plan		**Score**	
1	Medical Equipment have any frayed cords?		
2	Sharps container no more than ¾ full?		
3	Medication room is secure when not in use?		
4	Code Green buttons easily accessible and not blocked.		
5	No open medication containers lying on top of medication cart.		
	Section Score: / 5	**Percentage:** _____ %	

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 3W

Date: 8.6.25

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached WRS
2	Are ceiling tiles in place and in good condition? (i.e. no water stains, dirt or mold)	1	
3	Is furniture arranged so area is free from tripping and falling and in good working condition? (no loose screws, torn, etc.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	0	8-5.
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 logs 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	

7	Is fire/smoke doors free of being propped/held wedged open?	1	
8	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
9	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: 9 /9 **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 %

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: 25

Date: 7-15-25

Surveyors Signatures: [signature] [signature]

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached 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.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 11 / 12 **Percentage:** 92 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator logs 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	

7	Is fire/smoke doors free of being propped/held wedged open?	1	
8	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
9	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: 9 /9	**Percentage:** _____ %	

	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 %	

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant 1 = Compliant

Area: 3E

Date: 7.8.25

Surveyors Signatures:

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

Section Score: 10 / 12 **Percentage:** 83 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator logs 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	

7	Is fire/smoke doors free of being propped/held wedged open?	1	
8	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
9	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: 9 /9 **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?		
2	Sharps container no more than ¾ full?		
3	Medication room is secure when not in use?		
4	Code Green buttons easily accessible and not blocked.		
5	No open medication containers lying on top of medication cart.		

Section Score: 5 /5 **Percentage:** 100 %

Norfolk Regional Center

Bi-Annual Environmental Tour Inspection Form

Scoring
0 = Non-Compliant
1 = Compliant

Area: IW

Date: 5.27.25

Surveyors Signatures:

	Safety/Security Management	Score	Comments
1	Are walls in good condition? (i.e. no peeling paint, holes or patches)	0	See attached 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.)	1	
4	Storage areas are clean and used appropriately? (i.e. free of clutter, no boxes stored on floor, shelving secure)	1	
5	All employees are wearing ID badge in plain sight and carrying radios.	1	
6	Secure areas are locked and/or access controlled when not in use. (i.e. utility rooms, offices, class rooms, etc)	1	
7	Confidential papers are secure and protected.	1	
8	Are patient rooms free of clutter, debris and excess linens? (i.e. no boxes on floor, clothes not piled in corner) List room # if non-compliant.	1	
9.	Patients have bed and dresser for personal possessions? Mattress on floor is alright.	1	
10.	Units are free of excess staples?	1	
11.	Are staff members belongings secured? (no purse or bags, in office area, if found note location and unit)	1	
12.	Windows are not tampered with, not functioning, or damaged?	1	

Section Score: 11 / 12 **Percentage:** 92 %

	Infection Control	Score	Comment
1	Gloves are readily available in utility rooms	1	
2	Refrigerator logs 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	

7	Is fire/smoke doors free of being propped/held wedged open?	1	
8	Sprinkler heads are clear of lint/debris and have 18" clearance especially in storage areas.	1	
9	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: 9 /9 **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 %

1 West Assessment

Hunter Lewis, Drew English, Diana Mastny, Tyler Stender, Corey Banks

Items blocking egress in hallway. Table, Trash Cart. Question asked if we cant have items hanging for decoration, why can we have observation tables, carts, etc blocking fire egress paths.

1 West has blinds in the day hall that have drawstring. Should this be removed and replaced with similar style on other units.

Hanging hooks that have metal in the day hall. 1 West TL Stender was asked to remove the hooks.

Light Fixtures have glass globes, should these be replaced with plastic. Two light fixtures block camera views a little bit, should the cameras be moved or covers replaced.

Old heater covers are on the unit, should they be replaced with the safety heater covers similar to 2 East.

Vent Covers be removed from bathroom. Currently there are two covers for the vents, makes it hard to clean, but also a way to hang yourself from the vent in shower.

Breakroom door handle could be used to hang ones self. Is this the only option that we can use for staff breakrooms?

Soap dispensers are still affixed with screws, should be Velcro to prevent hanging, believe this was asked to be changed before.

Squeegee left in south shower, staff should have that in an area that is not accessible by patients.

The shelf in south bathroom shower was to be removed, still in area. (nothing of note being held in locked shelf)

Handrails are not solid in hallways, not ligature proof.

Does the fire exit need door closures? If not can they be removed for ligature reasons.

Glass Windows in S-16,S-15,S13, N-2,N-13, N-9, N-7

Solid brackets have area that can be used for ligature in bathroom sinks.

Baseboards need fixed on unit, either replaced or removed.

Does the hospital bed need the footboard, it is easy to remove and can be used as a weapon.

Door handles on S1 and S3 are unique, is that for patient's ability to use hands to open/close door?

Outlets have small gap in N shower. Outlets in South bathroom could be tightened.

Glass mirrors in bathrooms.

Privacy stalls could all be tightened around toilets. Years of being slammed and shut.

Pipes exposed in whirlpool. Does Whirlpool room need a camera?

Exposed piping by fire exit west hall.

Exposed wiring in Utility Closet

Book shelf has metal piece that needs removed.

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
What does a failing star logo mean?	There is a patient that is at high risk for falls.	✓	✓	✓	✓				
What ways can you call for extra help on the unit in case of an emergency?	Call over radio, press code green button, Page Press 1 then announce	✓	✓	✓	✓			✓	
What is a Code Yellow? Where do you get the checklist?	Bomb Threat, NRC Phone Directory	✓	✓		✓			✓	
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.	✓	✓	✓	✓				
Where is the emergency kit? and med sled located?	Medication room, Storage Room	✓	✓	✓	✓				
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 are the Crash Carts located?	Room 220 and 1 West		✓	✓	✓	✓			
Where is your red emergency manual located? Where is the SDS Located?	Should be in the nursing office/easily accessible. S Drive	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3336, 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 QA department and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A ____ (B)

= ____ (C)

X ____ number of employees questioned (D)

Subtotal = ____ (E)

Subtract total number of NO answers - ____ (F)

= ____ (G)

Divide (G) by (E) X 100 ____ %

2E

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
What does a failing star logo mean?	There is a patient that is at high risk for falls.	✓	✓	✓	✓				
What ways can you call for extra help on the unit in case of an emergency?	Call over radio, press code green button, Page Press 1 then announce	✓	✓	✓	✓				X
What is a Code Yellow? Where do you get the checklist?	Bomb Threat, NRC Phone Directory	✓	✓	✓	✓				
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.	✓	✓	✓	✓				
Where is the emergency kit? and med sled located?	Medication room, Storage Room	✓	✓	✓	✓				
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 are the Crash Carts located?	Room 220 and 1 West	✓	✓	✓	✓	X			
Where is your red emergency manual located? Where is the SDS Located?	Should be in the nursing office/easily accessible. S Drive	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3336, 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 QA department and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A ____ (B)

= ____ (C)

X ____ number of employees questioned (D)

Subtotal = ____ (E)

Subtract total number of NO answers - ____ (F)

= ____ (G)

Divide (G) by (E) X 100 ____ %

3E

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible								
What does a failing star logo mean?	There is a patient that is at high risk for falls.								
What ways can you call for extra help on the unit in case of an emergency?	Call over radio, press code green button, Page Press 1 then announce								
What is a Code Yellow? Where do you get the checklist?	Bomb Threat, NRC Phone Directory								
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.								
Where is the emergency kit? and med sled located?	Medication room, Storage Room								
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 are the Crash Carts located?	Room 220 and 1 West								
Where is your red emergency manual located? Where is the SDS Located?	Should be in the nursing office/easily accessible. S Drive								
Who is called if part or all of the Utility Systems failed?	Call 3336, 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 QA department and Maintenance Supervisor								

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A _____ (B)

= _____ (C)

X _____ number of employees questioned (D)

Subtotal = _____ (E)

Subtract total number of NO answers - _____ (F)

= _____ (G)

Divide (G) by (E) X 100 _____ %

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
What does a failing star logo mean?	There is a patient that is at high risk for falls.	✓	✓	✓	✓				
What ways can you call for extra help on the unit in case of an emergency?	Call over radio, press code green button, Page Press 1 then announce	✓	✓	✓	✓				
What is a Code Yellow? Where do you get the checklist?	Bomb Threat, NRC Phone Directory	✓	✓	✓	✓				
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.	✓	✓	✓	✓				
Where is the emergency kit? and med sled located?	Medication room, Storage Room	✓	✓	✓	✓				
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 are the Crash Carts located?	Room 220 and 1 West	✓	✓	✓	✓				
Where is your red emergency manual located? Where is the SDS Located?	Should be in the nursing office/easily accessible. S Drive	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3336, 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 QA department and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A ____0____ (B)

= ____14____ (C)

X ____4____ number of employees questioned (D)

Subtotal = ____56____ (E)

Subtract total number of NO answers - ____0____ (F)

= ____56____ (G)

Divide (G) by (E) X 100 ____100____ %

CRITERIA	RESPONSE	YES				NO			
Whose responsibility is it to ensure and promote safety in their work area?	ALL staff are responsible	✓	✓	✓	✓				
What does a failing star logo mean?	There is a patient that is at high risk for falls.	✓	✓	✓	✓				
What ways can you call for extra help on the unit in case of an emergency?	Call over radio, press code green button, Page Press 1 then announce	✓	✓	✓	✓				
What is a Code Yellow? Where do you get the checklist?	Bomb Threat, NRC Phone Directory	✓	✓	✓	✓				
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.	✓	✓	✓	✓				
Where is the emergency kit? and med sled located?	Medication room, Storage Room	✓	✓	✓	✓				
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 are the Crash Carts located?	Room 220 and 1 West	✓	✓	✓	✓				
Where is your red emergency manual located? Where is the SDS Located?	Should be in the nursing office/easily accessible. S Drive	✓	✓	✓	✓				
Who is called if part or all of the Utility Systems failed?	Call 3336, 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 QA department and Maintenance Supervisor	✓	✓	✓	✓				

TOTAL NUMBER OF QUESTIONS 14 (A)

MINUS N/A ___8___ (B)

= ___14___ (C)

X ___4___ number of employees questioned (D)

Subtotal = ___56___ (E)

Subtract total number of NO answers - ___6___ (F)

= ___56___ (G)

Divide (G) by (E) X 100 ___100___ %

(a)

Program Description

1. **Name/Identification of each Unit with brief description of the unit to include type of population served in the unit.**
2. **Total bed capacity per unit.**
3. **Population per unit as of 10/31/2025**

The Beatrice State Developmental Center is divided into two separate Intermediate Care Facilities (ICFs) and has 14 dedicated homes.

Solar Cottages ICF (long term care): BSDC is a 24-hour state and federally funded residential treatment facility dedicated to the provision of specialized psychological, medical and developmental supports to people with intellectual and developmental disabilities. Solar Cottages consists of 10 homes within the ICF: 753 Solar, 743 Solar, 723 Solar, 715 Solar, 3052 Peterson, 3054 Peterson, 3056 Peterson, 3060 Peterson, 3070 State and 3071 State.

*753 Solar - census 7

*743 Solar - census 7

*723 Solar - census 8

*715 Solar - census 9

*3052 Peterson - census 7

*3054 Peterson - census 8

*3056 Peterson - census 9

*3060 Peterson - census 6

*3070 State – census 5

*3071 State – census 0

400 State Building ICF (short term care): BSDC Crisis Stabilization and Community Reintegration program homes has a total bed capacity up to 12 admissions. They provide behavioral, psychiatric, and medical interventions for individuals with intellectual disabilities who are experiencing significant difficulties in their community placements. Through targeted lengths of stay from 30 to 180 days, the goal of the BSDC Crisis Stabilization program is to provide temporary stabilization leading to community reintegration with faded supports. 400 State Building ICF consists of 4 separate apartments (402, 404, 406, and 408 State).

*402 State - census 1

*404 State - census 1

*406 State - census 3

*408 State - census 2

(a)

Physical Review

PERIOD		SQ FT	FLAT RATE	Monthly Rate	Per Sq Ft Rate
7/1/2013 - 6/30/2015	Base Rent	516,419	2,449,374.94	204,114.58	4.74
	Renewal Assmt Fee	516,419	1,029,216.18	85,768.02	1.99

PERIOD		SQ FT	FLAT RATE	Monthly Rate	Per Sq Ft Rate
7/1/2017 - 6/30/2019	Base Rent	553,037	2,145,783.56	178,815.30	3.88
	Renewal Assmt Fee	553,037	1,034,179.19	86,181.60	1.87

PERIOD		SQ FT	FLAT RATE	Monthly Rate	Per Sq Ft Rate
7/1/2019 - 6/30/2021	Base Rent	553,037	3,362,468.00	280,205.67	6.08
	Renewal Assmt Fee	553,037	1,000,997.00	83,416.42	1.81

PERIOD		SQ FT	ANNUAL RENT	Monthly Rate	Per Sq Ft Rate
7/1/2021 - 6/30/2023	Base Rent	553,037	2,961,100.00	246,758.33	5.35
	Renewal Assmt Fee	553,037	724,478.00	60,373.17	1.31

Breakdown per AGREEMENT 14 - ADDENDUM 4

PERIOD		SQ FT	ANNUAL RENT	Monthly Rate	Per Sq Ft Rate
7/1/23-6/30/25	Base Rent	551,585	3,248,835.65	270,736.30	5.89
	Renewal Assmt Fe	551,585	678,449.55	56,537.46	1.23
TOTAL		551,585	3,927,285.20	327,273.77	

Asset #	Tag #	Description	Site	Site Name	Gross Area	
28412	25B0145600B	T BUILDING #11	557742	AS - BUILDING DIV - BEATRICE D	12,276	VBEL-complete, demolished
		B - BLDG	557742	AS - BUILDING DIV - BEATRICE D	17,710	VBEL-complete, demolished
		C - BLDG	557742	AS - BUILDING DIV - BEATRICE D	17,784	VBEL-complete, demolished
189523	25B049100B	GREENHOUSE	557742	AS - BUILDING DIV - BEATRICE D	5,798	VBEL-complete, demolished
				BSDC should not be charged for rent of VBEL'd Buildings	**VBEL**	**53,568**
				USED BY BUILDING DIVISION		
		GROUNDS BUILDING	557742	AS - BUILDING DIV - BEATRICE D	4,613	
28416	25B0145900B	BUILDING 14-A (barn)	557742	AS - BUILDING DIV - BEATRICE D	7,608	
28417	25B0146000B	BUILDING 14-B (barn)	557742	AS - BUILDING DIV - BEATRICE D	4,896	
28418	25B0146100B	BUILDING 14-G (grounds office)	557742	AS - BUILDING DIV - BEATRICE D	2,440	
28419	25B0146200B	BUILDING 14-H	557742	AS - BUILDING DIV - BEATRICE D	4,130	
28434	25B0147800B	HEATING POWER PLANT #25	557742	AS - BUILDING DIV - BEATRICE D	10,259	
28446	25B0148900B	HAY SHED 14-C	557742	AS - BUILDING DIV - BEATRICE D	2,880	
28447	25B0149000B	DOZER GARAGE 14-D	557742	AS - BUILDING DIV - BEATRICE D	355	
28449	25B0149200B	MAINTENANCE STORAGE 14-F	557742	AS - BUILDING DIV - BEATRICE D	1,576	
28450	25B0149300B	CAVE 14-J	557742	AS - BUILDING DIV - BEATRICE D	2,710	
28451	25B0149400B	CHLORINE HOUSE	557742	AS - BUILDING DIV - BEATRICE D	108	
28452	25B0149500B	WATER RESERVOIR	557742	AS - BUILDING DIV - BEATRICE D	2,827	
28466	25B0301900B	METER/BACKFLOW PREVENTER STAT.	557742	AS - BUILDING DIV - BEATRICE D	320	
28468	25B0334200B	VAPORIZER/MIXER SHELTER	557742	AS - BUILDING DIV - BEATRICE D	294	
				BUILDING DIVISION		**45,016**
				STATE BUILDING DIVISON		
28407	25B0145100B	F BUILDING #5 (400 State)	557742	AS - BUILDING DIV - BEATRICE D	26,731	
				STATE ICF		**26,731**
				SOLAR ICFs		
28423	25B0146700B	COTTAGE 1 (#411)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28424	25B0146800B	COTTAGE 2 (#412)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28425	25B0146900B	COTTAGE 3 (#413)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28426	25B0147000B	COTTAGE 4 (#414)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28427	25B0147100B	COTTAGE 5 (#415)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28428	25B0147200B	COTTAGE 6 (#416)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28429	25B0147300B	COTTAGE 7 (#418)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28430	25B0147400B	COTTAGE 8 (#420)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28431	25B0147500B	COTTAGE 9 (#422)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28432	25B0147600B	COTTAGE 10 (#424)	557742	AS - BUILDING DIV - BEATRICE D	5,105	
28437	25B0148000B	EMPLOYEES QUARTERS #27 (LAKE/31st St)	557742	AS - BUILDING DIV - BEATRICE D	12,251	**not ADA compliant**
28438	25B0148100B	EMPLOYEES QUARTERS #28 (LAKE/31st St)	557742	AS - BUILDING DIV - BEATRICE D	10,317	**not ADA compliant**
				SOLAR ICF		**73,618**
				MISC BLDGS/STRUCTURES		
28406	25B0145000B	D BUILDING #4	557742	AS - BUILDING DIV - BEATRICE D	67,816	
28409	25B0145300B	L BUILDING #7	557742	AS - BUILDING DIV - BEATRICE D	26,731	
28414	25B0145800B	Y BUILDING #13/ADDITION	557742	AS - BUILDING DIV - BEATRICE D	50,396	Cust & Bldg Div
28413	25B0145700B	CARSTEN'S CENTER #12	557742	AS - BUILDING DIV - BEATRICE D	28,825	
28420	25B0146300B	ADMIN BUILDING #15	557742	AS - BUILDING DIV - BEATRICE D	68,387	
28421	25B0146400B	2nd Flr ADMIN #17/WEST WING-1stFlr	557742	AS - BUILDING DIV - BEATRICE D	37,012	1st Flr = Bear Creek - PT/OT - Actv Ctr
28433	25B0147700B	LAUNDRY #22	557742	AS - BUILDING DIV - BEATRICE D	23,328	
28439	25B0148200B	CHAPEL #29	557742	AS - BUILDING DIV - BEATRICE D	5,569	
28436	25B0147900B	TRANSPORTATION	557742	AS - BUILDING DIV - BEATRICE D	5,733	
28444	25B0148700B	ENCLOSED WALKWAY (ADMIN-PT/OT)	557742	AS - BUILDING DIV - BEATRICE D	3,539	
28445	25B0148800B	FOOD SERVICE #18	557742	AS - BUILDING DIV - BEATRICE D	30,421	storage
28467	25B0334100B	PARK RESTROOM	557742	AS - BUILDING DIV - BEATRICE D	477	
28469	25B0361500B	BUS BARN	557742	AS - BUILDING DIV - BEATRICE D	4,224	
28470	25B0371300B	GAZEBO	557742	AS - BUILDING DIV - BEATRICE D	190	
28471	25B0391000B	CARSTENS STORAGE BLDG.	557742	AS - BUILDING DIV - BEATRICE D	320	
101337	25B0397500B	PHC/PHARMACY STORAGE BUILDING	557742	AS - BUILDING DIV - BEATRICE D	245	
199205	25B0397600B	CARSTENS GAZEBO	557742	AS - BUILDING DIV - BEATRICE D	95	
				MISC BLDGS/STRUCTURES		**353,308**

554903 Rent

524900 Depreciation (Bldg Renewal Assessment Fee)

Total Square Footage	**552,241**
Total Square Footage (LESS VBEL'd Buildings)	**498,673**
Total Square Footage (LESS Maintenance used areas & VBEL'd Bldgs)	**453,657**

NEBRASKA

Good Life. Great Service.

DEPT. OF ADMINISTRATIVE SERVICES

STATE FACILITY USE AGREEMENT 14 - ADDENDUM 6

This State Facility Use Agreement - Addendum 6, hereinafter this "Addendum," between the **Department of Administrative Services, State Building Division**, as "Owner," and the **Department of Health & Human Services**, as "Tenant Agency," for space located at:

BEATRICE STATE DEVELOPMENT CENTER
3000 LINCOLN STREET
BEATRICE, NE 68310

WHEREAS, Owner and Tenant Agency entered into the original Agreement, effective **July 1, 2015** and ending **June 30, 2017**; renewed by Addendum 1 effective July 1, 2017 and ending June 30, 2019; renewed by Addendum 2 effective July 1, 2019 and ending June 30, 2021; renewed by Addendum 3 effective July 1, 2021 and ending June 30, 2023; and renewed by Addendum 4 effective July 1, 2023 and ending June 30, 2025; and

WHEREAS, Owner and Tenant Agency desire to renew the Term of this Lease for two (2) years; and

WHEREAS, Owner and Tenant Agency agree to the rental rate provided herein; and

WHEREAS, Owner and Tenant Agency agree to the following terms and conditions; and

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties amend this Agreement as follows:

1. As to Section **2. TERM** of the original Agreement, it shall be deleted in its entirety and the following inserted in its place:

   TERM. The term of this Agreement, hereinafter "Term" shall be effective on **July 1, 2025**, and shall terminate on **June 30, 2027**, unless sooner terminated as hereinafter provided.

2. As to Section **3. RENT** of the original Agreement, it shall be deleted in its entirety and the following inserted in its place:
   RENT. Tenant Agency shall pay Owner rent in equal monthly installments payable on the first day of each month throughout the Term of this Agreement. The rent and building renewal assessment fee (Neb Rev Stat § 81-188.01, also known as LB530), hereinafter collectively "Rent," is shown in the following schedule:

July 1, 2025 - June 30, 2026				
	Total Square Feet	PSF	Annual Rent	Monthly Payment
Base Rent	491,711	$6.89	$3,387,889.00	$282,324.08
Renewal Assessment Fee	491,711	$1.32	$649,059.00	$54,088.25
TOTAL:	491,711		$4,036,948.00	$336,412.33

July 1, 2026 - June 30, 2027				
	Total Square Feet	PSF	Annual Rent	Monthly Payment
Base Rent	491,711	$7.16	$3,520,651.00	$293,387.58
Renewal Assessment Fee	491,711	$1.32	$649,059.00	$54,088.25
TOTAL:	491,711		$4,169,710.00	$347,475.83

Please provide one (1) **Rent Business Unit #:** 25980141.524600

Please provide one (1) **Building Renewal Assessment Fee Business Unit #:** 25980141.524900 which does not involve federal funds.

3. **ENTIRE AGREEMENT.** This Addendum constitutes the entire and integrated agreement between Owner and Tenant Agency relating to the subject matter of this Addendum and supersedes all prior understandings, agreements, or representations, between the Parties, written or oral, to the extent they relate in any way to the subjects of this Agreement. All other terms and conditions of the original Agreement not addressed herein, shall remain the same and are hereby ratified and confirmed.

IN WITNESS WHEREOF, the Parties have executed this Agreement on the date(s) and year(s) below written.

OWNER:

Brent Flachsbart

Brent D. Flachsbart, Administrator
DAS - State Building Division

5/2/2025
Date

TENANT AGENCY:

Blake Mikesell

Blake Mikesell, Director of Operations
Department of Health & Human Services

4-29-25
Date

(a)

Facility Capacity-Population

FACILITY CAPACITY											
Total number of admitted individuals to the facility (please include all individuals admitted to the program who are admitted, including those that may not be present on campus that particular day)											
Nov 1st, 2024	Dec 1st, 2024	Jan 1st, 2025	Feb 1st, 2025	March 1st, 2025	April 1st, 2025	May 1st, 2025	June 1st, 2025	July 1st, 2025	Aug 1st, 2025	Sept 1st, 2025	Oct 1st, 2025
77	76	76	77	77	75	75	73	72	73	73	74

(b)

Inspection Reports

SOLAR COTTAGES ICF

2025

PUBLIC HEALTH AND FIRE MARSHAL

2567'S AND PLANS OF CORRECTION

PUBLIC HEALTH REPORTS

****
FAX TX REPORT
****

TRANSMISSION OK

JOB NO.	0149
DESTINATION ADDRESS	14027422326
SUBADDRESS	
DESTINATION ID	
ST. TIME	02/19 13:49
TX/RX TIME	02'11
PGS.	8
RESULT	OK

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER
FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Admin Specialist

COMPANY:

DATE: February 19, 2025

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 pages for the 2567s received from Public Health for Solar Cottages ICF at the Beatrice State Developmental Center (BSDC) from Stacey Gydesen Interim ICF/DD Manager.

The plan of correction for Public Health is being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank you

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

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Please advise if further information is needed.

Thank you

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

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

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 _____ B. WING _____	02/07/2025

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 007	EP Program Patient Population CFR(s): 483.475(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by:	E 007		

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

Stacey Opdesen | Interim ICF Administrator | 2/19/25

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 _____ B. WING _____	02/07/2025

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 007	Continued From page 1 Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) included a current list of specific at-risk medical needs for the 2 of 17 clients (Client 16 and Client 17). This had the potential to affect all clients living at the facility. The facility census was 72 at the time of the survey. Findings: A) Review of the facility's Emergency Preparedness Plan (EPP, updated October 2024) revealed this plan did not include a current medical at-risk-assessment list. The EPP medical at-risk list included Client 17 who was deceased. The medical at-risk also included Client 16, who was not residing at the facility at the time of the survey as the client was receiving rehabilitation cares at another treatment facility. B) In an interview on 2/5/25 at 11:20am, the Interim-Administrator (identified a person responsible for the EPP) verified the EPP medical at-risk list was not current as it still included Client 17 who was deceased and identified Client 16 as being on campus. The Interim-Administer confirmed Client 16 was currently not in residence at the facility. The Interim Administrator verified the facility had a shift-to-shift report which included the most up-to-date client information, however this document was not included or referenced as a client data source within the facility's EPP.	E 007		

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 _____ B. WING _____	C 02/07/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Representatives of the DHHS, Division of Public Health conducted a Complaint Investigation in conjunction with the Recertification Survey completed on 2/7/2025 to determine compliance with the Federal Regulations at 42 CFR 483, Subpart I, section 483.410-483.480, (Appendix J) Conditions of Participation for Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFIID). The facility was found to be in compliance with these regulations as they related to the Complaint Investigation allegations. However, the facility was not in compliance with the following Appendix J regulations. The facility census was 72 at the time of the survey.	W 000		

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

Stacy Clydesen — ICF Interim Administrator — 2/19/25

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 _____ B. WING _____	02/07/2025

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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure staff demonstrated the skills necessary to provide dignity and respect to 1 of 6 sample clients (Client 2) and 3 clients added to the sample (Client 7 , Client 11, and Client 12). This failure had the potential to affect all clients living at the facility. The facility census was 72 at the time of the survey. Findings: A) Review of the document titled, "BSDC SOP on Abuse/Neglect" (dated 5/30/2023) identified the definition of "Verbal Abuse" to include "any use of insulting, demeaning, disrespectful, oral, written, or gestured language direct towards and in the presence of the individual(s) supported." B) Observation conducted on 2/3/25 at 6:00pm revealed Staff D, Staff E, and Staff F were discussing the nursing follow-up assessment of Client 11's ear problems. The discussion occurred as Client 11 was walking from the dining room into the living room after supper and in the presence of Client 13 and Client 14 who were finishing their supper meal. Client 11 sat on the sofa for a few seconds, then stood-up and started to walk toward Staff D, who turned and asked the client in loud voice if Client 11 needed "To go to	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Interim ICF Administrator — TITLE — (X6) DATE: 2/19/25

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 _____ B. WING _____	02/07/2025

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 189	Continued From page 1 the bathroom." Client 11 didn't respond so Staff D redirected them to sit back on the sofa. C) Observation conducted on 2/4/25 at 12:00pm revealed after Client 11 finished eating their lunch the client stood and started to walk away from the table to the vending machine room. Staff G stopped Client 11 and then physically redirected the client to the bathroom area stating in a loud voice, "Let's go to the bathroom, you gotta go by now." During this same time, Client 12 was cleaning up their place setting at the table. Staff H (who was about 5-foot away from the table) stated to Client 12 in a stern voice that the client should finish cleaning up and then "Go to the bathroom and make sure to wash your hands this time." Staff G and Staff H's comments were announced in front of Client 13, Client 14, and Client 15 who continued eating their lunches. D) Observation on 2/4/25 at 8:11am revealed Staff B and Staff C stood on either side of Client 2 and assisted Client 2 to walk by use of a gait belt from the living room to the client's bedroom where the staff assisted the client into their wheelchair. After Client 2 was positioned in their wheelchair, Staff B announced about Client 2, "Oh, they are such a pain." This was stated in front of Client 2 and Staff C. Observations at 8:16am revealed Staff B stated about Client 2, "Some days they are easy, sometimes they aren't." This was stated in front of Client 2. E) Interview on 2/5/25 at 10:30am with QIDP F confirmed the statements made by Staff B was inappropriate and staff needed to talk about clients with dignity and respect.	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING _____ B. WING _____	02/07/2025

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 189	Continued From page 2	W 189		

F) Observation conducted on 2/3/2025 at 1:35pm, found 8 clients and 2 male staff in a day site setting. Upon arrival, Staff A was finishing their lunch. Staff A stated aloud in front of the clients that the facility could not send anyone to cover their lunch time, so Staff A had to eat while assisting clients. Staff A continued to assist and engage with clients.

At 1:55pm, Client 7 stood up and began manipulating their belt and the front of their pants. Client 7 demonstrated this behavior 6 times from 1:55pm-2:00pm. After each behavior, Client 7 would sit down and then Staff A would offer Client 7 hand sanitizer. At 2:00pm, Staff A stated aloud to all in the room that Client 1 was "pretty OCD about their pants."

At 2:08pm, Client 10 asked Staff A if they were "Going to be here" on duty "tomorrow." Staff A answered by stating to the client, "Yes, unfortunately."

G) During an interview on 2/6/25 from 2:38pm to 3:30pm, the facility's Interim-Administrator confirmed that the comments identified above by Staff A, Staff B, Staff D, Staff E, Staff F, during observations were "Absolutely not acceptable" under any circumstances in the presence of clients or not. The Interim-Administrator verified their expectation was for all facility staff to intervene when disrespectful conversations or comments were made about, to, or in front of clients.

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, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN11
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E-0007		
	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 facility failed to ensure the Emergency Preparedness Plan (EPP) included a current list of specific at-risk medical needs for 2 of the 17 clients (Client 16 and Client 17).	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	The Medical Risk List has been updated to current status for all individuals residing at the Beatrice State Developmental Center and replaced in the manuals throughout the facility. A "disclaimer" page has been added to Section IV-6 Medical Risk Individuals Section of the Emergency Preparedness Plan Reference section. The disclaimer page states: **PLEASE NOTE: The following Medical Risk Individuals list is an evergreen document and is constantly being revised to be consistent with the addition of newly defined at medical risk individuals; new admissions and/or discharges. PLEASE refer to the daily End of Shift reports for any updates of BSDC individuals and/or status change.**	3/21/2025
	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:	
	Updates to the Emergency Preparedness Plan Manuals will be completed as changes occur for the medical risk individuals.	3/21/2025
	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 Interim ICF Administrator is the responsible position to monitor and ensure compliance.	3/21/2025

	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).	

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, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN11
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
W-0189		
	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 facility failed to ensure staff demonstrated the skills necessary to provide dignity and respect to 1 of 6 sample clients (Client 2) and other clients added to the sample (Client 7, Client 10, Client 11 and Client 12). Staff will be provided in-servicing regarding treating each and every client with dignity and respect and to immediately intervene when disrespectful conversations or comments are made about , to or in front of the clients served.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 11, Staff D, Staff E and Staff F will be provided an in-service regarding the inappropriate discussion of Client 11's nursing assessment while in the presence of Client 13 , Client 14 and to provide dignity and with respect of personal medical information.	3/21/2025
	For Client 11, Staff D and Staff G will be provided an in-service regarding inappropriate questions of personal care and use of the bathroom while in the presence of Client 12 and to provide dignity and respect for personal care needs.	3/21/2025
	For Client 12, Staff G and Staff H will be provided an in-service regarding inappropriate questions of personal care and use of the bathroom while in the presence of Clients 13, 14 and 15 and to provide dignity and respect for personal care needs.	3/21/2025
	For Client 12, Staff H will be provided an in-service regarding the tone of voice while engaging with Client 12 and to provide dignity, respect and appropriate tone when making a request.	3/21/2025
	For Client 2, Staff B and Staff C will be provided an in-service regarding derogatory statements made in front of Client 2 and to provide dignity and respect of personal needs.	3/21/2025
	Staff A will be provided with an in-service regarding eating inappropriately in front of the individuals.	3/21/2025

	For Client 7, Staff A will be provided an in-service regarding derogatory comments about Client 7s behavior and manipulation of pants and to provide dignity and respect.	3/21/2025
	For Client 10, Staff A will be provided an in-service regarding rude and disrespectful comments made to Client 10 when asked if would be on duty tomorrow and to provide dignity and respect when responding to questions.	3/21/2025
	All other staff members within the Solar Cottage ICF will be provided with an in-service regarding treating each and every client with dignity and respect and to immediately intervene when disrespectful conversations or comments are made about, to or in front of the individuals served.	3/21/2025
	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 on-going observations and quarterly audits by the Compliance Specialists, as well as mock audits.	3/21/2025
	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 Interim ICF Administrator is the responsible position for monitoring and to ensure compliance.	3/21/2025
	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).	

FIRE MARSHAL REPORTS

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Admin Specialist

COMPANY:

DATE: February 20, 2025

FAX NUMBER: 402.742.2326

TOTAL PAGES INCLUDING COVER: 11

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ☑ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received from the Fire Marshal for Solar Cottages ICF at the Beatrice State Developmental Center (BSDC) from Stacey Gydesen Interim ICF/DD Manager.

The plan of correction for the Fire Marshal is being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank you

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

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

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, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0500		
723 Solar	**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 2/4/25 revealed:	
	An oxygen concentrator in Room 5 with no warning signage was posted.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Work order #31816 was submitted to the Maintenance Department to add warning signage to the door of room #5 where the oxygen concentrator is located.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
K-0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2/4/25 revealed:	
	Two six-plex electrical adaptors in the Dining Room.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31817 was submitted to the Maintenance Department to remove the two six-plex electrical adaptors and add more electrical outlets if needed.	3/21/2025

	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 is the responisible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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:	
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Provider/Supplier Name:	SOLAR COTTAGES	Survey Date
STREET ADDRESS, CITY, ZIP:	3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0511		
743 Solar	**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 2/4/25 revealed:	
	1. Refrigerator plugged into a power strip in Nurse Office - Room 8.	3/21/2025
	2. Power strips plugged into each other in Nurse Office - Room 8.	3/21/2025
	3. Six-plex electrical adaptor in Room 8 - Nurse Office.	3/21/2025
	4. Six-plex electrical adaptor in the Dining Room.	3/21/2025
	5. Six-plex electrical adaptor in the Living Room under TV.	3/21/2025
	6. A toolbox and box of disinfecting wipes stored in front of panel boxes in the Electrical Room.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Work order #31809 was submitted to the Maintenance Department to ensure the refrigerator is not plugged into a power strip, but in to an appropriate electrical outlet.	3/21/2025
	2. Work order #31809 was submitted to the Maintenance Department to ensure that two power strips are not plugged into each other and to add additional electrical outlets to this office if needed.	3/21/2025
	3, 4, 5. Work order #31810 was submitted to the Maintenance Department to remove the six-plex electrical adaptors from #3-Nurse Office-Room 8; #4-Dining Room and; #5-Living Room under TV and to add additional electrical outlets as needed.	3/21/2025
	6. Work order #31811 was submitted to the Maintenance Department to remove the toolbox and box of disinfecting wipes from in front of the panel boxes in the Electrical Room so that no obstructions prevent access to the panel boxes.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025

	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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:	
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	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	

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		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0500		
753 Solar	**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 2/4/25 revealed:	
	1. An oxygen concentrator in Room #22 with no warning signage posted.	3/21/2025
	2. A portable heating device in Nurses Office.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Work order #31818 was submitted to the Maintenance Department to add warning signage to the door of room #22 where the oxygen concentrator is located.	3/21/2025
	2. Work order #31819 was submitted to the Maintenance Department to remove the portable heating device from the Nurses office.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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):	

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Provider/Supplier Name:	SOLAR COTTAGES	Survey Date
STREET ADDRESS, CITY, ZIP:	3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0511		
3054 Peterson	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 2/4/25 revealed:	
	Step stool stored in front of the panel boxes in the Electrical Room.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31820 was submitted to the Maintenance Department to remove the step stool from in front of the panel boxes in the Electrical Room to prevent obstruction.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsibloe position to monitor and ensure compliance.	3/21/2025
	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:	
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	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).	

PLAN OF CORRECTION

Provider/Supplier Name:		Survey Date
SOLAR COTTAGES		
STREET ADDRESS, CITY, ZIP:	3052,3054,3056,3060 PET BLV 753,743,723,715 SOL DR, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0500		
3060 Peterson	**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 2/4/25 revealed:	
	An oxygen concentrator in Room 2 with no warning signage posted.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31812 was submitted to the Maintenance Department to add warning signage to the door of room #2 where the oxygen concentrator is located.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
K-0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2/4/25 revealed:	
	Seven one gallon cans of paint, 3 five gallon buckets of paint, 1 five gallon bucket of drywall compound, paint trays, paint brushes and supplies stored in front of the panel boxes in the Electrical Room.	2/18/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Work order #31813 was submitted to the Maintenance Department to remove the seven one gallon cans of paint, 3 five gallon buckets of paint, 1 five gallon bucket of drywall compound, paint trays, paint brushes and supplies stored in front of the panel boxes in the Electrical Room. All painting and drywall materials have been removed or relocated away from the panel boxes in the Electrical Room.	2/18/2025
	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 is the responsible position to monitor and ensure compliance.	2/18/2025
	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 is the responsible position to monitor and ensure compliance.	2/18/2025
	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).	

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, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0222		
3070 State	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2/4/25 revealed:	
	The northwest exit door in the dayroom failed to unlock when the handle was engaged.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31814 was submitted to the Maintenance Department to ensure the northwest door will unlock when the handle is engaged.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
K-0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2/4/25 revealed:	
	The door between the Dining Room and the laundry equipment with a self-closing device failed to latch within the doorframe.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Work order #31815 was submitted to the Maintenance Department to adjust/repair the door between the Dining Room and the laundry equipment with a self-closing device so that it will properly latch within the doorframe.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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).	

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, 3070, 3071 STATE BEATRICE , NE 683	2/7/2025
		INPN21
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	ICFDD14E

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
K-0321		
3071 State	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 2/4/25 revealed:	
	Resident room 22 used as a storage room; the door failed to provide a self-closing device.	3/21/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31821 was submitted to the Maintenance Department to either remove the storage items or to install a self-closing device to the door of Room 22.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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 is the responsible position to monitor and ensure compliance.	3/21/2025
	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).	

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 1:03 PM
To: Fralin, Russell
Subject: WO# BSDC-31818 has been created.

WO# BSDC-31818 has been created.

Request Number	Request Description	Location
BSDC-31818	General:753 Solar/418 Solar: During the Fire Marshal observation on 2/4/25 it revealed an oxygen concentrator in Room #22 with no warning signage posted. Please add warning signage to the door of this room. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=pr9ck1zmiteruygm3ewe58rkth

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 1:05 PM
To: Fralin, Russell
Subject: WO# BSDC-31819 has been created.

WO# BSDC-31819 has been created.

Request Number	Request Description	Location
BSDC-31819	General:753 Solar/418 Solar: During the Fire Marshal observation on 2/4/25 it revealed a portable heating device in the Nursing Office at this home. Please remove the portable heating device. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=tcoh1tngt56r3bj7wf5mtow8ma

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:39 PM
To: Fralin, Russell
Subject: WO# BSDC-31809 has been created.

WO# BSDC-31809 has been created.

Request Number	Request Description	Location
BSDC-31809	General:743 Solar/420 Solar: During the Fire Marshal observation on 2/4/25 the following was noted: 1. Refrigerator plugged into a power strip in the Nurse Office - Room #8 2. Power strips plugged into each other in Nurse Office - Room #8 Need to ensure the refrigerator is not plugged into a power strip and two power strips are not plugged into each. Need to add additional electrical outlets to this office. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=rpsong1sn3hrxxo6xym67pr4bw

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:42 PM
To: Fralin, Russell
Subject: WO# BSDC-31810 has been created.

WO# BSDC-31810 has been created.

Request Number	Request Description	Location
BSDC-31810	General:743 Solar/420 Solar: During Fire Marshal observation on 2/4/25 the following were noted: 1. A six-plex electrical adaptor was being utilized in the Nurse Office - Room #8 2. A six-plex electrical adaptor was being utilized in the Dining Room 3. A six-plex electrical adaptor was being utilized in the living room under the TV. Need to remove the six-plex adaptors and add additional electrical outlets as needed. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=7esxo9qx1horimj8eji7nbh61a

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:45 PM
To: Fralin, Russell
Subject: WO# BSDC-31811 has been created.

WO# BSDC-31811 has been created.

Request Number	Request Description	Location
BSDC-31811	General:743 Solar/420 Solar: During the Fire Marshal observation on 2/4/25 it was noted that a toolbox and box of disinfecting wipes were stored in front of the panel boxes in the Electrical Room. Need to remove obstacles from in front of the panel boxes in the Electrical Room. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=axgdju59ek8rd8ib4gmtyzojue

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:58 PM
To: Fralin, Russell
Subject: WO# BSDC-31816 has been created.

WO# BSDC-31816 has been created.

Request Number	Request Description	Location
BSDC-31816	General:723 Solar/422 Solar: During the Fire Marshal observation on 2/4/25 it revealed an oxygen concentrator was in Room #5 with no warning signage posted. Need to add warning signage to the door of this room. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=fixrq7qt8j6r7phdfhqmjgzr1r

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 1:02 PM
To: Fralin, Russell
Subject: WO# BSDC-31817 has been created.

WO# BSDC-31817 has been created.

Request Number	Request Description	Location
BSDC-31817	General:723 Solar/422 Solar: During the Fire Marshal observation on 2/4/2025 it revealed two six-plex electrical adaptors in the Dining Room of this home. Please remove the six-plex adaptors and add more electrical outlets if needed. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=jsm361o7udqwupa5n5o64urciw

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 1:07 PM
To: Fralin, Russell
Subject: WO# BSDC-31820 has been created.

WO# BSDC-31820 has been created.

Request Number	Request Description	Location
BSDC-31820	General:3054 Peterson/415 Sheridan: During the Fire Marshal observation on 2/4/25 it revealed a step stool was stored in front of the panel boxes in the Electrical Room. Please remove the step stool from in front of the panel boxes to prevent obstruction. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=aygzyff831ir88wqebn7c9qptr

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:48 PM
To: Fralin, Russell
Subject: WO# BSDC-31812 has been created.

WO# BSDC-31812 has been created.

Request Number	Request Description	Location
BSDC-31812	General:3060 Peterson/413 State: During the Fire Marshal observation on 2/4/25 it was revealed an oxygen concentrator in Room #2 with no warning signage posted. Need to add signage to this door. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=mgziyug95ccrtpwkx3k1djpp9r

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 18, 2025 8:38 AM
To: Fralin, Russell
Subject: WO# BSDC-31813 has been completed - please verify.

WO# BSDC-31813 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31813	General:3060 Peterson/413 State: During the Fire Marshal observation on 2/4/25 it revealed that 7 - one gallon cans of paint, 3 five gallon buckets of paint, 1 five gallon bucket of drywall compound, paint trays, paint brushes and supplies stored in front of panel boxes in the Electrical Room. Need to remove these obstacles from in front of the panel boxes in the Electrical Room. Thank you	Floor 1

Assigned To:
Daniel Rash
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=pn4nyusektyrprh36g3w4qj65h
Completion Notes:
All painting and drywall material has been removed or relocated away from electrical panels.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:54 PM
To: Fralin, Russell
Subject: WO# BSDC-31814 has been created.

WO# BSDC-31814 has been created.

Request Number	Request Description	Location
BSDC-31814	General:3070 State/412 State: During the Fire Marshal observation on 2/4/25 it revealed the northwest exit door in the Dayroom failed to unlock when the handle was engaged. Need to ensure this door will unlock when the handle is engaged. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=g89p4gpc3npw7yfmnodbg9p1jr

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 12:55 PM
To: Fralin, Russell
Subject: WO# BSDC-31815 has been created.

WO# BSDC-31815 has been created.

Request Number	Request Description	Location
BSDC-31815	General:3070 State/412 State: During the Fire Marshal observation on 2/4/25 it revealed the door between the dining room and the laundry equipment with a self-closing device failed to latch within the doorframe. Please adjust/repair this door so that it will properly latch within the doorframe. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=1py4kix6dqzrbfrb51kyghbc9c

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Friday, February 14, 2025 1:09 PM
To: Fralin, Russell
Subject: WO# BSDC-31821 has been created.

WO# BSDC-31821 has been created.

Request Number	Request Description	Location
BSDC-31821	General:3071 State/411 State: During the Fire Marshal observation on 2/4/25 it revealed Resident Room #22 was used as a storage room and the door failed to have a self-closing device. Please either remove the storage items or install a self-closing device to the door of Room #22. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=cbk73ieqqaowze6n79phnxrs8r

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

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 09 - 753 SOLAR B. WING _____	02/04/2025

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 comply 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 14 skilled certified beds. At the time of the survey the census was 8. Solar Cottage, 753 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		
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 "Oxygen in Use" signs on rooms where oxygen was used and allowed space heaters. The deficient practices increase the potential for a fire and would not alert persons entering the room to use extra caution with	K0500		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim ICF Administrator	2/20/25

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 09 - 753 SOLAR B. WING _____	02/04/2025

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 1 potential sources of ignition. The facility has a census of 8 on the day of survey. Findings are: Observation on 2-4-25 at 1:42 pm and 1:47 pm revealed: 1. An oxygen concentrator in Room 22 with no warning signage was posted. 2. A portable heating device in Nurses Office. During an interview on 2-4-25 at 1:42 and 1:47 pm, Staff A confirmed the lack of signage and space heater.	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 02 - 743 SOLAR B. WING	02/04/2025

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, 743 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 14 skilled certified beds. At the time of the survey the census was 9. Solar Cottage, 743 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		
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 staff interview, the facility failed to assure adequate electrical receptacles which allowed the use of a multi-plug electrical adapters, improper use of power strips and allowed obstruction to electrical panel boxes. These deficient practices have the potential to increase the possibility for an electrical fire and	K0511		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Lydeen
TITLE: Interim ICF Administrator
(X6) DATE: 2/20/25

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 02 - 743 SOLAR B. WING _____	02/04/2025

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
K0511	Continued From page 1 would delay access to panel boxes. The facility census was 9 on the day of survey. Findings are: Observation on 2-4-25 between 1:55 pm and 2:15 pm revealed: 1. Refrigerator plugged into a power strip in Nurse Office Room 8. 2. Power-strips plugged into each other in Nurse Office Room 8. 3. Six-plex electrical adaptor in Room 8 Nurse Office. 4. Six-plex electrical adaptor in the Dining Room. 5. Six-plex electrical adaptor in Living Room under TV. 6. A toolbox and box of disinfecting wipes stored in front of panel boxes in the Electrical room. During an interview on 2-4-25 between 1:55 pm and 2:15 pm, Staff A confirmed the electrical adaptors used for permanent wiring, the lack of permanent electrical outlets and items stored in front of the panel boxes. NFPA Standard: 2011 NFPA 70, 65.26 Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. 2011 NFPA 70,65.32 Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (6172 ft) high (measured vertically from the floor or platform) or not less than 914	K0511		

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 B. WING _____	02/04/2025

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
K0511	Continued From page 2 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. NFPA Standard: NFPA 70, 2011, 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage UL Standard: Relocatable power taps are not intended to be piggybacked or daisy chained. UL 1363 User Guide for Relocatable Power Taps	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 **03 - 723 SOLAR** B. WING _____	02/04/2025

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 required to comply 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, 723 is a single story building of Type V (000) construction that was constructed in 2011 and is fully sprinkled. The facility has 14 skilled certified beds. At the time of the survey the census was 9. Solar Cottage, 723 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		
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 "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.	K0500		

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

Stacy Lydesen — Interim ICF Administrator — 2/20/25

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 B. WING _____	02/04/2025

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 1 The facility has a census of 9 on the day of survey. Findings are: Observation on 2-4-25 at 2:18 pm revealed, an oxygen concentrator in Room 5 with no warning signage was posted. During an interview on 2-4-25 at 2:18 pm, Staff A confirmed the lack of signage.	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 staff interview, the facility failed to prohibit the use of a multi-plug electrical adapters. This deficient practice had the potential to increase the possibility for an electrical fire. The facility has a census of 9 on the day of survey. Findings are: Observation on 2-4-25, at 2:20 pm revealed two six-plex electrical adaptors in the Dining Room. During an interview on 2-4-25 at 2:20 pm, Staff A confirmed the electrical adaptors used for permanent wiring.	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** B. WING _____	02/04/2025

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 comply 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 14 skilled certified beds. At the time of the survey the census was 9. Solar Cottage, 715 was found to be 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim ICF Administrator — (X6) DATE: 2/20/25

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 **10 - 3052 PETERSON** B. WING _____	**02/04/2025**

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 construction that was built in 1970 and is fully sprinkled. The facility has 14 certified beds. At the time of the survey the census was 8 residents. Solar Cottage, 3052 was found to be 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		

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

Interim ICF Administrator 2/20/25

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 13 - 3054 PETERSON B. WING _____	02/04/2025

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, 3054 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 5. Solar Cottage 3054 was found to not be 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		
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 disconnects boxes. This deficient practice could cause a delay and injury when turning off the power during an electrical issue	K0511		

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

Interim ICF Administrator 2/20/25

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 **13 - 3054 PETERSON** B. WING _____	**02/04/2025**

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
K0511	Continued From page 1 emergency. The facility has a census of 6 on the day of survey. Findings are: Observations on 2-4-25 at 11:42 am revealed, step stool stored in front of panel boxes in the Electrical room. During an interview on 2-4-25 at 11:42 am, Maintenance Staff A confirmed the items stored in front of the panel boxes. NFPA Standard: 2011 NFPA 70, 65.26 Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. 2011 NFPA 70,65.32 Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (61?2 ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 65.34(A). In all cases, the work space shall permit at least a 90 degree opening of doors or hinged panels.	K0511		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **11 - 3056 PETERSON** B. WING _____	**02/04/2025**

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 construction that was built in 1970 and is fully sprinkled. The facility has 14 certified beds. At the time of the survey the census was 7 residents. Solar Cottage, 3056 was found to be 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Andersen	Interim ICF Administrator	2/20/25

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 - 3060 PETERSON** B. WING _____	**02/04/2025**

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 construction that was built in 1970 and is fully sprinkled. The facility has 16 certified beds. At the time of the survey the census was 7 residents. Solar Cottage, 3060 was found to not be 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		
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 "Oxygen in Use" signs on rooms where oxygen was used. The deficient practices increase the potential for a fire and would not	K0500		

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

Stacey Oydesen — Interim ICF Administrator — 2/20/25

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 - 3060 PETERSON B. WING _____	02/04/2025

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 1 alert persons entering the room to use extra caution with potential sources of ignition. The facility has a census of 7 on the day of survey. Findings are: Observation on 2-4-25 at 1:42 pm and 1:47 pm revealed, an oxygen concentrator in Room 2 with no warning signage was posted. During an interview on 2-4-25 at 1:42 and 1:47 pm, Staff A confirmed the lack of signage.	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 allowed storage to obstruct access to the electrical disconnects boxes. This deficient practice could cause a delay and injury when turning off the power during an electrical issue emergency. The facility has a census of 7 on the day of survey. Findings are: Observations on 2-4-25 at 11:26 am revealed, 7-one-gallon cans of paint, 3-five-gallon buckets of paint, 1-five-gallon bucket of drywall compound, paint trays, paint brushes and supplies stored in front of panel boxes in the Electrical room. During an interview on 2-4-25 at 11:26 am,	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 **12 - 3060 PETERSON** B. WING _____	**02/04/2025**

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
K0511	Continued From page 2 Maintenance Staff A confirmed the items stored in front of the panel boxes. NFPA Standard: 2011 NFPA 70, 65.26 Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. 2011 NFPA 70,65.32 Sufficient space shall be provided and maintained about electrical equipment to permit ready and safe operation and maintenance of such equipment. Where energized parts are exposed, the minimum clear work space shall be not less than 2.0 m (61?2 ft) high (measured vertically from the floor or platform) or not less than 914 mm (3 ft) wide (measured parallel to the equipment). The depth shall be as required in 65.34(A). In all cases, the work space shall permit at least a 90 degree opening of doors or hinged panels.	K0511		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **15 - 3070 STATE AVE.** B. WING _____	**02/04/2025**

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, 3070 is a single story building of Type V construction that was built in 1970 and is fully sprinkled. The facility has 10 certified beds. At the time of the survey the census was 0 residents. Solar Cottage, 3070 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		
K0222	Egress Doors CFR(s): NFPA 101 Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied.	K0222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Andersen	Interim ICF Administrator	2/20/25

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 15 - 3070 STATE AVE. B. WING _____	02/04/2025

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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K0222	Continued From page 1 Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure exit doors would open when handle was engaged. This deficient practice would cause confusion and delay egress during an emergency. The facility has a census of 0 on the day of survey. Findings are: Observations on 2-4-25 at 11:19 am revealed, the northwest exit door in the Dayroom failed to unlock when the handle was engaged. During an interview on 2-4-25 at 11:19 am, Staff A confirmed the auto-locking device on the exit door failed to unlock.	K0222		
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	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **16 - 3070 STATE AVE.** B. WING _____	**02/04/2025**

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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K0321	Continued From page 2 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 This STANDARD is not met as evidenced by: Based on observations and interview the facility failed to assure hazard area doors would latch within the doorframe. This deficient practice would allow fire, smoke and gasses to spread. The facility has a census of 0 on the day of	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **15 - 3070 STATE AVE.** B. WING _____	**02/04/2025**

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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K0321	Continued From page 3 survey Findings are: Observations on 2-4-25 at 11:12 am revealed, the door between the Dining Room and the laundry equipment with a self-closing device failed to latch within the doorframe. During an interview on 2-4-25 at 11:12 am, Staff A confirmed the door failed to latch within the doorframe.	K0321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **16 - 3071 STATE AVE.** B. WING _____	**02/04/2025**

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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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, 3071 is a single story building of Type V construction that was built in 1970 and is fully sprinkled. The facility has 12 certified beds. At the time of the survey the census was 6 residents. Solar Cottage, 3071 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: Steve Sydesen — TITLE: Interim ICF Administrator — (X6) DATE: 2/20/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **16 - 3071 STATE AVE.** B. WING _____	**02/04/2025**

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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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 observations and interview, the facility failed to provide self-closing device on areas used as storage. This deficient practice increases the potential for fire, smoke and gasses to escape into other areas. The facility has a census of 6 on the day of survey. Findings are: Observations on 2-4-25 at 11:02 am revealed, Resident Room 22 used as a storage room; the door failed to provide a self-closing device. During an interview on 2-4-25 at 11:02 am, Staff A	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G114	A. BUILDING **16 - 3071 STATE AVE.** B. WING _____	**02/04/2025**

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K0321	Continued From page 2 confirmed the room was used as storage with the lack of a self-closing device.	K0321		

400 STATE BUILDING ICF

2025

PUBLIC HEALTH AND FIRE MARSHAL

2567'S AND PLANS OF CORRECTION

PUBLIC HEALTH REPORTS

****
FAX TX REPORT
****

TRANSMISSION OK

JOB NO.	2169
DESTINATION ADDRESS	14027422326
SUBADDRESS	
DESTINATION ID	
ST. TIME	01/27 10:21
TX/RX TIME	01'05
PGS.	3
RESULT	OK

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Admin Specialist

COMPANY:

DATE: January 27, 2025

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 pages for the 2567s received for 400 State Building ICF at the Beatrice State Developmental Center (BSDC) from Stacey Gydesen Interim ICF/DD Manager.

The plan of correction for Public Health is being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank you

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

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Please advise if further information is needed.

Thank you

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

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

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 _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure prescription eyeglasses were available for 1 of 1 client (Client 1) as specified in their Individual Support Plan (ISP) and associated records. This deficient practice had the potential to affect all clients who utilized supportive and adaptive equipment. The facility census was 4 at the time of the survey initiated on 1/13/25. Findings: A) Review of Client 1's 12/16/24 Admission ISP identified "Eyeglasses" were listed among Client 1's required adaptive equipment. According to this ISP, Client 1 reported their eyeglasses were "broken" and an eye appointment would be made. B) Review of Client 1's 12/13/24 Pre-Admission Nursing Evaluation identified "Glasses" were listed within the section "Health Supportive Equipment." C) Review of Client 1's 12/12/24 Pre-Admission Review completed by the facility's Occupational Therapist identified it listed "Glasses" among the client's adaptive equipment.	W 436		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Andersen	Interim ICF Admin	1/27/2025

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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 _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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 436	Continued From page 1 D) Observations conducted throughout the survey 1/13/25 from 4:30pm - 5:40pm, 1/14/25 from 7:45am - 8:40am, 11/14/25 from 11:30am - 12:30pm, and 1/15/25 from 9:45am - 10:45am revealed at no time was Client 1 observed to wear eyeglasses. E) Observations on 1/14/25 at 7:52am during the implementation of Client 1's medication administration baseline-program, Client 1 asked Staff B to read the prescription label on the medication bottles as "I'm having problems seeing them." F) Observations on 1/14/25 at 11:35am during an "identification of time" activity at D Building revealed Client 1 to tell Staff B, "This is hard for me to see." Client 1 then asked Staff B to put "dots" on the worksheet relative to the minutes on the face of the clocks included on the worksheet. Client 1 stated "my glasses are broken, and my insurance won't pay for new ones for 2 years." G) Interview with Staff A on 1/15/25 at 10:37am confirmed they had never seen eyeglasses for Client 1 and it was their understanding Client 1's eyeglasses were broken. Staff A confirmed Client 1 occasionally reported issues related to their sight. H) Interview with Staff C on 1/15/25 at 2:45pm confirmed they had not seen Client 1 use eyeglasses and believed none were available at this time. I) Interview with Client 1's Qualified Intellectual Disabilities Professional (QIDP) on 1/15/25 at 2:00pm confirmed Client 1 had not worn eyeglasses since their admission on 12/16/24.	W 436		

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	28G107	A. BUILDING _____ B. WING _____	01/16/2025

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

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W 436	Continued From page 2 The QIDP confirmed eyeglasses were listed among Client 1's needed adaptive equipment but stated they had not seen Client 1's eyeglasses. J) Review of a 1/16/25 email from Client 1's QIPD included Client 1's personal possession inventory completed at the time of their admission to the facility. Review of the inventory found no eyeglasses listed among the items Client 1 brought with them at the time of their admission.	W 436		
W 502	COVID-19 Policies and Procedures: Education CFR(s): 483.460(a)(4)(iii) § 483.460(a)(4)(iii) Before offering COVID-19 vaccine, each client or the client's representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to develop and implement a system which included how the facility would ensure and provide education to 3 of 3 clients (Client 1, Client 2, and Client 3) regarding the benefits, risks, and potential side effects related to the Covid-19 vaccine. This had the potential to affect all clients living at the facility. The facility census was 4 at the time of the survey. Findings: A) Review of the Therap data base (client record data base) revealed the three clients admitted prior to 1/13/25 (survey initiation date) failed to	W 502		

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 _____	01/16/2025

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

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W 502	Continued From page 3 have in their record documentation that the facility had reviewed and/or provided education to the clients regarding the benefits, risks, and potential side effects of the Covid-19 vaccine. Client 1 (Admitted 12/16/24), No evidence of review of the facility's Covid-19 client guidelines. Client 2 (Admitted 5/16/24), No evidence of review of the facility's Covid-19 client guidelines. Client 3 (Admitted 9/16/24), No evidence of review of the facility's Covid-19 client guidelines. B) During interviews on 1/13/25 at 3:15pm and 1/14/25 at 9:44am, the BSDC Facility Administrator (responsible for the Covid-19 plan) confirmed the facility had no evidence prior to 1/13/25 that Client 1, Client 2, and Client 3 were provided education regarding Covid-19 Healthcare Vaccinations.	W 502		

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

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	28G107	A. BUILDING _____ B. WING _____	01/16/2025

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

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E 000	Initial Comments Representatives of the DHHS, Division of Public Health completed a Recertification Survey on 1/16/25 to determine compliance with the Appendix Z: Emergency Preparedness federal regulations. Based on evidence obtained during record review and interviews, the facility was found to be in compliance with the Appendix Z: Emergency Preparedness requirements pertaining to Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID). The facility census was 4 at the time of the Recertification Survey.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Gydesen	Interim ICF Admin	1-27-2025

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:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M11
	(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
W-436, W-502		
W-436	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	For Client 1, in review of the Admission ISP, Pre-Admission Nursing Evaluation and Pre-Admission review completed by the Occupational Therapist, documentation identified "eyeglasses" were required adaptive equipment. In review of Client 1's personal possession inventory completed at the time of admission on 12/16/24, no eyeglasses were brought at the time of admission. The QDDP has scheduled an eye examination for Client 1 on 1/27/2025 so that Client 1 can be assessed and can be fitted for the appropriate adaptive equipment.	2/25/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 1 and all other individuals residing within 400 State Building ICF, the QDDP(s) will ensure that adaptive equipment identified in the ISP is accessible and being utilized.	2/25/2025
	For Client 1 and all other individuals residing within 400 State Building ICF, the QDDP(s) will ensure in-servicing is available for all staff members to ensure individuals adaptive equipment is available and being utilized as identified in the ISP.	2/25/2025
	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 include random focused audits to ensure adaptive equipment identified in the ISP is available, in good order and being utilized.	2/25/2025
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator is the responsible position for monitoring and to ensure compliance.	2/25/2025

W-502	**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:**	
	In review of the Therap data base (client record data base) it revealed the three clients admitted to the 400 State Building ICF prior to 1/13/25 failed to have in their record documentation that the facility had reviewed and/or provided education to the clients regarding the benefits, risks and potential side effects of the Covid-19 vaccine.	2/25/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For Client 1, Client 2 and Client 3, the QDDPs have provided education regarding the benefits, risks and potential side effects of the Covid-19 vaccine.	2/25/2025
	For all other individuals currently within 400 State Building ICF, the QDDP reviewed to ensure Covid-19 education has been provided, at the time of admission.	2/25/2025
	For all future admissions, Covid-19 education regarding the benefits, risks and potential side effects will be provided at the time of admission.	2/25/2025
	All individuals within 400 State Building ICF will receive annual education on the benefits, risks and potential side effects of the Covid-19 vaccine; including at the time of admission.	2/25/2025
	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 all individuals receive education on the benefits, risks and potential side effects of the Covid-19 vaccine.	2/25/2025
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	The ICF Administrator is the responsible position for monitoring and to ensure compliance.	2/25/2025
	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

Jim Pillen, Governor

January 21, 2025

Stacey Gydesen, Interim Administrator
400 State Building
3104 State Ave
Beatrice, NE 68310

Dear Ms. Gydesen:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On January 13, 2025-January 16, 2025, DHHS representatives conducted surveys to determine whether your facility was in compliance with Federal Condition of Participation requirements, 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 Regulations Governing 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 **March 2, 2025.**

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 94669, Lincoln, NE 68509-4669
Email: mark.luger@nebraska.gov

EID:U74M11

ML/fe

FIRE MARSHAL REPORTS

****
FAX TX REPORT
****

TRANSMISSION OK

JOB NO.	0046
DESTINATION ADDRESS	14027422326
SUBADDRESS	
DESTINATION ID	
ST. TIME	02/07 15:44
TX/RX TIME	02' 24
PGS.	7
RESULT	OK

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

TO: DHHS DDBH Facilities

FROM: Russell Fralin, Admin Specialist

COMPANY:

DATE: February 7, 2025

FAX NUMBER: 402.742.2326

TOTAL PAGES INCLUDING COVER: 7

PHONE NUMBER:

PHONE NUMBER: 402.223.6827

☐ URGENT ✓ FOR REVIEW ☐ PLEASE REPLY ☐ AS REQUESTED

Attached are the signed front pages for the 2567s received for the Fire Marshal for 400 State Building ICF at the Beatrice State Developmental Center (BSDC) from Stacey Gydesen Interim ICF/DD Manager.

The plan of correction for The Fire Marshal is being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank you

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

BEATRICE STATE DEVELOPMENTAL CENTER

FACSIMILE TRANSMITTAL SHEET

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The plan of correction for The Fire Marshal is being emailed per the instructions on the letter received.

Please advise if further information is needed.

Thank you

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

3000 Lincoln Boulevard
Beatrice, NE 68310-3319

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-311		
	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:	
	1. The undercut for the 1 1/2 hour fire rated stair door was greater than 3/4 inch.	2/28/2025
	2. Two boxes of furnace filters stored on the basement landing.	2/28/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31218 was submitted to the Maintenance Department.	
	1. Work Order #31218 was submitted to the Maintenance Department for the 3/4 inch undercut of the 1 1/2 hour fire rated stair door. Maintenance will contact DHPace or another contractor to request a quote to determine which doors need to be completely replaced and which ones just need a new door or a new rating to meet compliance.	2/28/2025
	2. **Work Order #31218** was submitted to the Maintenance Department for the two boxes of furnace filters stored on the basement landing to ensure they are removed.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
K-321	**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:	

	1. The undercut for the 1 hour fire rated entry door into Apartment 406 was greater than 3/4 inch.	2/28/2025
	2. Resident Room 110 in Apartment 402 was used for storage and the door failed to provide a self-closing device.	2/28/2025
	3. The undercut for the 1 1/2 hour fire rated Staff door was greater than 3/4 inch.	2/28/2025
	4. The 1 1/2 hour fire rated Staff door was missing a self-closing device.	2/28/2025
	5. The undercut for the 20 minute fire rated Room 7 door on the first floor entry next to the elevator was greater than 3/4 inch.	2/28/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. **Work Order #31219** was submitted to the Maintenance Department for the 3/4 inch undercut of the 1 hour fire rated entry door into Apartment 406, Maintenance will contact DHPace or another contractor to request a quote to determine which doors need to be completely replaced and which ones just need a new door or a new rating to meet compliance.	2/28/2025
	2. **Work Order #31220** was submitted to the Maintenance Department for Resident Room 110 in Apartment 402 used for storage and the door failed to provide a self-closing device. The request has been made to add a self closing device to this door.	2/28/2025
	3. **Work Order #31220** was submitted to the Maintenance Department for the 3/4 inch undercut of the 1 1/2 hour fire rated Staff door. Maintenance will contact DHPace or another contractor to request a quote to determine which doors need to be completely replaced and which ones just need a new door or a new rating to meet compliance.	2/28/2025
	4. **Work Order #31220** was submitted to the Maintenance Department for the 1 1/2 hour fire rated Staff door that was missing a self-closing device. The request has been made to add a self closing device.	2/28/2025
	5. **Work Order #31221** was submitted to the Maintenance Department to repair the undercut of the 20 minute fire rated room #7 door on the first floor entry next to the elevator. Maintenance will contact DHPace or another contractor to request a quote to determine which doors need to be completely replaced and which ones just need a new door or a new rating to meet compliance.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025

K-331	**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 all 2 foot by 4 foot ceiling lights in Apartment 406 were covered with blue fabric.	2/5/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31222 was submitted to the Maintenance Department. For the 2 foot by 4 foot ceiling lights in Apartment 406 the blue fabric has been removed.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025
K-363	**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 in Apartment 406, Room 207, the door failed to latch within the doorframe.	2/4/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31223 was submitted to the Maintenance Department. Maintenance replaced the latch assembly to the door of Room 207 in Apartment 406. The door now will close and latch within the doorframe.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
K-511	**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 Christmas light electrical cord run under a door into Apartment 406.	2/5/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31224 was submitted to the Maintenance Department. The Christmas light electrical cord run under a door into Apartmetn 406 has been removed.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-211		
	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 south exit from the basement was covered with dried leaves, snow and ice.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31255 was submitted to the Maintenance Department. Maintenance cleaned up the leaves from the stairwell blocking outside the door, the snow and ice have melted and the south exit is now cleared.	1/31/2025
	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 be the responsible position to monitor and ensure compliance.	1/31/2025
	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 be the responsible position to monitor and ensure compliance.	1/31/2025
K-291	**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 north emergency light in the Craft Room failed to illuminate when test button was depressed.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Work Order #31226 was submitted to the Maintenance Department. Maintenance replaced the emergency light. The light will illuminate when the test button is depressed.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-321	**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:	
	1. The door to the changing room with a self-closing device was propped open with a wood door chuck.	1/31/2025
	2. The door to the west office next to the center stair was used for storage and no self-closing device was provided. The request was made to add a self-closing device to this door.	2/28/2025
	3. The kitchen storage door in Bear Creek equipped with a self-closing device failed to close and latch within the doorframe. The request was made to repair/adjust this door to ensure that it will latch within the doorframe.	2/28/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. **Work Order #31227** was submitted to the Maintenance Department. Maintenance removed the wood door chuck. The door now is closed and will latch within the doorframe.	1/31/2025
	2. **Work Order #31227** was submitted to the MaintenanceDepartment. The request was made to add a self-closing device to the door to the west office next to the center stair used for storage.	2/28/2025
	3. **Work Order #31227** was submitted to the Maintenance Department. The request was made to repair/adjust the kitchen storage door in Bear Creek equipped with a self-closing device to ensure it will close and latch within the doorframe.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025

	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 is the responsible position to monitor and ensure compliance.	2/28/2025
K-345	**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:**	
	Documentation review revealed not all of the semi-annual fire alarm reports were provided.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31228 was submitted to the Maintenance Department. Maintenance added reports to the binder in the emergency box and are available for review.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-321		
	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 door to the storage room in the Café was obstructed by a large rollling laundry cart filled with kitchen equipment.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31229 was submitted to the Maintenance Department. Maintenance moved the large rolling cart filled with kitchen equipment and the door is now free of obstruction.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-345	**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 manual fire alarm pull in the Café storage room was obstructed by a large storage rolling cart.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Work Order #31230 was submitted to the Maintenance Department. Maintenance has moved the large rolling cart that was obstructing the manual fire alarm pull and it is now free of obstruction.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-511	**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 electrical panel boxes in the Kitchen area were obstructed by floor fans.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31231 was submitted to the Maintenance Department. Maintenance removed the floor fans so that the electrical panel boxes in the Kitchen are not obstructed. The electrical panel boxes in the Kitchen are now unobstructed.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-211		
	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 north and south exits from the Chapel were covered with snow and ice.	2/5/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31232 was submitted to the Maintenance Department. The snow and ice at the north and south exits from the Chapel has been removed.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025
	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 is the responsible position to monitor and ensure compliance.	2/5/2025
K-321	**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 north door to the storage room behind the Alter failed to close and latch. The door appeared to drag on the closure.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	

	Work Order #31233 was submitted to the Maintenance Department. Maintenance removed the door closer arm and adjusted. Reinstalled the door closer arm and tested to ensure the door will now close and latch within the doorframe.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-920	**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 three power strips plugged into each other "daisy chained" in the Chapel behind the piano.	1/15/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31234 was submitted to the Maintenance Department. The Safety Coordinator removed the three power strips "daisy chained" together during this observation. Maintenance ensured that the power strips are gone and not in use.	1/15/2025
	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 is the responsible position to monitor and ensure compliance.	1/15/2025
	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 is the responsible position to monitor and ensure compliance.	1/15/2025

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-291	**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:	
	1. The emergency light in the center basement transfer room failed to illuminate when the test button was depressed.	2/3/2025
	2. No emergency lighting testing provided for 2024 in the inspection folder.	2/3/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31241 was submitted to repair the light and to provide the lighting testing documentation. The light has been repaired and the documentation has been replaced in the inspection binder.	2/3/2025
	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 is the responsible position to monitor and ensure compliance.	2/3/2025
	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 is the responsible position to monitor and ensure compliance.	2/3/2025
K-321	**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:	
	1. Supply room door #111 equipped with a self-closure device failed to latch and close.	2/4/2025

	2. 2nd Floor Activty storage room door, equipped with a self-closure device was held open with a 60 pound bag of sand.	2/4/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. **Work order # 31243** was submitted to the Maintenance Department to repair door #111. The supply room door #111, Maintenance lubricated the latch assembly, tested and the door is closing, latching within the doorframe.	2/4/2025
	2. **Work Order #31243** was submitted to the Maintenance Department. The 2nd floor Activity Storage room door equipped with a self-closure device was tested and it is closing and latching within the doorframe. The 60 pound bag of sand was removed at the time of the observation by the Safety Coordinator.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
K-345	**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:	
	1. Missing junction box cover for the fire alarm wiring in the room across from room #216.	2/3/2025
	2. No fire alarm report was provided.	2/3/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. Work order #31244 was submitted to the Maintenance Department. Midwest Alarms replaced the missing junction box cover for the fire alarm wiring in the room across from room #216.	2/3/2025
	2. Work Order #31244 was submitted to the Maintenance Department to replace the fire alarm reports for review and inspection.	2/3/2025
	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 is the responsible position to monitor and ensure compliance.	2/3/2025

	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-353	**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:**	
	During documentation review; observation revealed no quarterly inspection for 9/2024 was provided.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31245 was submitted to the Maintenance Department. The 9/2024 report is now in the binder for review.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-355	**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 fire extinguisher in the Recycling area was obstructed by a table full of items.	2/4/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31246 was submitted to the Maintenance Department. The table has been relocated and the fire extinguisher in the Recycling area is now unobstructed.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
K-374	**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 west smoke door, south end of the building near room #231 would not latch.	2/28/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31247 was submitted to the Maintenance Department to repair or adjust the west smoke door, south end of the building near room #231 to ensure it will latch.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
K-511	**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 electrical panels in the 3rd floor phone room were obstructed by storage items.	2/4/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31248 was submitted to the Maintenance Department. Maintenance cleared the storage items from in front of the electrical panels in the 3rd floor phone room. The electrical panels are now unobstructed.	2/4/2025

	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 is the responsible position to monitor and ensure compliance.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
K-753	**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 an open junction box in the 1st floor ceiling in the corridor near housekeeping room across from the Beauty Shop room #131.	2/4/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31250 was submitted to the Maintenance Department. Maintenance discovered that MidWest Alarms was on campus and had left the cover off. MidWest Alarms had come back at a later time and put the cover back on.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
	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 is the responsible position to monitor and ensure compliance.	2/4/2025
K-919	**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 entire room filled with excessive Halloween decoration displays including paper mache, pumpkins and life sized character, black plastic hanging over windows and used as wall covering, items hanging from the ceiling, full sized animated characters covered with fabric, floor covered with shredded paper, a cardboard egg crate arches, fabric cobwebbing arched tunnel, cobwebbing hung on walls. The decorations failed to provide documentation of flame retardant, the items had been up since last October and was brought in by staff.	2/6/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order #31249 was submitted to the Maintenance Department. The entire room filled with excessive Halloween decoration displays including paper mache, pumpkins and life sized character, black plastic hanging over windows and used as wall covering, items hanging from the ceiling, full sized animated characters covered with fabric, floor covered with shredded paper, a cardboard egg crate arches, fabric cobwebbing arched tunnel, cobwebbing hung on walls. The decorations failed to provide documentation of flame retardant, the items had been up since last October and was brought in by staff. The decorations have been removed from this room.	2/6/2025
	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 is the responsible position to monitor and ensure compliance.	2/6/2025
	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 is the responsible position to monitor and ensure compliance.	2/6/2025

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104, 3070, 3071 STATE AVE BEATRICE, NE 68310	1/16/2025
	SURVEY EVENT ID#	U74M12
	(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
K-291	**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:	
	1. The emergency light in old generator room failed to operate when the test button was depressed.	1/31/2025
	2. 2024 inspection reports were not provided in the binder provided for review.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	1. **Work Order #31237** was submitted to the Maintenance Department. The emergency light in the old generator room was out and replaced with a new one.	1/31/2025
	2. **Work Order #31237** was submitted to the Maintenance Department. The 2024 inspection reports are available in the main binder in the center (basement mechanical room) with additional reports. One sheet (emergency / egress lights) was pulled by Maintenance and has since been added back to the binder for review.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-321	**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 1 1/2 hour fire rated door in the basement mechanical room separating rooms was held open with a container of scale corrosive cleaner and a black hose approximately 1 1/2 inch.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31238 was submitted to the Maintenance Department to remove the door obstruction so that the door will close and latch within the doorframe. The obstructions were removed from the doorway, the door will now close and latch within the doorframe.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
K-345	**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 during documentation review revealed the fire alarm reports failed to include all the semi-annual inspections.	2/28/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order #31239 was submitted to the Maintenance Department to provide the inpection reports and ensure they are available for review.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
	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 is the responsible position to monitor and ensure compliance.	2/28/2025
K-353	**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 1 1/2 hour fire rated hatch in Room #032 was open and the springs were removed.	1/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work Order # 31240 was submitted to the Maintenance Department. The hatch in question is normally closed. Per management approval this door was left open during the short period of time of the artic blast of cold weather to try and prevent the sprinkler system from freezing as the heat was not keeping up due to the weather. The hatch has since been closed and the springs have been reattached.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025
	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 is the responsible position to monitor and ensure compliance.	1/31/2025

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** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 - 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 4 residents. 400 State Building - Main was found to not be 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		
K0311	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING (Prompt and Slow) Vertical openings shall be enclosed or protected in accordance with 8.6 unless: 1. Unprotected vertical openings not part of required egress shall be permitted by the authority having jurisdiction where such openings do not endanger required means of egress. This shall apply only in buildings protected throughout by an approved automatic sprinkler system in	K0311		

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

Stacey Clydesen | Interim ICF Administrator | 2/7/25

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 B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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
K0311	Continued From page 1 accordance with 33.3.3.5, and exits and required ways of travel thereto are adequately safeguarded against fire and smoke within the building, or in which every individual room has direct access to an exterior exit without passing through a public corridor. 2. In buildings not more than two stories in height, unprotected vertical openings shall be permitted by the authority having jurisdiction if the building is protected throughout by an approved automatic sprinkler system in accordance with 33.3.3.5. No floor below the level of exit discharge used only for storage, heating equipment, or purposes other than residential occupancy shall have unprotected openings to floors used for residential occupancy. 33.3.3.1.1.1, 33.3.3.1.1.2, 33.3.3.1.1.3, 33.3.3.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a door within a vertical opening and allowed storage on the stair. This deficient practice would allow smoke and gasses to move into the stair tower which would delay egress or render the stair enclosures useless during a fire emergency. The facility census was 4. Findings are: Observations on 1-15-25 at 10:40 am and 10:43 am revealed: 1. The undercut for the 1½ hour fire rated stair door was greater than ¾ inch. 2. Two boxes of furnace filters stored on the basement landing. During an interview 1-15-25 at 10:40 am and 10:43 am, Staff A confirmed the gap and the storage on	K0311		

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** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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
K0311	Continued From page 2 the stair landing.	K0311		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING (Prompt and Slow) Rooms containing high-pressure boilers, refrigerating machinery, transformers, or other service equipment subject to possible explosion shall not be located under or adjacent to exits. All such rooms shall be effectively separated from other parts of the building as specified in section 8.7. Hazardous areas shall be separated with construction of a minimum of 1-hour fire resistance with openings protected with self-closing fire doors or have an automatic extinguishment system and smoke partition in accordance with 8.4. Hazardous areas shall include but not be limited to the following: boiler or heating rooms, laundries, repair shop, spaces storing combustibles in quantities deemed hazardous. 33.3.3.2.2 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 self-closing devices and ensure undercut to the doors to hazardous areas were less than ¾ inches. These deficient practices would allow smoke to migrate into the exit corridors. The facility census was 4. Findings are: Observation on 1-15-25, between 10:00 am and 10:38 am revealed: 1. The undercut for the 1-hour fire rated entry door into Apartment 406 was greater than ¾ inch.	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **02 - 400 STATE** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 3 2. Resident Room 110 in Apartment 402 was used for storage and the door failed to provide a self-closing device. 3. The undercut for the 1 ½ -hour fire rated Staff door was greater than ¾ inch. 4. 1 ½ -hour fire rated Staff door was missing a self-closing device. 5. The undercut for the 20 minute-fire rated Room 7 door on the first-floor entry next to the elevator was greater than ¾ inch During an interview on 1-15-25, between 10:00 am and 10:38 am, Administration Staff A confirmed the findings.	K0321		
K0331	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING (Prompt & Slow) Interior wall and ceiling finish shall be Class A or Class B in accordance with Section 10.2. 33.3.3.3.2 This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to install ceiling coverings that met interior finish rating requirements. This deficient practice would accelerate the spread of fire, smoke and gasses. The facility census was 4. Findings are: Observation on 1-15-25, at 9:53 am revealed, all 2 foot by 4 foot ceiling lights in Apartment 406 were covered with blue fabric. During an interview 1-15-25, at 9:53 am, Staff A confirmed the material, and stated it was installed	K0331		

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	28G107	A. BUILDING **02 - 400 STATE** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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
K0331	Continued From page 4 because of a medical issue, no documentation was provided.	K0331		
K0363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors shall have a fire protection rating of not less than 20 minutes, unless the following condition exist: 1. Solid-bonded wood core doors of not less than 1-3/4 inches (4.4 cm)thickness shall be permitted to continue to be used. 2. In buildings protected throughout by an approved automatic sprinkler system in accordance with 33.3.3.5, doors that are nonrated shall be permitted to continue to be used. 3. Where automatic sprinkler protection is provided in the corridor in accordance with 31 3.5.8, doors shall not be required to have a fire protection rating but shall be in accordance with 8.4.3. The provisions of 8.4.3.5 shall not apply. Doors shall be equipped with latches for keeping the doors tightly closed. Walls and doors required by 33.3.3.6.1 and 33.3.3.6.2 shall be constructed as smoke partitions in accordance with 8.4. The provisions of 8.4.3.5 shall not apply. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Doors in walls separating sleeping rooms from corridors shall be automatic-closing in accordance with 7.2.1.8.2 unless the following conditions exist: 1. Doors to sleeping rooms that have occupant-control locks such that access is normally restricted to the occupants or staff personnel shall be permitted to be self-closing. 2. In buildings protected throughout by an approved	K0363		

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	28G107	A. BUILDING **02 - 400 STATE** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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
K0363	Continued From page 5 automatic sprinkler system installed in accordance with 33.3.3.5, doors, other than doors to hazardous areas, vertical openings, and exit enclosures, shall not be required to be self-closing or automatic-closing. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.3.3.6.4.1, 33.3.3.6.4.2, 33.3.3.6.4.3, 33.3.3.6.4.4, 33.3.3.6.5, 33.3.3.6.6.1, 33.3.6.6.2, 33.3.3.6.6.3, 33.7.7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to assure doors would latch within the doorframe. This deficient practice would allow smoke, fire and gases to spread outside the room The facility census was 4. Findings are: Observations on 1-15-25 at 10:04 am revealed, Apartment 406, Room 207 door failed to latch within the doorframe. During an interview on 1-15-25 at 11:04 am, Staff A confirmed the door failed to latch	K0363		
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 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to assure electrical cords were not run under doors. This deficient practice increases the potential for an electrical fire. The facility census	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** B. WING _____	**01/16/2025**

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

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K0511	Continued From page 6 was 4. Findings are: Observations on 1-15-25 at 9:44 am revealed, Christmas light electrical cord run under a door into Apartment 406. During an interview on 1-15-24 at 9:44 am, Staff A confirmed the electrical cord under the door.	K0511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **3A - BSDC-200 SHERIDAN-NON RES** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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. 200 Sheridan (Bear Creek/Therapy) is a two story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 200 Sheridan (Bear Creek/Therapy) was found not 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		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain means of egress free of obstructions and failed to assure that snow and ice was removed from the sidewalks. These	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Clydesen	Interim ICF Administrator	2/7/25

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 **3A - BSDC-200 SHERIDAN-NON RES** B. WING _____	**01/16/2025**

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

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K 211	Continued From page 1 deficient practices would delay egress and not impede it to full instant use in the case of fire or other emergency. Findings are: Observations on 1-16-25 at 2:52 pm revealed, the south exit from the basement was covered with dried leaves, snow and ice. During an interview on 1-16-25 at 2:52 am, Staff A confirmed the stair/sidewalk had not been cleared.	K 211		
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to maintain emergency lighting. This deficient practice would delay egress and cause confusion. Findings are: Observations on 1-16-25 at 2:40 pm revealed: 1 The north emergency light in the Craft room failed to illuminate when the test button was depressed. During an interview on 1-16-25, at 2:40 pm, Staff A confirmed the light failed to work.	K 291		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

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	28G107	A. BUILDING **3A - BSDC-200 SHERIDAN-NON RES** B. WING _____	**01/16/2025**

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

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K 321	Continued From page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the door to a hazardous area would latch within the frame. This deficient practice would allow fire, smoke and gasses to migrate into other areas. Findings are: Observation on 1-16-25 between 2:14 pm and 2:33	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **3A - BSDC-200 SHERIDAN-NON RES** B. WING _____	01/16/2025

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

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K 321	Continued From page 3 pm revealed: 1. The door to the Changing room located within Room 208, equipped with a self-closing device was propped open with a wood door chock. 2. The door to the west office next to the center stair was used for storage, and no self-closing device was provided. 3. The door in Kitchen storage door in Bear Creek, equipped with a self-closing device failed to close and latch within the doorframe. During an interview on 1-16-25 between 2:14 pm and 2:33 pm, Facility Staff A confirmed the findings.	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6 1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation, documentation review and interview, the facility failed to assure all fire alarm reports were provided. This deficient practice would increase the potential for the fire alarm system not to activate as designed. Findings are: Documentation review on 1-16-25 at 3:49 pm revealed not all semi-annual fire alarm reports were provided.	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 3A - BSDC-200 SHERIDAN-NON RES B. WING _____	01/16/2025

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

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K 345	Continued From page 4 During an interview on 1-16-25 at 3:49 pm, Staff A confirmed missing fire alarm reports.	K 345		

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 **4A - BSDC-CARSTENS CENTER** B. WING _____	**01/16/2025**

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

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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. Carstens is a single story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 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		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Lydeen — TITLE: Interim ICF Administrator — (X6) DATE: 2/7/25

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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 4A - BSDC-CARSTENS CENTER B. WING _____	01/16/2025

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

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K 321	Continued From page 1 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to assure doors to hazardous areas were not obstructed and could close within the doorframe. This deficient practice would allow fire, smoke and gasses to escape from the room during a fire emergency. Findings are: Observations on 1-15-25 at 11:51 am, revealed the door to the storage room in the Café was obstructed by a large rolling laundry cart filled with kitchen equipment. During an interview on 1-15-25 at 11:51 am, Staff A confirmed the door was obstructed.	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **4A - BSDC-CARSTENS CENTER** B. WING _____	**01/16/2025**

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

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K 345	Continued From page 2 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure that manual pull stations for the fire alarm system were not obstructed. This deficient practice would delay activation of the fire alarm. Findings are: Observations on 1-15-25 at 11:51 am, revealed the manual fire alarm pull in the Café storage room was obstructed with a large storage rolling cart. During an interview on 1-15-25 at 11:51 am, Staff A confirmed the pull was obstructed.	K 345		
K 511	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 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 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 electrical	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 4A - BSDC-CARSTENS CENTER B. WING _____	01/16/2025

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400 STATE BUILDING	3104 STATE AVE BEATRICE, NE 68310

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K 511	Continued From page 3 panel boxes. This deficient practice could cause injury and delay turning off the power during an electrical emergency. Findings are: Observation 1-15-25 at 11:57 am revealed, the electrical panel boxes in the Kitchen were obstructed by floor fans. During an interview on 1-15-25 at 11:57 am, Staff A confirmed the items stored in front of the panel boxes.	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **5A - BSDC-CHAPEL** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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. Chapel is a single story building of Type V (000) construction that was approved in 2002 and is not sprinkled. Chapel was found not to be 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		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain means of egress free of obstructions and failed to assure that snow and ice was removed from the sidewalks. These deficient practices would delay egress and not impede it to full instant use in the case of fire or	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Clydesen — TITLE: Interim ICF Administrator — (X6) DATE: 2/7/25

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 **5A - BSDC-CHAPEL** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 211	Continued From page 1 other emergency. Findings are: Observations on 1-15-25 at 10:52 am revealed, the north and south exits from the Chapel was covered with snow and ice. During interview on 1-15-25 at 10:52 am, Staff A confirmed the sidewalk had not been cleared.	K 211		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 2 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure doors to hazardous areas would close and latch within the doorframe. This deficient would allow smoke, fire and gasses to enter the assembly are and would cause confusion and delay egress. Findings are: Observations on 1-15-25 at 10:52 am revealed, the north door to the storage room behind the Alter failed to close and latch. The door appeared to drag on the closure. During an interview 1-15-25 at 10:52 am, Staff A confirmed the door failed to latch.	K 321		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips	K 920		

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K 920	Continued From page 3 meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of electrical power strips as a substitute for adequate wiring. This deficient practice would create electrical injury and increase a fire hazard. Findings are: Observation on 1-15-25 at 10:55 am revealed, three power strips plugged into each other "daisy chained" in the Chapel behind the piano. During an interview on 1-15-25 at 10:55 am, Staff A confirmed the use of power strips that were "daisy chained". NFPA Standard: NFPA 70, 2011, 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920	Continued From page 4 (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage UL Standard: Relocatable power taps are not intended to be piggybacked or daisy chained. UL 1363 User Guide for Relocatable Power Taps	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **6A - BSDC-D BUILDING-NON-RES** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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. D Building (training) is a three story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. D Building (training) was found to not be 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		
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to maintain emergency lighting. This deficient practice would delay egress and cause confusion. Findings are: Observations on 1-16-25 at 1:57 and 2:07 pm pm revealed.	K 291		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Andersen — TITLE: Interim ICF Administrator — (X6) DATE: 2/7/25

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	28G107	A. BUILDING **6A - BSDC-D BUILDING-NON-RES** B. WING _____	**01/16/2025**

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K 291	Continued From page 1 1. The emergency light in the center basement transfer room failed to illuminate when the test button was depressed. 2. No emergency lighting testing provided for 2024 in the inspection binder. During an interview on 1-16-25, at 1057 pm, Staff A confirmed the light failed to work. During an interview on 1-16-25 at 2:07 pm, Staff A confirmed the lack of 2024 inspection reports.	K 291		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		

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K 321	Continued From page 2 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a smoke resistant enclosures 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 1-16-25 at 2:27 pm and 3:11 pm revealed: 1. Supply room 111 door equipped with a self-closure, failed to close and latch. 2. 2nd floor Activity storage room door, equipped with a self-closure was held open with a 60-pound bag of sand. During an interview on 1-16-25 at 2:27 pm and 3:11 pm, Staff A confirmed the findings	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by:	K 345		

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K 345	Continued From page 3 Based on observation, documentation review and interview, the facility failed to assure all fire alarm reports were provided and failed to assure junction boxes were covered. This deficient practice would increase the potential for the fire alarm system not to activate as designed. Findings are: Observations and document review on 1-16-25 at 2:09 pm and 2:45 pm revealed, 1. Missing junction box cover for fire alarm wiring in the room across from room 216. 2. No fire alarm report were provided. During an interview on 1-16-25 at 2:45 pm, Staff A confirmed the open junction boxes. During an interview on 1-16-25 at 2:09 pm, Staff A confirmed missing fire alarm reports.	K 345		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		

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K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to provide all sprinkler inspection reports. This deficient practice would not assure that the sprinkler system would operate as designed. Findings are: Documentation review on 1-16-25 at 2:12 pm revealed, no quarterly inspection for 9/2024 was provided. During an interview on 1-16-25 at 2:12 pm, Staff A confirmed missing sprinkler reports.	K 353		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure portable fire extinguishers were not obstructed. This deficient practice would delay access to the extinguisher during a fire. Findings are: Observation on 1-16-25 at 3:03 pm revealed, the fire extinguisher in the Recycling area was obstructed by a table full of items.	K 355		

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K 355	Continued From page 5 During an interview on 1-16-25 at 3:03 pm, Staff A confirmed extinguisher was obstructed. NFPA Standard: 2010, NFPA 10, 7.2.1.3 Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place	K 355		
K 374	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per	K 374		

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K 374	Continued From page 6 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to assure that smoke doors would close and latch. This deficient practice would increase the potential for fire, smoke and gases to spread. Findings are: Observations on 1-16-25 at 2:38 pm revealed, the west smoke door, south end of building near room 231 failed to latch. During an interview on 1-16-25 at 2:38 pm, Staff A confirmed the smoke door would not latch.	K 374		
K 511	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 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 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 electrical	K 511		

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K 511	Continued From page 7 panel boxes. This deficient practice could cause injury and delay turning off the power during an electrical emergency. Findings are: Observation 1-16-25 at 2:57 pm revealed, the electrical panel boxes in the 3rd floor Phone Room were obstructed. During an interview on 1-16-25 at 2:57 pm, Staff A confirmed the items stored in front of the panel boxes.	K 511		
K 753	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of combustible decorations in a concentrated area. This deficient practice would allow fire, gasses and smoke	K 753		

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400 STATE BUILDING	**3104 STATE AVE BEATRICE, NE 68310**

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K 753	Continued From page 8 spread within the exit corridor, which would affect exiting during an emergency. Findings are: Observations on 1-16-25 at 3:34 pm revealed, the entire room filled with excessive Halloween decoration displays including, paper mâché pumpkins and life sized character, black plastic hanging over windows and used as wall covering, items hanging from the ceiling, full sized animated characters covered with fabric, floor covered with shredded paper, a cardboard egg crate arches, fabric cobwebbing arched tunnel, cobwebbing hung on walls. During an interview on 1-16-25 at 3:34 am, Staff A confirmed the decorations and failed to provide documentation for flame retardant, stated it had been up since last October and was brought in by staff. NFPA Standard: NFPA 101 2012 edition 13.7.3.2 The authority having jurisdiction shall impose controls on the quantity and arrangement of combustible contents in assembly occupancies to provide an adequate level of safety to life from fire. 10.2.4.6 Decorations and furnishings that do not meet the definition of interior finish shall be regulated by the provisions of Section 10.3.	K 753		
K 919	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99	K 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **6A - BSDC-D BUILDING-NON-RES** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 919	Continued From page 9 Chapter 10, Electrical Equipment, 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. Chapter 10 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit an open junction box. This deficient practice would create electrical injury and increase a fire hazard. Findings are: Observation on 1-16-25 at 2:34 pm revealed, an open junction box in the 1st floor ceiling in the corridor near housekeeping room across from the Beauty Shop 131. During an interview on 1-16-25 at 2:34 pm, Staff A confirmed the open junction box.	K 919		

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 1O - BSDC-ADMINISTRATION BUILDING B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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. Administration is a two story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. 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		
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, documentation review and interview, the facility failed to maintain emergency lighting. This deficient practice would cause confusion and delay egress the in the event of a power failure; no egress lighting would be available. Findings are: Observation on 1-16-25 at 3:00 pm and 3:36 pm revealed,	K 291		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacey Sydersen | TITLE: Interim ICF Administrator | (X6) DATE: 2/7/25

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 1O - BSDC-ADMINISTRATION BUILDING B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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 291	Continued From page 1 1. The emergency light in old generator room failed to operate when the test button was depressed. 2. 2024 inspection reports were not provided in the binder provided for review. During an interview on 1-16-25 at 3:00 pm, Staff A confirmed the emergency light failed to work During an interview on 1-16-25 at 3:36 pm, Staff A confirmed the emergency light testing report for 2024 was not in the binder.	K 291		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 1O - BSDC-ADMINISTRATION BUILDING B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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 321	Continued From page 2 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and 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 which could delay egress. Findings are: Observation on 1-16-25 at 3:12 pm revealed, the 1 ½ hour fire rated door in the basement mechanical room separating rooms was held open with a container of scale corrosive cleaner and a black hose approximately 1 ½ inch. During an interview on 1-16-25 at 3:12 pm Staff A confirmed the fire rated door was held open.	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on documentation and interview, the facility failed to assure that all fire alarm reports were	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 1O - BSDC-ADMINISTRATION BUILDING B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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 345	Continued From page 3 provided for review. This deficient practice would not allow the system to operate as designed. Findings are: Documentation review on 1-16-25 at 3:27 pm revealed, the fire alarm reports failed to include all semi-annual inspections. During an interview on 1-16-25 at 3:27 pm, Staff A confirmed the missing reports.	K 345		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure that the fire rated hatch between sprinkled and non-sprinkled areas was operational. This deficient practice would not assure the	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **1O - BSDC-ADMINISTRATION BUILDING** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 353	Continued From page 4 sprinkler system would operate as designed. Findings are: Observations on 1-16-25 at 3:05 pm revealed, the 1 ½ hour fire rated hatch in Room 032 was open and the springs were removed. During an interview on 1-16-25 at 3:05 pm, Staff A confirmed the hatch was not closed and the springs were removed.	K 353		

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 10:34 AM
To: Fralin, Russell
Subject: WO# BSDC-31218 has been created.

Building 0R

WO# BSDC-31218 has been created.

Request Number	Request Description	Location
BSDC-31218	General:3104 State Avenue/F Building: During Fire Marshal survey noted: * the undercut for the 1 1/2 hour fire rated stair door was greater than 3/4 inch. *Also two boxes of furnace filters stored on the basement landing. Please repair the door and remove the boxes of furnace filters. Thank you.	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=putgq5izghqr7jfk687mndebfc

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 10:37 AM
To: Fralin, Russell
Subject: WO# BSDC-31219 has been created.

Building 07

WO# BSDC-31219 has been created.

Request Number	Request Description	Location
BSDC-31219	General:3104 State Avenue/F Building: During Fire Marshal survey noted: *The undercut for the 1 hour fire rated entry door into home #406 was greater than 3/4". Please repair the door. Thank you.	Floor 2

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=n8n6x8cbxymwtx6ehnyzyg6rmr

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 10:40 AM
To: Fralin, Russell
Subject: WO# BSDC-31220 has been created.

Building 07

WO# BSDC-31220 has been created.

Request Number	Request Description	Location
BSDC-31220	General:3104 State Avenue/F Building: During the Fire Marshal survey noted: *Resident room #110 in home #402 was used for storage and the door failed to provide a self-closing device. *The under for the 1 1/2 hour fire rated Staff door was greater than 3/4" and the Staff door is missing a self closing device. Please repair the door and add a self-closing device. Thank you.	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=t94cpiwqgy1rznkduuxjb8w6ec

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 10:40 AM
To: Fralin, Russell
Subject: WO# BSDC-31221 has been created.

Building 08

WO# BSDC-31221 has been created.

Request Number	Request Description	Location
BSDC-31221	General:3104 State Avenue/F Building: During the Fire Marshal survey noted - *The undercut for the 20 minute fire rated room #7 door on the first floor entry next to the elevator is greater than 3/4". Please repair the door. Thank you.	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=emii4f51izhr9drd5gzqaoketr

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 4, 2025 1:23 PM
To: Fralin, Russell
Subject: WO# BSDC-31223 has been completed - please verify.

Building 05

WO# BSDC-31223 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31223	General:3104 State Avenue/F Building: During the Fire Marshal survey noted - *Room 207 in home 406 failed to latch within the doorframe. Please repair this door. Thank you	Floor 2

Assigned To:
Steven Robertson
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=wwpph8wy75iwzxcrbcxz8hz65a
Completion Notes:
Replaced latch assembly.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Wednesday, February 5, 2025 8:40 AM
To: Fralin, Russell
Subject: WO# BSDC-31224 has been completed - please verify.

Building 07

WO# BSDC-31224 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31224	General:3104 State Avenue/F Building: During the Fire Marshal survey noted - *Observation revealed a Christmas light electrical cord was run under a door into home #406. Please remove the cord. Thank you	Floor 2

Assigned To:
Richard Karas
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=kznt4w6tb11rfbprwbsfjcoapc
Completion Notes:
cord already removed

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Wednesday, February 5, 2025 8:40 AM
To: Fralin, Russell
Subject: WO# BSDC-31222 has been completed - please verify.

Building 02

WO# BSDC-31222 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31222	General:3104 State Avenue/F Building: During the Fire Marshal survey noted - *Observation revealed a 2 foot by 4 foot ceiling lights in home #406 were covered with blue fabric. Staff stated the material was for a medical condition. The blue light covers do not have flammability documentation and need to be removed and alternative covering ordered and installed. Thank you	Floor 2

Assigned To:
Richard Karas
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=qtjp87htyxzwdpgd5snxkuggxe
Completion Notes:
blue covering was already removed

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 11:31 AM
To: Fralin, Russell
Subject: WO# BSDC-31225 has been completed - please verify.

Building 30

WO# BSDC-31225 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31225	General:834 Sheridan/West Wing: During the Fire Marshal survey noted - *The south exit from the basement with dried leaves, snow and ice. Need to clear this area for egress. Thank you.	Floor 1

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=1ke31jxjtnuw8fnun3eqwgeuky
Completion Notes:
cleaned up the leaves from the stairwell blocking outside door

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
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'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 11:31 AM
To: Fralin, Russell
Subject: WO# BSDC-31226 has been completed - please verify.

Building 38A

WO# BSDC-31226 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31226	General:834 Sheridan/West Wing: During the Fire Marshal survey noted - *the north emergency light in the Craft Room failed to illuminate when the test button was depressed. Need to repair this light so that it illuminates. Thank you.	Floor 1

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=sn7gea7omssw5qdumsj4syk95y
Completion Notes:
replaced emergency exit sign as directed by fire marshal

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 1:15 PM
To: Fralin, Russell
Subject: WO# BSDC-31227 has been completed - please verify.

Building 38A

WO# BSDC-31227 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31227	General:834 Sheridan/West Wing: During the Fire Marshal survey noted - *The door to the changing room located in #208 was equipped with a self-closing device but was propped open with wood door chock. *The door to the west office next to the center stair was used for storage and no self-closing device provided. *The door in the kitchen storage area in Bear Creek equipped with a self-closing device failed to close and latch within door frame. Please remove wooden door chock, add self-closing device to storag	Floor 1

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=4ux73zrhma7wzpdyduqgrhwfhr
Completion Notes:
door was propped open with doorstop removed doorstop per fire marshal.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 11:36 AM
To: Fralin, Russell
Subject: WO# BSDC-31228 has been completed - please verify.

Building 397

WO# BSDC-31228 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31228	General:834 Sheridan/West Wing: During the Fire Marshal survey noted - *Revealed not all semi-annual fire alarm reports were provided. Please ensure all fire alarm reports are available. Thank you	Floor 1

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=bfppa76fo77wbka6upr9mbgiro
Completion Notes:
put more records back in emergency box per fire harshal

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 3:26 PM
To: Fralin, Russell
Subject: WO# BSDC-31229 has been completed - please verify.

Buildings 4A

WO# BSDC-31229 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31229	General:3000 Carstens Drive/Carstens Center: During the Fire Marshal survey noted - *Door to the storage area in the Cafe' was obstructed by a large rolling laundry cart filled with kitchen equipment. Please ensure the cart is removed. Thank you	Floor 1

Assigned To:
Terry Brown
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=z9xa1na7okur5rgxhtdj13675r
Completion Notes:
moved the large rolling laundry cart filled with kitchen equipment that was obstructing the door. nothing obstructing the door now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 3:20 PM
To: Fralin, Russell
Subject: WO# BSDC-31230 has been completed - please verify.

Building 4A

WO# BSDC-31230 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31230	General:3000 Carstens Drive/Carstens Center: During the Fire Marshal survey noted - *Manual fir alarm pull in the Cafe' storage area was obstructed with a large rolling cart. Please ensure the cart is removed. Thank you	Floor 1

Assigned To:
Terry Brown
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=ouwhijyddtywjgjr4u473hobxr
Completion Notes:
moved the large rolling cart that was obstructing the manual fire pull. nothing in front of it now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 3:17 PM
To: Fralin, Russell
Subject: WO# BSDC-31231 has been completed - please verify.

Building 4A

WO# BSDC-31231 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31231	General:3000 Carstens Drive/Carstens Center: During the Fire Marshal survey noted - *Electrical panel boxes in the kitchenette were obstructed by floor fans. Please ensure the floor fans are relocated. Thank you.	Floor 1

Assigned To:
Terry Brown
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=jq99d4hajbdrxqfc1wfpmatxho
Completion Notes:
moved floor fans out of the way of the electrical box. nothing in front of panels now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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Code Type:
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 3:14 PM
To: Fralin, Russell
Subject: WO# BSDC-31233 has been completed - please verify.

Buildings JH

WO# BSDC-31233 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31233	General:3065 Carstens Drive/Chapel: During the Fire Marshal survey noted - *The north door to the storage area behind the Alter failed to close and latch. The door appeared to drag on the closure. Please ensure the door will close and latch within the door frame without resistance. Thank you.	Floor 1

Assigned To:
Terry Brown
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=gukxw4r7n8ewfqpm75smendt8h
Completion Notes:
removed door closer arm and adjusted. reinstalled door closer arm. tested after completion works fine now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

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Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Wednesday, February 5, 2025 8:37 AM
To: Fralin, Russell
Subject: WO# BSDC-31232 has been completed - please verify.

Building 5A

WO# BSDC-31232 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31232	General:3065 Carstens Drive/Chapel: During the Fire Marshal survey noted - *the north and south exits from the Chapel were covered with snow and ice and were not cleared. Please ensure the north and south exits are cleared during this type of weather for egress. Thank you.	Grounds

Assigned To:
Richard Karas
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=z47e1igsnhawf8yijewouctiua
Completion Notes:
snow already removed

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Wednesday, February 5, 2025 10:26 AM
To: Fralin, Russell
Subject: WO# BSDC-31234 has been completed - please verify.

Buildings 5A

WO# BSDC-31234 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31234	General:3065 Carstens Drive/Chapel: During the Fire Marshal survey noted - *three power strips plugged into each other "daisy chained" behind the piano. Please ensure this practice is prohibited. Thank you	Floor 1

Assigned To:
Richard Karas
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=icj6yqqpu31wxktx8yy8y3ud7w
Completion Notes:
Already taken care of.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Monday, February 3, 2025 7:48 AM
To: Fralin, Russell
Subject: WO# BSDC-31241 has been completed - please verify.

Building 6A

WO# BSDC-31241 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31241	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *The emergency light in the center basement transfer room failed to illuminate when the test button was depressed. *No emergency light testing provided for 2024 in the inspection folder. Please repair the light and provide the testing documentation. Thank you.	Basement

Assigned To:
William Lux
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=eu7xwt3fgzkrzdr6g5o9d9x9jy
Completion Notes:
repaired light and Bob replaced the inspection sheet

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

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Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Monday, February 3, 2025 7:51 AM
To: Fralin, Russell
Subject: WO# BSDC-31244 has been completed - please verify.

Building 6A

WO# BSDC-31244 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31244	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *Missing junction box cover for fire alarm wiring in the room across from Room #216. *No fire alarm report provided. Please install the covering for fire alarm wiring and provide fire alarm documentation. Thank you	Floor 2

Assigned To:
William Lux
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=rfr6mi3tfderinu9izhxfth3hy
Completion Notes:
looked for described problem, Finally called Mike Balderson to find out what the problem was only to find out Midwest Alarms had already corrected the problem

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 3:02 PM
To: Fralin, Russell
Subject: WO# BSDC-31245 has been completed - please verify.

Building 6A

WO# BSDC-31245 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31245	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *During documentation review, no quarterly inspections for 9/2024 for sprinkler inspection. Please provide the sprinkler inspection documentation for 9/2024. Thank you	Floor 1

Assigned To:
Robert Bruhn
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=uydm8u6s87irjkwppgo4xo8a3o
Completion Notes:
The September report was in the binder, the fire marshall did not see it.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 2:43 PM
To: Fralin, Russell
Subject: WO# BSDC-31247 has been created.

Building 6A

WO# BSDC-31247 has been created.

Request Number	Request Description	Location
BSDC-31247	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *the West smoke door, south end of the building near room 231 failed to latch. Please adjust the door so that it will latch. Thank you	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=zfuy5ehrgbtrfy4ey3rkb8kzjo

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 4, 2025 9:35 AM
To: Fralin, Russell
Subject: WO# BSDC-31250 has been completed - please verify.

Building 6A

WO# BSDC-31250 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31250	General:941 Sheridan/ D Building: During the Fire Marshal survey noted - *Open junction box in the 1st floor ceiling in the corridor near housekeeping room across from the Beauty Shop - room 131. Please provide ensure the junction box is closed securely. Thank you	Floor 1

Assigned To:
William Lux
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=w7fao3r8n9prfkrjef9odjf9sh
Completion Notes:
looked for described defficency only to learn contractor had left cover off and had came back later and repaired it

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 4, 2025 11:44 AM
To: Fralin, Russell
Subject: WO# BSDC-31242 has been completed - please verify.

Building 6A

WO# BSDC-31242 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31242	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *Supply room door #111 equipped with a self-closure failed to latch Please repair door so it will latch within door frame. Thank you	Floor 1

Assigned To:
Steven Robertson
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=bm7thk9csefrifjhtg8qncamcc
Completion Notes:
Lubricated latch assembly, tested, working fine now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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Code Type:
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'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From:	replyto@cn90listener.corrigo.com
Sent:	Tuesday, February 4, 2025 11:53 AM
To:	Fralin, Russell
Subject:	WO# BSDC-31243 has been completed - please verify.

Building 6A

WO# BSDC-31243 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31243	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *2nd floor Activity storage room door with equipped with a self-closure was held open with a 60 pound bag of sand. Please ensure the door will close and latch within the door frame and not held open with sand bag. Thank you.	Floor 2

Assigned To:
Steven Robertson
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=1th7phdcrjww8nufej11owpbxo
Completion Notes:
I'm assuming this is room 201c. Staff had removed the sand bag. I checked the door it was closing and latching properly. I also checked room 222b, the other hall storage closet, it was closing and latching properly also.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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'nc' if the work is **N**ot **C**ompleted

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Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 4, 2025 1:08 PM
To: Fralin, Russell
Subject: WO# BSDC-31246 has been completed - please verify.

Building 6A

WO# BSDC-31246 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31246	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *The fire extinguisher in the Recycling area is obstructed by a table full of items. Need to move the table so that the fire extinguisher is not obstructed. Thank you.	Floor 3

Assigned To:
Steven Robertson
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=abi5zz6if1xw8btdn7rg6hi5oc
Completion Notes:
Staff had moved the table by the time I got there. The fire extinguisher is unobstructed now.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

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Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Tuesday, February 4, 2025 1:35 PM
To: Fralin, Russell
Subject: WO# BSDC-31248 has been completed - please verify.

Building 6A

WO# BSDC-31248 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31248	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *The electrical panel/boxes in the 3rd floor phone room were obstructed with various items. Ensure the electrical panel is not blocked. Thank you	Floor 3

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=xo38aeu86gxwxyps4suwi8hacy
Completion Notes:
cleared area around the electrical panel per fire marshal.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

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Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Thursday, February 6, 2025 7:35 AM
To: Fralin, Russell
Subject: WO# BSDC-31249 has been completed - please verify.

Building 6A

WO# BSDC-31249 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31249	General:941 Sheridan/D Building: During the Fire Marshal survey noted - *South room of 3rd floor filled with excessive halloween decorations. Decorations have been up since October and do not have documentation of flame retardant. Need to take all of these decorations down and ensure the room is back to normal standards. Thank you	Floor 3

Assigned To:
Ray Reckley
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=dwtw6rnmtyewjg7nfgsnpcduny
Completion Notes:
cleanout Halloween decorations from south end of third floor D bldg

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From:	replyto@cn90listener.corrigo.com
Sent:	Friday, January 31, 2025 9:52 AM
To:	Fralin, Russell
Subject:	WO# BSDC-31237 has been completed - please verify.

Building 10

WO# BSDC-31237 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31237	General:843 Wallman Drive/Admin Building: During the Fire Marshal survey noted - *Emergency light in the old generator room failed to operate when the test button was depressed. *Light testing reports were not provided in the binder for review. Please repair light and add testing reports to the binder for review. Thank you	Floor 1

Assigned To:
Aaron Smith
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=yofdyed6w7ww8c8ikpzrt64iao
Completion Notes:
The light was out, and we replaced it with a new one (separate work order was made prior to this report). The paperwork was available in the main binder in the center (basement mechanical room) with all the other paperwork. One sheet (emergency/egress lights) was pulled by a co-worker. since put back in for review.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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Code Type:
'cpos' if you are **Satisfied** with the work
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'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 7:53 AM
To: Fralin, Russell
Subject: WO# BSDC-31238 has been completed - please verify.

Building 10

WO# BSDC-31238 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31238	General:843 Wallman Drive/Admin Building: During the Fire Marshal survey noted - *The 1/2 hour fire rated door in the basement mechanical room separating rooms was held open with a container of scale corrosive cleaner and a black hose. Please remove the door obstruction so that the door will close and latch within the frame. Thank you	Basement

Assigned To:
Aaron Smith
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=mj6xpjh431xrpyrqw5w4k6ocnr
Completion Notes:

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

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'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

Fralin, Russell

From: Notifications.Acctname@corrigo.com
Sent: Thursday, January 30, 2025 1:40 PM
To: Fralin, Russell
Subject: WO# BSDC-31239 has been created.

Building ID

WO# BSDC-31239 has been created.

Request Number	Request Description	Location
BSDC-31239	General:843 Wallman Drive/Admin Building: During the Fire Marshal survey noted - *The facility failed to ensure that all fire alarm reports were provided for review - including the semi-annual inspections. Please provide the inspections for review. Thank you.	Floor 1

Assigned To:
Gayle Hawkins
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=0&WoKey=unr45by78tqrtmqdyod9eeezbc

The requestor will receive another email notification when the service request has been completed and the work is ready to be verified.

Fralin, Russell

From: replyto@cn90listener.corrigo.com
Sent: Friday, January 31, 2025 9:13 AM
To: Fralin, Russell
Subject: WO# BSDC-31240 has been completed - please verify.

Building 10

WO# BSDC-31240 has been completed - please verify.

Request Number	Request Description	Location
BSDC-31240	General:843 Wallman Drive/Admin Building: During the Fire Marshal survey noted - *The 1 1/2 hour fire rated hatch in room 032 was open and the springs were removed. Please repair. Thank you.	Floor 1

Assigned To:
Aaron Smith
Customer Portal:
https://stateofnebraska.corrigo.com/CP30/follow-link?FollowLinkTypeId=1&ActionId=6&WoKey=p3gy4kxytn9ricm5qid6yim1fe
Completion Notes:
The hatch in question has since been closed and is normally closed all the time. This is to the breezeway crawlspace between A Building and West-Wing. Per managements approval we left these, and the doors open (during a brief period of time of an artic blast) to try and prevent the sprinkler system from freezing as the heat could not keep up with heating this area. The springs were reattached this am.

Please login to the Customer Portal and verify their work.

-OR-

You may reply to this email by typing one of four (4) one word responses below, followed by any clarifying comments as described at the bottom of this email.

Please verify the work was completed and note your satisfaction by replying to this email and typing a response.

Code Type:
'cpos' if you are **Satisfied** with the work
'cneg' if the work was completed but you are **Not Satisfied**
'neutral' if the work was completed and your satisfaction level is **Neutral**
'nc' if the work is **N**ot **C**ompleted

***Any comments typed after the 'code' will be copied into the work order for the JLL team to review and follow up on according to your feedback.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING 6A - BSDC-D BUILDING-NON-RES B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	3104 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. D Building (training) is a three story building of Type II (000) construction that was approved in 2002 and is fully sprinkled. D Building (training) was found to not be 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}		
{K 374}	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by:	{K 374}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Interim ICF Area Admin	3/14/25

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 **6A - BSDC-D BUILDING-NON-RES** B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 374}	Continued From page 1 Based on observations and interview, the facility failed to assure that smoke doors would close and latch. This deficient practice would increase the potential for fire, smoke and gases to spread. Findings are: Observations on 3-4-25 at 11:38 am revealed, the west smoke door, south end of building near room 231 failed to latch. During an interview on 3-4-25 at 11:38 am, Staff A confirmed the smoke door would not latch.	{K 374}		

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** B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 - 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 4 residents. 400 State Building - Main was found to not be 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}		
{K0311}	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING (Prompt and Slow) Vertical openings shall be enclosed or protected in accordance with 8.6 unless: 1. Unprotected vertical openings not part of required egress shall be permitted by the authority having jurisdiction where such openings do not endanger required means of egress. This shall apply only in buildings protected throughout by an approved automatic sprinkler system in accordance with 33.3.3.5, and exits and required ways of travel thereto are adequately	{K0311}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Andersen | TITLE: Interim ICF Area Admin | (X6) DATE: 3/14/25

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** B. WING _____	R **03/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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
{K0311}	Continued From page 1 safeguarded against fire and smoke within the building, or in which every individual room has direct access to an exterior exit without passing through a public corridor. 2. In buildings not more than two stories in height, unprotected vertical openings shall be permitted by the authority having jurisdiction if the building is protected throughout by an approved automatic sprinkler system in accordance with 33.3.3.5. No floor below the level of exit discharge used only for storage, heating equipment, or purposes other than residential occupancy shall have unprotected openings to floors used for residential occupancy. 33.3.3.1.1.1, 33.3.3.1.1.2, 33.3.3.1.1.3, 33.3.3.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain door within a vertical opening and allowed storage on the stair. This deficient practice would allow smoke and gasses to move into the stair tower which would delay egress or render the stair enclosures useless during a fire emergency. The facility census was 4. Findings are: Observations on 1-15-18 at 11:48 am revealed, the undercut for the 1-½ hour fire rated stair door was greater than ¾ inch. During an interview 3-4-25 at 11:48 am, Staff A confirmed the gap and the storage on the stair landing.	{K0311}		
{K0321}	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	{K0321}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **02 - 400 STATE** B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 2012 EXISTING (Prompt and Slow) Rooms containing high-pressure boilers, refrigerating machinery, transformers, or other service equipment subject to possible explosion shall not be located under or adjacent to exits. All such rooms shall be effectively separated from other parts of the building as specified in section 8.7. Hazardous areas shall be separated with construction of a minimum of 1-hour fire resistance with openings protected with self-closing fire doors or have an automatic extinguishment system and smoke partition in accordance with 8.4. Hazardous areas shall include but not be limited to the following: boiler or heating rooms, laundries, repair shop, spaces storing combustibles in quantities deemed hazardous. 33.3.3.2.2 ~~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 self-closing devices and ensure undercut to the doors to hazardous areas were less than ¾ inches. These deficient practices would allow smoke to migrate into the exit corridors. The facility census was 4. Findings are: Observation on 3-4-25, between 11:50 am and 11:56 am revealed: 1. The undercut for the 1-hour fire rated entry door into Apartment 406 was greater than ¾ inch. 2. The undercut for the 1 ½ -hour fire rated Apartment 402 Staff door was greater than ¾ inch. 3. The undercut for the 20 minute-fire rated Room 7 door on the first-floor entry next to the elevator was greater than ¾ inch.	{K0321}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28G107	A. BUILDING **02 - 400 STATE** B. WING _____	R 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
400 STATE BUILDING	**3104 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 3 During an interview on 3-4-25, between 11:50 am and 11:56 am 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 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to assure electrical cords were run under doors. This deficient practice increases the potential for an electrical fire. The facility census was 4. Findings are: Observations on 3-4-25 at 12:14 pm revealed, Christmas light electrical cord run under a door into Apartment 406. During an interview on 1-15-24 at 12:14 9m, Staff A confirmed the electrical cord under the door.	{K0511}		

PLAN OF CORRECTION

Provider/Supplier Name:	400 STATE BUILDING	Survey Date
STREET ADDRESS, CITY, ZIP:	3104 STATE AVE BEATRICE, NE 68310	3/4/2025
	(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
K-0311		
	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 1/15/25 revealed the undercut for the 1 - 1/2 hour fire rated stair door was greater than 3/4 inch. During interview on 3/4/25 Staff A confirmed the gap.	3/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	A previous plan of correction was submitted to the Fire Marshal with an expected completion date of 2/28/25. The plan of correction was not completed by the expected completion date. A request for extension of this plan of correction was made to Doug Hohbein with an expected completion date of 3/31/25 while obtaining the materials needed to correct the deficiency. The extension request was approved with the expected completion date of 3/31/25. **Work order #31218** was submitted to the Maintenance Department to repair the 1 - 1/2 hour fire rated door once the materials are obtained to correct the deficiency.	3/31/2025
	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 is the responsible position to monitor and ensure compliance.	3/31/2025
	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 is the responsible position to monitor and ensure compliance.	3/31/2025
K-0321	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observations on 3/4/25 revealed :	

	1. The undercut for the 1-hour fire rated entry door into Apartment #406 was greater than 3/4 inch.	3/31/2025
	2. The undercut for the 1 - 1/2 hour fire rated Apartment #402 staff door was greater than 3/4 inch.	3/31/2025
	3. The undercut for the 20 minute fire rated Room #7 door on the first floor entry next to the elevator was greater than 3/4 inch.	3/31/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For the 1 hour fire rated entry door into Apartment #406: A previous plan of correction was submitted to the Fire Marshal with an expected completion date of 2/28/25. The plan of correction was not completed by the expected completion date. A request for extension of this plan of correction was made to Doug Hohbein with an expected completion date of 3/31/25 while obtaining the materials needed to correct the deficiency. The extension request was approved with the expected completion date of 3/31/25. Work order #31219 was submitted to the Maintenance Department to repair the 1 hour fire rated door once the materials are obtained to correct the deficiency.	3/31/2025
	For the 1- 1/2 hour fire rated Apartment #402 staff door: A previous plan of correction was submitted to the Fire Marshal with an expected completion date of 2/28/25. The plan of correction was not completed by the expected completion date. A request for extension of this plan of correction was made to Doug Hohbein with an expected completion date of 3/31/25 while obtaining the materials needed to correct the deficiency. The extension request was approved with the expected completion date of 3/31/25. Work order #31220 was submitted to the Maintenance Department to repair the 1 - 1/2 hour fire rated door once the materials are obtained to correct the deficiency.	3/31/2025
	For the 20 minute fire rated Room #7 door on the first floor entry next to the elevator: A previous plan of correction was submitted to the Fire Marshal with an expected completion date of 2/28/25. The plan of correction was not completed by the expected completion date. A request for extension of this plan of correction was made to Doug Hohbein with an expected completion date of 3/31/25 while obtaining the materials needed to correct the deficiency. The extension request was approved with the expected completion date of 3/31/25. Work order #31221 was submitted to the Maintenance Department to repair the 20 minute fire rated door once the materials are obtained to correct the deficiency.	3/31/2025
	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 is the responsible position to monitor and ensure compliance.	3/31/2025
	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 is the responsible position to monitor and ensure compliance.	3/31/2025

K-0511	**A. ACTION(S) THAT WILL BE TAKEN TO CORRECT THIS DEFICIENCY - ALONG WITH A DESCRIPTION OF HOW THE ACTION WILL CORRECT OR IMPROVE THE PROCESSES THAT LEAD TO THE CITED DEFICIENCY:**	
	Observation on 3/4/25 revealed Christmas light electrical cord run under a door into Apartment 406.	**3/5/2025**
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	For the Christmas light electrical cord that was run under a door into Apartment 406, the Safety Coordinator has removed the electrical cord that was run under the door and the decorative tree attached to it. The tree and the electrical cord will no longer be utilized in this area.	**3/5/2025**
	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 is the responsible position to monitor and ensure compliance.	**3/5/2025**
	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 is the responsible position to monitor and ensure compliance.	**3/5/2025**
	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 STATE AVE BEATRICE, NE 68310	3/4/2025
	(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
K-374		
	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 3-4-25 revealed the west smoke door, south end of building near Room 231 failed to latch.	3/13/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
	Work order # 31247 was submitted to the Maintenance Department to repair the west smoke door, south end of the building near Room 231 to ensure it will properly latch within the door frame. Maintenance replaced a broken hinge, tightened all hardware, and readjusted the locking bar mechanism position. The latch is hitting in the middle of the strike plate now an dthe door is latching as it should.	3/13/2025
	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 is the responsible position to monitor and ensure compliance.	3/13/2025
	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 is the responsible position to monitor and ensure compliance.	3/13/2025
	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.	

Waiver Request of Specific Life Safety Code Provisions

6/15/2018

Name of Facility: Beatrice State Developmental Center

City/State: Beatrice, NE 68310 **CCN#:** ICFDD07 / U74M12

Phone #: 402.239.5889 **Contact Name/Title:** Jesse Bjerrum, Interim Facility Administrator

Survey Date: 01/15/2025 **K-Tag :** K-311 **Annual or Temporary**

Requested Waiver End Date: 03/31/2025 Please use one form per K- tag waiver request

Temporary Waivers; Allow a nursing home time to implement an acceptable POC without the imposition of mandated remedies. Progress reports regarding the advancements or problems should be made to the State Agency Fire Authority. Extensions must be requested prior to a RV and limited to extreme circumstances. Failure to achieve compliance by the end-date will result in the recommendation of an appropriate enforcement remedy which will be imposed as outlined in 7410F3 of the SOM.

Annual Waivers; Allow a facility to achieve compliance when it is difficult to correct a requirement. Waivers will be re-evaluated during subsequent recertification surveys.

Additional Safety Measures: *The POC must address increased fire safety awareness as required by SOM 7410F1 and the documentation of the additional safety measures shall be kept on-site and provided to surveyors.*

Create or choose from additional safety measures below to compensate for the deficiency:
Circle items chosen and attach details.

1. Additional Fire Extinguishers	2. Additional smoke detection
3. Additional sprinklers/water curtain	4. Infrared inspection of motors and electrical panels
5. Additional inspections	6. Local fire department: monthly inspections
7. Additional maintenance	8. Local fire department: quarterly inspections
9. Install additional/horizontal exit	10. Local fire department: review of emergency plans
11. Additional fire drills	12. True fire watch
13. Safety rounds (dedicated, all areas inspected for fire safety issues)	
a. Once per shift/per day	b. Once per day
14. HVAC shut down tied to fire alarm	15. Practical and/or competency skills testing
16. Hands-on fire extinguisher training	17. Emergency procedure training
18. Hire a structural/electrical/ fire protection engineering firm to develop a plan of action	
19.	20

APPROVED
By Doug Hohbein Assistant State Fire Marshal at 2:30 pm, Mar 07, 2025

Doug Hohbein, Assistant State Fire Marshal, State Fire Marshal Office
246 South 14th Street, Lincoln, Nebraska 68508, 402-471-9478
Doug.Hohbein@nebraska.gov

Waiver Request of Specific Life Safety Code Provisions

6/15/2018

Due Dates	Justification
Send information to your Fire Authority on the following dates **Milestones** _____ _____ _____ _____ _____ _____ **Evidence of Correction (within 15 days of end date)** _____	**Evidence the deficiency does not pose a hazard to the occupants:** The doors cited for having undercut greater than ¾ inch are common and actively used doors daily. The issue does not pose a hazard to the occupants of the building, as Staff members will report any issues should they arise. **How correction poses a hardship to the facility:** DAS Maintenance contacted a contractor to request a quote to determine which doors need to be completely replaced and which ones just need a new door or a new rating to meet compliance. After receiving a quote, DAS Maintenance has made the decision to repair the doors that revealed an undercut of greater than ¾ inch. Per phone call discussion between Michael Heaps, DAS and Susen Lindner, Fire Marshal, door sweeps will be added to the doors cited at 400 State Building with the undercut greater than ¾ inch. The door sweeps need to be chosen; reviewed by the Fire Marshal for compliance and then ordered. Once received, BSDC Maintenance will need to install the sweeps on the doors to ensure the undercut is not greater than ¾ inch and meets compliance. BSDC respectfully requests to be granted an extension on K-311 for the fire rated doors at 400 State Building ICF that revealed an undercut greater than ¾ inch with a completion date of 3/31/2025. **APPROVED** *By Doug Hohbein Assistant State Fire Marshal at 2:28 pm, Mar 07, 2025*

Doug Hohbein, Assistant State Fire Marshal, State Fire Marshal Office
246 South 14th Street, Lincoln, Nebraska 68508, 402-471-9478
Doug.Hohbein@nebraska.gov

Waiver Request of Specific Life Safety Code Provisions

6/15/2018

Construction milestones (NA for annual waivers)

Administrator *(Signature)*	Title Facility Admin	Office BSDC	Date 3-6-25
Fire Official *(Signature)*	Title **Assistant Fire Marshal**	Office **Lincoln, NE**	Date **03-07-25**

Failure to follow the plan may result in waiver revocation and enforcement actions

APPROVED

By Doug Hohbein Assistant State Fire Marshal at 2:28 pm, Mar 07, 2025

Doug Hohbein, Assistant State Fire Marshal, State Fire Marshal Office
246 South 14th Street, Lincoln, Nebraska 68508, 402-471-9478
Doug.Hohbein@nebraska.gov

NEBRASKA

Good Life. Great Safety.

STATE FIRE MARSHAL AGENCY

Jim Pillen, Governor

03/07/2025

Russel Fralin
BSDC-400 State Building

Dear Russel:

IMPORTANT NOTICE – PLEASE READ CAREFULLY

On 03/04/2025, a Life Safety Code Survey was conducted by representatives of the State Fire Marshal's Agency to determine whether your facility was in compliance with Federal Conditions for Coverage Requirements, State Licensure Regulations and Life Safety Code Requirements for a FACILITY TYPE (Hospital, ASC, ICF-IID). Enclosed you will find the CMS-2567's and State Form documenting the results of that survey. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations and Title 153, Chapter 1, Nebraska State Fire Code Regulations.

PLAN OF CORRECTION (POC)

A POC for each deficiency cited must be submitted to doug.hohbein@nebraska.gov **NO LATER THAN 10 calendar days after receipt of the CMS-2567**. Failure to submit an acceptable POC 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 led to the deficiencies cited.
- The procedure for implementing the acceptable plan of correction for the deficiency cited;
- The monitoring procedure to ensure that the plan of correction and the specific deficiency cited remains corrected and in compliance with regulatory requirements;
- The title (not the name) of the person responsible for implementing the acceptable plan of correction;

- THE DATE WHEN THE CORRECTIVE ACTION WILL BE COMPLETED. Correction dates should be no later than forty-five calendar days from the exit date of the survey or DATE.
- SIGNATURE ON THE FIRST PAGE OF THE 2567'S and STATE FORM. The first page must be signed by the provider/supplier representative and emailed or faxed to 402-471-3118.
- SUPPORT DOCUMENTION. This can include, system test reports, new policies and procedures, attendance sign-in sheets for drills, copies of invoices or receipts, verifiable photos

We will notify you if your POC is not acceptable via email. If your POC 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.

Doug Hohbein
Assistant State Fire Marshal
Nebraska State Fire Marshal Agency

Enclosures: CMS 2567 – Life Safety Code
LSC e-POC

(c-i)

Staff Assaults

A. Staff Assaults: *The number of assaults on staff for the period of 11/1/2024 – 10/31/2025.*

Beatrice State Developmental Center (BSDC) has documentation on reported staff injuries due to Individual Aggression / Behavioral of Individuals.

11/01/2024 - 12/31/2024 = 5 Injuries
No Medical Treatment Indicated: **1**
Minor Clinic / Hospital: **3**
Emergency Room: **1**

01/01/2025 – 03/31/2025 = 12 Injuries
No Medical Treatment Indicated: **7**
Minor Clinic / Hospital: **3**
Emergency Room: **2**

04/01/2025 - 06/30/2025 = 5 Injuries
No Medical Treatment Indicated: **5**
Minor Clinic / Hospital: **0**
Emergency Room: **0**

07/01/2025 – 09/30/2025 = 7 Injuries *(As of 09/25/2025)*
No Medical Treatment Indicated: **2**
Minor Clinic / Hospital: **0**
Emergency Room: **5**

10/01/2025 – 10/31/2025 = 3 Injuries *(As of 10/31/2025)*
No Medical Treatment Indicated: 1
Minor Clinic / Hospital: 1
Emergency Room: 1

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

(c-ii)

Staffing Levels

	c) staffing information, listed separately for each institution, including, but not limited to:			
	ii) staffing levels			
	Number of **positions allocated** in FY25	Number of Positions **Filled by permanent staff** as of October 31st, 2025	Numbers of positions filled by Temporary/PRN Positions as of October 31st, 2025	Number of Positions **Vacant** as of October 31st, 2025
Lincoln Regional Center				
Norfolk Regional Center				
Beatrice State Developmental Center	305	235	8	62

Beatrice State Developmental Center			
POSITION TITLE	**Number Allocated on October 31, 2025**	**Permanent and/or Temp/PRN Staff on October 1, 2025**	**Percent Filled**
Accountant I	4	3	75%
Active Treatment Program Aide	2	0	0%
Active Treatment Program Assistant	14	12	86%
Active Treatment Program Specialist	3	3	100%
Active Treatment Program Supervisor	2	2	100%
Activty Specialist	3	3	100%
Administrative Nurse	2	2	100%
Administrative Programs Officer II	1	1	100%
Administrative Specialist	1	1	100%
Administrative Technician	3	3	100%
Automotive Mechanic II	1	1	100%
Behavior Support Specialist	2	2	100%
Board Certified Behavior Analyst Clinical Supervisor	1	1	100%
Compliance Specialist	3	3	100%
Custodial/Housekeeping Supervisor	1	1	100%
DD QDDP Quality Control Supervisor	1	1	100%
Developmental Disabilities Safety & Habilitation Specialist	41	34	83%
Developmental Disabilities Safety & Habilitation Specialist (Temp - part time - on call)	4	4	100%
Developmental Disabilities Safety & Habilitation Supervisor	6	5	83%
Developmental Technician I	4	2	50%
Developmental Technician I (Temp - part time - on call)	16	3	19%
Developmental Technician II	73	60	82%
Developmental Technician Shift Supervisor	17	14	82%
DHHS Program Specialist	1	1	100%
Dietitian	2	2	100%
Director of Nursing	1	1	100%

Facility Operating Officer	1	1	100%
HR Specialist Senior/HR Business Partner II	1	1	100%
HR Specialist Senior/HR Business Partner I	1	1	100%
HR Specialist Senior/HR Business Partner I	1	1	100%
HR Specialist/Generalist	2	2	100%
ICF/DD Home Manager	5	3	60%
ICF/DD Manager	1	1	100%
Interdisciplinary Team Leader / QDDP	11	8	73%
Licensed Practical Nurse	22	18	82%
Maintenance Technicians	9	9	100%
Nurse Practitioner	2	1	50%
Occupational Therapist	1	1	100%
Office Specialist	4	4	100%
Physical Therapist II	2	1	50%
OT/ Physical Therapy Aide	3	3	100%
Physical Therapy Director	1	0	0%
Physician	1	1	100%
Physician Assistant	1	1	100%
Procurement Officer	1	1	100%
Psychologist/Provisionally Licensed	1	1	100%
Recreation Specialist	1	1	100%
Registered Nurse	6	5	83%
Registered Nurse (Temp)	1	1	100%
Religious Coordinator	1	1	100%
Respiratory Therapist	1	1	100%
Safety Coordinator	1	1	100%
Security Communications Specialist	1	1	100%
Supply Technician II	2	2	100%
Training Coordinator	1	1	100%
Transportation Manager	1	1	100%
Vehicle Operator I	1	1	100%
Vehicle Operator II	2	1	50%
Total	**299**	241	300%

	c) staffing information, listed separately for each institution, including, but not limited to:											
	ii) staffing levels											
	List the total number overtime hours worked collectively by all hourly staff											
	Nov 1st, 2024	Dec 1st, 2024	Jan 1st, 2025	Feb 1st, 2025	Mar 1st, 2025	April 1st, 2025	May 1st, 2025	June 1st, 2025	July 1st, 2025	Aug 1st, 2025	Sept 1st, 2025	Oct 1st, 2025
Lincoln Regional Center												
Norfolk Regional Center												
Beatrice State Developmental Center	4,183	4,672	4,991	5,010	4,802	5,232	4,884	3,726	3,989	4,093	5,484	2,560

Rev. 10/2023

NEBRASKA
Good Life. Great Resources.
DEPT. OF ENVIRONMENT AND ENERGY

NDEE Inspection and Compliance
PO Box 98922, Lincoln NE 68509-8922
Phone: 402-471-0903 – FAX: 402-471-2909
Email: ndee.envsafety@nebraska.gov

FOOD EVALUATION CORRECTIVE ACTION REPLY FORM

In the facility you operate, critical violations were identified that were not corrected at the time of the inspection. To protect the health and safety of the public, the Nebraska Department of Environment and Energy requests immediate attention to all critical violations. You must: make the corrective actions, document the corrective actions on this form, and return this form, along with any supporting documentation to the Department.

Please Type or Print Clearly

Facility Name: Kearney High West (YRTC)			Permit Number: 10-15
Facility Address:	Street/PO/Route: 2802 30th AVE		
	City: Kearney	State: NE	ZIP: 68845

Food Facility Manager	Contact Number
Julie Kearns	(402) 314-7494
Facility Manager/Director/Superintendent (print and sign name)	Contact Number
4-1-2025	

Description of corrective action to critical violations that place the facility into compliance must be provided (use additional pages if necessary and provide any and all supporting documentation):

See attached

Report Made By (Print/Type Name): Julie Kearns

Signature

3/31/25
Date

After our Food Establishment Evaluation on 3/26/25, there were 3 priority deficiencies and 1 core deficiency.

The following actions were taken to address these concerns:

1. Employees must properly wash hands when changing tasks- clean to dirty- back to clean, and when putting on and changing gloves.

   Corrective Action: Food Service Director provided hand hygiene education to all Food Service staff on 3/27/25.

2. Staff cannot touch food with potentially contaminated gloves.

   Corrective Action: Food Service Director provided education to all Food Service staff on 3/27/25 about proper use of gloves and hand hygiene.

3. Cooked/held foods must be properly cooled: Jambalaya

   Corrective Action: Jambalaya was discarded right away. Food Service Director provided education on cooling log and how to properly cool left-over foods on 3/27/25.

4. Many floor areas need thorough cleaning.

   Corrective Action: All floors were thoroughly cleaned on 3/27-3/28/25. All floors are to be cleaned at the end of both shifts. Deep cleaning of the floor was also added to the weekly cleaning schedule.

Julie K

Julie Kearns, Food Service Director

Date: 3/31/25

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

☐ CAR
☒ HACCP

Firm: Kearney High West (YRTC)	
Address: 2802 30th Ave	
City: Kearney County: Buffalo	
Firm ID: 10-15	Inspector Code: 25
Facility Codes:	Inspection Date: 3-26-25

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:** 1

Purpose	
Regular: 1 Follow-up: 2 Complaint: 3	Investigation: 4 Other: 5

Temperature Observations

Food Product	Product Temp.	Location	Food Product	Product Temp.	Location
Carrots	159.5	steam table			
Pasta Bake	198.2	steam table			

Foodborne Illness Risk Factors and Public Health Interventions

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable

Mark "X" in appropriate box for C and/or R
C=corrected on site during inspection R=repeat violation

	Compliance Status		C	R
	Demonstration of Knowledge			
1	IN OUT	Certification by accredited program, compliance with code, or correct responses		
	Employee Health			
2	IN OUT	Management awareness; policy present		
3	IN OUT	Proper use of reporting, restriction & exclusion		
	Good Hygienic Practices			
4	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
5	IN OUT N/O	No discharge from eyes, nose & mouth		
	Preventing Contamination by Hands			
6	IN OUT N/O	Hands clean & properly washed		
7	IN OUT N/A N/O	No bare hand contact with RTE foods		
8	IN OUT	Adequate handwashing facilities supplied & accessible		
	Approved Source			
9	IN OUT	Food obtained from approved source		
10	IN OUT N/A N/O	Food received at proper temperature		
11	IN OUT	Food in good condition, safe & unadulterated		
12	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
13	IN OUT N/A	Food separated & protected		
14	IN OUT N/A	Food-contact surfaces; cleaned & sanitized		
15	IN OUT	Proper disposition of returned, previously served, recondition, unsafe food		

	Compliance Status		C	R
	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	Propor 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
P	6	2-301.14	Employees must properly wash hands when changing tasks clean to dirty back to clean - putting on or changing gloves
P	7	3-301.11	cannot touch food with potentially contaminate gloves - make sure to use utensil
P	18	3-501.14	cooked/held TCS foods must be properly cooled - shallow pan - discard

Follow-up
Yes 1 No 2

Received by: Julie K

Inspected by: Tim Burnham

Nebraska Department of Environment and Energy
PO Box 98922, Lincoln, NE 68509 | 402-471-0903

Distribution: WHITE – Lincoln; YELLOW – Local Office; PINK - Customer

21-012 06/2021

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

Firm: Kearney High West (YRTC)	
Address: 2802 30th Ave.	
City: Kearney County: Buffalo	

Firm ID: 10-15	Inspector Code: 25
Facility Codes:	Inspection Date: 3-26-25

Good Retail Practices

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

	Safe Food and Water	C	R
28	Pasteurized eggs used where required		
29	Water & ice from approved source		
30	Variance obtained for specialized proessing methods		
	Food Temperature Control		
31	Proper cooling methods used; adequate equipment for temperature control		
32	Plant food properly cooked for hot holding		
33	Approved thawing methods used		
34	Thermometers provided & accurate		
	Food Identification		
35	Food properly labeled; original container		
	Prevention of Food Contamination		
36	Insects, rodents, & animals not present; no unauthorized persons		
37	Contamination prevented during food preparation, storage, & display		
38	Personal cleanliness; hair restraints		
39	Wiping cloths; stored in sanitizing solution and properly used		
40	Washing fruits & vegetables washed prior to use		

	Proper Use of Utensils	C	R
41	In-use utensils; properly stored		
42	Utensils, equipment, & linens; properly stored, dried & handled		
43	Single-use & single-service articles; properly stored & used		
44	Gloves used properly		
	Utensils, Equipment, and Vending		
45	Food & non-food contact surfaces cleanable, properly designed, constructed & used		
46	Warewashing facilities; installed, maintained, & used; test strips		
47	Non-food contact surfaces clean		
	Physical Facilities		
48	Hot & cold water available; adequate pressure		
49	Plumbing installed, proper backflow devices		
50	Sewage & waste water properly disposed		
51	Toilet facilities; properly constructed, supplied & cleaned		
52	Garbage & refuse properly disposed, facilities maintained		
53	Physical facilities installed, maintained, & clean		
54	Adequate ventilation & lighting; designated areas used		

P or PF	Item #	Code Reference	Violation Description/Remarks/Corrections
	53	6-501.12	Many Floor Areas Need Thorough Cleaning
			* Inaccurate
			- Sanitizer Log, Dishwasher Temp Log, Refrigeration Log, Thermometer Calibration Log, Receiving Log, Damaged Discarded Log - Current all on Clipboard
			→ up to date. Okay
			- Cooling Log - in Binder - last entry 3-24-25.
			→ Incubator. Not Recorded properly - Discard
			- Food Safety Checklist - Missing July-Nov 2024
			- Food Temps - Recorded on Daily Production Records
			→ checked number of months - consistent
			- Prior months logs in Binder - suggestion - Seal by log / month
			Dishwasher temp log - 166°, sanitizer labeled - Cond. Ok

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). * Overall Good Job w/ Paperwork *

Received by: _____ Inspected by: Tim Burnham

Nebraska Department of Environment and Energy
PO Box 98922, Lincoln, NE 68509 | 402-471-0903

Distribution: WHITE – Lincoln; YELLOW – Local Office; PINK - Customer

21-012 06/2021

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

David Pleiss
Chief Boiler Inspector

Scott Cordes
State Fire Marshal

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

08/22/2024

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.

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: 06/04/2024
Expiration Date: 05/31/2025
Inspected By: Jacob Scherman
Inspecting Agency: Zurich American Insurance
Last Internal Inspection: 09/14/2023
National Board Number: 28747

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 35 PSI
Manufacturer: Burnham
Year Built: 2004
Print Date: 08/22/2024
Next Internal Due Date: 09/14/2024
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

Dave Pleiss

David Pleiss

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

David Pleiss
Chief Boiler Inspector

Scott Cordes
State Fire Marshal

Youth Development Center
2802 30th Ave
Kearney, NE 68845-4035

08/22/2024

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.

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: 06/04/2024
Expiration Date: 05/31/2025
Inspected By: Jacob Scherman
Inspecting Agency: Zurich American Insurance
Last Internal Inspection: 11/06/2023
National Board Number: 28757

Pressure Allowed: 150 PSI
Safety-Relief Valves Setting: 85 PSI
Manufacturer: Burnham
Year Built: 2004
Print Date: 08/22/2024
Next Internal Due Date: 11/06/2024
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

Dave Pleiss

David Pleiss

FIRE ALARM INSPECTION

Midwest Alarm Services

Customer: YRTC Kearney
2802 30th Ave
Kearney. NE 68845

Location: Dodge

Panel Type:Notifier 3030
100 % Smoke Test: 100 % Heat Test:
Frequency:
Notes:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations	11	11
3.	Remote Annunciators	1	1
4.	CO Detectors	—	—
5	Smoke Detectors	14	14
6..	Duct Detectors	2	2
7.	Flow Switches (35 sec)	3	3
8.	Pressure Switches (41 sec)	—	—
9	Tamper Switches (35 sec)	8	8
10.	Audibles	18	18
11.	Visuals	~~12~~36	36
12.	Door Holders	1	1
13.	Fan Relays	1	1
14.	Smoke Relays	—	—
15	FCPS	1	1
16	Voice Evac	1	1
	Heat	1	1

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? (Yes) No N/A
3. Signals received at receiving station? (Yes) No ~~N/A~~
4. Are system components functioning properly? (Yes) No
5. Did Trouble Signal Operate Properly? (Yes) No
6. Checked system in Emergency Power? (Yes) No
7. Elevator Recall? Yes No (N/A)
8. Main Power (120VAC) Test Value: 120
9. Emergency Power (Gel Cell) Test Value: ✓
10. Battery Change Out Date: 2028 26.2-25.6
11. Voice Evac Battery Chang e Out: 2028 26.3-25.7
12. FCPS Battery Change Out: 2028 25.0-24.8
13. FCPS Battery Change Out: —
14. FCPS Battery Change Out: —

Comments: Final acceptance test with AHJ
All systems function test OK

Inspection Start Time: 11:45
Inspection End Time: 12:45
Inspections Date: 3-20-25
Last Inspected: N/A
Inspector: Dan Kearn
License #: L23 Exp: 2026
Customer: Michael Hancock
Witness: Kyle Woods #8726

FIRE ALARM INSPECTION

Midwest Alarm Services

Customer: YRTC Kearney
2802 30th Ave
Kearney. NE 68845

Location: Bryan Creighton

Panel Type:Notifier 3030
100 % Smoke Test: 100 % Heat Test:
Frequency:
Notes:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations	5	5
3.	Remote Annunciators	1	1
4.	CO Detectors	—	—
5	Smoke Detectors	14	14
6..	Duct Detectors	—	—
7.	Flow Switches	4	4
8.	Pressure Switches	—	—
9	Tamper Switches	5	5
10.	Audibles	14	14
11.	Visuals	32	32
12.	Door Holders	1	1
13.	Fan Relays	—	—
14.	Smoke Relays	—	—
15	FCPS	1	1
16	Voice Evac	1	1

35 ✓
41
35 ✓

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? (Yes) No N/A
3. Signals received at receiving station? (Yes) No N/A
4. Are system components functioning properly? (Yes) No
5. Did Trouble Signal Operate Properly? (Yes) No
6. Checked system in Emergency Power? (Yes) No
7. Elevator Recall? Yes No (N/A)
8. Main Power (120VAC) Test Value: 120
9. Emergency Power (Gel Cell) Test Value: ____ 26.6 - 25.1
10. Battery Change Out Date: 2028 26.5 - 25.2
11. Voice Evac Battery Chang e Out: 2028
12. FCPS Battery Change Out: 2028 24.1 - 23.8
13. FCPS Battery Change Out: —
14. FCPS Battery Change Out: —

Comments: Final Acceptance test with AHJ
All systems function test OK.

Inspection Start Time: 10:30
Inspection End Time: 11:45
Inspections Date: 3-20-25
Last Inspected: N/A
Inspector: Lori Hearn
License #: L23 Exp: 2026
Customer: Richard Hancock
Witness: Kyle Wiedeman #8720

FIRE ALARM INSPECTION

Midwest Alarm Services

Customer: YRTC Kearney
2802 30th Ave
Kearney, NE 68845

Location: Dickson

Panel Type: Notifier 3030
100 % Smoke Test: 100 % Heat Test:
Frequency:
Notes:

Remote Connection:
Calibration:

		Actual	Tested
1.	Circuits	1	1
2.	Pull stations	3	3
3.	Remote Annunciators	1	1
4.	CO Detectors	–	–
5	Smoke Detectors	15	15
6..	Duct Detectors	2	2
32 Sec 7.	Flow Switches	2	2
30 Sec 8.	Pressure Switches	–	–
9	Tamper Switches	2	2
10.	Audibles	9	9
11.	Visuals	12	9
12.	Door Holders	–	–
13.	Fan Relays	1	1
14.	Smoke Relays	–	–
15	FCPS	1	1
16	Voice Evac	1	1

Additional Questions

1. Code the system installed under: NFPA 72
2. Is the ground Fault Functioning? (Yes) No N/A
3. Signals received at receiving station? (Yes) No N/A
4. Are system components functioning properly? (Yes) No
5. Did Trouble Signal Operate Properly? (Yes) No
6. Checked system in Emergency Power? (Yes) No
7. Elevator Recall? Yes No (N/A)
8. Main Power (120VAC) Test Value: 120
9. Emergency Power (Gel Cell) Test Value: ____ 26.2-25.1
10. Battery Change Out Date: 2028 26.3-25.2
11. Voice Evac Battery Chang e Out: 2028 24.5-24.
12. FCPS Battery Change Out: 2028
13. FCPS Battery Change Out: –
14. FCPS Battery Change Out: –

Comments: Final acceptance test with AHJ.
All systems function test ok

Inspection Start Time: 9:30
Inspection End Time: 10:30
Inspections Date: 3-20-25
Last Inspected: N/A
Inspector: Levi Kessman
License #: L23 Exp: 2026
Customer: Richard Howard
Witness: Kyle Wood #8720

1313 Farnam, Rm. 233
Omaha, NE 68102
NDOL.Conveyances@nebraska.gov
Office: 402-595-3184
Fax: 402-595-1360

Work Order ID: 1124454
BOF ID:

NEBRASKA
DEPARTMENT OF LABOR

Nebraska Annual Conveyance Safety Inspection Form

Building Name: Youth Rehab and Treatment Center **Building Address:** 2802 30th Ave Kearney NE 68845

Elevator No:	State ID Number:	Elevator Type:	Elevator Use:	# of Landings:
1	10	Hydro	Freight	2

Last Annual Insp. Date:	Elevator Speed:	Elevator Capacity:	Code Year:	Manufacturer:
05/09/2024	50 FPM	2000 LBS		Rotary

ELEVATORS

In Car — Devices Tested/Test Requirement	ASME A17.2 Item #	Pass	Fail	N/A	Results/Notes
1 Must make door reopening device operable.	1.1.1			√	
2 Must make car and floor sill's level.	1.3.1.1	√			
3 Must make emergency light operable.	1.5.1(b)			√	
4 Must make emergency Alarm Bell/Phone operable.	1.6.1	√			
5 Must make restrictors work outside 18" zone to 4" max open.	1.18.1			√	
Machine Room					
6 Ensure permanent/unobstructed access to machines/controls.	11.1.3	√			
7 Must provide ample, guarded, machine room lighting.	2.3.1	√			
8 Must provide sufficient heating/cooling for equipment	2.6.1	√			
9 Must provide lockable mainline and lighting disconnects.	2.11.1	√			
10 Must have fire extinguisher adjacent to controls/machine areas	2.7	√			
11 Clear of non-elevator storage, flammables, from oil, grease, dirt.	2.5.1	√			
12 Current relief test records tag/plate for pressure testing 1 year	2.31.1	√			12/10/2024
13 Must provide current governor test tag/plate 1/5 year.	2.13.2.1 (b) (6)			√	
14 MCP tasks w/dates, tests, repairs, callbacks, oil usage. 2013+	2.40.1	√			
Car Top					
15 Must make car top stop switch operable.	3.1.1	√			
16 Must make car top inspection station operable.	3.3.1	√			
17 Must make car top light and GFCI outlet operable.	3.2.1	√			
18 Must make hoist way venting clear and louvers operable.	3.11.1	√			
19 Check that a standard railing is provided where required.	3.4.3.1 (b)			√	
20 Must keep all ropes free from rust/kinks/broken strands.	3.23.1			√	
Fire					
21 Must test Fire Service Phase One & Two monthly.	6.5.2 & 6.5.3			√	
22 Must maintain monthly fire service testing log in control room	6.1.1			√	
Hoistway					
23 Must maintain door closing foot pound pressure within limits.	1.8.1			√	
24 Must properly adjust door equipment on car & hall doors.	3.17.1	√			
25 Must maintain door gibs and retainers if provided to code.	1.7.1	√			
26 Escutcheons intact, secure. Access switches & limits work OK.	4.5.1	√			
Pit Area					
27 Must provide pit ladder on all pits over 30", on P.U. side of door.	5.1.1(b)	√			
28 Must maintain a dry pit, clean and paint pit equipment.	5.1.1(e)	√			
29 Must make pit stop switch operable, locate adjacent to ladder.	5.1.1(c)	√			
30 Must make pit light operable, switch adjacent to ladder, 18" high	5.1.1(d)	√			
31 Sump cover must be grated or 5-2" holes to allow water inside	5.1.1(e)			√	
32 Must keep pit equipment rust free, clean to bare metal, paint	5.10-14	√			

ESCALATORS

33 Must keep handrails free from cuts, cracks, pinch points and other hazards.	7.3			√	
34 Must keep covers secure, no tripping hazards, maintain open area for access.	7.4			√	
35 Must keep safety decals or signs in good shape for passengers to read.	7.6			√	
36 Must keep stationary comb plates and escalator step edges which mesh	7.7.1			√	
37 Must maintain gap between moving step and stationary skirt panel 3/16-1/4.	7.17.1			√	
38 Must keep excessive play or rocking movement in steps to a minimum.	7.9.1(b,1)			√	
39 Current MCP tasks w/dates, tests, repairs, callbacks, start-up guide. 2013+	7.19.1			√	

Inspector Name: Kathy Blackmore-Hempel

Inspector Signature: Kathy B Hempel

Date: 03/21/2025

Building Contact Name:

Contact Signature:

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska YRTC	**DATE:** 2/11/25
ADDRESS:	**JOB ID:** 12310
SITE NAME: Boiler House	**TECHNICIAN:** Blake
CONTACT NAME: Rich	**CONTACT TEL:**
PRODUCT DETAILS	
GEN MAKE Cummins	**GEN MODEL:** GGHE-5785641
GEN SERIAL: A0700104485	**GEN HOURS:** 538.9

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
OTECB SN: L060001113	Quarterly	✔
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	212	**B-C**	213	**C-A**	213	**A-B**	207.6	**B-C**	207.9	**C-A**	208.2
A-N	122	**B-N**	123	**C-B**	123	**A-N**	119.6	**B-N**	119.9	**C-B**	120.1
A-Amps	29	**B-Amps**	23	**C-Amps**	16	**A-Amps**	0	**B-Amps**	0	**C-Amps**	0
A-Temp	NA	**B-Temp**	NA	**C-Temp**	NA	**A-Temp**	NA	**B-Temp**	NA	**C-Temp**	NA
PRE OPERATION CHECKS				**Coolant temp**	113	**Battery Charging voltage**	13.1				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✔			**CONTROL LIGHTS**	**Engine Run temp**	188	**W/ or W/O Load**	W/O
✔			**CONTROL DISPLAY**	**Oil Pressure**	54	**Exercise Duration**	30MIN
✔			**EMERGENCY STOP**	**Oil Temp**	NA	**Day**	WEDNESDAY
✔			**SWITCH/CONTROLS**	**Battery Voltage**	14.5	**Week**	WEEKLY
✔			**CB OPERATION**	**Frequency Rate**	60Hz	**Start Time**	9AM
	✔		**AUTO OPERATION**	**RPM**	1800		
✔			**COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses**				
✔			**EXHAUST SYSTEMS CONDITION**				
✔			**ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather**				
✔			**ALTERNATOR CONDITION**				
	✔		**FULL SERVICE PERFORMED**				
✔			**FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition**	**Fuel Level**	NG		
✔			**ENCLOSURE CONDITION**				
✔			**BATTERY CONDITION**				
✔			**ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger**				
✔			**OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM**				
✔			**Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs**				

Notes: 2/11/25 Blake. Arrived at the next generator and opened the generator enclosure. Performed a visual inspection and found no leaks or signs of damage at this time. Checked the oil and coolant levels and both are full. Measured battery voltage and found 13.1V. Manually started the generator and inspected the running condition for leaks, found no leaks present. Shut down the generator and connected the load bank cables to the generator. Connected the load bank cables to the load bank then started the generator. Verified voltage at the load bank then started adding load until 50% capability was achieved. Allowed the generator to run with 50% load for 30 minutes then increased the load to 75%. Allowed the generator to run with 75% load for an additional hour and a half. Once the load bank was complete, removed the load and allowed the generator and load bank to cool. Shut down the generator and disconnected the load bank cables. Placed the generator in AUTO and closed the generator enclosure. Cleaned up the load bank and cables then left the job site.

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Vocational Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney NE 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	4755	**Location:**	Vocational building
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA

Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	**RESULTS YES/NO/NA**
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	**RESULTS YES/NO/NA**
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	**RESULTS YES/NO/NA**
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	**RESULTS YES/NO/NA**
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	**RESULTS YES/NO/NA**
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	**RESULTS YES/NO/NA**
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector’s test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST						
#	**Location**	**Size Test Pipe**	**Static psi (before)**	**Residual psi**	**Return time to static pressure**	**Results differ more than 10 %?**
4755	Vocational building	1”	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Lincoln Washington Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney Nebraska 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	30268	**Location:**	Lincoln Washington building
Make:		**Model:**	
System Notes:	Basement		

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector’s test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
	Yes

ALARM PANEL CLEAR - Upon Leaving	
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
30268	Lincoln Washington building	1”	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

WET SYSTEM INFORMATION			
Unit #:	30267	**Location:**	Lincoln Washington upstairs 2nd floor
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
30267	Lincoln Washington upstairs 2nd floor	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	30269	**Location:**	1st floor
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
30269	1st floor	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	9403	**Location:**	Entire building
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
9403	Entire building	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Bryant Creighton Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney Nebraska 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	130271	**Location:**	Basement Bryant crieghton
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	85

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector’s test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
	Yes

ALARM PANEL CLEAR - Upon Leaving	
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
130271	Basement Bryant crieghton	1”	85	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

WET SYSTEM INFORMATION			
Unit #:	5243	**Location:**	Upstairs Bryant creighton
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5243	Upstairs Bryant creighton	1"	80	55	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	30272	**Location:**	Main floor
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
30272	Main floor	1"	80	55	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	9564	**Location:**	Entire building
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
9564	Entire building	1"	80	55	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Dickinson Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney Nebraska 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	109402	**Location:**	Main east side
Make:		**Model:**	
System Notes:	Zone 1		

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	75

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector’s test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
	Yes

ALARM PANEL CLEAR - Upon Leaving	
SYSTEM RETURNED TO SERVICE	N/A

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
109402	Main east side	1”	75	55	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

WET SYSTEM INFORMATION			
Unit #:	2	**Location:**	
Make:		**Model:**	
System Notes:	Zone 2		

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	75

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
2		1"	75	55	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Dodge Administrative Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney Nebraska 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	5248	**Location:**	Basement
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector’s test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
	Yes

ALARM PANEL CLEAR - Upon Leaving	
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5248	Basement	1”	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

WET SYSTEM INFORMATION			
Unit #:	5250	**Location:**	2nd floor odd basement riser
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	Yes
Test conducted with inspector's test connection	Yes
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5250	2nd floor odd basement riser	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	5249	**Location:**	Main floor in stairwell
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5249	Main floor in stairwell	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

ANTIFREEZE LOOP SYSTEM INFORMATION			
Unit #:	30284	**Type:**	
Location:	Dodge building south mop closet	**Make:**	
Model:		**Notes:**	

INSPECTION	RESULTS YES/NO/NA
Propylene Premix	Yes
Glycerine Premix	
Field Mix	
Date Tested	
System Gallon Size	10
Date of last antifreeze change	
Freeze point (tested at the riser)	
Freeze point (tested at the farthest/highest point)	
Freeze point (tested at center of the system)	
Antifreeze loop/zone control valve operated and in good condition	Yes
Antifreeze loop/zone check valve in good condition	Yes
Antifreeze loop/zone flow switch tested and in good condition	Yes
Time (seconds) it took for alarm to activate	Quarterly
Adjustments or corrections	
Desirable improvements	
SYSTEM RETURNED TO SERVICE	Yes
ALARM PANEL CLEAR - Upon Leaving	Yes

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

RAPID FIRE PROTECTION AN RFPG COMPANY
1530 Samco Road. Rapid City, SD 57702
Phone: 605.348.2342 Fax: 605.348.0108
Email: Service@RapidFireInc.com

QUARTERLY INSPECTION, TESTING & MAINTENANCE

CUSTOMER & JOB INFORMATION	
Company: Youth Rehab & Treatment Center | 10707	**Date:** 03-25-2025
Location: Gym/Reynolds Building	**Job Number:** 38958736
Location Address: 2802 30th Avenue, Kearney Nebraska 68845	**Tech & License # :** Brayden Morse NE Inspector
Contact: Richard Hancock	**Monitoring Co. & Phone #:**

OWNER SECTION	RESULTS YES/NO/NA
Is the building occupied?	Yes
Has the occupancy classification and hazard of contents remain the same since the last inspection?	Yes
Are all fire protection systems in service?	Yes
Has the system remained in service without modification since the last inspection?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Is all wet system piping protected from temperatures below 40*F?	Yes
Was the system free of actuations or alarms since the last inspection?	Yes
Prior inspection reports, logs and test data are available for review?	Yes
Plans of system onsite for review (located at the riser)	Yes
Copy of NFPA25 (located at the riser)	Yes
Was property free of fires since last inspection according to information furnished by owner or owner's rep?	Yes
Comments: Everything was good	
Customer Name / Signature: Kevin Quail	

WET SYSTEM INFORMATION			
Unit #:	5245	**Location:**	School
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector’s test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
	Yes

ALARM PANEL CLEAR - Upon Leaving	
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5245	School	1”	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	5246	**Location:**	Gym,pool,weight rm
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5246	Gym,pool,weight rm	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	5247	**Location:**	Locker room,office, south entry hallway shower
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5247	Locker room,office, south entry hallway shower	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	4	**Location:**	Basement
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
4	Basement	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	**Tech Name**	Brayden Morse
Customer Signature		**Tech Signature**	

WET SYSTEM INFORMATION			
Unit #:	5	**Location:**	
Make:		**Model:**	
System Notes:	Floor school		

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
5		1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

WET SYSTEM INFORMATION			
Unit #:	6	**Location:**	1st floor
Make:		**Model:**	
System Notes:			

INSPECTION

MASTER PRESSURE-REGULATING DEVICE	RESULTS YES/NO/NA
Supply pressure gauge PSI	
System pressure gauge PSI	80

CONTROL VALVES	RESULTS YES/NO/NA
Control valves in normal open or closed position	Yes
Control valves properly locked or supervised	Yes
Control valves accessible	Yes
Control valves provided with appropriate wrenches	Yes
Control valves free from external leaks	Yes

GAUGES	RESULTS YES/NO/NA
Gauges appear to be in good condition	Yes

ALARM VALVES/RISER CHECK	RESULTS YES/NO/NA
Alarm valve gauges indicate normal supply water pressure	N/A
Alarm valve free of physical damage	N/A
Alarm valve trim valves are in appropriate open or closed position	N/A
Alarm valve retarding chamber or alarm drain not leaking	N/A

FIRE DEPARTMENT CONNECTIONS	RESULTS YES/NO/NA
FDC is visible	Yes
FDC is accessible	Yes
FDC swivels/couplings undamaged/rotate smoothly	Yes
FDC plugs/caps in place/undamaged	Yes
FDC gaskets in place and in good condition	Yes
FDC check valve not leaking	Yes
FDC automatic drain valve in place and operating properly	Yes
FDC clapper is in place and operating properly	Yes

PRESSURE-REDUCING VALVE	RESULTS YES/NO/NA
Pressure reducing control valves (PRV) indicate open	N/A
PRV not leaking	N/A
PRV in good condition	N/A
PRV handwheel installed and not broken	N/A

SIGNAGE	RESULTS

	YES/NO/NA
Hydraulic nameplate attached and legible	Yes
Control valve identification signs in place	Yes
FDC identification sign in place	Yes
System control valve sign indicates area served	Yes

BACKFLOW	RESULTS YES/NO/NA
Backflow prevention assembly valves are locked or electrically supervised in open position	Yes
Reduced pressure backflow prevention assembly not in continuous discharge	N/A

TESTING	RESULTS YES/NO/NA
Alarm device free from physical damage	Yes
Water flow alarm (other than vane type) tested and is operational	N/A
Test conducted with inspector's test connection	N/A
Time of alarm activation	Quarterly
A main drain test conducted downstream from backflow preventer	Yes
A main drain test conducted downstream from pressure reducing valve	N/A
ALARM PANEL CLEAR - Upon Leaving	Yes
SYSTEM RETURNED TO SERVICE	Yes

MAIN DRAIN TEST

#	Location	Size Test Pipe	Static psi (before)	Residual psi	Return time to static pressure	Results differ more than 10 %?
6	1st floor	1"	80	60	0	no

DEFICIENCIES

CLOSING

Date & Time Complete	03-25-2025 09:58 AM	Tech Name	Brayden Morse
Customer Signature		Tech Signature	

Nebraska
Fire Sprinkler
OPEN

sh Ups
fingers
& Knees
STraight
2
Run in
200 Step
Knees-

sh Ups
fingers
& Knees
STraight
2
Run in
200 Step
Knees-

ALL
CALL

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: 12/13/2024

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 Lorenda Snyder	**Date of Signature:** 12/13/2024

AUDITOR INFORMATION	
Auditor name:	Snyder, Candy
Email:	snyder@gwtc.net
Start Date of On-Site Audit:	10/21/2024
End Date of On-Site Audit:	10/22/2024

FACILITY INFORMATION	
Facility name:	Youth Rehabilitation and Treatment Center Kearney
Facility physical address:	2802 30th Avenue, Kearney, Nebraska - 68845
Facility mailing address:	

Primary Contact

Name:	Shaylee Fortner
Email Address:	shaylee.fortner@nebraska.gov
Telephone Number:	308-455-0826

Superintendent/Director/Administrator	
Name:	Cindy Krolikowski
Email Address:	Cindy.krolikowski@nebraska.gov
Telephone Number:	308-293-6385

Facility PREA Compliance Manager	
Name:	Fred Boon
Email Address:	fred.boon@nebraska.gov
Telephone Number:	308-293-8523

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:	146
Current population of facility:	76
Average daily population for the past 12 months:	56
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Mens/boys

Which population(s) does the facility hold? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	14 - 18
Facility security levels/resident custody levels:	Medium
Number of staff currently employed at the facility who may have contact with residents:	160
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:	1

AGENCY INFORMATION	
Name of agency:	Nebraska Department of Health and Human Services
Governing authority or parent agency (if applicable):	
Physical Address:	301 Centennial Mall South, 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

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

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	• 115.311 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator • 115.341 - Obtaining information from residents
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2024-10-21
2. End date of the onsite portion of the audit:	2024-10-22
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Family Advocacy Network, Child Protective Services, Nebraska Ombudsman, Office of Inspector General
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	170
15. Average daily population for the past 12 months:	56
16. Number of inmate/resident/detainee housing units:	5
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	68
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	8
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	1
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	0

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	10
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	5
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	160
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	6
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	16
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☐ Race ☐ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None
36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Interviewed residents from all housing areas.
37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	◉ Yes ○ No

38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	6
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
40. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

40. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	2
42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
42. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
42. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
43. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0

45. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
45. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed screening documents of residents which corroborated that there were no residents with this characteristic to be interviewed.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	2

48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	2
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed residents and staff at the facility and reviewed other documents which corroborated that there were no residents with this characteristic to be interviewed.
50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	No text provided.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
51. Enter the total number of RANDOM STAFF who were interviewed:	13

52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☐ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	8
56. Were you able to interview the Agency Head?	◉ Yes ○ No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No

58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☒ Medical staff ☒ Mental health staff ☒ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff

	☐ Other
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
62. Enter the total number of CONTRACTORS who were interviewed:	2
62. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☒ Other
63. Provide any additional comments regarding selecting or interviewing specialized staff.	No text provided.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

64. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	No text provided.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	No text provided.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

72. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	31	0	31	0
Staff-on-inmate sexual abuse	4	0	4	0
Total	35	0	35	0

73. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	25	0	25	0
Staff-on-inmate sexual harassment	4	0	4	0
Total	29	0	29	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

74. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

75. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	10	5	16
Staff-on-inmate sexual abuse	0	4	0	0
Total	0	14	5	16

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

76. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

77. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	11	3	11
Staff-on-inmate sexual harassment	0	1	1	1
Total	0	12	4	12

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	8

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	7
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	2
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	1
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	2
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	No text provided.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

95. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff	
96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	(●) Yes ( ) No
96. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1
AUDITING ARRANGEMENTS AND COMPENSATION	
97. Who paid you to conduct this audit?	(●) The audited facility or its parent agency ( ) My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ( ) A third-party auditing entity (e.g., accreditation body, consulting firm) ( ) Other

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
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 - PREA Prevention 3. Agency Leadership 4. Organizational Chart **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. OJS Compliance Manager 4. PREA Compliance Specialist 5. Facility Administrator 6. 13 random staff 7. 16 random residents The Nebraska Department of Health and Human Services (DHHS) Office of Juvenile

Services (OJS) operates the Youth Rehabilitation Treatment Center (YRTC – K), a 146-bed juvenile facility in Kearney, Nebraska.

Findings by Provision:
115.311 (a): The DHHS OJS PREA Standard Operation Procedure (SOP) #1251 titled *PREA Prevention, Detection, Reporting, Staff Responses, Investigations* will be referred to throughout this report as SOP #1251 -- *PREA Prevention*. SOP #1251 -- *PREA Prevention* states in the scope that, "The OJS and all YRTC's mandates zero tolerance toward all forms of sexual abuse, sexual harassment, or sexual assault from other juveniles, staff, contractors or volunteers. All juveniles and staff who report sexual abuse or sexual harassment or cooperate with investigations of sexual abuse or sexual harassment have the right to be free from retaliation and will be protected from retaliation by other juveniles or staff. The OJS shall establish procedures each YRTC must follow to prevent, detect, and respond to such conduct."

115.311(b): The PREA Coordinator holds the position of OJS Compliance Coordinator and reports directly to the DHHS Facilities Director. She is a member of the senior staff and therefore has the authority to develop and oversee the efforts of YRTC-K to prevent, detect, and respond to sexual abuse and sexual harassment. The OJS PREA Coordinator is knowledgeable as to her role and stated she has enough time to manage all of her PREA-related responsibilities. She stated that if she has an issue with complying with a PREA standard she works with the facility administration to develop a plan of action for immediate correction and a long term, permanent solution. There is one Compliance Manager, and five Compliance Specialists that report to the Compliance Coordinator.

115.311(c): Each YRTC facility has a PREA Compliance Specialist responsible for maintaining the day-to-day compliance within the facility. The auditor interviewed the YRTC-K PREA Compliance specialist who also stated that he has enough time to manage all of his PREA-related responsibilities. It is important to stress to the reader of this report that anywhere it says PREA Compliance Specialist in this report, the reader must interpret that as the equivalent to the standards definition of a PREA Compliance Manager – the person responsible for coordinating ***within the facility*** efforts to comply with the PREA standards.

In addition, the OJS has a mid-level OJS Compliance Manager position that assists the PREA Coordinator in all compliance activities, in all facilities. In addition to PREA Compliance, this team is responsible for compliance with American Correctional Association standards and Performance Based Standards with the ultimate goal of making sure that all residents are safe within YRTC facilities.

The auditor determined that the YRTC-K has exceeded this standard in that they have an additional level of PREA compliance staffing with the OJS Compliance Manager position. It was apparent to the auditor the benefits this position brings in the amount of organization and cohesion witnessed throughout the audit process. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251 and the organization chart, and interviews with the DHHS Facilities Director, the PREA Coordinator, the OJS Compliance Manager, and the

	YRTC-K PREA Compliance Specialist. In interviews with staff and residents, all were knowledgeable of the zero-tolerance policy.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator **Findings by Provision:** **115.312 (a) and (b):** The YRTC-K facility does not contract for the confinement of residents with an outside entity. The auditor determined compliance through a review of the pre-audit questionnaire and interviews with the DHHS Facilities Director and the PREA Coordinator.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1063 - Juvenile Supervision 3. Organizational Chart 4. Staff schedule 5. Staffing Plan Update – May 2024 6. Movement and Count Sheet 7. Morning Report **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator **Findings by Provision:** **115.313 (a):** The auditor reviewed the Organization Chart, verified the staffing levels through the Staffing Plan Update – May 2024, the schedule that was provided,

	and verified through direct observation and monitoring cameras while on the facility tour and throughout the onsite audit. The auditor reviewed SOP #1063 -- *Juvenile Supervision* which states that, “In accordance with the Prison Rape Elimination Act (PREA) standard 115.313, YRTC-K will develop, implement, document a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring, to protect juveniles against sexual abuse. Relevant factors to consider when calculating adequate staffing levels are referenced in this SOP”. The YRTC-K facility has strong, consistent leadership, a good training program, and a positive culture. There have been no deviations from the staffing plan. The latest revised staffing plan completed in May 2024 is signed by the Facility Administrator and the PREA Coordinator. The auditor toured all areas of the facility and observed all areas including the administrative areas, dining hall, chapel, housing areas including resident sleeping areas, restrooms, shower rooms, and common areas, storage areas, the school building including all classrooms and vocational shops, and the gym. While touring the facility the auditor noted camera locations. The auditor was present at all shifts to observe operations at all times of the day. The auditor had informal conversations and made observations about resident supervision. The storage doors were locked, and the facility practices and procedures ensure staff and residents are not in a one-on-one situation off camera. **115.313 (b):** The auditor reviewed SOP # 1063 – *Juvenile Supervision* which states in paragraph 6.1.2 that, "The staffing plan will be followed except during limited and discrete exigent circumstances. Any deviations from the plan during such circumstances will be documented”. The auditor reviewed the pre-audit questionnaire and interviewed the Facility Administrator and the PREA Coordinator which stated there were no times they were out of ratio. When there was a staff shortage, it was filled with overtime or by an administrative staff filling the youth supervision position. **115.313 (c):** The auditor reviewed the Staffing Plan Update – May 2024 which states that, “The current staffing ratio at YRTC-K is 1:8 staff-to-youth during waking hours and 1:16 staff-to-youth during sleeping hours”. The auditor verified this ratio was maintained while observing operations within the facility during all shifts and in all areas and in reviewing samples of the Movement and Count Sheet, and the Morning Report which contains the shift report for the day including all counts. **115.313 (d):** The auditor reviewed SOP #1063 -- *Juvenile Supervision* which states in paragraph 6.1.4 that, “On an annual basis, the PREA Compliance Manager, along with the PREA Coordinator shall access, determine, and document whether are adjustments are needed to the staffing plan”. The auditor verified this provision is followed through a review of the latest revised staffing plan completed in May 2024 that is signed by the Facility Administrator and the PREA Coordinator. It includes items as outlined within the standard. Such as cameras, blind spots, physical layout, supervision of juveniles, number and placement of supervisory staff and the prevalence of substantiated and unsubstantiated incidents of sexual abuse.

	115.313 (e): The auditor reviewed SOP # 1063 -- *Juvenile Supervision* which states in paragraph .4.2.5 that Designated intermediate-level or higher-level supervisors will conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The auditor reviewed the Morning Report, which has several entries throughout each shift in which the Youth Security Supervisor (YSS) conducts rounds throughout the campus. In addition, YRTC-K maintains an Unannounced Rounds logbook in which upper-level administrators log their unannounced rounds. A calendar is completed for the year in which each upper-level administrator is assigned a one-week period from Sunday through Saturday in which they are the duty administrator. This duty entails being available for after-hours calls and coming in to complete an unannounced round. Through all living units. By policy staff are prohibited from alerting other staff/units of the unannounced visit. The auditor determined compliance with this standard through a review of the documents listed above, through direct observations of rounds and watching staff monitor the facility both in person and through video monitors, through a review of the pre-audit questionnaire, interviews with the DHHS Facilities Director, the PREA Coordinator, PREA Compliance Manager, and the Facility Administrator. In informal conversations with residents, they stated they felt safe here and that staff conduct rounds regularly, including managers.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 -- PREA Prevention 3. SOP #1075 – Searches 4. Youth Security Search form 5. Exigent Circumstance logbook 6. Staff training records **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. PREA Compliance Specialist 3. Facility Administrator 4. 13 random staff 5. 16 random residents **Findings by Provision:** **115.315 (a):** YRTC-K is an all-male facility. The auditor reviewed SOP #1075 –

	Searches which states in paragraph 6.2.2.3.3 that “All strip searches must be approved by the Facility Administrator or designee. Strip searches may only be conducted when there is a reasonable belief that the juvenile is carrying contraband or other prohibited material. All strip searches of juveniles are conducted privately by two gender specific staff”. Also, in paragraph 6.2.2.4.2 -6.2.2.4.3. which states that “A body orifice search will be authorized by the Facility Administrator or designee and designated health authority. A body orifice search will be conducted in private by a health care practitioner”. The auditor interviewed and had informal conversations with random staff who stated that only male staff conduct searches of residents. Visual body cavity searches are not done. If they were needed the Facility Administrator and medical would be involved. The YRTC-K has completed no cross-gender strip searches or body cavity searches. **115.315 (b):** The auditor reviewed SOP #1075 – *Searches* in paragraph 6.2.2.2.4 which states that “Pat searches on a juvenile will be conducted by two staff members; however, the staff member completing he search will be of the same anatomical sex as the juvenile (see 6.2.2.2.5. for pat searches for juveniles who identify s transgender or intersex). The auditor interviewed and had informal conversations with random staff and random residents who all consistently stated only male staff conduct pat searches of residents. **115.315 (c):** The auditor reviewed SOP #1075 – *Searches* in paragraph 6.3.1 which states that “All searches will be documented in the YSS logbook, and a Pat Search Form will be filled out and forwarded to the Facility Administrator or designee for review. The auditor reviewed the Youth Security Search Form which verified documentation of searches by two staff of the same gender. The auditor interviewed the Facility Administrator who stated that if a cross-gender pat-down search was to occur in an exigent circumstance, it will be reported to a supervisor and to her and documented in an incident report and the exigent circumstance book. **115.315 (d):** The auditor reviewed SOP #1251 - *PREA Prevention* in paragraphs 6.2.2.1 – 6.2.3 which states that Female staff will announce their presence prior to entering a housing unit occupied by male juveniles. Male staff will announce their presence prior to entering a housing unit occupied by female juveniles. This announcement shall be made loud enough for juveniles to hear. For opposite-gender staff scheduled in a particular housing unit for an entire shift, they will have to announce once, at the beginning of their shift. The only exception to this would be if the opposite gender staff has left the building for a significant amount of time and is returning to the building. All other opposite-gender staff entering a housing unit at any given time will be required to make the announcement each time they enter the housing unit. Staff (excluding medical staff) will allow juveniles to shower, perform bodily functions, and change clothing without viewing their buttocks or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (including viewing on video camera)”. The auditor interviewed and had informal conversations with random staff and random residents who all consistently stated female staff announce themselves when entering their housing unit. The auditor also verified this practice while on the facility tour. They also have an intercom outside the building that allows them to announce prior to entering.

	115.315 (e): The auditor reviewed SOP #1075 – *Searches* in paragraphs 6.2.2.2.5 – 6.2.2.2.5.5 which states, "If a juvenile identifies as a transgender or intersex upon their admission to YRTC-K or if there is prior knowledge that the juvenile identifies as transgender or intersex, the following will take place: the juvenile will be given the opportunity to complete a Statement of Search Preference form. Upon completion of the Statement of Search Preference form, the form will be submitted to the PREA Compliance Manager(s), who will meet with a multi-disciplinary team to review the request and make a determination on a case-by-case basis. Upon completion of the review, the juvenile will be notified by the PREA Compliance Manager(s) or designee as to the outcome of the review. Upon approval of the request, the staff member performing the search should be the same sex as identified by the juvenile's search preference, when possible. The search shall be documented as to whether the search preference was followed. If not followed, the reasons why should be documented. Document in the Living unit and or the YSS logbook who performed the pat search and who was the second staff. Medical staff will not search or physically examine a transgender or intersex resident for the sole purpose of determining the juvenile's genital status. If the status is unknown, it will be determined during conversations with the juvenile, 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 auditor interviewed the administrators who confirmed this practice. There were no residents who identified as transgender present to be interviewed. The auditor interviewed the administrators and the staff who conduct the intake and screening who stated that information regarding sexual identity is typically known before the resident arrives. If it is not known ahead of time, they do not conduct any type of search at this facility. Identity as a transgender or intersex person would be gathered through conversation with the resident. **115.315 (f):** The auditor reviewed SOP #1075 – *Searches* in paragraphs 6.1.1 which states, "Employees receive pre-service, on-the-job, and annual training regarding how to conduct searches and searches of transgender and intersex juveniles, in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs". The auditor reviewed the training curriculum and interviewed random staff. Employees receive classroom instruction, view the video "Guidance in Cross-Gender and Transgender Pat Searches" and must demonstrate a proper pat search. The auditor determined compliance with this standard through a review of the documents listed above, through direct observations while on the tour of the restroom procedures, through a review of the pre-audit questionnaire, interviews with the DHHS Facilities Director, the PREA Coordinator, the PREA Compliance Specialist, the Facility Administrator, and through random interviews with staff and residents. The auditor reviewed the camera coverage to verify there is no camera in an area where residents might be in a state of undress. The auditor had informal conversations with residents regarding their privacy during showering, toileting, and changing clothing.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #700 - Special Needs Program 3. PREA Posters 4. Language Line materials **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. Random Staff **Findings by Provision:** **115.316 (a):** The auditor reviewed DHHS YRTC-K SOP #700 -- *Special Needs Program* in paragraph 6.5 which states that YRTC-K shall ensure that juveniles with disabilities (including juveniles 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 facility's efforts to prevent, detect, and respond to sexual and abuse and sexual harassment. SOP #700 outlines specifically the many ways in which they accomplish this. In addition, the auditor interviewed the DHHS Facilities Director, and random staff who stated that they offer multiple options to present the material such as in writing, video with subtitles, translations services for non-English speaking people to include a contract with Language Link, a list of in-person interpreters available in multiple languages and a telephone for the hearing impaired, and working individually with youth who may need the material presented to them in a specific manner. There were no residents within the facility that needed interpretation services. PREA posters were posted in both English and Spanish. Spanish is the non-English language that would most predominantly be encountered at this facility. During staff interviews, staff verified that they would not use residents to interpret for other residents when discussing any important, sensitive, or confidential information. The auditor determined compliance with this standard through a review of the policies, the interpretation service documentation, and through interviews with administrators, and staff.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1641 – Hiring and Promotions 3. Human Resource Documents (sample size 10 random staff) **Interviews Conducted:** 1. Human Resources Manager **Findings by Provision:** **115.317 (a):** The auditor reviewed SOP #1641 – *Hiring and Promotions* paragraph 6.1 which states that "YRTC-K will not hire or promote any employee or enlist the services of any contractor who may have contact with juveniles if: 6.1.1 They have 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). 6.1.2 They have 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. 6.1.3 They have been civilly or administratively adjudicated to have engaged in sexual activity in the community". The auditor interviewed the Human Resources Manager and reviewed personnel files. The files support their statements. These processes include law enforcement background checks, child abuse and neglect registry checks, asking the employees and contractors directly before employing their services and annually thereafter, and asking previous institutional employers about any sexual misconduct. These actions are described in more detail in the following paragraphs. **115.317 (b):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.2 that, "All YRTCs will consider any incidents of sexual harassment in determining whether to hire or promote employee or enlist the services of any contractor who may have contact with juveniles. The auditor interviewed the Human Resource Manager who confirmed their compliance with this policy by conducting a reference check with previous institutional employees and a review of a staff member's personnel record and PREA documentation for any incidents of sexual harassment when considering an employee for hire or promotion or the services of a contractor. **115.317 (c):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.3 that, "Prior to hiring new employees who may have contact with juveniles, the following will be completed by the Human Resources Office with the Department of Health and Human Services (DHHS). 6.3.1 A security check in accordance with state and federal statutes. 6.3.1.1 This check includes a criminal history, adult and child abuse and neglect, state driving record, state and federal prison check, and Nebraska Sex Offender check. 6.3.2 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". The auditor interviewed the Human Resources Manager who stated that they conduct criminal

	background checks and child and abuse and neglect registry checks on applicants before an offer of employment is made and on current employees when they are promoted. In addition, they check with all previous employers about any substantiated sexual misconduct where they were previously employed. The auditor reviewed a random sampling of 10 employee files and found that the necessary background checks, child abuse and neglect registry checks, and required reference checks of all prior institutional employers. **115.317 (d):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.4 that, "Each YRTC will perform a criminal background record check and consult applicable child abuse registries before enlisting the services of any contractor who may have contact with juveniles". The auditor interviewed the Human Resources Manager who stated that they conduct criminal background checks on contractors before their services can be used at the facility. The auditor reviewed sample documentation required for contractors. **115.317 (e):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.5 that, "All YRTC's will conduct criminal background records checks at least every five years of all current employees and contractors who may have contact with juveniles". The auditor reviewed a sample of background checks for both newly hired employees and veteran employees with over 30 years of service. All staff had the most recent five-year update as well as employees who had the background check run during the hiring process this past year. **115.317 (f):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.6 that, "Applicants to the YRTC's will attest to any previous misconduct as described in Procedures 6.1 on Page 1 in the application process". Also, in paragraph 6.5.2 it states that "Each YRTC will impose upon employees a continuing affirmative duty to disclose any such misconduct. The auditor reviewed employment applications that include the questions as stated in provision (a) of this standard as well as an attestation that they understand they have a continuing duty to report any sexual misconduct throughout the terms of their employment. In addition, each year the facility pushes out an annual digital course which requires staff to answer sexual misconduct questions again and attest to their continuing duty to report during the annual self-evaluation process. **115.317 (g):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.5.2 that, "Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination". The auditor reviewed a sample of employee applications which states in the PREA – Applicant Acknowledgement paragraph "For the Safety and Protection of the juvenile residents, the DHHS -Youth Programs comply with the Prison Rape Elimination Act (PREA) Standards. In accordance with PREA Standard 115.17 the DHHS Youth Programs will ask all applicants who may have contact with youth directly about previous misconduct described below. The DHHS-Youth Programs also require a continuing affirmative duty to disclose any such misconduct. Failure to answer each question could result in the disqualification of your application. Material omissions regarding such misconduct, or the provision of materially false

	information, shall be grounds for termination if hired. By entering I accept at the bottom of this form you are acknowledging your answers are accurate. Your previous employers may also be contacted and asked the questions below." **115.317 (h):** The auditor reviewed SOP #1641 – *Hiring and Promotions* which states in paragraph 6.7 that, "Unless prohibited by law, the YRTC's shall 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. The auditor interviewed the Human Resources Manager who stated that they provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from another confinement facility. The auditor determined compliance with this standard through a review of the policies, and a review of human resources forms used in the hiring and employment processes. The auditor selected a random sample of ten employee personnel files and found the necessary documents to substantiate compliance with this standard. The auditor also confirmed these policies and procedures through an interview with the Human Resources Manager.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #683 – Space and Program Assessment Process 3. 2024 Annual Report **Interviews Conducted:** 1. DHHS Facilities Director 2. Facility Administrator 3. PREA Compliance team **Findings by Provision:** **115.318 (a):** The auditor reviewed SOP #683 – *Space and Program Assessment Process* in paragraph 6.3.1.4.1 which states, "When designing or acquiring any new facility and in planning any substantial expansion, or modification of existing facilities, YRTC-K shall consider the effect of the design, acquisition, expansion, or modification upon the staff's ability to protect juveniles from sexual abuse. The auditor directly observed the facility and conducted interviews with the DHHS Facilities Director and the Facility Administrator. The facility considers the protection of residents and the standards when contemplating new facilities or upgrades to the facility. The YRTC-K facility demolished a building that was older and did not provide adequate lines of sight and methods for juvenile supervision. They are currently in

	the planning and design phase for a new structure and are consulting specialists in juvenile facility design. **115.318 (b):** The auditor reviewed SOP #683 – *Space and Program Assessment Process* in paragraph 6.3.1.4.3 which states, "When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the YRTC-K shall consider how such technology may enhance the staff's ability to protect juveniles from sexual abuse". The auditor observed the facility, noting camera locations, viewing video monitors, and conducted interviews with the DHHS Facilities Director, the Facility Administrator, and the PREA Compliance team. The auditor also reviewed the 2024 Annual Report which identifies any issues that were addressed. The facility considers the protection of residents and the standards when contemplating upgrades monitoring technology or in the application of new technology. They have identified and installed multiple cameras in locations that were determined to need more video coverage since the last audit. They go over this information with all employees and employees are trained to never enter an area in a one-on-one situation with a youth when there is no camera in that area. The auditor determined compliance through a review of the pre-audit questionnaire, through a tour of the facility, through viewing the camera locations and a review of SOP #683, and through interview with the DHHS Facilities Director, the Facility Director, and the PREA Compliance team.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment, Follow Up and Reports 3. Investigative training certificates 4. MOU with the Family Advocacy Network (FAN) 5. Nebraska Statute 28-728 Legislative findings and intent; child abuse and neglect investigation team; child advocacy center; child abuse and neglect treatment team; powers and duties. **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist/ Administrative Investigator 4. Family Advocacy Network Director 5. Random Staff **Findings by Provision:**

115.321 (a): The auditor reviewed SOP #1252 – *PREA Treatment, Follow Up and Reports* in paragraph 6.1.1 which states, “Uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The auditor interviewed the PREA Compliance Specialist who is one of the administrative investigators who conduct administrative investigations for this facility. The administrative investigators have completed multiple courses from various organizations to include the PREA Resource Center and the Moss Group, that all emphasize a uniform evidence protocol for collecting physical evidence.

115.321 (b): The auditor reviewed SOP #1252 – *PREA Treatment, Follow Up and Reports* in paragraph 6.1.1.1 which states that, “The protocol shall be developmentally appropriate for juveniles and shall be adapted from or based on the most recent edition of the United States 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. The auditor interviewed the Facility Administrator who stated that all sexual abuse allegations will be referred to Child Protection Services and Nebraska State Patrol for investigation. They will only complete administrative investigations of a non-criminal nature. All others will be referred unless they are informed by Child Protection Services or law enforcement that they will not be investigating. In these instances, an administrative investigator will use the protocols applicable to their administrative investigation from “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents.

115.321 (c): The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.1.2 which states, “Juveniles who experience sexual abuse/ assault shall be offered access to forensic medical examinations at an outside facility, without financial cost, where medically appropriate. 6.1.2.1 Forensic medical examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. 6.1.2.2 If SAFEs or SANEs are not available, the examination shall be performed by other qualified medical practitioners; however, the YRTC will document its efforts to provide SAFEs or SANEs. The auditor interviewed the Facility Administrator and the nurse who stated that youth would be transported to Family Advocacy Network or elsewhere if directed by the Nebraska State Patrol, for the forensic examination. The auditor spoke with the Director of the Family Advocacy Network who stated that they are set up to handle adolescents at their facility to include the forensic interview, the forensic medical examination performed by SANEs, and advocacy services. They have three SANEs and their SANE Director is a physician. They almost always are able to perform the examination within their facility. If SAFEs or SANEs cannot be made available, the examination can be performed at the emergency room. The local hospital, the Good Samaritan, has five SANEs. There have been no forensic medical exams conducted during the past 12 months. The auditor interviewed a random sample of staff to confirm they understand their responsibilities to preserve and protect evidence.

	115.321 (d): The auditor reviewed SOP #1252 – *PREA Treatment, Follow Up and Reports* in paragraph 6.2.7 which states, that “Each YRTC will make available to the victim a victim advocate from a rape crisis center”. In 6.2.7.1 it lists for YRTC – Kearney, the Family Advocacy Network as the local rape crisis center available for this facility. In paragraph 6.1.3 it states, “Victims of sexual abuse/assault shall be assessed by the Family Advocacy Network, Child Advocacy Center, or the local hospital located near each YRTC facility, which shall be determined by the Nebraska State Patrol. The auditor interviewed the PREA Coordinator, the PREA Compliance Specialist and the Director of the Family Advocacy Network, the local rape crisis center, who confirmed that YRTC-Kearney has a Memorandum of Understanding (MOU) with FAN. **115.321 (e):** The auditor reviewed the FAN MOU and interviewed the Director of FAN who stated that they will provide an advocate who will provide the residents with information about options and resources and assist them through the criminal justice process. They provide accompaniment and emotional support to the residents through forensic medical examinations and investigatory interviews. **115.321 (f) & (g):** The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states, “Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities”. **115.321 (h):** The YRTC-K always offers the services of an advocate from the Family Advocacy Network. Nebraska state law under Chapter 28-278 states, “Each county or contiguous group of counties will be assigned by the Department of Health and Human Services to a child advocacy center. The purpose of a child advocacy center is to provide a child-focused location for conducting forensic interviews and medical evaluations for alleged child victims of abuse and neglect and for coordinating a multidisciplinary team response that supports the physical, emotional, and psychological needs of children who are alleged victims of abuse or neglect. Each child advocacy center shall meet accreditation criteria set forth by the National Children's Alliance. Nothing in this section shall prevent a child from receiving treatment or other services at a child advocacy center which has received or is in the process of receiving accreditation". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, and the documentation as stated in each provision above. The auditor also drew on interviews with the Facility Administrator/trained administrative investigator, the PREA Coordinator, the PREA Compliance Specialist/ Administrative Investigator, and the director of the local rape crisis center.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment, Follow Up and Reports 3. PREA allegations and investigative reports 4. DHHS YRTC website **Interviews Conducted:** 1. PREA Coordinator 2. PREA Compliance Specialist/Administrative Investigator **Findings by Provision:** **115.322 (a) – (d):** The auditor reviewed SOP #1252 – *PREA Treatment, Follow Up and Reports* in paragraph 6.12.1 which states, that “YRTC shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. 6.12.2 YRTC shall ensure that all allegations of abuse, neglect, sexual harassment, sexual abuse/assault are referred for criminal investigation to the Nebraska State Patrol to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. 6.12.2.1. When the Nebraska State Patrol (NSP) or other outside agencies investigate sexual abuse, all staff shall cooperate with investigators and the facilities shall endeavor to remain informed about the progress of the investigation. 6.12.2.2 Criminal investigations conducted by the NSP shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence when feasible". **115.322 (e):** Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations. There have been no Department of Justice investigations within this facility. The auditor is not required to audit this provision. The auditor verified compliance through a review of the pre-audit questionnaire and SOP 1252, interviews with the Facility Administrator and the PREA Coordinator, a review of the letter from the Nebraska State Patrol, and a review of the agency website at https://dhhs.ne.gov/Pages/YRTC-Reports.aspx where the investigative policy is published and may be viewed by opening the “Facility: All Facilities” drop down and selecting the pdf file “OJS PREA Standard Operating Procedures”. This documents explicitly describes the responsibilities of the Nebraska State Patrol or other law enforcement agency, Child Protective Services, and the facility’s administrative investigators. The PREA Coordinator provided the investigatory reports for the auditor to review which includes any law enforcement referrals. In addition, the auditor interviewed the PREA Compliance Specialist/Administrative Investigator, and the PREA Coordinator who both provided statements consistent

	with policies as to each entity's role in a criminal and/or administrative sexual abuse or sexual harassment investigation.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 – New and In-Service Employee Training 3. training records 5. PREA PowerPoints **Interviews Conducted:** 1. PREA Coordinator 2. 13 random staff **Findings by Provision:** **115.331 (a):** The auditor reviewed the SOP #1280 – *New and In-service Employee Training* in paragraph 6.3 which states that "All employees will receive PREA training and education which will be tailored to the unique needs and attributes of the juveniles at each YRTC. At a minimum, training will include: 6.3.2 Zero-tolerance policy for sexual abuse and sexual harassment. 6.3.3 Staff responsibilities with the sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. 6.3.4 Juveniles' right to be free from sexual abuse and sexual harassment. 6.3.5. Staff and juveniles right to be free from retaliation for reporting sexual abuse and sexual harassment. 6.3.6 Facility specific dynamics of sexual abuse and sexual harassment at the employees assigned YRTC. 6.3.7 Common reactions of juvenile victims of sexual abuse and sexual harassment. 6.3.8 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 juveniles.6.3.9 How to avoid inappropriate relationships with residents. 6.3.10 How to communicate effectively and professionally with juveniles, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming juveniles. 6.3.11 How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. 6.3.12. Relevant laws regarding the applicable age of consent. The auditor interviewed the Facility Administrator, the PREA Coordinator, and staff, and reviewed the training curriculum of various training topics. A review of the PREA training curriculum confirms that the training includes information on components required by the standard and outlined within their policy. **115.331 (b):** The auditor interviewed the PREA Coordinator who stated YRTC – Kearney houses only male residents. Staff who transfer from another facility are given training specifically in policies and procedures at this facility. When reviewing

	the PREA training PowerPoint Unity 2, there was information specific to PREA incidents in a male facility. Staff interviews included descriptions of male behaviors that are more aggressive acts against each other like hitting each other in the groin and aggressive bullying. **115.331 (c):** The auditor reviewed training curriculum and training records and interviewed administrators and random staff to verify that training happens consistently and per the policy. Staff stated that they have PREA training every year that includes a basic refresher on the main PREA components with additional training components at various times to include various topics that are relevant at that time. **115.331 (d):** The auditor interviewed the PREA Coordinator and random staff and reviewed the training records. The auditor requested and was provided with random samples of training documentation which included the course's name, the date it was completed, and tests with scores to verify understanding of the material. The auditor determined compliance with this standard through a review of the training policy, a review of the pre-audit questionnaire, a review of the curriculum, and a review of training records. The auditor also confirmed these policies and procedures through interviews with the PREA Coordinator and random staff.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 -- New and In-service Employee Training 3. Volunteer/Contractor training records **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. 2 Contractors **Findings by Provision:** **115.332 (a) and (b):** The auditor reviewed SOP #1280 – *New and In-service Employee Training* in paragraph 6.2.10 states that “Volunteers, Contractual Personnel and Interns, and all Part-time staff complete orientation and training as the Facility Administrator or designee determines is appropriate for the individual’s duties and responsibilities.6.2.10.1 The volunteer training will be monitored by the Volunteer Coordinator. 6.2.10.2 Orientation Training includes at a minimum: All volunteers, contractors, and interns who have contact with juveniles shall be notified of the zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

	The auditor interviewed the PREA Coordinator and two contractors who confirmed that they receive training from staff who go over the PREA information with them including the critical components of a zero-tolerance policy for sexual abuse and sexual harassment and how to report. This training is consistent with this provision and the training is based on the services they provide and the level of contact they have with residents. **115.332 (c):** The auditor reviewed SOP #1280 – *New and In-service Employee Training* in paragraph 6.2.10.5 states that "Documentation will be maintained confirming that volunteers, contractors, and interns understand the training they received. The auditor reviewed the training documentation signed by volunteers/ contractors. YRTC-K maintains documentation confirming that volunteers and contractors understand the training they have received. The auditor verified compliance with this standard through a review of the volunteer/contractor training documentation and through interviews with volunteers/contractors and the PREA Coordinator.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. Resident Training Documentation 4. "End the Silence" brochure 5. End Silence – Youth Comic Book 6. Posters posted throughout the facility Interviews Conducted: 1. Facility Administrator 2. PREA Coordinator 3. Intake staff 4. 16 random residents 5. 13 random staff **Findings by Provision:** **115.333 (a):** The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.1.1 which states, "Upon arrival, a juvenile will be provided information explaining, in an age-appropriate fashion, the zero-tolerance policy regarding abuse, sexual assault/abuse/harassment or neglect. This information will include (both orally and in writing in a language clearly understood by the juvenile): 6.1.1.1 Prevention/ intervention 6.1.1.2 Self-protection 6.1.1.3 Reporting incidents or suspicions of sexual abuse/assault/harassment 6.1.1.4 Treatment and counseling". The auditor

	reviewed training information provided to the residents, requested an Intake staff go over the process with the auditor as there were no new intakes to observe, and discussed the information with the residents who were interviewed. The YRTC-K facility provides extensive PREA information to a resident during the intake process. This information includes their zero-tolerance policy and how to report which is immediately explained to them while going over a brochure they can keep. **115.333 (b):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, “Within 10 days of admission, the juvenile will receive orientation/education regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents; as well as how YRTC respond to such incidents. The auditor reviewed the training materials, interviewed random residents, and interviewed an intake staff and the PREA Coordinator to have the intake and orientation processes explained. They are also provided the End Silence youth comic book and shown the PREA video, “Safeguarding Your Sexual Safety”. If the juvenile is admitted early enough during the day and they are receptive to learning the material as determined by the intake staff, they are typically given the information on the first day. If they arrive later in the day or are not in a good mindset to retain the information, they are provided the orientation a day or two later, but definitely within the first ten days. The orientation process specifically outlines residential rules, definitions, information on how to keep themself safe, the facility’s investigative process, the grievance process, and resources for support services that can assist victims in their recovery process. The auditor discussed this section of the policy with both the Facility Administrator and the PREA Coordinator. All PREA information is provided within 10 days of intake as all information, both the basic and the comprehensive, is provided typically on the first day. The auditor explained that the standards were written with the basic information at the time of intake and more comprehensive information with the first ten days. This was purposefully done to not overwhelm residents during the intake process but to give the basic information of the zero-tolerance policy and how to report in case that information is needed right away. However, once the resident has had an opportunity to acclimate to the facility, the staff then provide the more comprehensive information such as an explanation of PREA, definitions, support services, and the investigative process. Dickson, the building used to house newly admitted juveniles, is separated from other housing buildings. Juveniles are housed in this building for the orientation and screening process. This area most often only has only a few residents. The education and screening are done in a quiet, private room and it is easy to provide both basic and comprehensive information to the residents in a staff-to-youth, one-on-one, calm environment. The residents’ education was very evident in the residents’ responses during the interviews. **115.333 (c) and (d):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.5 which states, “All new admissions will receive orientation, in formats accessible to all juveniles, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as juveniles who have limited reading skills. It is the goal of each YRTC that all juveniles have an equal opportunity to participate in and benefit from all aspects of the facility’s

	efforts to prevent, detect, and respond to sexual abuse and harassment". The auditor reviewed materials in English and Spanish and interviewed the PREA Coordinator, an intake staff who presents the intake and orientation information, and 16 random residents who confirmed that the information is explained to them and given in a manner that they are able to understand. **115.333 (e):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.1.6 which states, "All juveniles will initial and date the appropriate area on the Orientation Check Sheet documenting the juveniles' participation in the orientation/ education session. The auditor reviewed the intake and orientation documentation for 16 residents to confirm that they received the education required per standard and the YRTC policy. The documentation has the resident's name and the date they completed the PREA education as well as a statement acknowledging that they understand the information that was provided and that they received the "End the Silence" brochure and the comic and viewed the video. The residents and the staff administering the education sign the form. **115.333 (f):** The auditor interviewed the staff, residents, and toured the facility. Materials are continuously and readily available to the residents. There are Zero Tolerance posters posted throughout the facility. Youth are given the "End the Silence" brochure and handbook at intake to keep with them for later reference. The auditor verified compliance with this standard through a review of the resident training documentation and materials, materials posted and available to residents, and interviews with the Facility Administrator, PREA Coordinator, intake staff, random staff, and random residents.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. Training certificates of Specialized Investigator Training 4. Investigator training curriculum **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist/Administrative Investigator **Findings by Provision:** **115.334 (a):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, "Only investigators who have received special training in sexual

	abuse investigations involving juvenile victims pursuant to PREA standard 115.334 will conduct the investigation". **115.334 (b):** The auditor reviewed the training curriculums for specialized investigator training and it included techniques for interviewing youth sexual abuse victims, the use of Garrity and Miranda, sexual abuse evidence collection in residential/group settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral." The auditor interviewed the PREA Compliance Manager who is also trained as an Administrative Investigator. He was well versed in conducting PREA investigations in confinement settings including techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. **115.334 (c):** The auditor reviewed training documentation to include the curriculum and the training certificates to include certificates from National PREA Resource Center/the Moss Group "PREA Juvenile Specialized Investigator Training". **115.334 (d):** The auditor interviewed the Facility Administrator and the PREA Coordinator who stated that the Nebraska State Patrol and Child Protection Services conduct their criminal investigations. The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states that. "Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous report. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities". The auditor verified compliance with this standard through a review of the investigator training curriculum and specialized training certificates for investigators. The auditor also confirmed investigative knowledge through an interview with the PREA Compliance Specialist/Administrative Investigator.

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 – New and In-Service Employee Training 3. Specialized training documentation for medical and mental health staff

	Interviews Conducted: 1. PREA Coordinator 2. Administrative Nurse 3. Clinical Program Manager **Findings by Provision:** **115.335 (a):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.4 which states, “All medical and mental health care practitioners will receive specialized training in addition to the mandatory PREA training and education. Specialized training will include: 6.4.1.1 How to detect and assess signs of sexual abuse and sexual harassment. 6.4.1.2 How to preserve physical evidence of sexual abuse. 6.4.1.3 How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment. 6.4.1.4 How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. **115.335 (b):** The auditor interviewed the Facility Administrator and the nurse who stated that they do not conduct forensic examinations at the facility. Residents would be transported to the Family Advocacy Network or the emergency room at the local hospital as directed by the Nebraska State Patrol. **115.335 (c) & (d):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.4 which states, “Documentation will be maintained confirming that medical and mental health practitioners have received the training”. The auditor reviewed the training documentation and curriculum submitted by the PREA Coordinator which verifies that the medical and mental health staff have completed the specialized training as well as the training mandated for employees under § 115.331. The auditor verified compliance with this standard through a review of the training curriculum and specialized training certificates for medical and mental health staff. The auditor also confirmed knowledge through interviews with the PREA Coordinator, the administrative nurse, and the Clinical Program Manager.

115.341	**Obtaining information from residents**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. 16 Resident risk screenings 4. 6 45-day periodic re-screenings **Interviews Conducted:**

1. Licensed mental health practitioner who administers the assessments
2. PREA Coordinator
3. 16 Random residents
4. Staff

Findings by Provision:
115.341 (a) and (e): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.3.1 which states, “Within 24 hours of admission to a YRTC the Screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior, which is an objective screening instrument, will be completed on every juvenile by a licensed mental health practitioner. This assessment will identify those juveniles as high risk who have the potential to act out in sexually or physically aggressive manners or who may be vulnerable to being sexually victimized. Information on each juvenile’s personal history and behavior will be gathered to reduce the risk of sexual abuse by or upon the juvenile”. The auditor selected and reviewed a random sample of 16 risk screenings and 6 periodic 45-day re-screenings. The auditor interviewed a licensed mental health staff who administers the risk screenings, and 16 random residents. All those interviewed stated the assessment was typically completed as soon as the youth arrived at the facility. The couple of exceptions were if the youth arrived at the facility later in the day or during the evening hours. Those screenings were completed the following day. The resident is housed in the Dickson cottage until the assessment process is completed. A staff member who administers the assessment walked the auditor through the assessment process as there were no new intakes while the auditor was on site. The facility conducts periodic reassessment if a youth has been a victim or a perpetrator -- they will reevaluate if they need to change how they are housed or their supervision level during programming. They have a set periodic rescreening at 45-days after admission and anytime staff feel there is need to rescreen. 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 juvenile. 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 the 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.

The auditor verified compliance with this standard through a review of 16 sample

	screenings and 6 periodic re-screening documents, and interviews with staff and residents.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1739 – Classification 4. 16 initial PREA Assessments 5. Resident Roster with housing assignment 6. YRTC Classification Minutes 7. 16 Resident risk screenings 8. 6 45-day periodic re-screenings **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist 4. Nurse 5.Clinical Program Manager 6. Licensed mental health practitioner who administers the assessments **Findings by Provision:** **115.342 (a):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.2.6 which states that “The results of the Screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior tool are used in providing appropriate housing, programming, education, work assignments, and supervision”. The auditor interviewed the Facility Administrator, the PREA Coordinator, PREA Compliance Specialist, and a Licensed mental health practitioner who administers the assessments during the intake process. They stated that the information from the risk screening is utilized to determine housing and bed assignment. Residents who may be at more risk are assigned beds closer to the staff area, closer supervision during all aspects of their programming. The auditor reviewed resident risk screenings and YRTC Classification Minutes for insight as to how the classification decisions are made. **115.342 (b):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.1 which states that “Juveniles may be confined from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged”. The SOP continues to outline that they must have large-muscle

	exercise, educational programming or special education services, daily visits from a medical or mental health care clinician, access to other programs, and work opportunities to the extent possible. The auditor interviewed the Facility Administrator, the PREA Coordinator, and the PREA Compliance Specialist. YRTC-K uses isolation as a means for keeping residents safe only as a last resort or to have the time to come up with an individualized safety plan for that particular resident. The preferred method is more targeted supervision to keep the residents safe. They would utilize more appropriate supervision methods such as ensuring a staff was in closer proximity to a resident who may be at risk. The Facility Administrator stated that they would immediately remove the youth, make adjustments that are needed, and put a safety plan in place. They have had times where a youth who was in threat of physical altercations and bullying was housed in Dickson for safety reasons, but only until they could come up with a plan. Their goal is to not house them in Dickson. **115.342 (c):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.2 which states that “Lesbian, gay, bisexual, transgender, or intersex juveniles shall be placed a particular housing or bed solely on the basis of such identification or status, nor shall staff consider lesbian, gay, bisexual, transgender, intersex juveniles as an indicator of likelihood of being sexually abusive”. The auditor interviewed, the PREA Coordinator, and the PREA Compliance Specialist. These interviews confirmed that YRTC-K does not use a resident’s identification as LGBTI as a criterion for making any housing or bed assignment or as an indicator of likelihood of being sexually abusive. The PREA Compliance Specialist stated that the DHHS Facilities Director, the PREA Coordinator, the OJS PREA Compliance Manager, and the Clinical Program Manager will meet to discuss the best placement for transgender or intersex youth based on that resident’s individual treatment needs and safety, not their status – which is the same way housing decisions are made for all youth by the classification team. There were no juveniles who identified as LGBTI to be interviewed. **115.342 (d):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.2.1 which states that “When making housing and programming assignments for a transgender or intersex juvenile, consideration will be given on a case-by-case basis whether a placement would ensure the juvenile’s health and safety and whether the assignment would present management or security problems”. The auditor interviewed the Facility Administrator, the PREA Coordinator, and the PREA Compliance Specialist. They would gather as a group, discuss, and take every factor into account when deciding whether to assign a transgender or intersex resident to a unit for male or female residents. **115.342 (e):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.2.2 which states that “Placement and programming assignments for each transgender or intersex juvenile shall be reassessed at least twice each year to review any threats to safety experienced by the juvenile”. The auditor interviewed the PREA Coordinator who stated that there have been no transgender or intersex juveniles within the facility that required a six-month review, but it would be a part of their periodic reassessment process.

	115.342 (f): The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.2.3 which states that “A transgender or intersex juvenile’s own view with respect to their own safety shall be given serious consideration”. The auditor interviewed the PREA Compliance Specialist stated that a transgenders or intersex resident’s own views with respect to his or her how safety is given serious consideration as are all resident’s own views as to their safety. **115.342 (g):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.2.4 which states that “Transgender and intersex juveniles shall be given the opportunity to shower separately from other residents”. The auditor interviewed the PREA Compliance Specialist who stated that they would be offered a different time to shower than the group or they would shower in Dickson, where there is an individual shower. This accommodation is done currently for youth who may have boundary issues. **115.342 (h):** The auditor reviewed the SOP #1739 – Classification in paragraph 6.2.2.5.1.4 which states in regard to the use of isolation that “Staff shall document the reason for the juvenile’s safety; and the reason why no alternative means of separation can be arranged”. There have been no residents placed in isolation due to risk of victimization. **115.342 (i):** The auditor reviewed SOP #1739 – Classification in paragraph 6.2.2.5.1.5 which states in regard to the use of isolation that “A weekly review will be completed to determine whether there is a continuing need for separation from the general population”. The auditor interviewed administrators who stated that if isolation is used, there would be constant evaluation for the continuation of isolation. The use of continued isolation would also be reviewed weekly. Isolation is only used if a resident is in immediate danger of being hurt or hurting others. The auditor interviewed the nurse regarding isolation, and she stated that they check in with the youth every day. The Clinical Program Manager stated that they check on them a minimum of every 24 hours. Probably more than that as they assign a regular therapist to work with them to help develop a plan on how to get back to a housing unit. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #1739, the PREA Assessment form, Classification Minutes, the resident roster with housing assignments and through multiple interviews as listed above.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire

2. SOP #1251 -- PREA Prevention
3. End the Silence brochure
4. Posters
5. Staff training documents
6. Resident training documents

Interviews Conducted:
1. PREA Coordinator
2. PREA Compliance Specialist
2. Child Protective Services External Reporting Entity
3. Ombudsman's Office
4. Inspector General for Child Welfare
5. 13 Random staff
6. 16 Random residents

Findings by Provision:
115.351 (a): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.1 which states, "Juveniles may privately report to any facility staff, including those who are not immediate point-of-contact line staff members, incidents of sexual abuse, sexual harassment, retaliation by other juvenile or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to such incidents". The auditor interviewed staff and residents and toured the facility. The auditor interviewed residents who provided multiple ways that they could report internally. Most youth stated that they would tell their staff. They can always ask to talk to staff in private. Some youth stated they could write a grievance and that they could direct the grievance to a specific staff member including the Facility Director. Both from observations and through interviews with the residents it is apparent they have a lot of trust in their staff to help them with whatever the concern may be. The auditor interviewed the Facility Administrator, the PREA Coordinator, and the staff and reviewed the training materials provided to the residents and the posters displayed throughout the facility. Residents can report in the following ways: a facility staff member, counselor, teacher, or medical professional. They can also use the facility grievance system or just write it on a note. Residents consistently stated that they had access to a pencil and paper.

115.351 (b): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.4.1 which states, "Juveniles may report incidents of sexual abuse or harassment to the Child Abuse/Neglect Hotline through the youth inmate calling system and will be allowed to remain anonymous. These calls are not recorded. Upon receiving these reports, the Child Abuse/Neglect Hotline will immediately forward these reports to the OJS administrative team". The SOP lists the address and phone number and states that juveniles will be allowed a state stamp for communication with the Child Abuse/Neglect Hotline.

The auditor interviewed residents who were able to list the methods as stated in policy. Residents stated they have regular contact with their family and attorney and stated they can report to any third party to make a report on their behalf. They were

aware of the ability to call externally to the Nebraska Ombudsman's Office or Children's Protective Services (CPS) CPS's Child Abuse/Neglect Hotline from a resident phone. The auditor made a test call from a youth dayroom phone to the CPS Child Abuse/Neglect Hotline by dialing a generic Personal Identification Number (PIN) of nine 1s. The auditor spoke with a CPS worker who stated that they would allow the youth to remain anonymous and that for all YRTCs they have a two-step notification process if the allegation involves a staff member, to keep the report confidential when the reporting goes forward to the facility administration and to notify the Office of the Inspector General (IG) of Child Welfare.

The auditor also dialed the Nebraska State Ombudsman's office using an inmate PIN. That number has been set up to not record the call or record the information about the call on the phone software. The PREA Coordinator provided the auditor with a printout from their phone service software for all calls between 6:37 AM and 12:20 PM. The auditor made the call at approximately 11AM and the number called, and the PIN used was not on the report.

The auditor had a more detailed, private conference call with a Deputy Ombudsman from the Nebraska Ombudsman's office and the IG for Child Welfare. They reported that they would look into complaints regarding the facility. They emphasized that the actual investigations are left up to law enforcement, but they look into allegations brought to their attention to ensure that the staff followed their policy and procedures. The IG stated that data and information from the YRTC's has to be reported to them for oversight purposes including PREA cases that are substantiated and any critical incidents. Outgoing mail addressed to the Child Abuse/Neglect Hotline or the Ombudsman's office is confidential and not opened by facility staff. Telephone calls to these agencies are free and not recorded.

115.351 (c) and (e): The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.7.2.1 which states, "Staff will accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports". The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.7.2.1 which states, "Staff have an obligation to report any sexual abuse and sexual harassment of juveniles but may do so privately to the facility investigator and the Facility Administrator". The auditor interviewed residents and staff who confirmed the policy is followed through procedures.

The auditor interviewed staff who stated that they would immediately report the incident to the Facility Administrator. They would document any verbal reports right away but before the end of their shift. Staff stated that they can privately report sexual abuse and sexual harassment to either the Facility Administrator, the Associate Director, or to the PREA Coordinator. The auditor interviewed the administrators and staff who stated that staff accept reports any way that it is reported.

115.351 (d): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.3.1 which states, "Staff members will provide juveniles the tools necessary to make a written report. If writing utensils are not available to a juvenile due to their

	behavior, they will be allowed to have access to these utensils as soon as they are not a threat to themselves or others". The auditor interviewed staff and residents who stated that residents have access to pencils and paper. The auditor witnessed residents writing while on the tour. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of posters, and training materials for both staff and residents, and through interviews with the PREA Coordinator, the PREA Compliance Specialist, staff and residents. The auditor is confident that residents at this facility are aware that if they need to use an external reporting entity, they have multiple options through the CPS reporting line, the Ombudsman's office, or their family.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 3. Youth Handbook 4. Parent Handbook 5. PREA Poster 6. Grievance Poster 7. Staff Training materials 8. Resident training materials 9. Break the Silence brochure **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. Random staff 4. Random residents **Findings by Provision:** **115.352 (a):** YRTC-K is not exempt from this standard as it does have administrative procedures to address resident grievances regarding sexual abuse. The auditor interviewed the Facility Administrator and the PREA Coordinator who stated that residents can file a grievance or administrative remedy regarding allegations of sexual abuse or sexual harassment. All allegations of sexual abuse or sexual harassment when received by staff, would immediately result in an administrative or criminal investigation. **115.352 (b):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.3 which states, "A time limit will not be imposed as to when a juvenile may submit a grievance regarding an allegation of sexual abuse". The policy goes on to

	state that grievance that do not allege an incident of sexual abuse must be filed within the time parameters noted in SOP 116.1 Juvenile Rights relating to the formal grievance process. Paragraph 6.8.4 states, “An informal grievance process should not be used by juvenile to resolve any issues with staff relating to an alleged incident of sexual abuse.” The auditor interviewed the Facility Administrator and the PREA Coordinator, reviewed the grievance policy and the resident handbook. The auditor spoke with residents about using the grievance process and they were aware of this option and new about the blue box. **115.352 (c):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.2 which states, “Juveniles who allege sexual abuse may submit a grievance without submitting to a staff member who is the subject of the complaint, nor will that staff member be allowed to review the grievance.” **115.352 (d):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.5 which states that, “A final decision on the merits of any portion of a grievance alleging sexual abuse shall be issued within 90 days of the initial filing of the grievance.” The policy continues to state that computation of the 90-days does not include time in preparing any administrative appeals and an extension of time to respond, of up to 70 days, may be utilized, if the normal time period of response is insufficient to make an appropriate decision. The juvenile will be notified in writing of any such extension and provided a date by which a decision will be made. At any level of the administrative process, including the final level, if the juvenile does not receive a response with the time allotted for reply, including any properly noticed extension, the juvenile may consider the absence of a response to be a denial at that level. **115.352 (e):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.5.4 which states, “Third parties, including fellow juveniles, staff members, family members, attorneys, and outside advocates, shall be permitted assist juveniles in filing request for administrative remedies relation to allegation of sexual abuse, and shall also be permitted to file such request on behalf of juveniles. The policy continues to state that if a third party, other than a parent or legal guardian, files such a request on behalf of a juvenile, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on their behalf and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. If the juvenile declines to have the request processed on their behalf, the juvenile’s decision shall be documented. The auditor reviewed the Parent Handbook which states on page 5 that, “As parents, grandparents, and legal guardians you are encouraged to report if your youth for whom you serve as guardian reports to you that they have been sexually harassed or sexually abused. We ask that you call the DHHS Abuse / Neglect Hotline at 1-800-652-1999. Like you, YRTC-Kearney wants to provide the safest possible environment for the youth we serve”. **115.352 (f):** “The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.1 which states, “Juveniles shall be allowed to file an emergency grievance to staff if the juvenile alleges, they are at substantial risk of imminent sexual abuse”.

	The policy continues by stating that if a juvenile is subject to a substantial risk of imminent sexual abuse, the YRTC at which the juvenile is placed shall take immediate action to protect the juvenile. Upon receiving an emergency grievance, staff will immediately contact the Youth Security Supervisor (YSS), or the Behavioral Technician Lead (BTL) on shift so that immediate action may be taken. Paragraph 6.8.1.3 states, “An initial response within 48 hours shall be provided to the juvenile, and a final decision will be provided within 5 calendar days, which shall indicate whether the juvenile is in substantial risk of imminent sexual abuse and the action taken in response to the emergency report. The auditor spoke with the Facility Administrator who described the process. If an emergency grievance is filed, the first response will be to make sure that the resident is safe by separating the resident from the threat. They will then gather the details and begin the investigation process and will provide an initial response to a resident immediately, but well within 48 hours. A final response will be given to a resident within 5 days. The PREA Compliance team will be involved in this process. **115.352 (g):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.8.6 which states, “If it is determined that a juvenile filed a grievance in bad faith, the Compliance Specialist will work with the juvenile’s treatment team to determine the appropriate consequences. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of grievances, a review of the Youth Handbook, a review of PREA posters, and training materials for both staff and residents, and through interviews with the Facility Administrator, the PREA Coordinator, staff and residents.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment 3. Family Advocacy Network Posters **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. Family Advocacy Network Director 4. 16 Random residents **Findings by Provision:**

	115.353 (a): The auditor reviewed the SOP #1252 – PREA Treatment in paragraph 6.2.6 which states, “All juveniles with be provided access to outside victim advocates for emotional support services related to sexual abuse” The policy and the Family Advocacy Network (FAN) posters that are located in all juvenile housing areas list the Family Advocacy Network address and phone number. The auditor spoke with the Director for the Family Advocacy Network, who stated that they will provide advocacy services as well as confidential support services to youth at this facility. **115.353 (b):** The auditor interviewed the PREA Coordinator stated that the facility will enable reasonable communication between residents and FAN in as confidential a manner as possible. These procedures were confirmed by speaking with both staff and residents. Residents can either call from a resident phone in the dayroom or ask their case manager for a private call in an office. **115.353 (c):** The auditor reviewed the Memorandum of Understanding (MOU) that the YRTC-K facility entered into with the FAN. The MOU outlines the services such as providing an advocate that can accompany and support the victim through the forensic medical examination process and investigatory interviews and provide confidential emotions support, crisis intervention, information and referrals. **115.353 (d):** The auditor reviewed the SOP #1129 – Privileged Communication in paragraph 6.1.1 it states, the Persons who are afforded confidential contact with a juvenile shall include: a juvenile’s Attorney, committing Judge, Guardian ad Litem, PO, CFSS Worker, any representative of the Office of the Public Counsel, an representative of the Office of Inspection General for Child Welfare, Office of Juvenile Services Administration (OJS) and any Nebraska State Senator. Juveniles will make a request for a phone call or visit through their YCM or Living Unity Manager”. In paragraph 6.3.1 it states, “Juveniles may send sealed letters to a specified class of persons and organization, including but not limited to: courts, counsel, officials of the confining authority, administrators of the grievance system, and members of the releasing authority. The juvenile must note on the sealed letter in the upper left hand envelop corner under their name that it is “specified” mail. The policy states, “YRTC-K staff shall not read mail from Attorneys under any circumstances. If the juvenile does not understand the contents of a letter from the Attorney and requested a YRTC-K staff member to read and interpret the letter, The YRTC-K staff member shall refuse such a request and immediately arrange a phone call between the juvenile and their attorney so that the Attorney may explain the contents of the letter. The auditor also reviewed the youth handbook and spoke with residents who stated that they can speak with their case manager to set up an appointment with the attorney at any time. Youth stated that they are given 60 minutes per week to speak with their family. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, SOP 1129, and the MOU with FAN, and through interviews with the Facility Administrator, the PREA Coordinator, FAN Director, and residents.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 3. Information on DHHS website 4. End the Silence brochure 5. Parent Handbook **Interviews Conducted:** 1. Facility Administrator 2. PREA Compliance Specialist 3. 16 Random residents **Findings by Provision:** **115.354:** The auditor reviewed the Nebraska DHHS website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx. The website provides in big, bold information the Adult & Child Abuse & Neglect Hotline (800) 652-1999. Also, the Parent Handbook and the Youth Handbook are available on the website as well. These publications provide information on how an individual can make a third-party report. Methods include agency and facility leadership, Child Protective Services, and Nebraska Ombudsman with contact information for each of these. The auditor interviewed the PREA Compliance Specialist who stated that the YRTC-K facility has received third-party reports. The auditor reviewed an investigative file that resulted from a third-party report. Interviews with staff and residents confirm that third-party reporting options are available. The auditor determined compliance through a review of the pre-audit questionnaire, a review of the SOP #1251, a review of the website, by testing some of the third-party reporting options, and through interviews with the PREA Compliance Specialist, and residents.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. Mental Health Informed Consent form 4. YRTC- PREA Reporting Guide for Outside Representatives form

Interviews Conducted:
1. Facility Administrator
2. PREA Compliance Specialist
3. Nurse
4. Clinical Program Manager
5. Random Staff

Findings by Provision:
115.361 (a) and (b): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.1 which states, “Staff shall report immediately any knowledge, suspicion, or information they receive regarding an allegation included from the list of 6.4.1.1-14. This shall be done in accordance with the mandatory child abuse reporting laws”. The auditor reviewed the list that is referenced in this SOP, and it includes sexual abuse, sexual assault, sexual harassment, retaliation for reporting sexual abuse or sexual harassment, or cooperating with investigations of sexual abuse or sexual harassment and voyeurism. The auditor interviewed the Facility Administrator, the PREA Compliance Specialist, and random staff who consistently stated that all YRTC-K facility staff are required to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment. When an allegation of sexual abuse or sexual harassment are reported they are immediately turned over to the Compliance Team who are all trained administrative investigators and reported to Child Protective Services and/or Nebraska State Patrol.

115.361 (c): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.1 which states, “Aside from reporting the incident to Facility Administrator or designee, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary.

115.361 (d): The auditor interviewed the nurse and a clinical program manager who stated that they know that if they become aware of any reports of sexual abuse, they are immediately required to report it to Child Protective Services and the Compliance team. All youth sign a Mental Health Informed Consent form at intake that describes their limits to confidentiality to include if they tell them if they are being abused, physically, sexually, or emotionally, or that they have been abused or neglected in the past and this abuse has not been previously reported. The law requires that they file a report with DHHS as required by law.

115.361 (e): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.14.6 which states, “At the conclusion of the administrative investigation of an alleged sexual abuse, the PREA Compliance Specialist or designee will notify the alleged victim’s parent/guardian to inform them that a Hotline call was made, an internal investigation has taken place, and the results of that investigation, unless the facility has official documentation showing that parents/guardian should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim’s caseworker. The victim’s attorney or other legal representative of record within 14 days of receiving the allegation. The auditor interviewed the PREA Compliance Specialist and reviewed the YRTC- PREA

	Reporting Guide for Outside Representatives. This form documents the contacts made to parents/guardian, caseworkers, attorney, and assigned probation officer. **115.361 (f):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.3 which states, “Staff shall immediately contact facility investigators of any knowledge, suspicion, or information they receive or observe regarding incidents of sexual abuse or sexual harassment that occurred at any YRTC or to a juvenile under the care of a YRTC. Retaliation against juveniles or staff who reported such an incident or cooperated with an investigation of sexual abuse or sexual harassment. Any staff neglect/violation of responsibilities that may have contributed to an incident or retaliation. Third party and anonymous reports”. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of the residents' YRTC- PREA Reporting Guide for Outside Representatives, and through interviews with the administrative staff, medical and mental health staff, and random staff.

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 -- PREA Prevention **Interviews Conducted:** 1. DHHS Facilities Director 2. Facility Administrator 3. Random staff **Findings by Provision:** **115.362:** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.11 which states that, “At any time, staff learns that a juvenile is subject to a substantial risk of imminent sexual abuse, they will take immediate action to protect the juvenile”. The auditor interviewed the DHHS Facilities Director who stated that his expectation is that they make sure that the resident is safe. He expects them to do something immediately by either taking the resident to a safe place or be with them the entire time under direct supervision. Their next step is to report it. The Facility Administrator stated that she expects the staff to immediately remove the resident from the threat making whatever adjustments are necessary, call a YSS, and put a safety plan in place. If they need to, they will remove someone into a separate housing unit. During interviews with staff, they also responded that making sure they were immediately separated and for staff to be vigilant in their supervision. The auditor determined compliance through a review of the pre-audit questionnaire,

	a review of SOP #1251, and through interviews with the DHHS Facilities Director, the Facility Administrator, and random staff.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. Email to Facility Administrator 4. Documentation of call to Child Protective Services **Interviews Conducted:** 1. Facility Administrator **Findings by Provision:** **115.363 (a):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.10.1 it states that “If a juvenile was sexually abused while confined at another facility, the YRTC Facility Administrator or designee will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. **115.363 (b):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.10.2 it states that “Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. **115.363 (c):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.10.3 it states that “The Facility Administrator will document that it has provided such notification. **115.363 (d):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.10.3 it states that “The facility that receives such notification shall ensure that the allegation is investigated”. criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The auditor interviewed the Facility Administrator. If there is an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator notifies the head of the facility or appropriate office of the agency where the alleged abuse occurred. If such an allegation is received by them from another facility, an investigation will be initiated immediately. Both notifying other agencies and receiving notifications are documented. The Facility Administrator stated that all reports are also reported to the PREA Compliance Team. There was one incident reported regarding sexual abuse that occurred at another facility. The

	auditor reviewed the documentation verifying that the incident was reported to the other facility as well as documentation that it was reported to the Child Protective Services hotline. There have been no incidents reported to the YRTC-K facility administrators by other facilities. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review incident spreadsheet that documents who the notice was made to and through interviews with the Facility Administrator.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 -- PREA Prevention 3. First Responder report **Interviews Conducted:** 1. Random Staff 2. Volunteer/Contractor **Findings by Provision:** **115.364 (a):** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 6.11.2.1 which states, “Immediately separate the alleged victim and the abuser. 6.11.2.2 Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. 6.11.2.3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request and ensure that the alleged victim and 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.6.11.3 Staff will immediately contact a Youth Security Supervisor (YSS) or a Behavior Tech Lead (BTL) on shift so that immediate action may be taken.6.11.4 Staff will complete the First Responder form6.11.5 The YSS or BTL will then notify the Facility Administrator and the Compliance Coordinator”. The auditor interviewed staff who were aware of their first responder duties and could articulate how to implement proper procedures. Staff stated they would first separate the alleged victim and the alleged abuser. The alleged victim would be taken to a more private area. They would encourage the alleged victim to protect any evidence by not washing, brushing teeth, changing clothes, using the restroom, drinking or eating until the physical evidence can be collected by the SANE. They would remove the alleged abuser and again, not allow them to wash, brush teeth, change clothes, use the restroom, drink or eat until the physical evidence can be collected by the SANE. The staff would secure and protect any physical area where

	there may be evidence to be collected. They will determine if the situation requires immediate involvement of law enforcement or medical personnel and also notify the supervisor. If immediate medical attention is needed, they would call for medical staff, an ambulance, or arrange to take them to the hospital to provide immediate medical care. There have been three instances where the first responder response required they separate the alleged victim and abuse, but there been no times that it required physical evidence collection, preservation of a crime scene, or request or ensure that the victim and the abuse not take any actions that could destroy physical evidence. has been used during this auditing period. **115.364 (b):** The auditor interviewed a volunteer/contractor who stated that they are trained to stay with the juvenile until they can turn them over to a YSS so as to ensure that they don't destroy evidence. There have been no incidents reported involving a non-custody staff. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, the First Responder report, and through interviews with the random staff.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1252 – PREA Treatment 3. First Responder form **Interviews Conducted:** 1. Facility Administrator 2. Nurse Administrator 3. Clinical Program Manager 4. 13 Random staff **Findings by Provision:** **115.365:** The auditor reviewed the SOP #1251 – PREA Prevention in paragraph 3.3 which states, "When a YRTC has reasonable cause to believe that a juvenile has been subjected to abuse or neglect, including sexual and physical abuse, harassment, or assault, they have a legal and ethical duty to report said abuse/ neglect. Therefore, each YRTC maintains detailed procedures to report these incidents and ensures that follow-up counseling and supervision concerns are addressed. These procedures include the YRTC written plan outlining coordinated actions in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility administration".

	The auditor also reviewed the First Responder form which includes a checklist and outlines First Responder duties, the notification processes to include contacting the Youth Security Supervisor on duty, a Compliance Team staff member, and Administration. The form includes a section for compliance staff to document evidence collection documentation. All Compliance Team staff are trained administrative investigators. The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.2 which states, “The compliance Coordinator or designee will contact the Nebraska State Patrol to report incidents of sexual assault. The Compliance Coordinator or designee will facilitate contact between the Nebraska State Patrol and the Family Advocacy Network to arrange for initial intake and transportation arrangements. All subsequent medical and investigative provisions are conducted according to the protocols of the Family Advocacy Network/Child Advocacy Cener, DHHS staff, and/or Nebraska State Patrol officials. The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.2.4 that, “Juvenile victims of sexual abuse will receive timey, 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”. The auditor interviewed the nurse administrator and the clinical program manager who both confirmed that they or their staff will respond to any immediate medical or mental health emergency on the campus. The auditor interviewed the Facility Administrator, the nurse administrator, the clinical program manager, and staff who verified the coordinated actions for the coordinated response plan. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #1252, and the First Responder form, and through interviews with the Facility Administrator, the nurse administrator, the clinical program manager, and random staff.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline **Interviews Conducted:** 1. DHHS Facilities Director **Findings by Provision:** **115.366 (a):** The auditor reviewed SOP #1268 – Employee Discipline in paragraph

	6.8.1 which states, “Neither the OJS/YRTC’s or any other governmental entity responsible for collective bargaining on OJS/YRTC’s behalf shall entire into or renew any collective bargaining agreement or other agreement that limits OJS/YRTC’s ability to remove alleged staff sexual abusers from contact with juveniles pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. The auditor interviewed the DHHS Facilities Director and the collective bargaining agreements disciplinary sections. The DHHS Facilities Director stated that there is nothing that would prohibit the Facility Administrator’s ability to remove an alleged abuser from contact with residents. **115.366 (b):** The auditor reviewed the SOP #1268 –Employee Discipline in paragraph 6.8.2 which states, “OJS/YRTC shall not restrict the entering into or renewal of agreements that govern: 6.8.2.1 The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions that pertain to the PREA evidentiary standards or PREA disciplinary sanctions for staff as noted in applicable PREA standards. 6.8.2.2.2 Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member’s personnel file following a determination that the allegation of sexual abuse is not substantiated. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, and an interview with the DHHS Facilities Director.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 -- PREA Prevention 3. 90 Day Tracking Sheet 4. Protection Against Retaliation – Staff Form 5. Protection Against Retaliation – Youth Form **Interviews Conducted:** 1. DHHS Facilities Director 2. Facility Administrator 3. PREA Compliance Manager 4. Case Manager 5. Juvenile who reported sexual abuse **Findings by Provision:** **115.367 (a) and (e):** The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.7 which states, “The Compliance Specialist will ensure juveniles and staff who report sexual abuse or sexual harassment or who cooperate with the

	investigation will be protected from retaliation by other juveniles or staff". The auditor discussed retaliation monitoring with the PREA Compliance Manager who stated that the Case Manager will monitor the conduct or treatment of juveniles, and the Unit Managers will monitor the conduct or treatment of staff. The auditor interviewed a juvenile who reported sexual abuse, and he stated that there was no retaliation, and that he felt protected. Both the DHHS Facilities Director and the Facility Administrator stated that they provide appropriate training to staff regarding protective measures against retaliation and ensure that, if necessary, the parties are separated to prevent retaliation. **115.367 (b):** The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.8 which states that "Protection measures, such as removal of housing changes/ transfers for juvenile victims or abusers, removal of alleged staff or juvenile abusers from contact with the victim, as well as emotional support services for the juvenile and/or staff who fear retaliation for reporting sexual abuse or sexual harassment will be implemented. The PREA Compliance Manager stated when monitoring staff who may have reported another staff, they check-in with the staff and look for a change in duties or assignments and disciplinary actions or negative behaviors toward them. The Case Manager interviewed stated that their measures would depend on the severity of the incident. The juvenile could be moved to a different cottage, or there could be a loss of privilege. **115.367 (c):** The staff interviewed and SOP #1251 both stated that monitoring would continue for a minimum of 90 days but would continue beyond that if needed. **115.367 (d):** The staff interviewed stated that they would visit with the juvenile or staff regarding any threats, comments, or actions against them. **115.367 (f):** The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.10 which states, "Monitoring for retaliation shall terminate if it is determined the allegation is unfounded". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of the documents listed above, and through interviews with the administrators, the PREA Compliance Manager, a youth Case Manager, and a juvenile who reported sexual abuse.

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. Investigative Reports

	Interviews Conducted: 1. Facility Administrator 2. Nurse 3. 13 random staff **Findings by Provision:** **115.368:** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.2.2.5.1 which states, “Juveniles may be confined from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged”. The auditor interviewed the Facility Administrator, the nurse, and staff who all consistently stated that they do not use isolation as protection to keep residents safe from sexual abuse or who suffered from sexual abuse. Isolation is used for behavioral issues and only until those behaviors are under control. There are two areas within Dickson. One is a confinement room area, and one is for juveniles who may need closer supervision. The closer supervision area has individual rooms, a dayroom, and a recreation area. A youth may be put in the closer supervision area, but not confinement rooms until they can come up with a safety plan for them. They will ensure that the resident who is alleged to have suffered sexual abuse will be watched continuously through close staff supervision both in the cottages and in Dickson. There have been no juveniles placed in confinement from other juveniles for protective measures against sexual abuse.

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1252 – PREA Treatment 3. Investigative Reports 4. Administrative Investigator training certificates 5. Nebraska State Patrol letter **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. Facility Administrative Investigator **Findings by Provision:** **115.371 (a):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.12.3.1 which states, “To the extent that YRTC conducts its own investigations into allegations of sexual abuse and sexual harassment, shall do so promptly,

	thoroughly, and objectively for all allegations, inducing third-party and anonymous reports". The auditor interviewed the Facility Administrator, the PREA Coordinator, and a Facility Administrative Investigator who stated that as soon as they receive the allegation, the investigator from compliance is assigned and immediately begins the investigation. **115.371 (b):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, "Only investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to PREA standard 115.334 will conduct the investigation". The YRTC has six trained facility investigators to conduct administrative investigations. The auditor reviewed specialized training certificates which showed they completed specialized investigator training. **115.371 (c):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.4 which states, "YRTC investigators shall take measures to secure the scene and protect and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. Interviews shall be conducted with alleged victims, suspected perpetrators, and witnesses, and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator". The auditor interviewed the PREA Compliance Specialist who has been specially trained as an administrative investigator. He stated that to the extent they would be responsible for their facility administrative investigations they are trained to gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviews of alleged victims, suspected perpetrators, and witnesses. They will review prior complaints and reports of sexual abuse involving the suspected perpetrator. They are also responsible for gathering, preserving, and reviewing camera footage. The auditor reviewed the investigative reports, and they documented well all evidence gathered through the investigative process. **115.371 (d):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.8 which states, "An investigation will not be terminated solely because the source of the allegation recants the allegation". The auditor interviewed the administrative investigator who verified that the investigation would not terminate solely because the resident later recanted the allegation. The auditor reviewed an investigative file in which the youth recanted his story. The auditor also interviewed the youth who recanted. Both the investigative report and the interviews confirm that the investigation is not terminated due to the source recanting. **115.371 (e):** The auditor interviewed the administrative investigator who stated that when it is a criminal case, the Nebraska State Patrol handles the consultation with the prosecutor before conducting compelled interviews. **115.371 (f):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.6 which states, "The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as a juvenile or staff. YRTC shall not require a juvenile who alleges sexual abuse to submit to a polygraphy examination or other truth-telling device as a

	condition for proceeding with the investigation of such an allegation" The auditor interviewed a facility administrative investigator who stated that he doesn't take the staff side. He looks at the facts and the evidence and does not judge based on who they are. They do not use polygraphy examination. The auditor reviewed investigative reports that verify that they look for consistent statements and evidence that supported the credibility of the people interviewed. **115.371 (g):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.10 which states, "Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse. 16.12.11 Administrative investigations shall be documented in a written report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings". The facility administrative investigator stated that he looks at what the staff were doing at the time of the incident. The auditor reviewed investigative reports. The reports include information on what staff were doing when they review the camera footage and make a statement regarding proper supervision or lack of supervision. The investigator stated that if they find staff's actions or failures to act during the investigation, they refer them to the Facility Administrator. **115.371 (h):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.2.2 which states, "Criminal investigations conducted by the NSP shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence when feasible". The auditor interviewed the PREA Coordinator who stated that they will request criminal investigative reports from NSP. **115.371 (i):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.2 which states, "YRTC shall ensure that all allegations of abuse, neglect, sexual harassment, sexual abuse/assault are referred for criminal investigation to the Nebraska State Patrol to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. Paragraph 6.12.2.3 states, "Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution." The auditor interviewed the administrative investigator who stated that they will defer to law enforcement when the criminal case is substantiated and referred for prosecution. They have had no cases at this facility that were referred for prosecution. **115.371 (j):** The auditor reviewed the SOP #1252— PREA Treatment in paragraph 6.4.1 which states, "Each YRTC shall retain written reports from all criminal and administrative investigations for as long as the alleged abuser is incarcerated or employed by a YRTC, plus five years, unless the abuse was committed by a juvenile and applicable law requires a shorter period of retention." **115.371 (k):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.9 which states, "The departure of the alleged abuse or victim from a YRTC shall not provide a basis for terminating an investigation". The Facility Administrative Investigator stated that investigations are completed regardless of whether the staff

	member was still employed, or the resident was still housed at the facility. **115.371 (l):** The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states, “Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities”. **115.371 (m):** The auditor reviewed the SOP #1251— PREA Prevention in paragraph 6.12.2.1 which states, “When the Nebraska State Patrol (NSP) or other outside agencies investigate sexual abuse, all staff shall cooperate with investigators and the facilities shall endeavor to remain informed about the progress of the investigation. The Facility Administrative Investigator stated that their role in any investigation led by NSP is to provide whatever assistance they may need and remain informed of the progress of the investigation". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #1252, a review of investigative reports, a review of specialized investigator training, and through interviews with the Facility Administrative Investigator.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. Investigative Reports **Interviews Conducted:** 1. Administrative Investigator **Findings by Provision:** **115.372:** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.12.7 which states, “When conducting an investigation, a YRTC shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated”. The auditor interviewed the administrative investigator and reviewed investigative reports and was satisfied that this facility uses no standard higher than a preponderance of the evidence. He stated that they use a preponderance of evidence which means that more than 50%

	believed through the evidence that the incident occurred. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251 and the administrative investigation reports, and through an interview with the administrative investigator.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment 3. Investigative Reports 4. Outcome to Resident **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. Administrative Investigator 4. Resident who received an outcome **Findings by Provision:** **115.373 (a):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.1 that, “Following an investigation into a juvenile’s allegation of sexual abuse occurring at a YRTC, the juvenile shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded”. The auditor interviewed the Facility Administrator and an Administrative Investigator who stated that they will deliver in person a letter which will have the outcome of the investigation and the youth signs, acknowledging that they received the outcome of the investigation. The auditor reviewed a sample notice of the outcome to the resident. **115.373 (b):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.3.1 that, “If the investigation was conducted by an external agency, the YRTC hall request the relevant information to inform the juvenile”. The auditor interviewed the PREA Coordinator who stated that if the Nebraska State Patrol conducts the investigation, they will obtain the information from them so that they can inform the resident as to the progress of the case and the conclusion. **115.373 (c):** The auditor reviewed the SOP #1252 – PREA Treatment which states in paragraph 6.3.2 which states that, “Following a juvenile’s allegation that a staff member has committed sexual abuse against the juvenile, the juvenile shall be informed following (unless it was determined the allegation is unfounded): 6.3.2.1 If the staff member is no longer posted within the juvenile’s living unit; 6.3.2.2 If the

	staff member is no longer employed at the facility. 6.3.2.3 If it is known that the staff member has been indicted or convicted on a charge related to sexual abuse within the facility. The auditor reviewed the investigative files and interviewed the Administrative Investigator. There have been no substantiated or unsubstantiated allegations of sexual abuse against staff in which these processes were required. However, there was a charge of sexual harassment that was substantiated. The juvenile was provided with notice that the staff member was terminated. **115.373 (d):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.3 that, "Following a juvenile's allegation that they been sexually abused by another juvenile, the juvenile shall be informed of the following: 6.3.3.1 If it is known that the alleged abuser has been indicted or convicted on a charge related to sexual abuse at a YRTC. The auditor reviewed the investigative files and interviewed the Administrative Investigator. There have been no substantiated or unsubstantiated allegations against residents in which the resident abuser was indicted or charged. However, there were incidents in which sexual touching was substantiated, and the resident was notified of the outcome of the investigation. **115.373 (e):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.4 that, "All such notifications or attempted notifications shall be documented". The auditor reviewed notices to residents in which the residents signed that they received the outcome of the investigation **115.373 (f):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.4.1 that, "YRTC's obligation to report shall terminate if the juvenile is released from a YRTC". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, a review of the investigative reports, and notice of the outcome to the resident, and through interviews with the Facility Administrator, an Administrative Investigator, and a resident who received an outcome notice.

115.376	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline 3. Investigative Reports 4. Staff disciplinary action **Interviews Conducted:** 1. Facility Administrator

	Findings by Provision: **115.376 (a):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.1 which states, “Employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies”. **115.376 (b):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.1.1 which states, “Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse”. **115.376 (c):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.2 which states that “Disciplinary sanctions for violations of policy relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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”. **115.376 (d):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.3 which states “All terminations for violations of sexual abuse and sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement, unless the activity was clearly not criminal, and to any relevant licensing bodies”. The auditor interviewed the Facility Administrator who stated that discipline would be commensurate with the nature and circumstances of the allegation committed, the staff member’s disciplinary history, and comparable incidents, but that termination would be the presumptive discipline for substantiated allegations of sexual abuse. All reports of sexual abuse perpetrated by a staff will be reported to law enforcement, CPS, and any relevant licensing bodies. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, a review of investigative reports, of staff disciplinary action, and through an interview with the Facility Administrator.

115.377	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline 3. Investigative Reports **Interviews Conducted:** 1. Facility Administrator

	Findings by Provision: **115.377 (a):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.7.1 which states, “Any contact personnel or volunteer who engages in sexual abuse shall be prohibited from contact with any juvenile and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies”. **115.377 (b):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.7.2 which states, “The OJS and the YRTCs will take appropriate remedial measures and shall consider whether to prohibit further contact with juveniles, in case of any other violation of sexual abuse or sexual harassment policies by contract personnel or volunteers”. The auditor interviewed the Facility Administrator who stated that it would depend on the situation. If it were a serious act involving sexual abuse, they would immediately be removed from the campus and if criminal, contact law enforcement to seek prosecution. There may be a less serious situation where they would always have to be with a YRTC staff. She stated that contractors and volunteers are typically supervised by staff while providing services to youth within the facility. The auditor reviewed the investigative reports and there were no allegations against contractors or volunteers. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, and through interviews with the Facility Administrator.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1279 – Youth Rights 3. Investigative Reports **Interviews Conducted:** 1. Facility Administrator **Findings by Provision:** **115.378 (a):** The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6 which states, “Juveniles may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the juvenile engaged in juvenile-on-juvenile sexual abuse or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse”.

	115.378 (b): The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.1 which states, “Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the juvenile’s disciplinary history, and the sanctions imposed for comparable offenses by other juveniles with similar histories. In the event a disciplinary sanction results in the confinement of a juvenile, they will receive Daily large-muscle exercise; Educational programming or special education services; and Other programming and work opportunities to the extent possible. The Facility Administrator stated that discipline would depend on the level of the abuse. Rule infractions mean that a juvenile does not progress in their program, but it could mean a loss of privileges, or for criminal acts, they would pursue criminal charges. She stated that isolation is only used if they are a threat to someone’s safety because their behaviors are not under control. **115.378 (c):** The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.2 which states, “The disciplinary process shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed”. The auditor interviewed the Facility Administrator who stated that this would always be considered. The whole team meets to discuss. In the case of a youth who may have a mental disability or mental illness, mental health staff will give suggestions for what is appropriate. **115.378 (d):** The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.3 which states, “The juvenile may receive counseling, therapy, or other interventions designed to address and correct underlying reasons or motivations for the abuse”. Paragraph 6.6.6.4 states “Juveniles may be required to participate in such interventions as a condition to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access general programming or education". **115.378 (e):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.6.5 which states, “Juveniles may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact”. The auditor interviewed the Facility Administrator who stated there have been no incidents of this type at the facility. **115.378 (f):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.7 which states, “A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation”. **115.378 (g):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.8 which states, “Sexual activity between juveniles is prohibited and juveniles will be disciplined for such activity; however, sexual action will not constitute sexual abuse if it is determined that the activity is not coerced.” The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, a review of investigative reports, and an interview with the Facility Administrator.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. Informed Consent form 4. PREA Screening **Interviews Conducted:** 1. Clinical Program Manager 2. Mental Health Staff responsible for screening **Findings by Provision:** **115.381 (a) and (b):** The auditor reviewed SOP #1251 – PREA Prevention which states in paragraph 6.2.7 that "If the screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior tool indicates that a juvenile has experienced prior sexual victimization or previously perpetrated sexual abuse, staff will ensure that the juvenile is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake process". A mental health staff completes the screening process within the first 24 hours of a youth's arrival. If there is any previous sexual abuse history or a history of the perpetration of sexual abuse, this information becomes a part of the mental health file and is discussed with the treatment team. The auditor interviewed the clinical program manager who stated that mental health staff assess all juveniles to determine their treatment needs, and a treatment team meets with the youth during the first week after orientation to discuss their treatment plan with the youth. **115.381 (c) and (d):** The auditor reviewed SOP #1251 – PREA Prevention which states in paragraph 6.2.8 that "Any information related to sexual victimization will be strictly limited to medical and mental health practitioners and other staff, as necessary, when decisions are made regarding treatment plans, security, and management of the juvenile". Paragraph 6.2.9 states, "Medical and mental health practitioners shall obtain informed consent from juveniles before reporting information about prior sexual victimization that did not occur in an institutional setting unless the juvenile is under the age of 18". The clinical program manager stated that all residents sign an informed consent form when they first meet with the mental health staff. This form advises them of their rights concerning confidential information but states that as required by law, they have to report any type of abuse for juveniles. The auditor confirmed that the screening information was either locked in an office or stored on a secure drive in which access is given only to those who need to know the information and password protected.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #697 – Emergency Medical Care **Interviews Conducted:** 1. Clinical Program Manager 2. Nurse Administrator 3. First Responders **Findings by Provision:** **115.382 (a):** The auditor reviewed SOP #697 -- Emergency Medical Care in paragraph 6.4.1 which states, “Juvenile victims of sexual abuse shall 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”. **115.382 (b):** The auditor reviewed SOP #697 -- Emergency Medical Care in paragraph 6.4.1.1 which states, “If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take the necessary steps to protect the victim and notify appropriate personnel”. **115.382 (c):** The auditor reviewed SOP #697 -- Emergency Medical Care in paragraph 6.4.2 which states, “Juvenile victims of sexual abuse while at YRTC-K shall be offered information about sexually transmitted infections prophylaxis in a timely fashion and in accordance with professionally accepted standards of care, where medically appropriate”. **115.382 (d):** The auditor reviewed SOP #697 -- Emergency Medical Care in paragraph 6.4.3 which states, “Treatment services shall be 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”. The auditor reviewed SOP #697 and interviewed the nurse administrator, the clinical program manager, and first responders. The nurse and mental health staff can provide immediate medical care and crisis intervention services, but if more critical care is needed the juvenile would be transported to the hospital or an ambulance called. Both the nurse and the clinical program manager stated that their personal judgement at that facility would be followed.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents Reviewed:
1. Pre-Audit Questionnaire
2. SOP #695 – Availability of Health Care

Interviews Conducted:
1. Nurse Administrator
2. Clinical Program Manager

Findings by Provision:
115.383 (a): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.1 which states, “Staff shall offer medical and mental health evaluation and, as appropriate, treatment to all juveniles who have been victimized by sexual abuse”.

115.383 (b): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.2 which states, “The evaluation and treatment of such victims shall 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”.

115.383 (c): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.3 which states, “Staff shall provide such victims with medical and mental health services consistent with the community level of care”.

115.383 (d) and (e): YRTC-K is an all-male facility. These provisions are non-applicable as they only apply to facilities that house female juveniles.

115.383 (f): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.5 which states, “Juveniles who are victims of sexual abuse while at the facility shall be offered tests for sexually transmitted infections as medically appropriate”.

115.383 (g): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.6 which states, “Treatment services shall be provided to the juvenile who is the victim of sexual abuse without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident”.

115.383 (h): The auditor reviewed SOP #695 – Availability of Health Care in paragraph 6.3.7.7 which states, “A mental health evaluation for all juvenile-on-juvenile abusers will be conducted within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners”.

The auditor reviewed SOP #695 and interviewed the nurse and clinical program manager who stated that ongoing medical and mental health evaluations and treatment are offered at no cost to sexual abuse victims and abusers. The nurses or

	the mental health staff would follow up to ensure that follow-up services recommended by the providers would be continued. These staff stated that the level of care provided is consistent with the community level of services, if not better than what some juveniles receive when in their home communities. Services are consistently offered, the juveniles can't avoid services, and the health staff and mental health staff address their needs right away.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment 3. 5 Incident Review forms 4. 10 Investigative Reports **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. OJS Compliance Specialist **Findings by Provision:** **115.386 (a):** The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.1 which states, "A sexual abuse incident review will be conducted 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". **115.386 (b):** The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.2 which states, "Sexual abuse incident reviews will occur within 30 days of the conclusion of the investigation". **115.386 (c):** The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.1 which states, "Sexual abuse incident reviews will be conducted by a review team including upper-level management, with input from line supervisors, investigators, and medical or mental health practitioners. **115.386 (d):** The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.3 which states, "The review team shall consider the following during the review: 6.5.4.1 Whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. 6.5.4.2 Whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at

	the facility. 6.5.4.3 Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. 6.5.4.4 Assess the adequacy of staffing levels in that area during different shifts. 6.5.4.5 Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. **115.386 (e):** The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.5 which states, “The review team will prepare a report of its findings, including but not necessarily limited to the criteria listed above and any recommendations for improvement. The report will be submitted for the Facility Administrator and filed with the Compliance Specialist. 6.5.5.1 The facility shall implement the recommendations for improvement or shall document its reasons for not doing so”. The auditor reviewed the documentation of five sexual abuse incident reviews. The YRTC-K uses a form to complete their incident review. The form has headings to trigger discussion on the motivation for the incident and has a required explanatory section so that it is not a “check the box” form. The form includes areas for discussion on the area where the incident occurred and changes that may be needed in policy or practice. The managers documented meaningful discussion on the incident review forms related to the specifics of the sexual abuse incidents. Reviews were completed within 30 days of the incidents and all the required components of the standard were considered. Although it is commendable that they would review substantiated sexual harassment incidents as well, this is not required by the standard. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, a review of 10 investigative reports, and five sexual abuse incident reviews, and through interviews with the Facility Administrator, the PREA Coordinator, and the OJS Compliance Specialist.

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information Systems 3. 10 Investigative Reports 4. 2023 Annual Report with aggregate data 5. 2024 aggregate data up to October 2024 **Interviews Conducted:** 1. PREA Coordinator **Findings by Provision:**

	115.387 (a): The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Accurate and uniform data will be collected for every allegation of sexual abuse at facilities using a standardized instrument and set of definitions”. **115.387 (b) and (d):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Available reports, investigation files, and sexual abuse incident reviews will be used to collect data. This data will be maintained, reviewed, and totaled at least annually”. **115.387 (c):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Data collected shall 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?”. **115.387 (e):** The auditor interviewed the PREA Coordinator who stated that they do not contract for the confinement of their residents with another agency. **115.387 (f):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Upon request, all data from the previous calendar year shall be reported to the Department of Justice no later than June 30th”. The PREA Coordinator provided aggregate annual data for 2023 and 2024 up through the October audit date. The data included the number of allegations by type and outcome. The aggregated data for 2023 is also included in their annual report. The facility does not contract for the confinement of its residents. They have provided data to the Department of Justice in the Survey of Sexual Violence when requested.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information System 3. 2023 Annual reports with aggregate data **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. OJS Compliance Manager 4. PREA Compliance Specialist

	Findings by Provision: **115.388 (a):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, “All data shall be reviewed in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. This should include identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions. **115.388 (b):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, “The annual report should include a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the facility’s progress in addressing sexual abuse. **115.388 (c):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, “The annual report shall be approved by the Facility Administrator and made readily available to the public through its website. **115.388 (d):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, “The facility may redact specific material from the annual report when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. The auditor interviewed the DHHS Facilities Director who stated that he reviews and approves the annual report before it is posted on the agency website where it is made readily available to the public through their website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx. The auditor discussed the aggregate data and the annual report with the PREA Coordinator, the OJS Compliance Manager, and the PREA Compliance Specialist and reviewed the annual report which has no redacted information. The YRTC-K facility’s annual report is well written and meets the standard by containing information that discusses the effectiveness of their sexual abuse prevention, detection, and response policies, practices, and training, including identifying problem areas and taking corrective action on an ongoing basis.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information System 3. 2023 Annual report with aggregate data **Interviews Conducted:**

	1. PREA Coordinator **Findings by Provision:** **115.389 (a):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, “All data collected will be securely retained”. **115.389 (b) and (c):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, “Totaled data will be made readily available to the public at least annually through its website. All personal identifiers will be removed”. **115.389 (d):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, “Data will be maintained for at least 10 years after the date of its initial collection unless Federal, State, and local law requires otherwise”. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #681, conversations and observation of previous information stored, and the 2023 annual report with the aggregate data and through interviews with the PREA Coordinator.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. DHHS website 3. Campus maps **Findings by Provision:** **115.401 (a) and (b):** There are three facilities operated by the Nebraska DHHS Office of Juvenile Services that require a PREA Audit – YRTC- Kearney, YRTC-Hastings, and YRTC-Lincoln. The first audit was conducted for YRTC-Kearney in October 2015, the second in October 2018, the third in October 2021, and this audit in October 2024. The first audit for the girls’ facility was for the YRTC-Geneva facility in October 2015 and the second in October 2018. The Geneva facility closed in 2019 and for a short time, some of the girls were at the Kearney facility until their new buildings on the Hastings campus could be completed. The YRTC-Hastings campus opened in 2021 and their third audit was completed in October 2021. The YRTC-Lincoln facility opened in 2020 and their first audit was completed after one year of operation in January 2021. The YRTC-Lincoln’s second audit was completed in January 2024. These facilities have consistently been audited every three years since they began their compliance efforts with their first audits in 2015. The original two facilities

	began their compliance efforts in year three of the first audit cycle and continue to audit in year three of each audit cycle. The Lincoln facility opened in January 2020 and conducted its first audit after one year of operation in January 2021. For this reason, they do not audit one facility in each year of every three-year audit cycle. **115.401 (h):** The auditor had complete access and observed operations in every area of the facility. The auditor conducted a tour of the facility on the first day which included every area of the facility to include administrative areas, the resident housing buildings, the school building, the gym, the chapel, the intake building, the vocational building, and the dining hall. **115.401 (i):** The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information). The auditor requested many documents throughout the audit process. The YRTC-K facility provided numerous copies of documents to include policies, resident screenings, human resource documentation, forms, and investigative information. **115.401 (m):** The auditor conducted private interviews with staff and residents in a conference room that was provided for this purpose. The YRTC-K facility staff were very cooperative throughout the audit process. **115.401 (n):** The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor did not receive any confidential correspondence. The auditor received photographs of the audit notice posted throughout the facility with the auditor's contact information and verified it was posted while on the facility tour. The auditor determined compliance through a review of the pre-audit questionnaire, a review of previous PREA Audits, a very thorough tour, and a review of numerous documents.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. DHHS website **Findings by Provision:** **115.403 (f):** This is the fourth audit for the YRTC-K facility. Their audits have always been conducted in October of 2015, 2018, 2021, and now 2024. These audits as well as those of the Hastings and Lincoln facilities are posted on the DHHS website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx.

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	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	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.)	yes
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	yes

	functions of the facility? (N/A for non-secure facilities)	
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	yes

	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?	
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:	yes

	Residents who have speech disabilities?	
	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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
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	**Hiring and promotion decisions**	

(c)		
	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	yes

	employees?	
	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 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.)	yes
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	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	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.)	yes
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	yes

	the agency attempt to ascertain information about: Age?	
	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	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
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	yes

	making facility and housing placement decisions and programming assignments?	
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	yes

	entity or office that is not part of the agency?	
	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	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
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	yes

	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?	
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	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	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	yes

	accordance with these standards?	
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	yes

	of sexual abuse, does the agency: Act promptly to remedy any such 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: 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	**Criminal and administrative agency investigations**	

(f)		
	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	yes

	does not provide a basis for terminating an investigation?	
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	yes

	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?	
	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	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
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.)	na
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.)	na
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	yes

	cooperates with any investigation arising out of the incident?	
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	na

	the confinement of its residents.)	
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	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
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

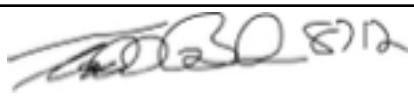
Nebraska State Fire Marshal
Existing Business Inspection Report

Facility Name	Hastings YRTC - Administration Bldg
Portion of Facility Inspected	
Address	4200 W 2nd St, Hastings, NE
ZIP	68901
Facility Phone Number	
Inspector Name	Todd Brehm
Inspector Badge Number	8712
Inspector Agency	Nebraska State Fire Marshal
Inspector Email	todd.Brehm@nebraska.gov
Inspector Phone Number	402-276-3879
Number of Visits	1
Inspection Type	Initial
Occupant Load	40
Fee Card	N/A
Fee Sheet/Facility ID Number	
Code Reviews	
Date of Inspection	2025-10-30
Date of Submission	2025-10-30
Status	Pass
Complete Corrections By	N/A

Inspectors and Operator Staff Involved			
Lead Inspector	**Badge #**	**Agency**	**Phone Number**
Todd Brehm	8712	Nebraska State Fire Marshal	402-276-3879

This facility was inspected and found to meet applicable requirements of the Fire and Life Safety Code and/or Fire Systems Installation Standards at the time of inspection; the facility is approved for occupancy.
Any modifications or changes made to this facility after the date of approval may void this approval

If you have questions on this Order, contact Todd Brehm by phone at 402-276-3879 or by Email at todd.Brehm@nebraska.gov.

Inspector Comments / Notes	The facility is approved for occupancy at the time of inspection.
Report completed by Deputy	Todd Brehm 8712
Date Signed	2025-10-30
Signature	

Summary	
Passed Item	**Status**
EXISTING BUSINESS	
1. Were plans submitted to the plans division and physical address meets requirements?	N/A
2. If a parking structure is attached to the Business Occupancy, is 2 hour fire separation provided?	N/A
3. The means of egress is accessible and approved?	Pass
4.Doors and locks are in compliance with egress requirements?	Pass
5. Stair, if provided, are approved?	Pass
6. The capacity of the means of egress is approved?	Pass
7. The number of exits and exit arrangement is approved?	Pass
8. Emergency lighting, if required is approved?	Pass
9. Means of egress and exits are provided with approved exit signs?	Pass
10.All hazardous areas are protected by approved fire rated construction?	Pass
11.Interior wall, floor and ceiling finishes are an approved type?	Pass
12.Fire Alarm system are tested and approved?	Pass
13. Are portable fire extinguishers provided?	Pass
14. Do all electrical components meet compliance?	Pass
15. Are the parking spaces meet the ADA requirements?	Pass

Summary	
Passed Item	**Status**
16. Do the bathrooms meet the ADA requirements in compliance, if applicable?	Pass
17. Does Fire Department access meet requirements?	Pass
Has a State of Nebraska Electrical Inspector been on site?	N/A
Additional NFPA1 Violations	Pass
Additional NFPA101 Violations	Pass
General Violations	Pass

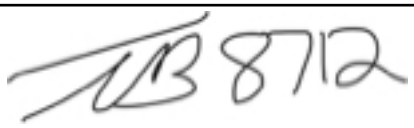
Nebraska State Fire Marshal
Existing Assembly Inspection Report

Facility Name	Hastings YRTC - Chapel Bldg
Portion of Facility Inspected	
Address	4200 W 2nd St, Hastings, NE
ZIP	68901
Facility Phone Number	
Inspector Name	Todd Brehm
Inspector Badge Number	8712
Inspector Agency	Nebraska State Fire Marshal
Inspector Email	todd.Brehm@nebraska.gov
Inspector Phone Number	402-276-3879
Number of Visits	1
Inspection Type	Initial
Occupant Load	217
Fee Card	N/A
Fee Sheet/Facility ID Number	
Code Reviews	
Date of Inspection	2025-10-30
Date of Submission	2025-10-30
Status	Pass
Complete Corrections By	N/A

Inspectors and Operator Staff Involved			
Lead Inspector	**Badge #**	**Agency**	**Phone Number**
Todd Brehm	8712	Nebraska State Fire Marshal	402-276-3879

This facility was inspected and found to meet applicable requirements of the Fire and Life Safety Code and/or Fire Systems Installation Standards at the time of inspection; the facility is approved for occupancy.
Any modifications or changes made to this facility after the date of approval may void this approval

If you have questions on this Order, contact Todd Brehm by phone at 402-276-3879 or by Email at todd.Brehm@nebraska.gov.

Inspector Comments / Notes	
Report completed by Deputy	Todd Brehm 8712
Date Signed	2025-10-30
Signature	

Summary	
Passed Item	**Status**
EXISTING ASSEMBLY	
1. Were plans submitted to the plans division and physical address meets requirements?	N/A
2. Minimum construction requirements met?	Pass
3. Facility does not exceed occupant load?	Pass
4. Are portable fire extinguishers present and in compliance?	Pass
5. Have life safety evaluations been done if occupant load is over 6,000?	N/A
6. Are means of egress compliant?	Pass
7. Are egress components compliant?	Pass
8. Are doors compliant?	Pass
9. If vertical security grilles or doors are installed do they meet requirements?	N/A
10. If required are panic bars on egress doors?	Pass
11. No delayed egress on main entrance?	N/A
12. If used are revolving doors and turnstiles compliant?	N/A

Summary	
Passed Item	**Status**
13. Are stairs compliant?	Pass
14. Horizontal exits properly maintained?	Pass
15. Are ramps installed correctly?	N/A
16. Are fire escape ladders or alternating tread devices used to access normally unoccupied spaces?	N/A
17. Are areas of refuge compliant?	Pass
18. Do exits meet the occupant load?	Pass
19. Number of egress meet?	Pass
20. Are aisle accessways compliant?	Pass
21. Are layouts approved?	Pass
22. Are exits illuminated?	Pass
23. Are exit signs correctly installed and maintained?	Pass
24. Is emergency lighting compliant?	Pass
25. Are handrails installed properly?	N/A
26. Are vertical openings enclosed?	Pass
27. Do all hazardous areas meet compliance?	Pass
28. Cooking equipment producing grease vapors protected with a hood?	N/A
29. Is interior finish compliant?	Pass
30. Is fire alarm system installed?	N/A
31. Does the initiation of fire alarms meet the requirements?	N/A
32. Is notification equipment compliant?	N/A
33. Is live or recorded voice evacuation provided?	N/A
34. If the occupant load is over 300 is a sprinkler system installed?	N/A
35. When required, are standpipes compliant?	N/A
36. Are projection rooms protected?	N/A
37. Are special amusement building requirements met?	N/A
38. Are grandstands compliant?	N/A
39. Are folding and telescopic seating compliant?	N/A
40. Are airport loading walkways compliant?	N/A
41. Are utilities properly installed?	Pass
42. Is HVAC equipment properly installed?	Pass

Summary	
Passed Item	**Status**
43. Are egress doors inspected to prevent blockage?	Pass
44. Are food service operations are installed in a way to prevent injury?	N/A
45. If open flames or pyrotechnics are used has the AHJ approved their use?	N/A
46. Are furnishings compliant?	Pass
47. Are exhibits compliant?	N/A
48. If required are there enough crowd managers?	N/A
49. Are emergency drills conducted?	Pass
50. Is seating compliant?	N/A
51. Are grandstands appropriately maintained?	N/A
52. Is folding and telescoping seating maintained?	N/A
53. Clothing and personal effects are not stored in corridors unless in metal lockers?	N/A
54. Do all electrical components meet compliance?	Pass
55. Do the parking spaces meet the ADA requirements?	N/A
56. Do the bathrooms meet the ADA requirements in compliance, if applicable?	N/A
57. Does Fire Department access meet requirements?	Pass
Has a State of Nebraska Electrical Inspector been on site?	N/A
Additional NFPA1 Violations	Pass
Additional NFPA101 Violations	Pass
General Violations	Pass

Nebraska State Fire Marshal
Existing Detention Center Inspection Report

Facility Name	Hastings YRTC - North Dorm
Portion of Facility Inspected	
Address	4200 W 2nd St, Hastings, NE
ZIP	68901
Facility Phone Number	
Inspector Name	Todd Brehm
Inspector Badge Number	8712
Inspector Agency	Nebraska State Fire Marshal
Inspector Email	todd.Brehm@nebraska.gov
Inspector Phone Number	402-276-3879
Number of Visits	1
Inspection Type	Initial
Occupant Load	12
Fee Card	N/A
Fee Sheet/Facility ID Number	
Code Reviews	
Date of Inspection	2025-10-30
Date of Submission	2025-10-30
Status	Pass
Complete Corrections By	N/A

Inspectors and Operator Staff Involved			
Lead Inspector	**Badge #**	**Agency**	**Phone Number**
Todd Brehm	8712	Nebraska State Fire Marshal	402-276-3879

This facility was inspected and found to meet applicable requirements of the Fire and Life Safety Code and/or Fire Systems Installation Standards at the time of inspection; the facility is approved for occupancy.
Any modifications or changes made to this facility after the date of approval may void this approval

If you have questions on this Order, contact Todd Brehm by phone at 402-276-3879 or by Email at todd.Brehm@nebraska.gov.

Inspector Comments / Notes	
Report completed by Deputy	Todd Brehm 8712
Date Signed	2025-10-30
Signature	

Summary	
Passed Item	**Status**
EXISTING DETENTION CENTER	
1. Were plans submitted to the plans division and physical address meets requirements?	N/A
2. Is the facility designed as a total concept?	Pass
3. Facility does not exceed occupant load?	Pass
4. Where egress is required to be locked is the hardware compliant?	Pass
5. Are attached occupancies separated with 2 hour fire separation?	N/A
6. Are egress corridors a minimum of 48 inches?	Pass
7. Are Dead end corridors compliant?	Pass
8. Are common paths of travel under 100 ft or under 50ft for non sprinkled facility?	Pass
9. Are travel distance to exits compliant?	Pass
10. Are emergency and egress lighting provided and operational?	Pass
11. Are emergency exit signs provided and operational?	Pass
12.Do all remote release operated doors have manual operation?	Pass
13. Emergency power provided and does it activate within 10 seconds of power loss?	Pass
14. Are hazardous areas separated?	Pass
15. Is interior finish compliant?	Pass

Summary	
Passed Item	**Status**
16. Is the fire alarm compliant?	Pass
17. If required is the sprinkler system compliant?	Pass
18. Are fire extinguishers provided and maintained?	Pass
19. Are furniture and mattresses compliant?	Pass
20. Are utilities and HVAC equipment compliant?	Pass
21. Are staff trained on emergency plans?	Pass
22. Do all electrical components meet compliance?	Pass
23. Do the parking spaces meet the ADA requirements?	Pass
24. Do the bathrooms meet the ADA requirements in compliance, if applicable?	Pass
25. Does Fire Department access meet requirements?	Pass
Has a State of Nebraska Electrical Inspector been on site?	N/A
Additional NFPA1 Violations	Pass
Additional NFPA101 Violations	Pass
General Violations	Pass

Nebraska State Fire Marshal
Existing Detention Center Inspection Report

Facility Name	Hastings YRTC - South Dorm
Portion of Facility Inspected	
Address	4200 W 2nd St, Hastings, NE
ZIP	68901
Facility Phone Number	
Inspector Name	Todd Brehm
Inspector Badge Number	8712
Inspector Agency	Nebraska State Fire Marshal
Inspector Email	todd.Brehm@nebraska.gov
Inspector Phone Number	402-276-3879
Number of Visits	1
Inspection Type	Initial
Occupant Load	12
Fee Card	N/A
Fee Sheet/Facility ID Number	
Code Reviews	
Date of Inspection	2025-10-30
Date of Submission	2025-10-30
Status	Pass
Complete Corrections By	N/A

Inspectors and Operator Staff Involved			
Lead Inspector	**Badge #**	**Agency**	**Phone Number**
Todd Brehm	8712	Nebraska State Fire Marshal	402-276-3879

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Inspector Comments / Notes	
Report completed by Deputy	Todd Brehm 8712
Date Signed	2025-10-30
Signature	

Summary	
Passed Item	**Status**
EXISTING DETENTION CENTER	
1. Were plans submitted to the plans division and physical address meets requirements?	N/A
2. Is the facility designed as a total concept?	Pass
3. Facility does not exceed occupant load?	Pass
4. Where egress is required to be locked is the hardware compliant?	Pass
5. Are attached occupancies separated with 2 hour fire separation?	N/A
6. Are egress corridors a minimum of 48 inches?	Pass
7. Are Dead end corridors compliant?	Pass
8. Are common paths of travel under 100 ft or under 50ft for non sprinkled facility?	Pass
9. Are travel distance to exits compliant?	Pass
10. Are emergency and egress lighting provided and operational?	Pass
11. Are emergency exit signs provided and operational?	Pass
12.Do all remote release operated doors have manual operation?	Pass
13. Emergency power provided and does it activate within 10 seconds of power loss?	Pass
14. Are hazardous areas separated?	Pass
15. Is interior finish compliant?	Pass
16. Is the fire alarm compliant?	Pass

Summary	
Passed Item	**Status**
17. If required is the sprinkler system compliant?	Pass
18. Are fire extinguishers provided and maintained?	Pass
19. Are furniture and mattresses compliant?	Pass
20. Are utilities and HVAC equipment compliant?	Pass
21. Are staff trained on emergency plans?	Pass
22. Do all electrical components meet compliance?	Pass
23. Do the parking spaces meet the ADA requirements?	Pass
24. Do the bathrooms meet the ADA requirements in compliance, if applicable?	Pass
25. Does Fire Department access meet requirements?	Pass
Has a State of Nebraska Electrical Inspector been on site?	N/A
Additional NFPA1 Violations	Pass
Additional NFPA101 Violations	Pass
General Violations	Pass

Nebraska State Fire Marshal
Existing Detention Center Inspection Report

Facility Name	Hastings YRTC - Program Bldg
Portion of Facility Inspected	
Address	4200 W 2nd St, Hastings, NE
ZIP	68901
Facility Phone Number	
Inspector Name	Todd Brehm
Inspector Badge Number	8712
Inspector Agency	Nebraska State Fire Marshal
Inspector Email	todd.Brehm@nebraska.gov
Inspector Phone Number	402-276-3879
Number of Visits	1
Inspection Type	Initial
Occupant Load	N/A
Fee Card	N/A
Fee Sheet/Facility ID Number	
Code Reviews	
Date of Inspection	2025-10-30
Date of Submission	2025-10-30
Status	Pass
Complete Corrections By	N/A

Inspectors and Operator Staff Involved			
Lead Inspector	**Badge #**	**Agency**	**Phone Number**
Todd Brehm	8712	Nebraska State Fire Marshal	402-276-3879

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Inspector Comments / Notes	
Report completed by Deputy	Todd Brehm 8712
Date Signed	2025-10-30
Signature	

Summary	
Passed Item	**Status**
EXISTING DETENTION CENTER	
1. Were plans submitted to the plans division and physical address meets requirements?	N/A
2. Is the facility designed as a total concept?	Pass
3. Facility does not exceed occupant load?	Pass
4. Where egress is required to be locked is the hardware compliant?	Pass
5. Are attached occupancies separated with 2 hour fire separation?	N/A
6. Are egress corridors a minimum of 48 inches?	Pass
7. Are Dead end corridors compliant?	Pass
8. Are common paths of travel under 100 ft or under 50ft for non sprinkled facility?	Pass
9. Are travel distance to exits compliant?	Pass
10. Are emergency and egress lighting provided and operational?	Pass
11. Are emergency exit signs provided and operational?	Pass

Summary	
Passed Item	**Status**
12.Do all remote release operated doors have manual operation?	Pass
13. Emergency power provided and does it activate within 10 seconds of power loss?	Pass
14. Are hazardous areas separated?	Pass
15. Is interior finish compliant?	Pass
16. Is the fire alarm compliant?	Pass
17. If required is the sprinkler system compliant?	Pass
18. Are fire extinguishers provided and maintained?	Pass
19. Are furniture and mattresses compliant?	Pass
20. Are utilities and HVAC equipment compliant?	Pass
21. Are staff trained on emergency plans?	Pass
22. Do all electrical components meet compliance?	Pass
23. Do the parking spaces meet the ADA requirements?	Pass
24. Do the bathrooms meet the ADA requirements in compliance, if applicable?	Pass
25. Does Fire Department access meet requirements?	Pass
Has a State of Nebraska Electrical Inspector been on site?	N/A
Additional NFPA1 Violations	Pass
Additional NFPA101 Violations	Pass
General Violations	Pass

Nebraska Fire Sprinkler

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Hastings Regional Center 4200 W. 2nd Street Hastings, NE 68901	10/20/25 INSPECTION DATE
JOB / WO#:	TYPE OCCUPANCY

FORMS INCLUDED WITH THIS COVER SHEET		TYPE OF INSPECTION	
X	FIRE HYDRANT TEST		INITIAL ACCEPTANCE OF SYSTEM
	FIRE PUMP TEST		REINSPECTION DUE TO REMODEL, REPAIR, ETC
X	REPORT OF INSPECTION	X	PERIODIC ANNUAL INSPECTION
	DRY PIPE VALVE TEST	X	BACKFLOW PREVENTER TEST
	FULL FLOW TEST		QUARTERLY INSPECTION
	5 YEAR INTERNAL INSPECTION		MONTHLY INSPECTION

ITEM # DIRECTORY

1 - WET RISER
2 - DRY RISER
3 - PREACTION RISER
5 - BACKFLOW PREVENTER
6 - STANDPIPE
7 - OTHER

DEFICIENCIES

ITEM DEFICIENCIES NOTED ON INSPECTION AND ANY OTHER PERTINENT COMMENTS ON SYSTEM

TAG#	ITEM#	MAJOR DEFICIENCIES / COMMENTS
4924	5	
4925	1	

STATUS OF SYSTEM - CHECK ONE

☒ IN COMPLIANCE ☐ MINOR DEFICIENCIES ☐ MAJOR DEFICIENCIES

COMPANY PERFORMING INSPECTION:

NEBRASKA FIRE SPRINKLER
118 S. APOLLO ST.
ALDA, NEBRASKA 68810
(308) 381-2033

Lowell Miller
INSPECTOR SIGNATURE

NE LICENSE #: 03021

TESTER BFP LICENSE #: 6922

Kevin Glover
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

Report of Inspection, Testing & Maintenance of Fire Sprinkler Systems

INSPECTING FIRM: NEBRASKA FIRE SPRINKLER, 118 APOLLO AVE, ALDA, NE 68810 - (308) 381-2033

NAME OF INSPECTED PROPERTY: Hastings Regional Center

INSPECTOR NAME: Lowell Mitteis DATE: 10/20/62

INSPECTION FREQUENCY: ☐ MONTHLY ☐ QUARTERLY ☒ ANNUALLY ☐ OTHER:

	Y	N	N/A
SYSTEM IN SERVICE BEFORE INSPECTION	X		
PERTINENT PARTIES NOTIFIED BEFORE TESTING	X		
ADEQUATE DRAINAGE PROVIDED BEFORE FLOW TESTING	X		
MAIN DRAIN			
SUPPLY WATER GAUGE READING BEFORE FLOW (STATIC)	54 PSI		
GAUGE READING DURING STABLE FLOW (RESIDUAL)	41 PSI		
TIME FOR SUPPLY PRESSURE TO RETURN TO NORMAL	2 SEC		
IS RESIDUAL PRESSURE WITHIN 10% FROM PREVIOUS TEST	X		
PRESSURE GAUGES ON SYSTEM IN GOOD CONDITION	X		
INSPECTOR'S TEST CONNECTION CAUSED ALARM TO SOUND	X		
ALL CONTROL VALVES INCLUDING PIVs OPERATED THROUGH FULL FULL RANGE AND RETURNED TO NORMAL POSITION	X		
ALL CONTROL VALVES LOCKED OPEN OR ELECTRONICALY SUPERVISED	X		
IF ELECTRONICALY SUPERVISED DO ALARMS OPERATE	X		
PIVs AND OS&Ys BACKED $\frac{1}{4}$ TURN FROM FULL OPEN	X		
FIRE DEPARTMENT CONNECTION (FDC) IS VISIBLE & ACCESSIBLE	X		
FDC COUPLINGS & SWIVELS ARE IN GOOD CONDITION & ROTATE	X		
PLUG AND CAPS ARE IN PLACE AND IN GOOD CONDITION	X		
CHECK VALVE IS IN GOOD CONDITION AND NOT LEAKING	X		
AUTOMATIC BALL DRIP DRAIN IS WORKING PROPERLY	X		
IDENTIFICATION SIGNS ARE PROVIDED	X		
BACKFLOW PREVENTER FLOW TEST CONDUCTED AS REQUIRED	X		
BACKFLOW PREVENTION ASSEMBLY FORWARD FLOW TEST PERFORMED	X		
PERTINENT PARTIES NOTIFIED OF TEST CONCLUSION	X		
HANGERS APPEARS UNDAMAGED AND TIGHTLY ATTACHED	X		
PIPING APPEARS FREE OF MECHANICAL DAMAGE, LEAKAGE, CORROSION, OR EXTERNAL LOADING	X		
SPRINKLERS APPEAR FREE OF LEAKAGE, CORROSION, PAINT, FOREIGN MATERIALS, OR PHYSICAL DAMAGE	X		
STANDARD RESPONSE MANUFACTURE DATE LESS THAN 50 YEARS OLD			X
QUICK RESPONSE MANUFACTURE DATE IS LESS THAN 20 YEARS OLD	X		
DRY SPRINKLER MANUFACTURE DATE IS LESS THAN 10 YEARS OLD SPRINKLERS APPEAR PROPERLY ORIENTED			X
ADEQUATE CLEARANCE BETWEEN SPRINKLER & BUILDING FEATURES	X		
SPARE SPRINKLERS ARE OF PROPER NUMBER (AT LEAST 6) TYPE AND TEMPERATURE RATING	X		
SPARE SPRINKLERS STORED WHERE TEMPERATURE MAXIMUM IS 100 DEGREES FAHRENHEIT	X		
WRENCH AVAILABLE FOR EACH TYPE OF SPRINKLER	X		
BUILDING IS SECURE AS NOT TO EXPOSE PIPING TO FREEZING	X		
ADEQUATE HEAT IS PROVIDED MAINTAINING TEMPERATURES AT 40 DEGREES FAHRENHEIT OR HIGHER	X		
ANTIFREEZE SOLUTION FREEZING POINT (IF APPLICABLE)	n/a °F		
HYDRAULIC DATA PLATES ARE LEGIBLE AND ATTACHED TO RISER	X		

	Y	N	N/A
IS THERE A DRY SYSTEM		X	
IS THERE A PREACTION SYSTEM		X	
IS THERE A DELUGE SYSTEM		X	
IF YES TO ANY OF THE 3 ABOVE CONTINUE BELOW			
VALVE MAKE: MODEL: SIZE:			
DOES THE VALVE HAVE AN ACCELERATOR (Q.O.D.)			
IS THE VALVE IN GOOD CONDITION			
ADEQUATE HEAT IS PROVIDED MAINTAINING TEMPERATURES AT 40 DEGREES FAHRENHEIT OR HIGHER AT THE LOCATION OF VALVE			
DRY PIPE SYSTEM LOW POINTS DRAINED (OWNER TO MAINTAIN)			
ALARM OPERATED			
SYSTEM NORMAL AIR PRESSURE			PSI
VALVE TRIP TIME			SEC
AIR PRESSURE WHEN VALVE TRIPPED			SEC
IF FULL FLOWED TIME WATER TO INSPECTORS TEST			SEC
MAIN DRAIN TEST			
SUPPLY WATER GAUGE READING BEFORE FLOW (STATIC)			PSI
GAUGE READING DURING STABLE FLOW (RESIDUAL)			PSI
TIME FOR SUPPLY PRESSURE TO RETURN TO NORMAL			SEC

COMMENTS:

ALARM PANEL CLEAR	X		
SYSTEM RETURNED TO SERVICE	X		

SIGNATURE OF INSPECTOR: Lowell Mitteis

SIGNATURE OF OWNER/AGENT: [signature]

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: 10/20/25 **Inspector:** Lowell Mitters **System:** _____

Location: 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: 14

Static pressure (residual hydrant): 55 psi (bar)

Residual pressure (residual hydrant): 31 psi (bar)

Pitot pressure (flow hydrant): 23 psi (bar)

Nozzle Size (flow hydrant): 2 1/2 in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other _____

Available water flow: 805 gpm (L/min) at 23 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 13

Static pressure (residual hydrant): 55 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 19 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 731 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 11

Static pressure (residual hydrant): 54 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 20 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): 0.9; other _____

Available water flow: 750 gpm (L/min) at 20 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: 10/20/25 **Inspector:** Lowell Mittens **System:** _____

Location: 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: 10

Static pressure (residual hydrant): 54 psi (bar)

Residual pressure (residual hydrant): 33 psi (bar)

Pitot pressure (flow hydrant): 18 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 712 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: 10/20/25 **Inspector:** Lowell Mittess **System:** _____

Location: 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: 9

Static pressure (residual hydrant): 55 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 22 psi (bar)

Nozzle Size (flow hydrant): 2 1/2 in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 787 gpm (L/min) at 22 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: 10/20/24 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 8

Static pressure (residual hydrant): 54 psi (bar)

Residual pressure (residual hydrant): 37 psi (bar)

Pitot pressure (flow hydrant): 22 psi (bar)

Nozzle Size (flow hydrant): 2 1/2 in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 787 gpm (L/min) at 22 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 7

Static pressure (residual hydrant): 52 psi (bar)

Residual pressure (residual hydrant): 36 psi (bar)

Pitot pressure (flow hydrant): 24 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 822 gpm (L/min) at 24 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 6

Static pressure (residual hydrant): 55 psi (bar)

Residual pressure (residual hydrant): 26 psi (bar)

Pitot pressure (flow hydrant): 25 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 839 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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): 54 psi (bar)

Residual pressure (residual hydrant): 33 psi (bar)

Pitot pressure (flow hydrant): 29 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 904 gpm (L/min) at 29 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: 10/20/24 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 3

Static pressure (residual hydrant): 53 psi (bar)

Residual pressure (residual hydrant): 41 psi (bar)

Pitot pressure (flow hydrant): 7 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 744 gpm (L/min) at 7 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: 10/20/22 **Inspector:** Lowell Mitteis **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: 3

Flow Hydrant Location: 4

Static pressure (residual hydrant): 56 psi (bar)

Residual pressure (residual hydrant): 24 psi (bar)

Pitot pressure (flow hydrant): 29 psi (bar)

Nozzle Size (flow hydrant): 2 ½ in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 904 gpm (L/min) at 29 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: 10/20/25 **Inspector:** Lowell Mitteis **System:** _____

Location: 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: 3

Flow Hydrant Location: 2

Static pressure (residual hydrant): 51 psi (bar)

Residual pressure (residual hydrant): 28 psi (bar)

Pitot pressure (flow hydrant): 33 psi (bar)

Nozzle Size (flow hydrant): 2 1/2 in. (mm)

Nozzle coefficient (flow hydrant): (0.9) other _____

Available water flow: 964 gpm (L/min) at 33 psi (bar)

Notes/Comments _____

Backflow Prevention Device
Test and Maintenance Report

To: City water dept.
(water purveyor or regulatory agency)

Hastings Ne.

Attn: Cross-connection Control Section

The cross-connection control device detailed hereon has been tested and maintained as required by the *(rules or regulations)* of *(purveyor or regulatory agency)* and is certified to comply with these *(rules or regulations)*.

Make of device Ames
Model Number 2000B
Serial Number 50988

size 2
located at Regional Center
4200 W. 2nd
Hastings Ne. 68901

	Reduced Pressure Devices			Pressure Vacuum Breaker	
	Double Check Devices		Relief Valve	Air Inlet	Check Valve
	1st check	2nd check			
Initial Test	DC-Closed Tight [X] RP-_____ psid Leaked [ ] 1.6 psid	Closed Tight [X] Leaked [ ] 1.4 psid	Opened at _____ psid	Opened at _____ psid Did Not Open [ ]	_____ psid Leaked [ ]
Repairs and Materials Used					
Forward Flow Test	Drain Size 1	Design Flow _____		Design Loss _____	
	Flow Pressure 41	Actual Flow _____		Actual Loss 4.6	
Test After Repair	DC-Closed Tight [ ] RP-_____ psid	Closed Tight [ ]	Opened at _____ psid	Opened at _____ psid	_____ psid

The above is certified to be true.

Certified Tester _____

Cert. Tester No. 6922 Date 10/20/25

Nebraska Fire Sprinkler

118 S. APOLLO AVE.
ALDA, NEBRASKA 68810
(308) 381-2033

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Youth Rehab and Treatment 4200 W 2nd N. Building Hastings, NE

10-7-25
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
483608	1	
483609	2	
		Owner to verify all heads in units 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
ADDRESS: 2521 West "L" Street, Suite 5
CITY: Lincoln **STATE:** NE
ZIP CODE: 68522
PHONE: 402-466-2616

Jason Stutzo
INSPECTOR SIGNATURE
NE LICENSE #: 05046
TESTER BFP LICENSE #: 9004

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
FIRE SPRINKLER SPECIALIST

White: AHJ Yellow: MFP Pink: Business

MEISINGER FIRE PROTECTION
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: YRTC N. Bldg
Inspector Name: Jim Date: 10-7-25
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	X			
A.3.0	Control valves in normal open or closed position	X			
A.3.1	Control valves properly locked or supervised	X			
A.3.2	Control valves accessible	X			
A.3.3	Control valves provided with appropriate wrenches	X			
A.3.4	Control valves free from external leaks	X			
A.3.5	Control valve identification signs in place	X			
A.3.6	System control valve sign indicates area served	X			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	X			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		X		
A.5.0	Alarm valve gauges indicate normal supply water pressure		X		
A.5.1	Alarm valve free of physical damage		X		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		X		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		X		
A.6.0	**ALARM PANEL CLEAR**	X			
A.7.0	**COMMENTS:**				

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEINGER FIRE PROTECTION
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: YRTC N. Bldg

Inspector Name: JM Date: 10-7-25

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	X		
B.2.0	Hydraulic nameplate attached and legible	X		
B.2.1	Alarm device free from physical damage	X		
B.3.0	FDC is visible	X		
B.3.1	FDC is accessible	X		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	X		
B.3.3	FDC plugs/caps in place/undamaged	X		
B.3.4	FDC gaskets in place and in good condition	X		
B.3.5	FDC identification sign in place	X		
B.3.6	FDC check valve not leaking	X		
B.3.7	FDC automatic drain valve in place and operating properly	X		
B.3.8	FDC clapper is in place and operating properly	X		
B.3.9	FDC interior inspected where caps missing		X	
B.3.10	FDC obstructions removed as necessary		X	
B.4.0	Pressure reducing control valves (PRV) indicate open		X	
B.4.1	PRV not leaking		X	
B.4.2	PRV maintaining downstream pressure per design		X	
B.4.3	PRV in good condition		X	
B.4.4	PRV handwheel installed and not broken		X	
B.5.0	**ALARM PANEL CLEAR**	X		

B.6.0 COMMENTS:

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	X			
C.1.1	Pertinent parties notified before testing	X			
C.1.2	Adequate drainage provided before flow testing	X			
C.2.0	Water flow alarm (other than vane type) tested and is operational	X			
C.2.1	Test conducted with inspector's test connection	X			
C.2.2	Test conducted with bypass connection (freezing weather)		X		
C.2.3	Test conducted per manufacturer's instructions	X			
C.2.4	Alarm devices appear free of physical damage	X			
C.3.0	Adequate drainage provided before flow testing	X			
C.3.1	A main drain test conducted downstream from backflow preventer	X			
C.3.2	A main drain test conducted downstream from pressure reducing valve		X		
C.3.3	Supply water gauge reading before flow (static)	50			psi
C.3.4	Gauge reading during stable flow (residual)	35			psi
C.3.5	Time for supply pressure to return to normal	0			sec
C.4.0	Pertinent parties notified of test conclusion	X			
C.5.0	**ALARM PANEL CLEAR**	X			
C.6.0	**SYSTEM RETURNED TO SERVICE**	X			

C.7.0 COMMENTS:

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	X			
D.1.1	Pertinent parties notified before testing	X			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	X			
D.2.1	Signal restored only when valve returned to normal position	X			
D.3.0	Adequate drainage provided before flow testing	X			
D.3.1	Main drain test conducted	X			
D.3.2	Supply water gauge reading before flow (static)	50			psi
D.3.3	Gauge reading during stable flow (residual)	35			psi
D.3.4	Time for supply pressure to return to normal	0			sec
D.4.0	Pertinent parties notified of test conclusion	X			
D.5.0	**ALARM PANEL CLEAR**	X			
D.6.0	**SYSTEM RETURNED TO SERVICE**	X			

D.7.0 COMMENTS:

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MENAGER FIRE PROTECTION
FIRE SPRINKLER & ALARM
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: YRTC N. Bldg

Inspector Name: Jim Date: 10-7-25

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	X		
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	X		
E.4.7	Glass bulbs appear full of liquid	X		
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**	X		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	X		
F.1.1	Pertinent parties notified before testing	X		
F.1.2	Adequate drainage provided before flow testing	X		
F.2.0	Main drain test conducted	X		
F.2.1	Supply water gauge reading before flow (static)	50 psi		
F.2.2	Gauge reading during stable flow (residual)	35 psi		
F.2.3	Time for supply pressure to return to normal	0 sec		
F.3.0	Antifreeze solution tested and freezing point determined		X	
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	X		
F.4.1	PIVs opened until spring or torsion felt in rod	X		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	X		
F.4.3	Main drain test conducted (see F.2.0)	X		
F.5.0	Backflow prevention assembly forward flow test conducted		X	
F.5.1	System demand flow was achieved through the device		X	
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		X	
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)	X		
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		X	
F.5.5	Forward flow test satisfied by annual fire pump flow test		X	
F.5.6	Backflow preventer performance test conducted as required by the AHJ	X		
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		X	
F.7.0	Pertinent parties notified of test conclusion	X		
F.8.0	**ALARM PANEL CLEAR**	X		
F.9.0	**SYSTEM RETURNED TO SERVICE**	X		
F.10.0	**COMMENTS:**			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	X		
G.2.0	Pertinent parties notified before conducting maintenance	X		
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated		X	
G.3.1	Valve completely closed and reopened		X	
G.4.0	Adequate drainage provided before flow testing	X		
G.4.1	Main drain test conducted	X		
G.4.2	Supply water gauge reading before flow (static)	50 psi		
G.4.3	Gauge reading during stable flow (residual)	35 psi		
G.4.4	Time for supply pressure to return to normal	0 sec		
G.5.0	Pertinent parties notified after conclusion of maintenance	X		
G.6.0	**ALARM PANEL CLEAR**	X		
G.7.0	**SYSTEM RETURNED TO SERVICE**	X		
G.8.0	**COMMENTS:**			

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEINTZER FIRE PROTECTION
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: YBTC N. Bldg
Inspector Name: JM Date: 10-7-25
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	X		
A.1.1	Supply (water) gauge pressure	50 psi		
A.1.2	System (air) gauge pressure	1-2 psi		
A.1.3	Quick opening device gauge pressure	— psi		
A.1.4	Gauge near compressor	100 psi		
A.1.5	Gauge pressures are normal	X		
A.2.0	Control valves in normal open or closed position	X		
A.2.1	Control valves properly locked or supervised	X		
A.2.2	Control valves accessible	X		
A.2.3	Control valves provided with appropriate wrenches	X		
A.2.4	Control valves free from external leaks	X		
A.2.5	Control valve identification signs in place	X		
A.2.6	System control valve sign indicates area served	X		
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	X		
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		X	
A.4.0	Dry pipe valve free of physical damage	X		
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	X		
A.4.2	Dry pipe valve intermediate chamber not leaking	X		
A.5.0	**ALARM PANEL CLEAR**	X		
A.6.0	**COMMENTS:**			

Quarterly Inspection of Dry Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	X		
B.2.0	Hydraulic nameplate attached and legible	X		
B.2.1	Alarm device free from physical damage	X		
B.3.0	FDC is visible	X		
B.3.1	FDC is accessible	X		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	X		
B.3.3	FDC plugs/caps in place/undamaged	X		
B.3.4	FDC gaskets in place and in good condition	X		
B.3.5	FDC identification sign in place	X		
B.3.6	FDC check valve not leaking	X		
B.3.7	FDC automatic drain valve in place and operating properly	X		
B.3.8	FDC clapper is in place and operating properly	X		
B.3.9	FDC interior inspected where caps missing		X	
B.3.10	FDC obstructions removed as necessary		X	
B.4.0	Pressure reducing control valves (PRV) indicate open		X	
B.4.1	PRV not leaking		X	
B.4.2	PRV maintaining downstream pressure per design		X	
B.4.3	PRV in good condition		X	
B.4.4	PRV handwheel installed and not broken		X	
B.5.0	**ALARM PANEL CLEAR**	X		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

		Y	N/A	N
C.1.0	System in service before testing	X		
C.1.1	Pertinent parties notified before testing	X		
C.1.2	Adequate drainage provided before flow testing	X		
C.2.0	Water flow alarm tested and is operational	X		
C.2.1	Test conducted with inspectors test connection			X
C.2.2	Test conducted with bypass connection (freezing weather)		X	
C.2.3	Test conducted per manufacturer's instructions	X		
C.2.4	Alarm devices appear free of physical damage	X		
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)*	X		
C.3.1	Signal restored only when valve returned to normal position *(semi-annual)*	X		
C.4.0	One main drain test conducted downstream from backflow preventer	X		
C.4.1	One main drain test conducted downstream from pressure reducing valve		X	
C.4.2	Supply water gauge reading before flow (static)	50 psi		
C.4.3	Gauge reading during stable flow (residual)	35 psi		
C.4.4	Time for supply pressure to return to normal	9 sec		
C.5.0	Priming water level tested		X	
C.6.0	Quick opening device(s) (QOD) tested		X	
C.7.0	Low pressure alarm tested	X		
C.8.0	Pertinent parties notified of test conclusion	X		
C.9.0	**ALARM PANEL CLEAR**	X		
C.10.0	**SYSTEM RETURNED TO SERVICE**	X		
C.11.0	**COMMENTS:**			

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MENAGER FIRE PROTECTION
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: YRTC N. Bldg

Inspector Name: Jim Date: 10-7-25

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	X		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	X		
D.3.0	Piping appears free of mechanical damage	X		
D.3.1	Piping appears free of leakage	X		
D.3.2	Piping appears free of corrosion	X		
D.3.3	Piping appears properly aligned	X		
D.3.4	Piping appears free of external loading	X		
D.4.0	Sprinklers appear free of leakage	X		
D.4.1	Sprinklers appear free of corrosion	X		
D.4.2	Sprinklers appear free of foreign materials	X		
D.4.3	Sprinklers appear free of paint	X		
D.4.4	Sprinklers appear free of physical damage	X		
D.4.5	Sprinklers appear properly oriented	X		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	X		
D.4.7	Glass bulbs appear full of liquid	X		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	X		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	X		
D.4.10	Wrench available for each type of sprinkler	X		
D.5.0	Dry pipe valve in good condition internally (check at trip test)		X	
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	X		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	X		
D.7.0	**ALARM PANEL CLEAR**	X		

D.8.0 **COMMENTS:**

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N	
E.1.0	System in service before conducting maintenance	X			
E.2.0	Pertinent parties notified before conducting maintenance	X			
E.3.0	Adequate drainage provided before flow testing or draining	X			
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated		X		
E.4.1	Valve completely closed and reopened		X		
E.5.0	Main drain test conducted	X			
E.5.1	Supply water gauge reading before flow (static)		50		psi
E.5.2	Gauge reading during stable flow (residual)		35		psi
E.5.3	Time for supply pressure to return to normal		0		sec
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		X		
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		X		
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve	X			
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	X			
E.9.0	Pertinent parties notified after conclusion of maintenance	X			
E.10.0	**ALARM PANEL CLEAR**	X			
E.11.0	**SYSTEM RETURNED TO SERVICE**	X			

E.12.0 **COMMENTS:**

Trip Test Table

Dry Valve	Size 6-1/2	Year	Q.O.D.		Year
Make	Model	Serial No.	Make	Model	Serial No.
VICTAULIC	768 N				

Dry Pipe Operating Test	Time to Trip Thru Test Pipe		Water Pressure	Air Pressure	Time Water Trip Point Air Pressure	Reached Test Outlet		Alarm Operated	
	Min	Sec	PSI	PSI	PSI	Min	Sec	Yes	No
Without Q.O.D			50	0-2- PARTIAL				X	
With Q.O.D									

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MENAGER FIRE PROTECTION
FIRE SPRINKLER SYSTEMS

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: YRTC N. Bldg

Inspector Name: Jim Date: 10-7-25

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)	50 psi		
F.5.2	Gauge reading during stable flow (residual)	35 psi		
F.5.3	Time for supply pressure to return to normal	0 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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

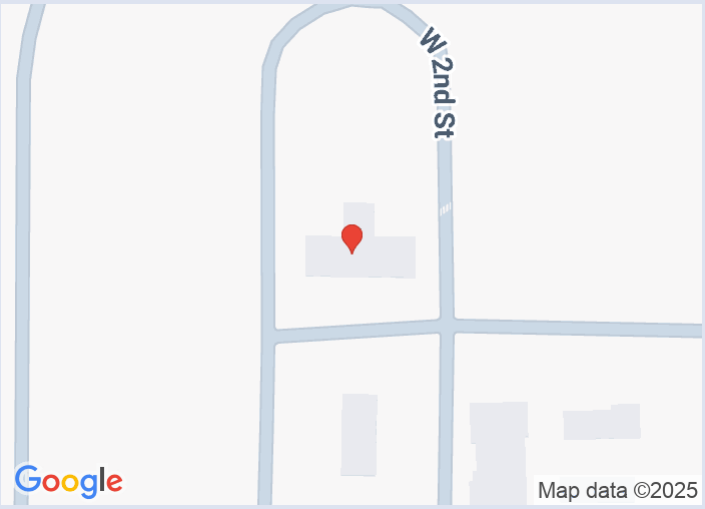
Inspection Report

Presented To

Hastings Youth Treatment Facility

For

South Dorm
4200 W 2nd St
Hastings, NE 68901



This site has been inspected and tested in compliance with applicable standards.

Completed:
Tuesday, October 07, 2025

Tested By:

Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:

Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	Hastings Youth Treatment Facility	Address:	4200 W 2nd St
City:	Hastings	State:	NE
ZIP:	68901	AR#:	1001896
Email:	daniel.browitt@nebraska.gov		

BUILDING INFORMATION

Name:	South Dorm	Occupancy Type:	Institutional (Group I)
Address:	4200 W 2nd St	City:	Hastings
State:	NE	ZIP:	68901
AR#:	1001896	Monitoring Company Account Number:	RDMP15652

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	3630 W Old Hwy 30
City:	Grand Island	State:	NE
Zip:	68803	License:	-
Email:	tracy.hesman@mw-as.com	Phone:	(308) 389-3981

AUTHORITY HAVING JURISDICTION

Name:	State of Nebraska Fire Marshal	Address:	246 S 14th St
City:	Lincoln	State:	NE
Zip:	68508	Email:	-
Phone:	(402) 471-2027		

MONITORING COMPANY

Name:	Per Mar	Address:	1910 E Kimberly Rd
City:	Davenport	State:	IA
Zip:	52807	Email:	-
phone:	800-227-9805		

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	23	23 (100%)	23 (100%)	0 (0%)
Supervisory Signal Device	6	6 (100%)	6 (100%)	0 (0%)
Auxiliary Device	2	2 (100%)	2 (100%)	0 (0%)
Alarm Notification Appliance	21	21 (100%)	21 (100%)	0 (0%)

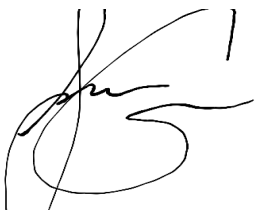
Fire Alarm Inspection- NFPA 72 (2013)

This testing was performed in accordance with applicable NFPA 72 Standards.

Midwest Alarm Services provides many services to our community. If you would like quarterly, semi-annual or annual testing/inspection, the inspection coordinator can reach out and offer inspections on a time and material basis. Signing an Inspection Agreement with Midwest Alarm Services has many benefits. Not only do you save money, but our inspection coordinator will work with you to ensure your Fire System stays in code as well as has proper documentation sent to the local jurisdiction for compliance. If you need an estimate or have questions about our services, please reach out to our operations manager.

Gary Hesman
Operations Manager
308-389-3981
gary.hesman@mw-as.com

Tested By:



Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:

Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Control Unit 1

Location

Location	Behind Front Desk

Specification

Type/Make/Model	Notifier / NFS320

Sofware Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	120v
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	panel LSD1 breaker 4

Visual/ Functional

Control Unit	Tested functionally
Lamps/LEDs/LCDs	Tested functionally
Fuses	Tested functionally
Trouble Signal	Tested functionally
Disconnect Switch	Tested functionally
Ground-Fault Monitoring	Tested functionally

Batteries

Battery Date	07/10/2024
Battery Type	Lead Acid
Nominal Voltage	27.1v
Amps/Hour Rating	18ah
Standby Mode (hrs)	-
Alarm Mode (mins)	-

Visual/ Functional

Load Voltage	Tested functionally
Charge Test	Tested functionally
Discharge Test	Tested functionally
Battery Condition	Tested functionally

Result

	● Passed

Notes

Number	-

Communicator

Specification

Type/Make/Model			
DMP			

Type

Type			
Dialer			

Result

● Passed			

Supervising Station Monitoring

Specification

Type/Make/Model			
-			

Supervising Station Monitoring

Alarm Signal	Alarm Restoration	Trouble Signal	Trouble Restoration
Tested functionally	Tested functionally	Tested functionally	Tested functionally
Supervisory Signal	Supervisory Restoration		
Tested functionally	Tested functionally		

Result

● Passed			

Alarm Initiated Device

Location	Specification	New Section	Result	Notes
Location Front Desk by FACP / L1D1	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location East Hall / L1D2	Type/Make/Model Duct Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 213 / L1D3	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 212 / L1D4	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 211 / L1D5	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 208 / L1D6	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 209 / L1D7	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location Room 210 / L1D8	Type/Make/Model Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -
Location West Hall / L1D9	Type/Make/Model Duct Smoke Detector / Notifier	Visual Tested functionally	Result ● Passed	Number -

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual	Result	Number
Data Room 218 / L1D10	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 219 / L1D11	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 220 / L1D12	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 221 / L1D13	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 224 / L1D14	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 223 / L1D15	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 222 / L1D16	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Outside Severe Weather Shelter / L1D18	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Front Entrance / L1D17	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
East Hall / L1D19	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
East Hall / L1D20	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
West Hall / L1D21	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
West Hall / L1D22	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Storage Room by Front Desk	Manual Pull Station / Notifier	Tested functionally	● Passed	-

Supervisory Signal Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Mechanical Room / L1M2	Water Flow / Notifier	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Mechanical Room / L1M4	Water Flow / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Wet Tamper / L1M1	Tamper Switch / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Mechanical Room / L1M3	Supervisory - High/Low Air Pressure Switch	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Dry Tamper / L1M5	Sprinkler Tamper Switch / Valve / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Spare / L1M6	Monitor Module / Notifier	Tested functionally	● Passed	-

Auxiliary Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
West Hall	Door Holder	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
East Hall	Door Holder	Tested functionally	● Passed	-

Alarm Notification Appliance

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Exercise 205	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Lounge 204	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 203	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom221	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 220	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 219	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 213	Strobe / System Sensor / SWL	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 212	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 211	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
West Corridor 216	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
West Corridor 216	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Bath 207	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Bedroom 210	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 222	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 223	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 224	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Laundry 226	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bath 207	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 208	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 209	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 210	Strobe / System Sensor / SWL	Tested functionally	● Passed	-

Comments

Number	COMMENT	IMAGE
1	Fire Alarm Inspection. No issues.	

2	Panel Clear Upon Completion	

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 308-389-3981.

Life Safety Solutions Experts Since 1950

For more than 70 years, Midwest Alarm Services has been providing the best, innovative fire, security and technology solutions for homes and businesses. As a systems integrator, we can design, install, maintain, monitor and service a wide variety of equipment and software. We take the time to understand your needs and customize solutions to fit your needs and budget. To learn more about our company and the services we provide, please visit:

www.midwestalarmservices.com

Tested By:
Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:
Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Annual Sprinkler Report

Report # SPI - 1358893

General Information

Service Provider:	Nebraska Fire Sprinkler	SP ID:	SP13302
Customer Account #:			
Address:	118 South Apollo Street Alda NE 68810-9643		
Phone:	(308) 381-2033	Fax:	--
General Email:	hr@nebraskafire.com		
Report Entered By:	Lowell Mitteis	User's Email:	office@nebraskafire.com
SP Lead Technician:	Lowell Mitteis	Date Inspection Completed:	2025-10-20
Lead Tech Nicet #:	--		
Other License #:	--	Other License Type:	--

Primary AHJ's Name:	Hastings Fire & Rescue	Primary AHJ ID:	ANE0000746
Primary AHJ Phone:	(402) 461-2350	Primary AHJ Email:	amurphy@cityofhastings.org

PO ID:	--		
Business Occupant:	Hastings Regional Center		
Number:	4200		
Street Name	West 2nd Street	Unit #:	--
City:	Hastings	State:	NE
Zip:	68901		
PIN#:	--	Classification:	--
Contact Name:	Daniel Browitt		
Contact Phone:	(402) 759-1188	Contact Email:	daniel.browitt@nebraska.gov

Attach Report

Report Status:	Compliant
Report:	SPI - Sprinkler
Frequency:	Annual
Next Inspection Due Date:	2026-10-20
Report Completed By:	Lowell Mitteis
Email Sent To:	daniel.browitt@nebraska.gov

Notes

None

Supplemental Attachments

None

Test performed in accordance with the following code or standard: NFPA 25

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Youth Rehab and Treatment
4200 W 2nd St South Building
Hastings, NE

10-7-25
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
48360	1	
48307	2	
		Owner to verify all heads in units 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

ADDRESS: 2521 West "L" Street, Suite 5

CITY: Lincoln **STATE:** NE

ZIP CODE: 68522

PHONE: 402-466-2616

INSPECTOR SIGNATURE

NE LICENSE #: 05046

TESTER BFP LICENSE #: 9004

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
FIRE SERVICE IS A PLANT

White: AHJ Yellow: MFP Pink: Business

2521 West L St., Suite #5
Lincoln, NE 68522 • 402-466-2616

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

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

Inspecting Firm: MFP Inspection Contract#
Name of Inspected Property: YRTC S Bldg
Inspector Name: JM Date: 10-7-25
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	X			
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	X			
A.3.0	Control valves in normal open or closed position	X			
A.3.1	Control valves properly locked or supervised	X			
A.3.2	Control valves accessible	X			
A.3.3	Control valves provided with appropriate wrenches	X			
A.3.4	Control valves free from external leaks	X			
A.3.5	Control valve identification signs in place	X			
A.3.6	System control valve sign indicates area served	X			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	X			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		X		
A.5.0	Alarm valve gauges indicate normal supply water pressure		X		
A.5.1	Alarm valve free of physical damage		X		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		X		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		X		
A.6.0	**ALARM PANEL CLEAR**	X			
A.7.0	**COMMENTS:**				

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MELVAGER FIRE PROTECTION
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: 9RTC S. Bldg

Inspector Name: JIM Date: 10-7-25

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	X		
B.2.0	Hydraulic nameplate attached and legible	X		
B.2.1	Alarm device free from physical damage	X		
B.3.0	FDC is visible	X		
B.3.1	FDC is accessible	X		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	X		
B.3.3	FDC plugs/caps in place/undamaged	X		
B.3.4	FDC gaskets in place and in good condition	X		
B.3.5	FDC identification sign in place	X		
B.3.6	FDC check valve not leaking	X		
B.3.7	FDC automatic drain valve in place and operating properly	X		
B.3.8	FDC clapper is in place and operating properly	X		
B.3.9	FDC interior inspected where caps missing		X	
B.3.10	FDC obstructions removed as necessary		X	
B.4.0	Pressure reducing control valves (PRV) indicate open		X	
B.4.1	PRV not leaking		X	
B.4.2	PRV maintaining downstream pressure per design		X	
B.4.3	PRV in good condition		X	
B.4.4	PRV handwheel installed and not broken		X	
B.5.0	**ALARM PANEL CLEAR**	X		
B.6.0	**COMMENTS:**			

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	X			
C.1.1	Pertinent parties notified before testing	X			
C.1.2	Adequate drainage provided before flow testing	X			
C.2.0	Water flow alarm (other than vane type) tested and is operational	X			
C.2.1	Test conducted with inspector's test connection	X			
C.2.2	Test conducted with bypass connection (freezing weather)		X		
C.2.3	Test conducted per manufacturer's instructions	X			
C.2.4	Alarm devices appear free of physical damage	X			
C.3.0	Adequate drainage provided before flow testing	X			
C.3.1	A main drain test conducted downstream from backflow preventer	X			
C.3.2	A main drain test conducted downstream from pressure reducing valve		X		
C.3.3	Supply water gauge reading before flow (static)	50			psi
C.3.4	Gauge reading during stable flow (residual)	35			psi
C.3.5	Time for supply pressure to return to normal	0			sec
C.4.0	Pertinent parties notified of test conclusion	X			
C.5.0	**ALARM PANEL CLEAR**	X			
C.6.0	**SYSTEM RETURNED TO SERVICE**	X			
C.7.0	**COMMENTS:**				

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	X			
D.1.1	Pertinent parties notified before testing	X			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	X			
D.2.1	Signal restored only when valve returned to normal position	X			
D.3.0	Adequate drainage provided before flow testing	X			
D.3.1	Main drain test conducted	X			
D.3.2	Supply water gauge reading before flow (static)	50			psi
D.3.3	Gauge reading during stable flow (residual)	35			psi
D.3.4	Time for supply pressure to return to normal	0			sec
D.4.0	Pertinent parties notified of test conclusion	X			
D.5.0	**ALARM PANEL CLEAR**	X			
D.6.0	**SYSTEM RETURNED TO SERVICE**	X			
D.7.0	**COMMENTS:**				

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MENAGER FIRE PROTECTION
FIRE SPRINKLER INSTALLATION
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: YRTC S. Bldg

Inspector Name: Jim Date: 10-7-25

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	X		
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	X		
E.4.7	Glass bulbs appear full of liquid	X		
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**	X		
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing	X		
F.1.1	Pertinent parties notified before testing	X		
F.1.2	Adequate drainage provided before flow testing	X		
F.2.0	Main drain test conducted	X		
F.2.1	Supply water gauge reading before flow (static) 50 psi			
F.2.2	Gauge reading during stable flow (residual) 35 psi			
F.2.3	Time for supply pressure to return to normal 0 sec			
F.3.0	Antifreeze solution tested and freezing point determined		X	
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	X		
F.4.1	PIVs opened until spring or torsion felt in rod	X		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	X		
F.4.3	Main drain test conducted (see F.2.0)	X		
F.5.0	Backflow prevention assembly forward flow test conducted		X	
F.5.1	System demand flow was achieved through the device		X	
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		X	
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)	X		
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		X	
F.5.5	Forward flow test satisfied by annual fire pump flow test		X	
F.5.6	Backflow preventer performance test conducted as required by the AHJ	X		
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve		X	
F.7.0	Pertinent parties notified of test conclusion	X		
F.8.0	**ALARM PANEL CLEAR**	X		
F.9.0	**SYSTEM RETURNED TO SERVICE**	X		
F.10.0	**COMMENTS:**			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance	X		
G.2.0	Pertinent parties notified before conducting maintenance	X		
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated		X	
G.3.1	Valve completely closed and reopened		X	
G.4.0	Adequate drainage provided before flow testing	X		
G.4.1	Main drain test conducted	X		
G.4.2	Supply water gauge reading before flow (static) 50 psi			
G.4.3	Gauge reading during stable flow (residual) 35 psi			
G.4.4	Time for supply pressure to return to normal 0 sec			
G.5.0	Pertinent parties notified after conclusion of maintenance	X		
G.6.0	**ALARM PANEL CLEAR**	X		
G.7.0	**SYSTEM RETURNED TO SERVICE**	X		
G.8.0	**COMMENTS:**			

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEINGER FIRE PROTECTION
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: YRTC S. Bldg
Inspector Name: Jim Date: 10-7-25
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	30 psi		
A.1.3	Quick opening device gauge pressure	— psi		
A.1.4	Gauge near compressor	100 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

		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 Dry 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 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)	50 psi		
C.4.3	Gauge reading during stable flow (residual)	35 psi		
C.4.4	Time for supply pressure to return to normal	0 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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MENNGER FIRE PROTECTION
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: YRTC S. Bldg

Inspector Name: JM Date: 10-7-25

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	X		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	X		
D.3.0	Piping appears free of mechanical damage	X		
D.3.1	Piping appears free of leakage	X		
D.3.2	Piping appears free of corrosion	X		
D.3.3	Piping appears properly aligned	X		
D.3.4	Piping appears free of external loading	X		
D.4.0	Sprinklers appear free of leakage	X		
D.4.1	Sprinklers appear free of corrosion	X		
D.4.2	Sprinklers appear free of foreign materials	X		
D.4.3	Sprinklers appear free of paint	X		
D.4.4	Sprinklers appear free of physical damage	X		
D.4.5	Sprinklers appear properly oriented	X		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	X		
D.4.7	Glass bulbs appear full of liquid	X		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	X		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	X		
D.4.10	Wrench available for each type of sprinkler	X		
D.5.0	Dry pipe valve in good condition internally (check at trip test)		X	
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	X		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	X		
D.7.0	**ALARM PANEL CLEAR**	X		

D.8.0 **COMMENTS:**

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N	
E.1.0	System in service before conducting maintenance	X			
E.2.0	Pertinent parties notified before conducting maintenance	X			
E.3.0	Adequate drainage provided before flow testing or draining	X			
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated		X		
E.4.1	Valve completely closed and reopened		X		
E.5.0	Main drain test conducted	X			
E.5.1	Supply water gauge reading before flow (static)	50			psi
E.5.2	Gauge reading during stable flow (residual)	35			psi
E.5.3	Time for supply pressure to return to normal	6			sec
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		X		
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		X		
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve	X			
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	X			
E.9.0	Pertinent parties notified after conclusion of maintenance	X			
E.10.0	**ALARM PANEL CLEAR**	X			
E.11.0	**SYSTEM RETURNED TO SERVICE**	X			

E.12.0 **COMMENTS:**

Trip Test Table

Dry Valve			Size 2 1/2		Year	Q.O.D.			Year
Make			Model		Serial No.	Make		Model	Serial No.
VICTAULIC			768N						

Dry Pipe Operating Test	Time to Trip Thru Test Pipe		Water Pressure	Air Pressure	Time Water Trip Point Air Pressure	Reached Test Outlet		Alarm Operated	
	Min	Sec	PSI	PSI	PSI	Min	Sec	Yes	No
Without Q.O.D			50	30	PARTIAL			X	
With Q.O.D									

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION
FIRE SPRINKLER CONTRACTOR

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: YRTC S. Bldg

Inspector Name: JM Date: 10-7-25

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	X		
F.1.1	Pertinent parties notified before testing	X		
F.1.2	Adequate drainage provided before flow testing	X		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	X		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer		X	
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV	X		
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	X		
F.2.4	Records of tripping time maintained for full flow trip tests	X		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	X		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	X		
F.4.1	PIVs opened until spring or torsion felt in rod	X		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	X		
F.5.0	Main drain test conducted	X		
F.5.1	Supply water gauge reading before flow (static)	50 psi		
F.5.2	Gauge reading during stable flow (residual)	35 psi		
F.5.3	Time for supply pressure to return to normal	0 sec		
F.6.0	Backflow prevention assembly forward flow test conducted		X	
F.6.1	System demand flow was achieved through the device		X	
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		X	
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)	X		
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		X	
F.6.5	Forward flow test satisfied by annual fire pump flow test		X	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	X		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		X	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		X	
F.9.0	Pertinent parties notified of test conclusion	X		
F.10.0	**ALARM PANEL CLEAR**	X		
F.11.0	**SYSTEM RETURNED TO SERVICE**	X		
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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

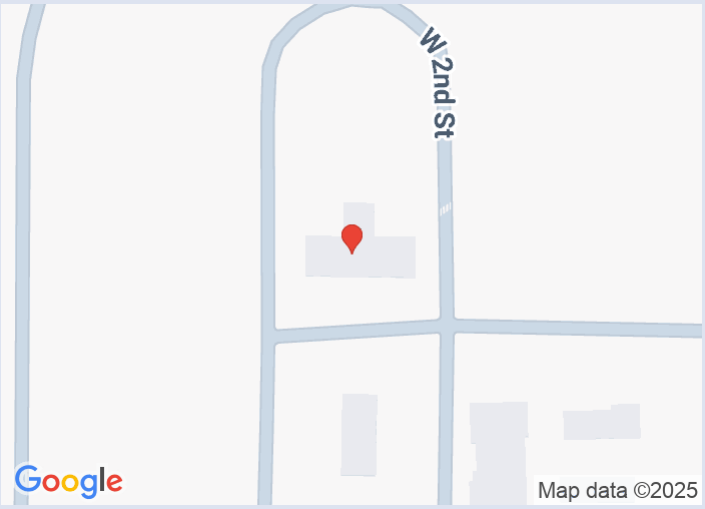
Inspection Report

Presented To

Hastings Youth Treatment Facility

For

Program Building
4200 W 2nd St
Hastings, NE 68901



This site has been inspected and tested in compliance with applicable standards.

Completed:
Tuesday, October 07, 2025

Tested By:

Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:

Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	Hastings Youth Treatment Facility	Address:	4200 W 2nd St
City:	Hastings	State:	NE
ZIP:	68901	AR#:	1001896
Email:	daniel.browitt@nebraska.gov		

BUILDING INFORMATION

Name:	Program Building	Occupancy Type:	Institutional (Group I)
Address:	4200 W 2nd St	City:	Hastings
State:	NE	ZIP:	68901
AR#:	1001896	Monitoring Company Account Number:	RDMP15650

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	3630 W Old Hwy 30
City:	Grand Island	State:	NE
Zip:	68803	License:	-
Email:	tracy.hesman@mw-as.com	Phone:	(308) 389-3981

AUTHORITY HAVING JURISDICTION

Name:	State of Nebraska Fire Marshal	Address:	246 S 14th St
City:	Lincoln	State:	NE
Zip:	68508	Email:	-
Phone:	(402) 471-2027		

MONITORING COMPANY

Name:	Per Mar	Address:	1910 E Kimberly Rd
City:	Davenport	State:	IA
Zip:	52807	Email:	-
phone:	800-227-9805		

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	2	2 (100%)	2 (100%)	0 (0%)
Supervisory Signal Device	6	6 (100%)	6 (100%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	53	53 (100%)	53 (100%)	0 (0%)

Fire Alarm Inspection- NFPA 72 (2013)

This testing was performed in accordance with applicable NFPA 72 Standards.

Midwest Alarm Services provides many services to our community. If you would like quarterly, semi-annual or annual testing/inspection, the inspection coordinator can reach out and offer inspections on a time and material basis. Signing an Inspection Agreement with Midwest Alarm Services has many benefits. Not only do you save money, but our inspection coordinator will work with you to ensure your Fire System stays in code as well as has proper documentation sent to the local jurisdiction for compliance. If you need an estimate or have questions about our services, please reach out to our operations manager.

Gary Hesman
Operations Manager
308-389-3981
gary.hesman@mw-as.com

Tested By:

Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:

Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Control Unit 1

Location

Location	Front Entrance

Specification

Type/Make/Model	Notifier / NFS2-3030D

Sofware Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	120v
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested functionally
Lamps/LEDs/LCDs	Tested functionally
Fuses	Tested functionally
Trouble Signal	Tested functionally
Disconnect Switch	Tested functionally
Ground-Fault Monitoring	Tested functionally

Batteries

Battery Date	10/01/2024
Battery Type	Lead Acid
Nominal Voltage	27.2v
Amps/Hour Rating	18ah
Standby Mode (hrs)	24hr.
Alarm Mode (mins)	5 minutes

Visual/ Functional

Load Voltage	Tested functionally
Charge Test	Tested functionally
Discharge Test	Tested functionally
Battery Condition	Tested functionally

Result

	● Passed

Notes

Number	-

Communicator

Specification

Type/Make/Model			
DMP			

Type

Type			
Dialer			

Result

● Passed			

Supervising Station Monitoring

Specification

Type/Make/Model			
-			

Supervising Station Monitoring

Alarm Signal	Alarm Restoration	Trouble Signal	Trouble Restoration
Tested functionally	Tested functionally	Tested functionally	Tested functionally
Supervisory Signal	Supervisory Restoration		
Tested functionally	Tested functionally		

Result

● Passed			

Alarm Initiated Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual	Result	Number
W. Entry over FACP / L1D1	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Breakroom	Manual Pull Station / Notifier	Tested functionally	● Passed	-

Supervisory Signal Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Low Air Mechanical Room / L1M1	Sprinkler Pressure Switch / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Dry Flow / L1M3	Sprinkler Pressure Switch / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Dry Tamper Back Flow / L1M2	Tamper Switch / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Tamper / L1M3	Tamper Switch / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Wet Flow / L1M4	Water Flow / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Kitchen Hood System / L1M5	Monitor Module / Notifier	Tested functionally	● Passed	-

Alarm Notification Appliance

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Storage 144	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Kitchen 138	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
By Restroom 139	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Kitchen 138	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Kitchen 138	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Cafeteria 136	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Cafeteria 136	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Small Meeting Room 118	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
PVX 115	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Small Meeting Room 114	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Medium Meeting 119	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Small Meeting 117	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Small Meeting Room 117	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Sleeping Unit 104A	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Visitor Meeting 116	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Small Meeting 113	Strobe / System Sensor / SWL	Tested functionally	Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Visitor Meeting 110	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sleeping Unit 104A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Intake Health 103	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 112	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 111	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Exam 104B	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 105	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 106	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Restroom 106	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Admin Work 109A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Admin Break109B	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Waiting 108A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Art 120	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Waiting 108A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Waiting 108A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Waiting 108A	Strobe / System Sensor / SWL	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Art 120	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Study 121	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Classroom 132	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Classroom 131	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Restroom 122	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 122	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Restroom 123	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Corridor 134	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Classroom 133	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Classroom 130	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Library 126	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 123	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Corridor 134	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 124	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 124	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 125	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Oasis 133B	Strobe / System Sensor / SWL	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Osis 130 B	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside IT Data 128	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside on West Side of building	Horn/Strobe / System Sensor	Tested functionally	● Passed	-

Comments

Number	COMMENT	IMAGE
1	Fire Alarm Inspection. No issues.	
2	Panel Clear Upon Completion	

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 308-389-3981.

Life Safety Solutions Experts Since 1950

For more than 70 years, Midwest Alarm Services has been providing the best, innovative fire, security and technology solutions for homes and businesses. As a systems integrator, we can design, install, maintain, monitor and service a wide variety of equipment and software. We take the time to understand your needs and customize solutions to fit your needs and budget. To learn more about our company and the services we provide, please visit:

www.midwestalarmservices.com

Tested By:
Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:
Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

NEBRASKA STATE FIRE MARSHAL
FIRE SPRINKLER INSPECTION

LOCATION OF SYSTEM: Youth Reception and Treatment 4200 W. 2nd Program Bldg Hastings, NE	10-7-25 **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
48361	5	
48362	1	
48363	2	
48364	7	
48365	7	
		Owner to verify all heads in units 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	Jim Stutz **INSPECTOR SIGNATURE**
ADDRESS: 2521 West "L" Street, Suite 5	
CITY: Lincoln **STATE:** NE	**NE LICENSE #:** 05046
ZIP CODE: 68522	**TESTER BFP LICENSE #:** 9004
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

White: AHJ Yellow: MFP Pink: Business

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: Meininger Fire Protection Inspection Contract#
Name of Inspected Property: YRTC Program
Inspector Name: Jim Date: 10-7-25
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	X			
A.2.0	Supply pressure gauge	55			psi
A.2.1	System pressure gauge	60			psi
A.2.2	Gauges appear to be in good condition	X			
A.3.0	Control valves in normal open or closed position	X			
A.3.1	Control valves properly locked or supervised	X			
A.3.2	Control valves accessible	X			
A.3.3	Control valves provided with appropriate wrenches	X			
A.3.4	Control valves free from external leaks	X			
A.3.5	Control valve identification signs in place	X			
A.3.6	System control valve sign indicates area served	X			
A.4.0	Backflow prevention assembly valves are locked or electrically supervised in open position	X			
A.4.1	Reduced pressure backflow prevention assembly not in continuous discharge		X		
A.5.0	Alarm valve gauges indicate normal supply water pressure		X		
A.5.1	Alarm valve free of physical damage		X		
A.5.2	Alarm valve trim valves are in appropriate open or closed position		X		
A.5.3	Alarm valve retarding chamber or alarm drain not leaking		X		
A.6.0	**ALARM PANEL CLEAR**	X			
A.7.0	**COMMENTS:**				

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION
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: Meininger Fire Protection Inspection Contract#

Name of Inspected Property: YRTC Program

Inspector Name: Jim Date: 10-7-25

Inspection Frequency: ☐ Monthly ☐ Quarterly ☒ Annually ☐ Other

Quarterly Inspection for Wet Pipe Sprinkler Systems

		Y	N/A	N
B.1.0	System in service on inspection	✓		
B.2.0	Hydraulic nameplate attached and legible	✓		
B.2.1	Alarm device free from physical damage	✓		
B.3.0	FDC is visible	✓		
B.3.1	FDC is accessible	✓		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	✓		
B.3.3	FDC plugs/caps in place/undamaged	✓		
B.3.4	FDC gaskets in place and in good condition	✓		
B.3.5	FDC identification sign in place	✓		
B.3.6	FDC check valve not leaking	✓		
B.3.7	FDC automatic drain valve in place and operating properly	✓		
B.3.8	FDC clapper is in place and operating properly	✓		
B.3.9	FDC interior inspected where caps missing		✓	
B.3.10	FDC obstructions removed as necessary		✓	
B.4.0	Pressure reducing control valves (PRV) indicate open		✓	
B.4.1	PRV not leaking		✓	
B.4.2	PRV maintaining downstream pressure per design		✓	
B.4.3	PRV in good condition		✓	
B.4.4	PRV handwheel installed and not broken		✓	
B.5.0	**ALARM PANEL CLEAR**	✓		

B.6.0 COMMENTS:

Quarterly Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
C.1.0	System in service before testing	✓			
C.1.1	Pertinent parties notified before testing	✓			
C.1.2	Adequate drainage provided before flow testing	✓			
C.2.0	Water flow alarm (other than vane type) tested and is operational	✓			
C.2.1	Test conducted with inspector's test connection	✓			
C.2.2	Test conducted with bypass connection (freezing weather)		✓		
C.2.3	Test conducted per manufacturer's instructions	✓			
C.2.4	Alarm devices appear free of physical damage	✓			
C.3.0	Adequate drainage provided before flow testing	✓			
C.3.1	A main drain test conducted downstream from backflow preventer	✓			
C.3.2	A main drain test conducted downstream from pressure reducing valve		✓		
C.3.3	Supply water gauge reading before flow (static)	60			psi
C.3.4	Gauge reading during stable flow (residual)	45			psi
C.3.5	Time for supply pressure to return to normal	0			sec
C.4.0	Pertinent parties notified of test conclusion	✓			
C.5.0	**ALARM PANEL CLEAR**	✓			
C.6.0	**SYSTEM RETURNED TO SERVICE**	✓			

C.7.0 COMMENTS:

Semi-Annual Testing for Wet Pipe Sprinkler Systems

		Y	N/A	N	
D.1.0	System in service before testing	✓			
D.1.1	Pertinent parties notified before testing	✓			
D.2.0	Supervisory switch initiates distinct signal during first two hand wheel revolutions or before valve stem moved one-fifth from normal position	✓			
D.2.1	Signal restored only when valve returned to normal position	✓			
D.3.0	Adequate drainage provided before flow testing	✓			
D.3.1	Main drain test conducted	✓			
D.3.2	Supply water gauge reading before flow (static)	60			psi
D.3.3	Gauge reading during stable flow (residual)	45			psi
D.3.4	Time for supply pressure to return to normal	0			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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION
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: Meininger Fire Protection Inspection Contract#

Name of Inspected Property: YRTC Program

Inspector Name: Jim Date: 10-7-25

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	X		
E.2.0	Hangers and seismic bracing appears undamaged and tightly attached			
E.3.0	Piping appears free of mechanical damage			
E.3.1	Piping appears free of leakage			
E.3.2	Piping appears free of corrosion			
E.3.3	Piping appears properly aligned			
E.3.4	Piping appears free of external loading			
E.4.0	Sprinklers appear free of leakage			
E.4.1	Sprinklers appear free of corrosion			
E.4.2	Sprinklers appear free of foreign materials			
E.4.3	Sprinklers appear free of paint			
E.4.4	Sprinklers appear free of physical damage			
E.4.5	Sprinklers appear properly oriented			
E.4.6	Sprinkler spray patterns appear free of unacceptable obstructions			
E.4.7	Glass bulbs appear full of liquid			
E.4.8	Spare sprinklers are of proper number (at least 6), type and temperature rating			
E.4.9	Spare sprinklers stored where temperature maximum is 100°F			
E.4.10	Wrench available for each type of sprinkler			
	PRIOR TO FREEZING WEATHER:			
E.5.0	Building is secure such as not to expose piping to freezing conditions			
E.5.1	Adequate heat is provided maintaining temperatures at 40°F or higher			
E.6.0	**ALARM PANEL CLEAR**			
E.7.0	**COMMENTS:**			

Annual Testing for Wet Pipe Sprinkler Systems

F.1.0	System in service before testing			
F.1.1	Pertinent parties notified before testing			
F.1.2	Adequate drainage provided before flow testing			
F.2.0	Main drain test conducted			
F.2.1	Supply water gauge reading before flow (static)	60 psi		
F.2.2	Gauge reading during stable flow (residual)	45 psi		
F.2.3	Time for supply pressure to return to normal	0 sec		
F.3.0	Antifreeze solution tested and freezing point determined		X	
F.3.1	Antifreeze solution freezing point	— °F		
F.3.2	Antifreeze solution freezing point after adjustment	— °F		
F.4.0	Control valves (including backflow and PIVs) operated through full range and returned to normal position			
F.4.1	PIVs opened until spring or torsion felt in rod			
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open			
F.4.3	Main drain test conducted (see F.2.0)			
F.5.0	Backflow prevention assembly forward flow test conducted			
F.5.1	System demand flow was achieved through the device			
F.5.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)			
F.5.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)			
F.5.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)			
F.5.5	Forward flow test satisfied by annual fire pump flow test			
F.5.6	Backflow preventer performance test conducted as required by the AHJ			
F.6.0	PRV control valves partial flow test conducted and adequate to unseat valve			
F.7.0	Pertinent parties notified of test conclusion			
F.8.0	**ALARM PANEL CLEAR**			
F.9.0	**SYSTEM RETURNED TO SERVICE**			
F.10.0	**COMMENTS:**			

Annual Maintenance for Wet Pipe Sprinkler Systems

G.1.0	System in service before conducting maintenance			
G.2.0	Pertinent parties notified before conducting maintenance			
G.3.0	Operating stems of OS&Y (including backflow) valves lubricated			
G.3.1	Valve completely closed and reopened			
G.4.0	Adequate drainage provided before flow testing			
G.4.1	Main drain test conducted			
G.4.2	Supply water gauge reading before flow (static)	60 psi		
G.4.3	Gauge reading during stable flow (residual)	45 psi		
G.4.4	Time for supply pressure to return to normal	0 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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEININGER FIRE PROTECTION
FIRE SERVICE INTEGRATION

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: Meininger Fire Protection Inspection Contract#

Name of Inspected Property: YRTC Program

Inspector Name: JM Date: 10-7-25

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	X		
A.1.1	Supply (water) gauge pressure	60 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	100 psi		
A.1.5	Gauge pressures are normal	X		
A.2.0	Control valves in normal open or closed position	X		
A.2.1	Control valves properly locked or supervised	X		
A.2.2	Control valves accessible	X		
A.2.3	Control valves provided with appropriate wrenches	X		
A.2.4	Control valves free from external leaks	X		
A.2.5	Control valve identification signs in place	X		
A.2.6	System control valve sign indicates area served	X		
A.3.0	Backflow prevention assembly valves are locked or electrically supervised in open position	X		
A.3.1	Reduced pressure backflow prevention assembly not in continuous discharge		X	
A.4.0	Dry pipe valve free of physical damage	X		
A.4.1	Dry pipe valve trim valves are in appropriate open or closed position	X		
A.4.2	Dry pipe valve intermediate chamber not leaking	X		
A.5.0	**ALARM PANEL CLEAR**	X		
A.6.0	**COMMENTS:**			

Quarterly Inspection of Dry Pipe Sprinkler Systems

B.1.0	System in service on inspection	X		
B.2.0	Hydraulic nameplate attached and legible	X		
B.2.1	Alarm device free from physical damage	X		
B.3.0	FDC is visible	X		
B.3.1	FDC is accessible	X		
B.3.2	FDC swivels/couplings undamaged/rotate smoothly	X		
B.3.3	FDC plugs/caps in place/undamaged	X		
B.3.4	FDC gaskets in place and in good condition	X		
B.3.5	FDC identification sign in place	X		
B.3.6	FDC check valve not leaking	X		
B.3.7	FDC automatic drain valve in place and operating properly	X		
B.3.8	FDC clapper is in place and operating properly	X		
B.3.9	FDC interior inspected where caps missing		X	
B.3.10	FDC obstructions removed as necessary		X	
B.4.0	Pressure reducing control valves (PRV) indicate open		X	
B.4.1	PRV not leaking		X	
B.4.2	PRV maintaining downstream pressure per design		X	
B.4.3	PRV in good condition		X	
B.4.4	PRV handwheel installed and not broken		X	
B.5.0	**ALARM PANEL CLEAR**	X		
B.6.0	**COMMENTS:**			

Quarterly Testing for Dry Pipe Sprinkler Systems

C.1.0	System in service before testing	X		
C.1.1	Pertinent parties notified before testing	X		
C.1.2	Adequate drainage provided before flow testing	X		
C.2.0	Water flow alarm tested and is operational	X		
C.2.1	Test conducted with inspectors test connection	X		
C.2.2	Test conducted with bypass connection (freezing weather)		X	
C.2.3	Test conducted per manufacturer's instructions	X		
C.2.4	Alarm devices appear free of physical damage	X		
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)***	X		
C.3.1	Signal restored only when valve returned to normal position ***(semi-annual)***	X		
C.4.0	One main drain test conducted downstream from backflow preventer	X		
C.4.1	One main drain test conducted downstream from pressure reducing valve		X	
C.4.2	Supply water gauge reading before flow (static)	60 psi		
C.4.3	Gauge reading during stable flow (residual)	45 psi		
C.4.4	Time for supply pressure to return to normal	0 sec		
C.5.0	Priming water level tested		X	
C.6.0	Quick opening device(s) (QOD) tested		X	
C.7.0	Low pressure alarm tested	X		
C.8.0	Pertinent parties notified of test conclusion	X		
C.9.0	**ALARM PANEL CLEAR**	X		
C.10.0	**SYSTEM RETURNED TO SERVICE**	X		
C.11.0	**COMMENTS:**			

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

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: YRTC Program

Inspector Name: JIM Date: 10-7-25

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	X		
D.2.0	Hangers and seismic bracing appears undamaged and tightly attached	Y		
D.3.0	Piping appears free of mechanical damage	Y		
D.3.1	Piping appears free of leakage	Y		
D.3.2	Piping appears free of corrosion	X		
D.3.3	Piping appears properly aligned	Y		
D.3.4	Piping appears free of external loading	Y		
D.4.0	Sprinklers appear free of leakage	X		
D.4.1	Sprinklers appear free of corrosion	Y		
D.4.2	Sprinklers appear free of foreign materials	Y		
D.4.3	Sprinklers appear free of paint	X		
D.4.4	Sprinklers appear free of physical damage	Y		
D.4.5	Sprinklers appear properly oriented	X		
D.4.6	Sprinkler spray patterns appear free of unacceptable obstructions	X		
D.4.7	Glass bulbs appear full of liquid	Y		
D.4.8	Spare sprinklers are of proper number (at least 6), type, and temperature rating	X		
D.4.9	Spare sprinklers stored where temperature maximum is 100°F	X		
D.4.10	Wrench available for each type of sprinkler	X		
D.5.0	Dry pipe valve in good condition internally (check at trip test)		X	
	PRIOR TO FREEZING WEATHER:			
D.6.0	Building is secure such as not to expose piping to freezing conditions	X		
D.6.1	Adequate heat is provided maintaining temperatures at 40°F or higher	Y		
D.7.0	**ALARM PANEL CLEAR**	Y		

D.8.0 **COMMENTS:**

Annual Maintenance for Dry Pipe Sprinkler Systems

		Y	N/A	N
E.1.0	System in service before conducting maintenance	Y		
E.2.0	Pertinent parties notified before conducting maintenance	Y		
E.3.0	Adequate drainage provided before flow testing or draining	X		
E.4.0	Operating stems of OS&Y (including backflow) valves lubricated		Y	
E.4.1	Valve completely closed and reopened		X	
E.5.0	Main drain test conducted	X		
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	0 sec		
E.6.0	Leaks resulting in air pressure losses greater than 10 psi/week located and repaired		X	
E.7.0	Dry pipe valve interior thoroughly cleaned and parts replaced/repaired as necessary		X	
E.7.1	Grease or other sealing materials not applied to seating surfaces of dry pipe valve	X		
E.8.0	Dry pipe system low points drained after operation and before onset of freezing weather conditions	X		
E.9.0	Pertinent parties notified after conclusion of maintenance	X		
E.10.0	**ALARM PANEL CLEAR**	X		
E.11.0	**SYSTEM RETURNED TO SERVICE**	Y		

E.12.0 **COMMENTS:**

Trip Test Table

Dry Valve	Size	Year	Q.O.D.		Year
Make	Model	Serial No.	Make	Model	Serial No.
VICTAULIC	768N				

Dry Pipe Operating Test

	Time to Trip Thru Test Pipe		Water Pressure	Air Pressure	Time Water Trip Point Air Pressure	Reached Test Outlet		Alarm Operated	
	Min	Sec	PSI	PSI	PSI	Min	Sec	Yes	No
Without Q.O.D			60	22				X	
With Q.O.D				PARTIAL					

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

WHITE - AHJ YELLOW - MFP PINK - OWNER

MEINGER FIRE PROTECTION
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: YRTC Program

Inspector Name: Jim Date: 10-7-25

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	X		
F.1.1	Pertinent parties notified before testing	X		
F.1.2	Adequate drainage provided before flow testing	X		
F.2.0	Dry pipe valve trip tested with control valve partially open ***(required at full flow every 3 years)***	X		
F.2.1	Dry pipe valve protecting freezers trip tested in manner not introducing moisture into piping in freezer		X	
F.2.2	Tag or card showing trip test date and name of person and organization conducting test attached to DPV	X		
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	X		
F.2.4	Records of tripping time maintained for full flow trip tests	X		
F.3.0	Automatic air pressure maintenance devices tested in accordance with mfg. inst.	X		
F.4.0	Control valves (including backflow and PIVs) operated through full range & returned to normal position	X		
F.4.1	PIVs opened until spring or torsion felt in rod	X		
F.4.2	PIVs and OS&Ys backed 1/4 turn from full open	X		
F.5.0	Main drain test conducted	X		
F.5.1	Supply water gauge reading before flow (static)	60 psi		
F.5.2	Gauge reading during stable flow (residual)	45 psi		
F.5.3	Time for supply pressure to return to normal	0 sec		
F.6.0	Backflow prevention assembly forward flow test conducted		X	
F.6.1	System demand flow was achieved through the device		X	
F.6.2	Forward flow test conducted at maximum rate possible (only where connections do not permit full flow test)		X	
F.6.3	Forward flow test conducted without measuring flow (device</=2" and outlet sized to flow system demand)	X		
F.6.4	Backflow prevention assembly internal inspection conducted (where shortages last more than 1 year and rationing enforced by AHJ)		X	
F.6.5	Forward flow test satisfied by annual fire pump flow test		X	
F.6.6	Backflow preventer performance test conducted as required by the AHJ	X		
F.7.0	PRV control valves partial flow test conducted and adequate to unseat valve		X	
F.8.0	Low temperature alarm tested at beginning of heating season (where provided for valve enclosure)		X	
F.9.0	Pertinent parties notified of test conclusion	X		
F.10.0	**ALARM PANEL CLEAR**	X		
F.11.0	**SYSTEM RETURNED TO SERVICE**	X		
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 _____ (All "NO" answers to be explained.) OWNER/DESIGNATED REP. INITIAL _____ DATE _____

WHITE - AHJ YELLOW - MFP PINK - OWNER

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

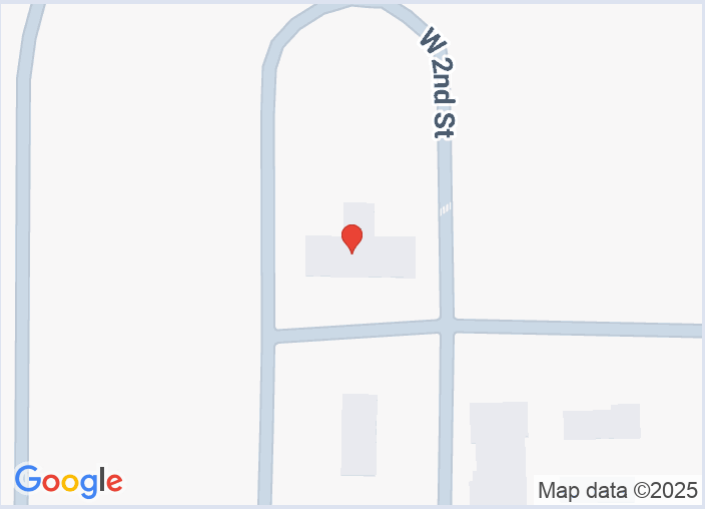
Inspection Report

Presented To

Hastings Youth Treatment Facility

For

North Dorm
4200 W 2nd St
Hastings, NE 68901



This site has been inspected and tested in compliance with applicable standards.

Completed:
Tuesday, October 07, 2025

Tested By:
Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:
Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	Hastings Youth Treatment Facility	Address:	4200 W 2nd St
City:	Hastings	State:	NE
ZIP:	68901	AR#:	1001896
Email:	daniel.browitt@nebraska.gov		

BUILDING INFORMATION

Name:	North Dorm	Occupancy Type:	Institutional (Group I)
Address:	4200 W 2nd St	City:	Hastings
State:	NE	ZIP:	68901
AR#:	1001896	Monitoring Company Account Number:	RDMP15651

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	3630 W Old Hwy 30
City:	Grand Island	State:	NE
Zip:	68803	License:	-
Email:	tracy.hesman@mw-as.com	Phone:	(308) 389-3981

AUTHORITY HAVING JURISDICTION

Name:	State of Nebraska Fire Marshal	Address:	246 S 14th St
City:	Lincoln	State:	NE
Zip:	68508	Email:	-
Phone:	(402) 471-2027		

MONITORING COMPANY

Name:	Per Mar	Address:	1910 E Kimberly Rd
City:	Davenport	State:	IA
Zip:	52807	Email:	-
phone:	800-227-9805		

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	23	23 (100%)	23 (100%)	0 (0%)
Supervisory Signal Device	6	6 (100%)	6 (100%)	0 (0%)
Auxiliary Device	2	2 (100%)	2 (100%)	0 (0%)
Alarm Notification Appliance	21	21 (100%)	21 (100%)	0 (0%)

Fire Alarm Inspection- NFPA 72 (2013)

This testing was performed in accordance with applicable NFPA 72 Standards.

Midwest Alarm Services provides many services to our community. If you would like quarterly, semi-annual or annual testing/inspection, the inspection coordinator can reach out and offer inspections on a time and material basis. Signing an Inspection Agreement with Midwest Alarm Services has many benefits. Not only do you save money, but our inspection coordinator will work with you to ensure your Fire System stays in code as well as has proper documentation sent to the local jurisdiction for compliance. If you need an estimate or have questions about our services, please reach out to our operations manager.

Gary Hesman
Operations Manager
308-389-3981
gary.hesman@mw-as.com

Tested By:

Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:

Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

Control Unit 1

Location

Location	Behind Front Desk

Specification

Type/Make/Model	Notifier / NFS320

Sofware Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	120v
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested functionally
Lamps/LEDs/LCDs	Tested functionally
Fuses	Tested functionally
Trouble Signal	Tested functionally
Disconnect Switch	Tested functionally
Ground-Fault Monitoring	Tested functionally

Batteries

Battery Date	12/19/2023
Battery Type	Lead Acid
Nominal Voltage	27.1v
Amps/Hour Rating	18ah
Standby Mode (hrs)	24 hrs
Alarm Mode (mins)	5 minutes

Visual/ Functional

Load Voltage	Tested functionally
Charge Test	Tested functionally
Discharge Test	Tested functionally
Battery Condition	Tested functionally

Result

	● Passed

Notes

Number	-

Communicator

Specification

Type/Make/Model			
DMP			

Type

Type			
Dialer			

Result

● Passed			

Supervising Station Monitoring

Specification

Type/Make/Model			
-			

Supervising Station Monitoring

Alarm Signal	Alarm Restoration	Trouble Signal	Trouble Restoration
Tested functionally	Tested functionally	Tested functionally	Tested functionally
Supervisory Signal	Supervisory Restoration		
Tested functionally	Tested functionally		

Result

● Passed			

Alarm Initiated Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual	Result	Number
Front Desk by FACP / L1/D1	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
East Hall / L1D2	Duct Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 313 / L1/D3	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 312 / L1/D4	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 311 / L1/D5	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 308 / L1/D6	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 309 / L1/D7	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 310 / L1/D8	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
West Hall / L1/D9	Duct Smoke Detector / Notifier	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual	Result	Number
Data Room 319 / L1/D10	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 319 / L1/D11	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 320 / L1/D12	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 321 / L1D13	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 324 / L1/D14	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 323 / L1/D15	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Room 322 / L1/D16	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
West Hall / L1/D19	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
West Hall / L1/D20	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
By Front Entrance / L1/D17	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Outside Weather Shelter / L1/D18	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
East Hall / L1/D21	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
East Hall / L1/D22	Smoke Detector / Notifier	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual	Result	Number
Storage Room by Front Desk	Manual Pull Station	Tested functionally	● Passed	-

Supervisory Signal Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Wet/Mechanical Room / L1M1	Water Flow / Notifier	Tested functionally	● Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Wet/Mechanical Room / L1M2	Tamper Switch / Notifier	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Low Air / L1M3	Sprinkler Pressure Switch / Notifier	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Dry Flow / L1M4	Sprinkler Pressure Switch / Notifier	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Spare / Mechanical Room / L1M5	Monitor Module / Notifier	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Sprinkler Dry Tamper / L1M6	Tamper Switch / Notifier	Tested functionally	Passed	-

Auxiliary Device

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
West Hall	Door Holder	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
East Hall	Door Holder	Tested functionally	Passed	-

Alarm Notification Appliance

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Exercise 305	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Lounge 304	Horn/Strobe / System Sensor / P2WL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Restroom 303	Strobe / System Sensor / SWL	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 331	Sounder Base / System Sensor / B200S-LF	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 320	Sounder Base / System Sensor / B200S-LF	Tested functionally	Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 319	Sounder Base / System Sensor / B200S-LF	Tested functionally	Passed	-

Location	Specification	New Section	Result	Notes
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 313	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 312	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 311	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
West Corridor 316	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
West Corridor 316	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Bath 307	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Outside Bedroom 310	Horn/Strobe / System Sensor / P2WL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 322	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 323	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 324	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Laundry 326	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bath 307	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 308	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 309	Strobe / System Sensor / SWL	Tested functionally	● Passed	-
Location	Type/Make/Model	Visual / Functional	Result	Number
Bedroom 310	Strobe / System Sensor / SWL	Tested functionally	● Passed	-

Comments

Number	COMMENT	IMAGE
1	Fire Alarm Inspection. No issues.	

2	Panel Clear Upon Completion	

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 308-389-3981.

Life Safety Solutions Experts Since 1950

For more than 70 years, Midwest Alarm Services has been providing the best, innovative fire, security and technology solutions for homes and businesses. As a systems integrator, we can design, install, maintain, monitor and service a wide variety of equipment and software. We take the time to understand your needs and customize solutions to fit your needs and budget. To learn more about our company and the services we provide, please visit:

www.midwestalarmservices.com

Tested By:
Lucas Canfield
Midwest Alarm Services
3630 W Old Hwy 30
Grand Island, NE 68803

Accepted By:
Chris Jacobe
Hastings Youth Treatment Facility
4200 W 2nd St
Hastings, NE 68901

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

☐ CAR
☐ HACCP

Firm: West Hastings High (Yate)	Firm ID: 01-32 / Inspector Code: 25
Address: 4200 W 2nd St.	Facility Codes: / Inspection Date: 9-25-25
City: Hastings County: Adams	

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:** 1

Purpose	
Regular: 1 Follow-up: 2 Complaint: 3	Investigation: 4 Other: 5

Temperature Observations

Food Product	Product Temp.	Location	Food Product	Product Temp.	Location
Mashed potatoes	169.4	steam table	chicken Breast	150.9	steam table
corn	171.5	steam table	Sliced cheese	37.4	within cooler

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	X	
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 package condition - seam integrity
			2 cans - appearance - pulled and discarded
PF	18	3-501.14	Cooked on 4th hrs TCS foods must be cooked
			properly and recorded on cooling log - found
			2 items cooked and date but not on log
			⇒ product was discarded

Follow-up
Yes 1 No 2

Received by: Lisa [illegible] Inspected by: Tim Burnham

NEBRASKA
DEPT. OF ENVIRONMENT AND ENERGY

Nebraska Department of Environment and Energy

FOOD ESTABLISHMENT EVALUATION

Firm: West Hastings High (Yard)	Firm ID: 01-32 / Inspector Code: 25
Address: 4200 W 7th St	Facility Codes: / Inspection Date: 9-25-25
City: Hastings County: ADAMS	

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
			* Kitchen very well maintained, clean and organized *
			* Spot checked HACCP logs - current
			Check Food Temps on Production Records *
			Taco meat 7-24-25 - on log
			Refrigerator logs posted & each unit - current
			Sanitizer testing - conc. okay
			Dishwasher temp 165.3, thermometers

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).

Received by: _____ Inspected by: Tim Burmeister

Nebraska Department of Environment and Energy

PO Box 98922, Lincoln, NE 68509 | 402-471-0903

Distribution: WHITE – Lincoln; YELLOW – Local Office; PINK - Customer

21-012 06/2021

№ 50718

HYDRO TECH INC.

Fire Extinguishers Sales & Service

CO_2 Gas • Dry Ice • Restaurant Hood Systems

Hydro Static Testing & Repair

P.O. Box 877, Grand Island, NE 68802-0877
Phone: (308) 384-7083 Fax: (308) 675-1254

P.O. # _____ 12/11/24

Name: Hasting Regional Center

Address: _____

_____

Qty	Description	Price Ea.	Amount
62	fire Ext Insp		335.00
1	10lb 6yr Maint		45.00
3	5lb 12yr Maint	55.00	165.00
9	5lb 6yr Maint	35.00	315.00
	APPROVED FOR PAYMENT		
	Initials DB Date 12/11/24		
	B/U 65047006		
	P/O _____ /NONE		
	R.Batch 526100		
		TAX	
		TOTAL	860.00

Please Pay From This Invoice

NEBRASKA STATE FIRE MARSHAL

DATE: 10/10/2025

ACCEPTANCE ☐

FIRE ALARM TEST REPORT

RE-ACCEPTANCE ☐

PERIODIC 1 ☐ 2 ■

ELECTRONIC SYSTEMS, INC P.O BOX 1260 HASTINGS, NEBRASKA 68902-1260

TELEPHONE (402) 463-0200

CUSTOMER: HASTINGS REGIONAL CENTER ADMIN BUILDING		
ADDRESS:		
PREMISES PROTECTED:ADMIN BUILDING		
ADDRESS:		
TYPE OF SYSTEM: FIRE ALARM	**MODEL#:FC 901**	**STANDBYE POWER TYPE: GEL**
MANUFACTURER: SIEMENS	**SERIAL#:**	**TROUBLE BATTERY TYPE: SLA**

SYSTEM REMOTELY MONITORED BY:	**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		
WATERFLOW DEVICES (TIME TO ACTIVATE)	1	1
SUPERVISORY SWITCHES	2	2
AUDIBLE DEVICES	12	12
VISUAL DEVICES	18	18
ANNUNCIATORS		
CONTROL UNIT		
LAMPS AND LED'S	7	7
FUSES		
PRIMARY POWER SUPPLY	1	1
SECONDARY POWER SUPPLY	1	1
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	YES	YES
GROUND FAULT	YES	YES
ELEVATOR CONTROLS		
POWERED FIRE AND SMOKE DAMPERS		

DISCONNECT A.C. POWER AND CHECK SYSTEM ON EMERGENCY POWER

DID TROUBLE SIGNAL OPERATE? YES NO DATE: 04/15/2025

DID ALARM SIGNAL OPERATE? YES NO

BATTERY TEST VOLTAGE UNDER 1 AMPERE TEST LOAD

EMERGENCY POWER BATTERY TYPE SLA TEST VOLTS 26.8

MAIN OPERATING POWER TYPE PS 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:	**LICENSE#:L05**
AUSTIN TIMMERMAN	**EXPIRATION DATE:07/16/2028**
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

PREA Facility Audit Report: Final

Name of Facility: Youth Rehabilitation and Treatment Center Hastings
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 12/19/2024

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. Snyder	**Date of Signature:** 12/19/2024

AUDITOR INFORMATION	
Auditor name:	Snyder, Candy
Email:	snyder@gwtc.net
Start Date of On-Site Audit:	10/23/2024
End Date of On-Site Audit:	10/24/2024

FACILITY INFORMATION	
Facility name:	Youth Rehabilitation and Treatment Center Hastings
Facility physical address:	4200 West 2nd Street , Hastings, Nebraska - 68901
Facility mailing address:	

Primary Contact

Name:	Shaylee Fortner
Email Address:	Shaylee.Fortner@nebraska.gov
Telephone Number:	3084550826

Superintendent/Director/Administrator	
Name:	Camella Jacobe
Email Address:	Camella.Jacobe@nebraska.gov
Telephone Number:	402-460-3164

Facility PREA Compliance Manager	
Name:	Samuel Johnston
Email Address:	Samuel.johnston@nebraska.gov
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	Kristie Himmelberg
Email Address:	Kristie.Himmelberg@nebraska.gov
Telephone Number:	402-462-1971

Facility Characteristics	
Designed facility capacity:	24
Current population of facility:	20
Average daily population for the past 12 months:	15
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Womens/girls

Which population(s) does the facility hold? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	14-18
Facility security levels/resident custody levels:	Medium
Number of staff currently employed at the facility who may have contact with residents:	78
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	10

AGENCY INFORMATION	
Name of agency:	Nebraska Department of Health and Human Services
Governing authority or parent agency (if applicable):	
Physical Address:	301 Centennial Mall South, 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

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

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	• 115.311 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator • 115.341 - Obtaining information from residents
Number of standards met:	
41	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION	
GENERAL AUDIT INFORMATION	
On-site Audit Dates	
1. Start date of the onsite portion of the audit:	2024-10-23
2. End date of the onsite portion of the audit:	2024-10-24
Outreach	
10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Family Advocacy Network. Child Protective Services, Nebraska Ombudsman, Office of Inspector General
AUDITED FACILITY INFORMATION	
14. Designated facility capacity:	24
15. Average daily population for the past 12 months:	15
16. Number of inmate/resident/detainee housing units:	2
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	15
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	1
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	5

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	6
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	11
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	No text provided.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	74
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	10

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	2
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	11
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☐ Age ☐ Race ☐ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☐ Housing assignment ☐ Gender ☐ Other ☑ None
If "None," explain:	Interviewed all 15 residents present at the facility.
36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Interviewed all 15 residents present at the facility.

37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	◉ Yes ○ No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	4
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
40. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

40. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility, interviewed staff, and reviewed all screening documents of residents present which corroborated that there were no residents with this characteristic to be interviewed.
41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1
42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
42. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
42. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility, interviewed staff, and reviewed all screening documents of residents present which corroborated that there were no residents with this characteristic to be interviewed.
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
43. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility, interviewed staff, and reviewed all screening documents of residents present which corroborated that there were no residents with this characteristic to be interviewed.
44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility, interviewed staff, and reviewed all screening documents of residents present which corroborated that there were no residents with this characteristic to be interviewed.
45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1

46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility, interviewed staff, and reviewed all screening documents of residents present which corroborated that there were no residents with this characteristic to be interviewed.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	1
48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	1
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0

49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interviewed all residents present at the facility and interviewed staff and reviewed other documents which corroborated that there were no residents with this characteristic to be interviewed.
50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	No text provided.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
51. Enter the total number of RANDOM STAFF who were interviewed:	12
52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☐ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No

54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	No text provided.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	8
56. Were you able to interview the Agency Head?	(●) Yes ( ) No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☒ Medical staff ☒ Mental health staff ☒ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff

	☐ Other
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
62. Enter the total number of CONTRACTORS who were interviewed:	2
62. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ☐ Medical/dental ☒ Food service ☐ Maintenance/construction ☒ Other
63. Provide any additional comments regarding selecting or interviewing specialized staff.	Interviewed to two probation officers who visit with residents within the facility. Both have had PREA training for contractors.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

64. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	No text provided.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	No text provided.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

72. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	26	0	26	0
Staff-on-inmate sexual abuse	1	0	1	0
Total	27	0	27	0

73. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	8	0	8	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	8	0	8	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

74. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

75. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	12	14
Staff-on-inmate sexual abuse	0	1	0	0
Total	0	1	12	14

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

76. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

77. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	2	6	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	2	6	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	5

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	4
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	1
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	( ) Yes (●) No ( ) NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	1
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	There were no staff-on-resident sexual harassment allegations reported at this facility and therefore no staff-on-resident sexual harassment investigation files.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

95. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff	
96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	(●) Yes ( ) No
96. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1
AUDITING ARRANGEMENTS AND COMPENSATION	
97. Who paid you to conduct this audit?	(●) The audited facility or its parent agency ( ) My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ( ) A third-party auditing entity (e.g., accreditation body, consulting firm) ( ) Other

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
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1676 – Management Structure 4. Agency Leadership 5. Organizational Chart **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. OJS Compliance Manager 4. PREA Compliance Specialist 5. Facility Administrator 6. 12 random staff 7. 15 random residents

The Nebraska Department of Health and Human Services (DHHS) Office of Juvenile Services (OJS) operates the Youth Rehabilitation Treatment Center (YRTC –H), a 24-bed juvenile facility in Hastings, Nebraska.

Findings by Provision:

115.311 (a): The DHHS OJS PREA Standard Operation Procedure (SOP) #1251 titled PREA Prevention, Detection, Reporting, Staff Responses, Investigations will be referred to throughout the report as SOP #1251 – PREA Prevention. SOP #1251 – PREA Prevention states in the scope that, "The OJS and all YRTC's mandates zero tolerance toward all forms of sexual abuse, sexual harassment, or sexual assault from other juveniles, staff, contractors or volunteers. All juveniles and staff who report sexual abuse or sexual harassment or cooperate with investigations of sexual abuse or sexual harassment have the right to be free from retaliation and will be protected from retaliation by other juveniles or staff. The OJS shall establish procedures each YRTC must follow to prevent, detect, and respond to such conduct".

115.311(b): The DHHS OJS PREA SOP #1676 – Management Structure and Chain of Command states in paragraph 6.1.6, "DHHS/OJS will designate an upper-level agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee efforts comply with the PREA standards at each YRTC". The PREA Coordinator holds the position of OJS Compliance Coordinator and reports directly to the DHHS Facilities Director. She is a member of the senior staff and therefore has the authority to develop and oversee the efforts of YRTC-H to prevent, detect, and respond to sexual abuse and sexual harassment. The OJS PREA Coordinator is knowledgeable as to her role and stated she has enough time to manage all of her PREA-related responsibilities. She stated that if she has an issue with complying with a PREA standard she works with the facility administration to develop a plan of action for immediate correction and a long-term, permanent solution. There is one Compliance Manager, and five Compliance Specialists that report to the Compliance Coordinator.

115.311(c): The DHHS OJS PREA SOP #1676 – Management Structure and Chain of Command states in paragraph 6.1.6.1, "Each YRTC will have a designated Prison Rape Elimination Act (PREA) compliance manager(s)with sufficient time and authority to coordinate each YRTC's efforts to comply with the PREA standards". Each YRTC facility has a PREA Compliance Specialist responsible for maintaining day-to-day compliance within the facility. The auditor interviewed the YRTC-H PREA Compliance Specialist who also stated that he has enough time to manage all of his PREA-related responsibilities. It is important to stress to the reader of this report that anywhere it says PREA Compliance Specialist in this report, the reader must interpret that as the equivalent to the standards definition of a PREA Compliance Manager – the person responsible for coordinating within the facility efforts to comply with the PREA standards.

In addition, the OJS has a mid-level OJS Compliance Manager position that assists the PREA Coordinator in all compliance activities, in all facilities. In addition to PREA Compliance, this team is responsible for compliance with American Correctional

	Association standards and Performance Based Standards with the ultimate goal of making sure that all residents are safe within YRTC facilities. The auditor determined that the YRTC-H has exceeds this standard in that they have an additional level of PREA compliance staffing with the OJS Compliance Manager position. It was apparent to the auditor the benefits this position brings in the amount of organization and cohesion witnessed throughout the audit process. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of SOP #1676, and the organization chart, and interviews with the DHHS Facilities Director, the PREA Coordinator, the PREA Compliance Manager, and the YRTC-H PREA Compliance Specialist. In interviews with staff and residents, all were knowledgeable of the zero-tolerance policy.

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator **Findings by Provision:** **115.312 (a) and (b):** The YRTC-H facility does not contract for the confinement of residents with an outside entity. The auditor determined compliance through a review of the pre-audit questionnaire and interviews with the DHHS Facilities Director and the PREA Coordinator.

115.313	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #205 – Juvenile Supervision 3. Organizational Chart 4. Staff schedule 5. Staffing Plan Update – January 2024

6. Morning Report

Interviews Conducted:
1. Facility Administrator
2. PREA Coordinator

Findings by Provision:
115.313 (a): The auditor reviewed the Organization Chart, verified the staffing levels through the Staffing Plan Update – January 2024, the schedule that was provided, and verified through direct observation and monitoring cameras while on the facility tour and throughout the onsite audit. The auditor reviewed SOP #205 -- Juvenile Supervision which states in paragraph 5.3.1, “The agency must ensure that each facility it operates must develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities must take into consideration: Generally accepted juvenile detention and correctional/secure residential practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; All components of the facility’s physical plant (including “blind spots” or areas where staff or residents may be isolated); The composition of the resident population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and Any other relevant factors".

The YRTC-H facility has strong, consistent leadership, a good training program, and a positive culture. There have been no deviations from the staffing plan. The latest revised staffing plan completed in January 2024 is signed by the Facility Administrator and the PREA Coordinator.

The auditor toured all areas of the facility and observed all areas including the administrative areas, the chapel/gym, the two housing units including resident sleeping areas, restrooms, shower rooms, and common areas, storage areas, and the program building which includes the classrooms, kitchen, dining hall, medical and admissions. While touring the facility the auditor noted camera locations. The auditor was present at all shifts to observe operations at all times of the day. The auditor had informal conversations and made observations about resident supervision. The storage doors were locked, and the facility practices and procedures ensure staff and residents are not in a one-on-one situation off camera.

115.313 (b): The auditor revised SOP #205 – Juvenile Supervision which states in paragraph 5.3.2 that, “The agency must comply with the staffing plan except during limited and discrete exigent circumstances and must fully document deviations from the plan during such circumstances”. The auditor reviewed the pre-audit questionnaire and interviewed the Facility Administrator and the PREA Coordinator which stated there were no times they were out of ratio. When there was a staff shortage, it was filled with overtime or by an administrative staff filling the youth

	supervision position. **115.313 (c):** The auditor reviewed the Staffing Plan Update – January 2024 which states, “The YRTC-H continues with compliance of the 1:8 staff to youth ratio during waking hours and 1:16 staff to youth ratio during sleeping hours”. The auditor verified this ratio was maintained while observing operations within the facility during all shifts and in all areas and in reviewing samples of the Morning Report which contains the shift report for the day including all counts. **115.313 (d):** The auditor reviewed SOP #205 – Juvenile Supervision which states in paragraph 5.3.4 that, “Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA Coordinator required by 115.311, the agency much access, determine, and document whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section; prevailing staffing patterns; the facilities deployment of video monitoring systems and other monitoring technologies; and the resources the facility has available to ensure adherence to the staffing plan". The auditor verified this provision is followed through a review of the latest revised staffing plan completed in January 2024 that is signed by the Facility Administrator and the PREA Coordinator. It includes items as outlined within the standard. Such as cameras, blind spots, physical layout, supervision of juveniles, number and placement of supervisory staff, and the prevalence of substantiated and unsubstantiated incidents of sexual abuse. **115.313 (e):** The auditor reviewed SOP #205 -- Juvenile Supervision which states in paragraph 5.3.5 that “Each secure facility must implement 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. Each secure facility must have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring unless such an announcement is related to the legitimate operational functions of the facility". The auditor reviewed the Morning Report, which has several entries throughout each shift in which the Youth Security Supervisor (YSS) conducts rounds throughout the campus. In addition, YRTC-H maintains an Unannounced Rounds logbook in which upper-level administrators log their unannounced rounds. The auditor determined compliance with this standard through a review of the documents listed above, through direct observations of rounds and watching staff monitor the facility both in person and through video monitors, through a review of the pre-audit questionnaire, interviews with the DHHS Facilities Director, the PREA Coordinator, OJS Compliance Manager, and the Facility Administrator. In informal conversations with residents, they stated they felt safe here and that staff conduct rounds regularly, including managers.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #229 – Searches 4. Youth Security Search form 5. Exigent Circumstance logbook 6. Staff training records **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. PREA Compliance Manager 4. Facility Administrator 5. 12 random staff 6. 15 random residents **Findings by Provision:** **115.315 (a):** YRTC-H is an all-female facility. The auditor reviewed the SOP #229 – Searches which states in paragraph 6.3.4.1 that, “The facility must not conduct cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by a medical practitioner”. The auditor interviewed and had informal conversations with random staff who stated that only female staff conduct searches of residents. Visual body cavity searches are not done. If they were needed the Facility Administrator and medical would be involved. The YRTC-H has completed no cross-gender strip searches or body cavity searches. **115.315 (b):** The auditor reviewed SOP #229 – Searches in paragraph 6.3.4.2 which states that “The agency must not conduct cross-gender pat-down searches except in exigent circumstances". The auditor interviewed and had informal conversations with random staff and random residents who all consistently stated only female staff conduct pat searches of residents. **115.315 (c):** The auditor reviewed SOP #229 – Searches in paragraph 6.3.4.3 which states that, “The facility must document all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down search". Paragraph 6.3.4.7 states that “Pat searches on a juvenile are conducted by two staff members; the staff member completing the search must be of the same anatomical sex as the juvenile”. The auditor verified documentation of searches by two staff of the same gender as the youth. The auditor interviewed the Facility Administrator who stated that if a cross-gender pat-down search was to occur in an exigent circumstance, it would be reported to a supervisor and to her and documented in an incident report and the exigent circumstance book. **115.315 (d):** The auditor reviewed SOP #1251—PREA Prevention in paragraphs 6.2.2.1 – 6.2.3 which states, "Female staff will announce their presence prior to

	entering a housing unit occupied by male juveniles. Male staff will announce their presence prior to entering a housing unit occupied by female juveniles. This announcement shall be made loud enough for juveniles to hear. For opposite-gender staff scheduled in a particular housing unit for an entire shift, they will have to announce once, at the beginning of their shift. The only exception to this would be if the opposite gender staff has left the building for a significant amount of time and is returning to the building. All other opposite-gender staff entering a housing unit at any given time will be required to make the announcement each time they enter the housing unit. Staff (excluding medical staff) will allow juveniles to shower, perform bodily functions, and change clothing without viewing their buttocks or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (including viewing on video camera)". The auditor interviewed and had informal conversations with random staff and random residents who all consistently stated male staff announced themselves when entering their housing unit. The auditor also verified this practice while on the facility tour. **115.315 (e):** The auditor reviewed SOP #229 – Searches in paragraphs 6.3.4.5 which states, "The facility must 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 may be 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". Paragraph 6.3.4.8 states, "If a juvenile identifies as transgender or intersex at any time during their commitment or if there is prior knowledge that the juvenile identifies as transgender or intersex the following must take place: The juvenile will be given the opportunity to complete a Statement of Search Preference form. Upon completion of the Statement of Search Preference form, the form will be submitted to the facility compliance team who will meet with a multi-disciplinary team to review the request and decide on a case-by-case basis how to proceed. Upon completion of the request, the juvenile will be notified by the compliance team of the outcome of the review. Upon approval of the request the staff member performing the search should be the same sex as identified by the juvenile's search preference, when possible. The search must be documented as to whether the search preference was followed. If not followed, the reasons why should be documented". The auditor interviewed the administrators who confirmed this practice. There were no residents who identified as transgender present to be interviewed. The auditor interviewed the administrators and the staff who conduct the intake and screening who stated that information regarding sexual identity is typically known before the resident arrives. If it is not known ahead of time, they do not conduct any type of search at this facility. Identity as a transgender or intersex person would be gathered through conversation with the resident. **115.315 (f):** The auditor reviewed SOP #229 – Searches in paragraphs 6.3.4.6 which states, "The agency must train security staff how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner and in the least intrusive manner possible, consistent with security needs". The auditor reviewed the training curriculum and

	interviewed random staff. Employees receive classroom instruction, view the video “Guidance in Cross-Gender and Transgender Pat Searches” and must demonstrate a proper pat search. The auditor determined compliance with this standard through a review of the documents listed above, through direct observations while on the tour of the restroom procedures, through a review of the pre-audit questionnaire, interviews with the DHHS Facilities Director, the PREA Coordinator, the PREA Compliance Specialist, the Facility Administrator, and through random interviews with staff and residents. The auditor reviewed the camera coverage to verify there is no camera in an area where residents might be in a state of undress. The auditor had informal conversations with residents regarding their privacy during showering, toileting, and changing clothing.

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #171 – Special Needs Program 3. PREA Posters 4. Language Line Materials **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. 12 Random Staff 4. 15 Randon Residents 5. 2 Targeted Resident Interviews **Findings by Provision:** **115.316 (a):** The auditor reviewed SOP #171 -- Special Needs Program in paragraph 5.6 which states, “The agency shall take appropriate steps to ensure that juveniles with disabilities (including, 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 and abuse and sexual harassment". SOP #171 outlines specifically the many ways in which they accomplish this. In addition, the auditor interviewed the DHHS Facilities Director, and random staff who stated that they offer multiple options to present the material such as in writing, video with subtitles, translation services for non-English speaking people to include a contract with Language Line, a list of in-

	person interpreters available in multiple languages and a telephone for the hearing impaired, and working individually with youth who may need the material presented to them in a specific manner. There were no residents within the facility that needed interpretation services. PREA posters were posted in both English and Spanish. Spanish is the non-English language that would most predominantly be encountered at this facility. During staff interviews, staff verified that they would not use residents to interpret for other residents when discussing any important, sensitive, or confidential information. The auditor interviewed a youth with lower cognitive function. She stated that they went over the PREA pamphlet with her and explained everything. She stated that she was able to understand what they told her. They explained sexual abuse and harassment and if it happened, she could tell anybody or call the Abuse and Neglect Hotline number that is in the pamphlet and on the posters. The auditor interviewed a resident with low reading comprehension. She stated the material was explained to her verbally. The auditor determined compliance with this standard through a review of the policies, the interpretation service documentation, and through interviews with administrators, staff and interviews with residents.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1641 – Hiring and Promotions 3. Human Resource Documents (sample size 7 random staff) Interviews Conducted: 1. Human Resources Manager **Findings by Provision:** **115.317 (a):** The auditor reviewed SOP #1641 – Hiring and Promotions paragraph 6.1 which states that “YRTCs will not hire or promote any employee or enlist the services of any contractor who may have contact with juveniles if: 6.1.1 They have 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). 6.1.2 They have 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. 6.1.3 They have been civilly or administratively adjudicated to have engaged in sexual activity in the community”. The auditor interviewed the Human Resources Manager and reviewed personnel files. The files support their statements. These processes include law enforcement background checks, child abuse and neglect registry checks, asking

	the employees and contractors directly before employing their services and annually thereafter, and asking previous institutional employers about any sexual misconduct. These actions are described in more detail in the following paragraphs. **115.317 (b):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.2 that, “All YRTCs will consider any incidents of sexual harassment in determining whether to hire or promote employee or enlist the services of any contractor who may have contact with juveniles". The auditor interviewed the Human Resource Manager who confirmed their compliance with this policy by conducting a reference check with previous institutional employees and a review of a staff member's personnel record and PREA documentation for any incidents of sexual harassment when considering an employee for hire or promotion or the services of a contractor. **115.317 (c):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.3 that, “Prior to hiring new employees who may have contact with juveniles, the following will be completed by the Human Resources Office with the Department of Health and Human Services (DHHS). 6.3.1 A security check in accordance with state and federal statutes. 6.3.1.1 This check includes a criminal history, adult and child abuse and neglect, state driving record, state and federal prison check, and Nebraska Sex Offender check. 6.3.2 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”. The auditor interviewed the Human Resources Manager who stated that they conduct criminal background checks and child and abuse and neglect registry checks on applicants before an offer of employment is made and on current employees when they are promoted. In addition, they check with all previous employers about any substantiated sexual misconduct where they were previously employed. The auditor reviewed a random sampling of 10 employee files and found that the necessary background checks, child abuse and neglect registry checks, and required reference checks of all prior institutional employers. **115.317 (d):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.4 that, “Each YRTC will perform a criminal background record check and consult applicable child abuse registries before enlisting the services of any contractor who may have contact with juveniles”. The auditor interviewed the Human Resources Manager who stated that they conduct criminal background checks on contractors before their services can be used at the facility. The auditor reviewed sample documentation required for contractors. **115.317 (e):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.5 that, “All YRTCs will conduct criminal background records checks at least every five years of all current employees and contractors who may have contact with juveniles”. The auditor reviewed a sample of background checks for both newly hired employees and veteran employees with over 30 years of service. All staff had the most recent five-year update as well as employees who had the background check run during the hiring process this past year.

	115.317 (f): The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.6 that, “Applicants to the YRTCs will attest to any previous misconduct as described in Procedures 6.1 on Page 1 in the application process”. Also, paragraph 6.5.2 states that “Each YRTC will impose upon employees a continuing affirmative duty to disclose any such misconduct". The auditor reviewed employment applications that include the questions as stated in provision (a) of this standard as well as an attestation that they understand they have a continuing duty to report any sexual misconduct throughout the terms of their employment. In addition, each year the facility pushes out an annual digital course which requires staff to answer sexual misconduct questions again and attest to their continuing duty to report during the annual self-evaluation process. **115.317 (g):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.5.2 that, “Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination”. The auditor reviewed a sample of employee applications which states in the PREA – Applicant Acknowledgement paragraph “For the Safety and Protection of the juvenile residents, the DHHS -Youth Programs comply with the Prison Rape Elimination Act (PREA) Standards. In accordance with PREA Standard 115.17 the DHHS Youth Programs will ask all applicants who may have contact with youth directly about previous misconduct described below. The DHHS-Youth Programs also require a continuing affirmative duty to disclose any such misconduct. Failure to answer each question could result in the disqualification of your application. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination if hired. By checking, “I accept” at the bottom of this form you are acknowledging your answers are accurate. Your previous employers may also be contacted and asked the questions below.” **115.317 (h):** The auditor reviewed SOP #1641 – Hiring and Promotions which states in paragraph 6.7 that, “Unless prohibited by law, the YRTC’s shall 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". The auditor interviewed the Human Resources Manager who stated that they provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from another confinement facility. The auditor determined compliance with this standard through a review of the policies, and a review of human resources forms used in the hiring and employment processes. The auditor selected a random sample of ten employee personnel files and found the necessary documents to substantiate compliance with this standard. The auditor also confirmed these policies and procedures through an interview with the Human Resources Manager.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #152 – Space and Program Assessment Process 3. 2024 Annual Report **Interviews Conducted:** 1. DHHS Facilities Director 2. Facility Administrator 3. PREA Compliance team **Findings by Provision:** **115.318 (a):** The auditor reviewed SOP #152 – Space and Program Assessment Process in paragraph 5.4.1.4.1 which states, “When designing or acquiring any new facility and in planning any substantial expansion, or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse". The auditor directly observed the facility and conducted interviews with the DHHS Facilities Director and the Facility Administrator. The facility considers the protection of residents and the standards when contemplating new facilities or upgrades to the facility. **115.318 (b):** The auditor reviewed SOP #152– Space and Program Assessment Process in paragraph 5.4.1.4.2 which states, “When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency’s ability to protect residents from sexual abuse”. The auditor observed the facility, noting camera locations, viewing video monitors, and conducted interviews with the DHHS Facilities Director, the Facility Administrator, and the PREA Compliance team. The auditor also reviewed the 2024 Annual Report which identifies any issues that were addressed. The facility considers the protection of residents and the standards when contemplating upgrades monitoring technology or in the application of new technology. They have identified and installed multiple cameras in locations that were determined to need more video coverage since the last audit. They go over the camera placement information with all employees and employees are trained to never enter an area in a one-on-one situation with a youth when there is no camera in that area. The auditor determined compliance through a review of the pre-audit questionnaire, through a tour of the facility, through viewing the camera locations and a review of SOP #152, and through interview with the DHHS Facilities Director, the Facility Director, and the PREA Compliance team.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment, Follow Up and Reports 3. Investigative training certificates 4. MOU with the Family Advocacy Network (FAN) 5. Nebraska Statute 28-728 Legislative findings and intent; child abuse and neglect investigation team; child advocacy center; child abuse and neglect treatment team; powers and duties. **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist/ Administrative Investigator 4. Family Advocacy Network Director 5. 12 Random Staff **Findings by Provision:** **115.321 (a):** The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.1.1 which state, “Uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions". The auditor interviewed the PREA Compliance Specialist who is one of the administrative investigators who conduct administrative investigations for this facility. The administrative investigators have completed multiple courses from various organizations to include the PREA Resource Center and the Moss Group, that all emphasize a uniform evidence protocol for collecting physical evidence. **115.321 (b):** The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.1.1.1 which states, “The protocol shall be developmentally appropriate for juveniles and shall be adapted from or based on the most recent edition of the United States 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". The auditor interviewed the PREA Coordinator who stated that all sexual abuse allegations will be referred to Child Protection Services and Nebraska State Patrol for investigation. They will only complete administrative investigations of a non-criminal nature. All others will be referred unless they are informed by Child Protection Services or law enforcement that they will not be investigating. In these instances, an administrative investigator will use the protocols applicable to their administrative investigation from “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents". **115.321 (c):** The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.1.2 which states that, “Juveniles who experience sexual abuse/assault shall be offered access to forensic medical examinations at an outside facility, without financial cost, where medically appropriate. 6.1.2.1 Forensic medical

examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. 6.1.2.2 If SAFEs or SANEs are not available, the examination shall be performed by other qualified medical practitioners; however, the YRTC will document its efforts to provide SAFEs or SANEs". The auditor interviewed the Facility Administrator and the nurse who stated that youth would be transported to Family Advocacy Network or elsewhere if directed by the Nebraska State Patrol, for the forensic examination. The auditor spoke with the Director of the Family Advocacy Network who stated that they are set up to handle adolescents at their facility to include the forensic interview, the forensic medical examination performed by SANEs, and advocacy services. They have three SANEs and their SANE Director is a physician. They almost always are able to perform the examination within their facility. If SAFEs or SANEs cannot be made available, the examination can be performed at the emergency room. The local hospital, the Good Samaritan, has five SANEs. There have been no forensic medical exams conducted during the past 12 months. The auditor interviewed a random sample of staff to confirm they understand their responsibilities to preserve and protect evidence.

115.321 (d): The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.2.7 which states, “Each YRTC will make available to the victim a victim advocate from a rape crisis center”. In 6.2.7.1 it lists for YRTC – Hastings, the Family Advocacy Network as the local rape crisis center available for this facility. In paragraph 6.1.3 it states, “Victims of sexual abuse/assault shall be assessed by the Family Advocacy Network, Child Advocacy Center, or the local hospital located near each YRTC facility, which shall be determined by the Nebraska State Patrol". The auditor interviewed the PREA Coordinator, the PREA Compliance Specialist and the Director of the Family Advocacy Network, the local rape crisis center, who confirmed that YRTC-Hastings has a Memorandum of Understanding (MOU) with FAN.

115.321 (e): The auditor reviewed the FAN MOU and interviewed the Director of FAN who stated that they will provide an advocate who will provide the residents with information about options and resources and assist them through the criminal justice process. They provide accompaniment and emotional support to the residents through forensic medical examinations and investigatory interviews.

115.321 (f) & (g): The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states that. “Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities”.

115.321 (h): The YRTC-H always offers the services of an advocate from the Family Advocacy Network. Nebraska state law under Chapter 28-278 states, “Each county

	or contiguous group of counties will be assigned by the Department of Health and Human Services to a child advocacy center. The purpose of a child advocacy center is to provide a child-focused location for conducting forensic interviews and medical evaluations for alleged child victims of abuse and neglect and for coordinating a multidisciplinary team response that supports the physical, emotional, and psychological needs of children who are alleged victims of abuse or neglect. Each child advocacy center shall meet accreditation criteria set forth by the National Children's Alliance. Nothing in this section shall prevent a child from receiving treatment or other services at a child advocacy center which has received or is in the process of receiving accreditation". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, and the documentation as stated in each provision above. The auditor also drew on interviews with the Facility Administrator/trained administrative investigator, the PREA Coordinator, the PREA Compliance Specialist/ Administrative Investigator, and the director of the local rape crisis center.

115.322	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment, Follow Up and Reports 3. PREA allegations and 6 investigative reports 4. DHHS YRTC website **Interviews Conducted:** 1. PREA Coordinator 2. PREA Compliance Specialist/Administrative Investigator **Findings by Provision:** **115.322 (a) – (d):** The auditor reviewed SOP #1252 – PREA Treatment, Follow Up and Reports in paragraph 6.12.1 which states, that "YRTC shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. 6.12.2 YRTC shall ensure that all allegations of abuse, neglect, sexual harassment, sexual abuse/assault are referred for criminal investigation to the Nebraska State Patrol to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. 6.12.2.1. When the Nebraska State Patrol (NSP or other outside agencies investigate sexual abuse, all staff shall cooperate with investigators and the facilities shall endeavor to remain informed about the progress of the investigation. 6.12.2.2 Criminal investigations conducted by the NSP shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and

	attaches copies of all documentary evidence when feasible". **115.322 (e):** Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations. There have been no Department of Justice investigations within this facility. The auditor is not required to audit this provision. The auditor verified compliance through a review of the pre-audit questionnaire and SOP 1252, interviews with the Facility Administrator and the PREA Coordinator, a review of the letter from the Nebraska State Patrol, and a review of the agency website at https://dhhs.ne.gov/Pages/YRTC-Reports.aspx where the investigative policy is published and may be viewed by opening the "Facility: All Facilities" drop down and selecting the pdf file "OJS PREA Standard Operating Procedures". This documents explicitly describes the responsibilities of the Nebraska State Patrol or other law enforcement agency, Child Protective Services, and the facility's administrative investigators. The PREA Coordinator provided the investigatory reports for the auditor to review which includes any law enforcement referrals. In addition, the auditor interviewed the PREA Compliance Specialist/Administrative Investigator, and the PREA Coordinator who both provided statements consistent with policies as to each entity's role in a criminal and/or administrative sexual abuse or sexual harassment investigation.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 – New and In-Service Employee Training 3. training records (sample size 7 random staff) 4. PREA PowerPoints **Interviews Conducted:** 1. PREA Coordinator 2. 12 random staff **Findings by Provision:** **115.331 (a):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.3 which states that "All employees will receive PREA training and education which will be tailored to the unique needs and attributes of the juveniles at each YRTC. At a minimum, training will include: 6.3.2 Zero-tolerance policy for sexual abuse and sexual harassment. 6.3.3 Staff responsibilities with the sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. 6.3.4 Juveniles' right to be free from sexual abuse and

	sexual harassment. 6.3.5. Staff and juveniles right to be free from retaliation for reporting sexual abuse and sexual harassment. 6.3.6 Facility specific dynamics of sexual abuse and sexual harassment at the employees assigned YRTC. 6.3.7 Common reactions of juvenile victims of sexual abuse and sexual harassment. 6.3.8 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 juveniles.6.3.9 How to avoid inappropriate relationships with residents. 6.3.10 How to communicate effectively and professionally with juveniles, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming juveniles. 6.3.11 How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. 6.3.12. Relevant laws regarding the applicable age of consent". The auditor interviewed the Facility Administrator, the PREA Coordinator, and staff, and reviewed the training curriculum of various training topics. A review of the PREA training curriculum confirms that the training includes information on components required by the standard and outlined within their policy. **115.331 (b):** The auditor interviewed the PREA Coordinator who stated YRTC – Hastings houses only female residents. Staff who transfer from another facility are given training specifically in policies and procedures at this facility. When reviewing the PREA training PowerPoint Unit 3, there was information specific to the dynamics of sexual abuse in female facilities versus male facilities. The training also has group discussion time built in to discuss the specifics of their facility. Staff interviews included descriptions of female behaviors that are more relationship oriented, and that the girls try to “date” each other while in the program. The girls tend to be less physically aggressive but do more inappropriate touching. **115.331 (c):** The auditor reviewed training curriculum and training records and interviewed administrators and random staff to verify that training happens consistently and per the policy. Staff stated that they have PREA training every year that includes a basic refresher on the main PREA components with additional training components at various times to include various topics that are relevant at that time. **115.331 (d):** The auditor interviewed the PREA Coordinator and random staff and reviewed the training records. The auditor requested and was provided with random samples of training documentation which included the course's name, the date it was completed, and tests with scores to verify understanding of the material. The auditor determined compliance with this standard through a review of the training policy, a review of the pre-audit questionnaire, a review of the curriculum, and a review of training records. The auditor also confirmed these policies and procedures through interviews with the PREA Coordinator and random staff.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 - New and In-service Employee Training 3. Volunteer/Contractor training records (sample size 15) **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. 2 Contractors **Findings by Provision:** **115.332 (a) and (b):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.2.10 states that “Volunteers, Contractual Personnel and Interns, and all Part-time staff complete orientation and training as the Facility Administrator or designee determines is appropriate for the individual’s duties and responsibilities.6.2.10.1 The volunteer training will be monitored by the Volunteer Coordinator. 6.2.10.2 Orientation Training includes at a minimum: All volunteers, contractors, and interns who have contact with juveniles shall be notified of the zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents". The auditor interviewed the PREA Coordinator and two contractors who confirmed that they receive training from staff who go over the PREA information with them including the critical components of a zero-tolerance policy for sexual abuse and sexual harassment and how to report. This training is consistent with this provision and the training is based on the services they provide and the level of contact they have with residents. **115.332 (c):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.2.10.5 states that “Documentation will be maintained confirming that volunteers, contractors, and interns understand the training they received. The auditor reviewed the training documentation signed by volunteers/ contractors. YRTC-H maintains documentation confirming that volunteers and contractors understand the training they have received". The auditor verified compliance with this standard through a review of the volunteer/contractor training documentation and through interviews with contractors and the PREA Coordinator.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents Reviewed:
1. Pre-Audit Questionnaire
2. SOP #1251 – PREA Prevention
3. Resident Training Documentation (Sample Size 15 residents)
4. “End the Silence” brochure
5. End Silence – Youth Comic Book
6. Posters posted throughout the facility

Interviews Conducted:
1. Facility Administrator
2. PREA Coordinator
3. Intake staff
4. 15 random residents
5. 12 random staff
6. 2 specialized interviews for residents with learning disabilities

Findings by Provision:
115.333 (a): The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.1.1 which states, “Upon arrival, a juvenile will be provided information explaining, in an age-appropriate fashion, the zero-tolerance policy regarding abuse, sexual assault/abuse/harassment or neglect. This information will include (both orally and in writing in a language clearly understood by the juvenile): 6.1.1.1 Prevention/ intervention 6.1.1.2 Self-protection 6.1.1.3 Reporting incidents or suspicions of sexual abuse/assault/harassment 6.1.1.4 Treatment and counseling”. The auditor reviewed training information provided to the residents, requested an Intake staff go over the process with the auditor as there were no new intakes to observe, and discussed the information with the residents who were interviewed. The YRTC-H facility provides extensive PREA information to a resident during the intake process. This information includes their zero-tolerance policy and how to report which is immediately explained to them while going over a brochure they can keep.

115.333 (b): The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.4 which states, “Within 10 days of admission, the juvenile will receive orientation/education regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents; as well as how YRTC respond to such incidents". The auditor reviewed the training materials, interviewed random residents, and interviewed an intake staff and the PREA Coordinator to have the intake and orientation processes explained. A Case Manager shows the youth the video “Safeguarding Your Sexual Safety” and goes over the more detailed information about PREA usually within 24 hours of arrival. They are also provided with the End Silence youth comic book. The orientation process specifically outlines residential rules, definitions, information on how to keep themself safe, the facility’s investigative process, the grievance process, and resources for support services that can assist victims in their recovery process. The auditor discussed this section of the policy with both the Facility Administrator and the PREA Coordinator. All PREA information is provided within 10 days of intake. The education and screening is done in a quiet, private room, one-on-one, in a calm environment. The residents’ education was very evident in the residents’ responses

	during the interviews. **115.333 (c) and (d):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.5 which states, “All new admissions will receive orientation, in formats accessible to all juveniles, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as juveniles who have limited reading skills. It is the goal of each YRTC that all juveniles have an equal opportunity to participate in and benefit from all aspects of the facility’s efforts to prevent, detect, and respond to sexual abuse and harassment”. The auditor reviewed materials in English and Spanish and interviewed the PREA Coordinator, an intake staff who presents the intake and orientation information, and 15 random residents who confirmed that the information is explained to them and given in a manner that they are able to understand. The auditor conducted two specialized interviews for two youth who have identified learning difficulties. They stated that they went over the materially verbally in a way that they were able to understand the information. **115.333 (e):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, “All juveniles will initial and date the appropriate area on the Orientation Check Sheet documenting the juveniles’ participation in the orientation/ education session". The auditor reviewed the intake and orientation documentation for 15 residents to confirm that they received the education required per standard and the YRTC policy. The documentation has the resident’s name and the date they completed the PREA education as well as a statement acknowledging that they understand the information that was provided and that they received the “End the Silence” brochure and the comic and viewed the video. The residents and the staff administering the education sign the form. **115.333 (f):** The auditor interviewed the staff, residents, and toured the facility. Materials are continuously and readily available to the residents. There are Zero Tolerance posters posted throughout the facility. Youth are given the “End the Silence” brochure and handbook at intake to keep with them for later reference. The auditor verified compliance with this standard through a review of the resident training documentation and materials, materials posted and available to residents, and interviews with the Facility Administrator, PREA Coordinator, intake staff, random staff and random residents.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention

	3. Training certificates of Specialized Investigator Training 4. Investigator training curriculum **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist/Administrative Investigator **Findings by Provision:** **115.334 (a):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, “Only investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to PREA standard 115.334 will conduct the investigation”. **115.334 (b):** The auditor reviewed the training curriculums for specialized investigator training, and it included techniques for interviewing youth sexual abuse victims, the use of Garrity and Miranda, sexual abuse evidence collection in residential/group settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The auditor interviewed the PREA Compliance Manger who is also trained as an Administrative Investigator. He was well versed in conducting PREA investigations in confinement settings to include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. **115.334 (c):** The auditor reviewed training documentation to include the curriculum and the training certificates to include certificates from National PREA Resource Center/the Moss Group "PREA Juvenile Specialized Investigator Training”. **115.334 (d):** The auditor interviewed the Facility Administrator and the PREA Coordinator who stated that the Nebraska State Patrol and Child Protection Services conduct their criminal investigations. The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states that. “Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous report. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities”. The auditor verified compliance with this standard through a review of the investigator training curriculum and specialized training certificates for investigators. The auditor also confirmed investigative knowledge through an interview with the PREA Compliance Specialist/Administrative Investigator.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1280 – New and In-Service Employee Training 3. Specialized training documentation for medical and mental health staff **Interviews Conducted:** 1. PREA Coordinator 2. Nurse 3. Clinical Program Manager **Findings by Provision:** **115.335 (a):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.4 which states, “All medical and mental health care practitioners will receive specialized training in addition to the mandatory PREA training and education. Specialized training will include: 6.4.1.1 How to detect and assess signs of sexual abuse and sexual harassment. 6.4.1.2 How to preserve physical evidence of sexual abuse. 6.4.1.3 How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment. 6.4.1.4 How and to whom to report allegations or suspicions of sexual abuse and sexual harassment". **115.335 (b):** The auditor interviewed the Facility Administrator and the nurse who stated that they do not conduct forensic examinations at the facility. Residents would be transported to the Family Advocacy Network or the emergency room at the local hospital as directed by the Nebraska State Patrol. **115.335 (c) & (d):** The auditor reviewed SOP #1280 – New and In-service Employee Training in paragraph 6.4 which states, “Documentation will be maintained confirming that medical and mental health practitioners have received the training”. The auditor reviewed the training documentation and curriculum submitted by the PREA Coordinator which verifies that the medical and mental health staff have completed the specialized training as well as the training mandated for employees under § 115.331. The auditor verified compliance with this standard through a review of the training curriculum and specialized training certificates for medical and mental health staff. The auditor also confirmed knowledge through interviews with the PREA Coordinator, the nurse, and the Clinical Program Manager.

115.341	Obtaining information from residents
	Auditor Overall Determination: Exceeds Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. 15 Resident risk screenings 4. 12 45-day periodic re-screenings **Interviews Conducted:** 1. Staff who administers the assessments 2. Clinical Program Director 3. PREA Coordinator 4. 15 random residents 5. Staff **Findings by Provision:** **115.341 (a) and (e):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.3.1 which states, “Within 24 hours of admission to a YRTC the Screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior, which is an objective screening instrument, will be completed on every juvenile by a licensed mental health practitioner. This assessment will identify those juveniles as high risk who have the potential to act out in sexually or physically aggressive manners or who may be vulnerable to being sexually victimized. Information on each juvenile’s personal history and behavior will be gathered to reduce the risk of sexual abuse by or upon the juvenile”. The auditor selected and reviewed a random sample of 15 risk screenings and 12 periodic 45-day re-screenings. The auditor interviewed a staff who administers the initial screening. He stated that he does the initial screening and a licensed mental health staff administers a more through risk screening the following day. The auditor interviewed the Clinical Program Director who stated she reviews the assessments completed by the LMHP at the YRTC-H. The auditor interviewed 15 random residents. All those interviewed stated the assessment was typically completed as soon as the youth arrived at the facility. A staff member who administers the assessment walked the auditor through the assessment process as there were no new intakes while the auditor was on site. The facility conducts periodic reassessment if a youth has been a victim or a perpetrator -- they will reevaluate if they need to change how they are housed or their supervision level during programming. They have a set periodic rescreening at 45-days after admission and anytime staff feel there is need to rescreen. 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 juvenile. The auditor determined that YRTC-Hastings 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 the 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. The auditor verified compliance with this standard through a review of 15 sample screenings and 12 periodic re-screening documents, and interviews with staff and residents.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #199 – Classification 4. 16 initial PREA Assessments 5. Resident Roster with housing assignment 6. YRTC Classification Minutes 7. 15 Resident risk screenings 8. 12 45-day periodic re-screenings **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. PREA Compliance Specialist 4. Nurse 5. Clinical Program Manager 6. Licensed mental health practitioner who administers the assessments 7. 1 Specialized resident interview **Findings by Provision:** **115.342 (a):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.2.6 which states, "The results of the Screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior tool are used in providing appropriate housing, programming, education, work assignments, and supervision". The auditor interviewed the Facility Administrator, the PREA Coordinator, PREA Compliance Specialist, and a staff who administers the assessments during the intake process. They stated that all youth are housed in individual rooms and all youth shower

	separately. The information from the risk screening is utilized to determine if there are any issues that may need an immediate concern or closer supervision. Residents who may be at more risk may need closer supervision during all aspects of their programming. The auditor reviewed resident risk screenings and YRTC Classification Minutes for insight as to how the classification decisions are made. **115.342 (b):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.2 which states, “Residents may be 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”. The SOP continues to outline that they must have large-muscle exercise, educational programming or special education services, daily visits from a medical or mental health care clinician, access to other programs and work opportunities to the extent possible. The auditor interviewed the Facility Administrator, the PREA Coordinator, and the PREA Compliance Specialist. YRTC-H uses isolation as a means for keeping residents safe only as a last resort or to have the time to come up with an individualized safety plan for that particular resident. The facility does not have any type of confinement cells. The preferred method is more targeted supervision to keep the residents safe. They would utilize more appropriate supervision methods such as ensuring a staff member was in closer proximity to a resident who may be at risk. There have been no residents placed in isolation due to risk of victimization. **115.342 (c):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.3 which states, “Lesbian, gay, bisexual, transgender, or intersex residents shall be placed particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, intersex identification or status as an indicator of likelihood of being sexually abusive”. The auditor interviewed, the PREA Coordinator, and the PREA Compliance Specialist. These interviews confirmed that YRTC-H does not use a resident’s identification as LGBTI as a criterion for making any housing or bed assignment or as an indicator of likelihood of being sexually abusive. The PREA Compliance Specialist stated that the DHHS Facilities Director, the PREA Coordinator, the OJS PREA Compliance Manager, and the Clinical Program Manager will meet to discuss the best placement for transgender or intersex youth based on that resident’s individual treatment needs and safety, not their status – which is the same way housing decisions are made for all youth by the classification team. The auditor interviewed one resident who stated that every girl has their own room and you either are assigned to one cottage or the other, how you identify doesn’t have anything to do with that. **115.342 (d):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.4 which states, “In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the juvenile’s health and safety and whether a placement would the juvenile’s health and safety and whether a placement would present management or security problems”. The auditor interviewed the Facility

	Administrator, the PREA Coordinator, and the PREA Compliance Specialist. They would gather as a group, discuss, and take every factor into account when deciding whether to assign a transgender or intersex resident to a unit for male or female residents. **115.342 (e):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.5 which states that "Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident". The auditor interviewed the PREA Compliance Specialist who stated that there have been no transgender or intersex juveniles within the facility that required a six-month review, but it would be a part of their periodic reassessment process. All residents are reviewed in clinicals weekly and all have a monthly case management meeting to look for any issues in their treatment plan. **115.342 (f):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.6 which states that "A transgender or intersex resident's own views with respect to their own safety shall be given serious consideration". The auditor interviewed the PREA Compliance Specialist who stated that a transgenders or intersex resident's own views with respect to his or her how safety is given serious consideration as is all resident's own views as to their safety. **115.342 (g):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.7 which states, "Transgender and intersex residents shall be given the opportunity to shower separately from other residents". The auditor interviewed the PREA Compliance Specialist who stated that all residents shower separately. **115.342 (h):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.8 which states, "If a resident is isolated pursuant to paragraph 6.2.2.4.2 of this section, the facility shall clearly document the basis for the facility's concern for the resident's safety; and the reason why no alternative means of separation can be arranged". The auditor interviewed administrators who stated that if isolation is used, it would always be a last resort. They typically move a resident to the alternate housing unit. They prefer to use closer supervision by staff. The auditor interviewed the nurse regarding isolation, and she stated that she does a round into the girls housing units everyday regardless. The Clinical Program Manager stated that they check on them a minimum of every 24 hours. Probably more than that as they assign a regular therapist to work with them to help develop a safety plan. There have been no residents placed in isolation due to risk of victimization. **115.342 (i):** The auditor reviewed SOP #199 – Classification in paragraph 6.8.5.9 which states, "Every 30 days, the facility shall afford each resident described in paragraph 6.2.2.4.7 of this section a review to whether there is a continuing need for separation from the general population." Administrators, staff and mental health staff consistently stated that all youth are assessed on a weekly basis and on a monthly basis. No one would be in isolation for 30 days. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #199, the PREA Assessment form, Classification

	Minutes, the resident roster with housing assignments and through multiple interviews as listed above.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 3. End the Silence brochure 4. Posters 5. Staff training documents 6. Resident training documents **Interviews Conducted:** 1. PREA Coordinator 2. PREA Compliance Specialist 3. Child Protective Services External Reporting Entity 4. Ombudsman's Office 5. Inspector General for Child Welfare 6. 12 random staff 7. 15 random residents **Findings by Provision:** **115.351 (a):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.1 which states, "Juveniles may privately report to any facility staff, including those who are not immediate point-of-contact line staff members, incidents of sexual abuse, sexual harassment, retaliation by other juvenile or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to such incidents". The auditor interviewed staff and residents and toured the facility. The auditor interviewed residents who provided multiple ways that they could report internally. Most youth stated that they would tell their staff. They can always ask to talk to staff in private. Some youth stated they could write a grievance and that they could direct the grievance to a specific staff member including the Facility Director. Both from observations and through interviews with the residents it is apparent they have a lot of trust in their staff to help them with whatever the concern may be. The auditor interviewed the Facility Administrator, the PREA Coordinator, and the staff and reviewed the training materials provided to the residents and the posters displayed throughout the facility. Residents can report in the following ways: a facility staff member, counselor, teacher, or medical professional. They can also use the facility grievance system or just write it on a note. Residents consistently stated that they had access to a pencil and paper.

115.351 (b): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.4.1 which states, “Juveniles may report incidents of sexual abuse or harassment to the Child Abuse/Neglect Hotline through the youth inmate calling system and will be allowed to remain anonymous. These calls are not recorded. Upon receiving these reports, the Child Abuse/Neglect Hotline will immediately forward these reports to the OJS administrative team”. SOP lists the address and phone number and states that juveniles will be allowed a state stamp for communication with the Child Abuse/Neglect Hotline.

The auditor interviewed residents who were able to list the methods as stated in policy. Residents stated they have regular contact with their family and attorney and stated they can report to any third party to make a report on their behalf. They were aware of the ability to call externally to the Nebraska Ombudsman’s Office or Children’s Protective Services (CPS) CPS’s Child Abuse/Neglect Hotline from a resident phone. The auditor made a test call from a youth dayroom phone to the CPS Child Abuse/Neglect Hotline by dialing the call according to the directions on the poster that does not require a Personal Identification Number (PIN). The auditor spoke with a CPS worker who stated that they would allow the youth to remain anonymous. They would generate a report and enter into the system. If the allegation involves a staff member, to keep the report confidential when the reporting goes forward to the facility administration. The auditor also dialed the Nebraska State Ombudsman’s office using a resident PIN. That number has been set up to not record the call or record the information about the call on the phone software. The PREA Coordinator provided the auditor with a printout from their phone service software for the time the auditor placed the call. The number called was not on the report and it showed that it was a free call.

The auditor had a more detailed, private conference call with a Deputy Ombudsman from the Nebraska Ombudsman’s office and the Office of the Inspector General (IG) for Child Welfare. They reported that they would look into complaints regarding the facility. They emphasized that the actual investigations are left up to law enforcement, but they look into allegations brought to their attention to ensure that the staff followed their policy and procedures. The IG stated that data and information from the YRTC’s has to be reported to them for oversight purposes including PREA cases that are substantiated and any critical incidents. Outgoing mail addressed to the Child Abuse/Neglect Hotline or the Ombudsman’s office is confidential and not opened by facility staff. Telephone calls to these agencies are free and not recorded.

115.351 (c) and (e): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.2.1 which states, “Staff will accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports”. The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.2.1 which states, “Staff have an obligation to report any sexual abuse and sexual harassment of juveniles but may do so privately to the facility investigator and the Facility Administrator”. The auditor interviewed residents and staff who confirmed the policy is followed through procedures.

	The auditor interviewed staff who stated that they would immediately report the incident to the Facility Administrator. They would document any verbal reports right away but before the end of their shift. Staff stated that they can privately report sexual abuse and sexual harassment to either the Facility Administrator, the Associate Director, or to the PREA Coordinator. The auditor interviewed the administrators and staff who stated that staff accept reports any way that it is reported. **115.351 (d):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.7.3.1 which states, “Staff members will provide juveniles the tools necessary to make a written report. If writing utensils are not available to a juvenile due to their behavior, they will be allowed to have access to these utensils as soon as they are not a threat to themselves or others”. The auditor interviewed staff and residents who stated that residents have access to pencils and paper. The residents each have a box that contains their personal things which includes pens and paper. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of posters, and training materials for both staff and residents, and through interviews with the PREA Coordinator, the PREA Compliance Specialist, staff and residents. The auditor is confident that residents at this facility are aware that if they need to use an external reporting entity, they have multiple options through the CPS reporting line, the Ombudsman’s office, or their family.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 3. Youth Handbook 4. Parent Handbook 5. PREA Poster 6. Staff Training materials 7. Resident training materials 8. End the Silence brochure **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. 12 Random staff 4. 15 Random residents **Findings by Provision:** **115.352 (a):** YRTC-H is not exempt from this standard as it does have

	administrative procedures to address resident grievances regarding sexual abuse. The auditor interviewed the Facility Administrator and the PREA Coordinator who stated that residents can file a grievance or administrative remedy regarding allegations of sexual abuse or sexual harassment. All allegations of sexual abuse or sexual harassment when received by staff, would immediately result in an administrative or criminal investigation. While on the tour the auditor took photos of the grievance box with grievance forms which were right next to the phone and the outgoing mailbox. **115.352 (b):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.3 which states, “A time limit will not be imposed as to when a juvenile may submit a grievance regarding an allegation of sexual abuse”. The policy goes on to state that grievances that do not allege an incident of sexual abuse must be filed within the time parameters noted in SOP 116.1 Juvenile Rights relating to the formal grievance process. Paragraph 6.8.4 states that, “An informal grievance process should not be used by juvenile to resolve any issues with staff relating to an alleged incident of sexual abuse”. The auditor interviewed the Facility Administrator and the PREA Coordinator, reviewed the grievance policy and the resident handbook. The auditor spoke with residents about using the grievance process and they were aware of this option and new about the box. **115.352 (c):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.2 which states, “Juveniles who allege sexual abuse may submit a grievance without submitting to a staff member who is the subject of the complaint, nor will that staff member be allowed to review the grievance”. **115.352 (d):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.5 which states, “A final decision on the merits of any portion of a grievance alleging sexual abuse shall be issued within 90 days of the initial filing of the grievance.” The policy continues to state that computation of the 90-days does not include time in preparing any administrative appeals and an extension of time to respond, of up to 70 days, may be utilized, if the normal time period of response is insufficient to make an appropriate decision. The juvenile will be notified in writing of any such extension and provided a date by which a decision will be made. At any level of the administrative process, including the final level, if the juvenile does not receive a response with the time allotted for reply, including any properly noticed extension, the juvenile may consider the absence of a response to be a denial at that level. **115.352 (e):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.5.4 which states, “Third parties, including fellow juveniles, staff members, family members, attorneys, and outside advocates, shall be permitted assist juveniles in filing request for administrative remedies relation to allegation of sexual abuse, and shall also be permitted to file such request on behalf of juveniles”. The policy continues to state that if a third party, other than a parent or legal guardian, files such a request on behalf of a juvenile, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on their behalf and may also require the alleged victim to personally pursue any

	subsequent steps in the administrative remedy process. If the juvenile declines to have the request processed on their behalf, the juvenile's decision shall be documented. The auditor reviewed the Parent Handbook which states on page 6 that, "As parents, grandparents, and legal guardians you are encouraged to report if your youth for whom you serve as guardian reports to you that they have been sexually harassed or sexually abused. We ask that you call the DHHS Abuse / Neglect Hotline at 1-800-652-1999. Like you, YRTC-H wants to provide the safest possible environment for the youth we serve". The auditor conducted a test call to CPS – the Abuse and Neglect Hotline. **115.352 (f):** "The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.1 which states, "Juveniles shall be allowed to file an emergency grievance to staff if the juvenile alleges, they are at substantial risk of imminent sexual abuse". The policy continues by stating that if a juvenile is subject to a substantial risk of imminent sexual abuse, the YRTC at which the juvenile is placed shall take immediate action to protect the juvenile. Upon receiving an emergency grievance, staff will immediately contact the Youth Security Supervisor (YSS), or the Behavioral Technician Lead (BTL) on shift so that immediate action may be taken. Paragraph 6.8.1.3 states, "An initial response within 48 hours shall be provided to the juvenile, and a final decision will be provided within 5 calendar days, which shall indicate whether the juvenile is in substantial risk of imminent sexual abuse and the action taken in response to the emergency report". The auditor spoke with the Facility Administrator who described the process. If an emergency grievance is filed, the first response will be to make sure that the resident is safe by separating the resident from the threat. They will then gather the details and begin the investigation process and will provide an initial response to a resident immediately, but well within 48 hours. A final response will be given to a resident within 5 days. The PREA Compliance team will be involved in this process. **115.352 (g):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.8.6 which states, "If it is determined that a juvenile filed a grievance in bad faith, the Compliance Specialist will work with the juvenile's treatment team to determine the appropriate consequences". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of grievances, a review of the Youth Handbook, a review of PREA posters, and training materials for both staff and residents, and through interviews with the Facility Administrator, the PREA Coordinator, staff and residents.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

Documents Reviewed:
1. Pre-Audit Questionnaire
2. SOP #1252 – PREA Treatment
3. SOP #1129 – Privileged Communication
4. Family Advocacy Network Posters

Interviews Conducted:
1. Facility Administrator
2. PREA Coordinator
3. Family Advocacy Network Director
4. 15 random residents

Findings by Provision:
115.353 (a): The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.2.6 which states, “All juveniles will be provided access to outside victim advocates for emotional support services related to sexual abuse”. The policy and the Family Advocacy Network (FAN) posters that are located in all juvenile housing areas list the Family Advocacy Network address and phone number. The auditor spoke with the Director for the Family Advocacy Network, who stated that they will provide advocacy services as well as confidential support services to youth at this facility.

115.353 (b): The auditor interviewed the PREA Coordinator stated that the facility will enable reasonable communication between residents and FAN in as confidential a manner as possible. These procedures were confirmed by speaking with both staff and residents. Residents can either call from a resident phone in the dayroom or ask their case manager for a private call in an office.

115.353 (c): The auditor reviewed the Memorandum of Understanding (MOU) that the YRTC-H facility entered into with the FAN. The MOU outlines the services such as providing an advocate that can accompany and support the victim through the forensic medical examination process and investigatory interviews and provide confidential emotional support, crisis intervention, information, and referrals.

115.353 (d): The auditor reviewed the SOP #222 – Privileged Communication in paragraph 6.1 states, “Juveniles have access to counsel, confidential contact with attorneys, their authorized representatives, the courts, and to legal material. Contact includes, but is not limited to telephone communications, uncensored correspondence, and visit”. Paragraph 6.2 states, “Juveniles send sealed letters to a specified class of persons and organizations including but not limited: courts, counsel officials of the confining authority, administrators of grievance systems, and members of the releasing authority”. Paragraph 6.4.1 states, “The youth counselor I, or other supervisory staff, assist juveniles in making confidential contact with attorneys and their authorized representative, probation officer, children and family services case workers, and other judicial affiliates”. Paragraph 6.4.2 states, “Persons who are afforded confidential contact with a juvenile must include a juvenile’s attorney, committing Judge, Guardian Ad Litem, probation officer, children and family services case workers, any representative of the Office of the Public Counsel, any representative of the Office of Inspector General for Child Welfare, Office of

	Juvenile Services administrator, and any Nebraska state senator". In addition, SOP # 224 in paragraph 6.3 states, "The youth counselor I will verify the phone number(s) on the calling system form by confirming with the juvenile's probation officer. Only parents, grandparents, siblings, and guardians are allowed to be called, unless approval is received from administration for other numbers to be entered". The auditor also reviewed the youth handbook and spoke with residents who stated that they can speak with their staff to set up an appointment with their attorney and others at any time. Youth stated that they are given 60 minutes per week to speak with their family and typically speak with their family every day. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, SOP #1129, and the MOU with FAN, and through interviews with the Facility Administrator, the PREA Coordinator, FAN Director, and residents.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 3. Information on DHHS website 4. End the Silence brochure 5. Parent Handbook **Interviews Conducted:** 1. Facility Administrator 2. PREA Compliance Specialist 3. 15 random residents **Findings by Provision:** **115.354:** The auditor reviewed the Nebraska DHHS website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx. The website provides in big, bold information the Adult & Child Abuse & Neglect Hotline (800) 652-1999. Also, the Parent Handbook and the Youth Handbook are available on the website as well. These publications provide information on how an individual can make a third-party report. Methods include agency and facility leadership, Child Protective Services, and Nebraska Ombudsman with contact information for each of these. Interviews with staff and residents confirm that third-party reporting options are available. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of the website, by testing some of the third-party reporting options, and through interviews with the PREA Compliance Specialist, and residents.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. Mental Health Informed Consent form 4. YRTC- PREA Reporting Guide for Outside Representatives form **Interviews Conducted:** 1. Facility Administrator 2. PREA Compliance Specialist 3. Nurse 4. Clinical Program Manager 5. 12 Random Staff **Findings by Provision:** **115.361 (a) and (b):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.1 which states, “Staff shall report immediately any knowledge, suspicion, or information they receive regarding an allegation included from the list of 6.4.1.1-14. This shall be done in accordance with the mandatory child abuse reporting laws” The auditor reviewed the list that is referenced in this SOP, and it includes sexual abuse, sexual assault, sexual harassment, retaliation for reporting sexual abuse or sexual harassment, or cooperating with investigations of sexual abuse or sexual harassment and voyeurism. The auditor interviewed the Facility Administrator, the PREA Compliance Specialist, and random staff who consistently stated that all YRTC-H facility staff are required to report immediately any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment. When an allegation of sexual abuse or sexual harassment are reported they are immediately turned over to the Compliance Team who are all trained administrative investigators and reported to Child Protective Services and/or Nebraska State Patrol. **115.361 (c):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.1 which states, “Aside from reporting the incident to Facility Administrator or designee, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary”. **115.361 (d):** The auditor interviewed the nurse and a clinical program manager who stated that they know that if they become aware of any reports of sexual abuse, they are immediately required to report it to Child Protective Services and the Compliance team. All youth sign a Mental Health Informed Consent form at intake that describes their limits to confidentiality to include if they tell them if they are being abused, physically, sexually, or emotionally, or that they have been abused or neglected in the past and this abuse has not been previously reported. The law requires that they file a report with DHHS as required by law.

115.361 (e): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.14.6 which states, “At the conclusion of the administrative investigation of an alleged sexual abuse, the PREA Compliance Specialist or designee will notify the alleged victim’s parent/guardian to inform them that a Hotline call was made, an internal investigation has taken place, and the results of that investigation, unless the facility has official documentation showing that parents/guardian should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim’s caseworker. The victim’s attorney or other legal representative of record within 14 days of receiving the allegation". The auditor interviewed the PREA Compliance Specialist and reviewed the YRTC- PREA Reporting Guide for Outside Representatives. This form documents the contacts made to parents/guardian, caseworkers, attorney, and assigned probation officer.

115.361 (f): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.5.3 which states, “Staff shall immediately contact facility investigators of any knowledge, suspicion, or information they receive or observe regarding incidents of sexual abuse or sexual harassment that occurred at any YRTC or to a juvenile under the care of a YRTC. Retaliation against juveniles or staff who reported such an incident or cooperated with an investigation of sexual abuse or sexual harassment. Any staff neglect/violation of responsibilities that may have contributed to an incident or retaliation. Third party and anonymous reports”.

The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review of the residents' YRTC- PREA Reporting Guide for Outside Representatives, and through interviews with the administrative staff, medical and mental health staff, and random staff.

115.362	Agency protection duties

Auditor Overall Determination: Meets Standard

Auditor Discussion

Documents Reviewed:
1. Pre-Audit Questionnaire
2. SOP #1251 – PREA Prevention

Interviews Conducted:
1. DHHS Facilities Director
2. Facility Administrator
3. 12 Random staff

Findings by Provision:
115.362: The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.11 which states, “At any time, staff learns that a juvenile is subject to a substantial risk of imminent sexual abuse, they will take immediate action to protect the juvenile”.

	The auditor interviewed the DHHS Facilities Director who stated that his expectation is that they make sure that the resident is safe. He expects them to do something immediately by either taking the resident to a safe place or be with them the entire time under direct supervision. Their next step is to report it. The Facility Administrator stated that she expects the staff to immediately remove a resident from the threat -- making whatever adjustments are necessary, call a YSS, and put a safety plan in place. She expects a threat should be treated like the same as first response to a sexual abuse – separate and immediate call the YSS and get me so that we can make some housing decisions. If they need to, they will move someone into a different housing unit. During interviews with staff, their response was also to make sure they were immediately separated and for staff to be vigilant in their supervision. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, and through interviews with the DHHS Facilities Director, the Facility Administrator, and random staff.

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. Email to Facility Administrator 4. Documentation of call to Child Protective Services and facility **Interviews Conducted:** 1. Facility Administrator **Findings by Provision:** **115.363 (a):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.10.1 it states, “If a juvenile was sexually abused while confined at another facility, the YRTC Facility Administrator or designee will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency”. **115.363 (b):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.10.2 it states, “Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation”. **115.363 (c):** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.10.3 it states, “The Facility Administrator will document that it has provided such notification”.

	115.363 (d): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.10.4 it states, “The facility that receives such notification shall ensure that the allegation is investigated”. The auditor interviewed the Facility Administrator. If there is an allegation that a resident was sexually abused while confined in another facility, the Facility Administrator notifies the head of the facility or appropriate office of the agency where the alleged abuse occurred. If such an allegation is received by them from another facility, an investigation will be initiated immediately. Both notifying other agencies and receiving notifications are documented. The Facility Administrator stated that all reports are also reported to the PREA Compliance Team and to the Child Protection Services Abuse and Neglect Hotline. There were two incidents reported regarding sexual abuse that occurred at another facility. The auditor reviewed documentation verifying incidents are reported to the other facility as well as documentation that it was reported to the Child Protective Services hotline. There have been no incidents reported to the YRTC-H facility administrators by other facilities. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, a review incident spreadsheet that documents who the notice was made to and through interviews with the Facility Administrator.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. First Responder reports 4. 6 Investigative Files **Interviews Conducted:** 1. 12 Random Staff 2. Volunteer/Contractor **Findings by Provision:** **115.364 (a)**: The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.11.2.1 which states, “Immediately separate the alleged victim and the abuser. 6.11.2.2 Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. 6.11.2.3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request and ensure that the alleged victim and 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.6.11.3 Staff will immediately contact a

	Youth Security Supervisor (YSS) or a Behavior Tech Lead (BTL) on shift so that immediate action may be taken.6.11.4 Staff will complete the First Responder form6.11.5 The YSS or BTL will then notify the Facility Administrator and the Compliance Coordinator". The auditor interviewed staff who were aware of their first responder duties and could articulate how to implement proper procedures. Staff stated they would first separate the alleged victim and the alleged abuser. The alleged victim would be taken to a more private area. They would encourage the alleged victim to protect any evidence by not washing, brushing teeth, changing clothes, using the restroom, drinking or eating until the physical evidence can be collected by a SANE. They would remove the alleged abuser and again, not allow them to wash, brush teeth, change clothes, use the restroom, drink or eat until the physical evidence can be collected by a SANE. The staff would secure and protect any physical area where there may be evidence to be collected. They will determine if the situation requires immediate involvement of law enforcement or medical personnel and also notify the supervisor. If immediate medical attention is needed, they would call for medical staff, an ambulance, or arrange to take them to the hospital to provide immediate medical care. There have been no instances where the first responder response required. **115.364 (b):** The auditor interviewed a contractor who stated that they are trained to stay with the juvenile until they can turn them over to a YSS to ensure that they don't destroy evidence. There was one incident reported by a non-custody staff, but the alleged incident had happened two weeks prior to the report. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, the First Responder reports, a review of investigative files, and through interviews with the random staff and a contractor.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1252 – PREA Treatment 4. First Responder form **Interviews Conducted:** 1. Facility Administrator 2. Nurse 3. Clinical Program Manager 4. 12 random staff

	Findings by Provision: **115.365:** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 3.3 which states, “When a YRTC has reasonable cause to believe that a juvenile has been subjected to abuse or neglect, including sexual and physical abuse, harassment, or assault, they have a legal and ethical duty to report said abuse/ neglect. Therefore, each YRTC maintains detailed procedures to report these incidents and ensures that follow-up counseling and supervision concerns are addressed. These procedures include the YRTC written plan outlining coordinated actions in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility administration”. The auditor also reviewed the First Responder form which includes a checklist and outlines First Responder duties, the notification processes to include contacting the Youth Security Supervisor on duty, a Compliance Team staff member, and Administration. The form includes a section for compliance staff to document evidence collection documentation. All Compliance Team staff are trained administrative investigators. The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.2 which states, “The compliance Coordinator or designee will contact the Nebraska State Patrol to report incidents of sexual assault. The Compliance Coordinator or designee will facilitate contact between the Nebraska State Patrol and the Family Advocacy Network to arrange for initial intake and transportation arrangements. All subsequent medical and investigative provisions are conducted according to the protocols of the Family Advocacy Network/Child Advocacy Cener, DHHS staff, and/or Nebraska State Patrol officials". The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.2.4 that, “Juvenile victims of sexual abuse will receive timey, 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”. The auditor interviewed the nurse and the clinical program manager who both confirmed that they or their staff will respond to any immediate medical or mental health emergency on the campus. The auditor interviewed the Facility Administrator, the nurse, the clinical program manager, and staff who verified the coordinated actions for the coordinated response plan. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #1252, and the First Responder form, and through interviews with the Facility Administrator, the nurse, the clinical program manager, and random staff.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline 3. SOP #199 – Classification 4. SOP #1279 – Youth Rights **Interviews Conducted:** 1. DHHS Facilities Director **Findings by Provision:** **115.366 (a):** The auditor reviewed SOP #1268 – Employee Discipline in paragraph 6.8.1 which states, “Neither the OJS/YRTCs or any other governmental entity responsible for collective bargaining on OJS/YRTC’s behalf shall entire into or renew any collective bargaining agreement or other agreement that limits OJS/YRTC’s ability to remove alleged staff sexual abusers from contact with juveniles pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted". The auditor interviewed the DHHS Facilities Director and the collective bargaining agreements disciplinary sections. The DHHS Facilities Director stated that there is nothing that would prohibit the Facility Administrator’s ability to remove an alleged abuser from contact with residents. **115.366 (b):** The auditor reviewed SOP #1268 –Employee Discipline in paragraph 6.8.2 which states, “OJS/YRTC shall not restrict the entering into or renewal of agreements that govern: 6.8.2.1 The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions that pertain to the PREA evidentiary standards or PREA disciplinary sanctions for staff as noted in applicable PREA standards. 6.8.2.2.2 Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member’s personnel file following a determination that the allegation of sexual abuse is not substantiated". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, and an interview with the DHHS Facilities Director.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251—PREA Prevention 3. 90 Day Tracking Sheet 4. Protection Against Retaliation – Staff Form

5. Protection Against Retaliation – Youth Form

Interviews Conducted:
1. DHHS Facilities Director
2. Facility Administrator
3. PREA Compliance Manager
4. Case Manager
5. Unit Manager
6. Juvenile who reported sexual abuse

Findings by Provision:
115.367 (a) and (e): The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.7 which states, “The Compliance Specialist will ensure juveniles and staff who report sexual abuse or sexual harassment or who cooperate with the investigation will be protected from retaliation by other juveniles or staff”. The auditor discussed retaliation monitoring with the PREA Compliance Manager who stated that the Case Manager will monitor the conduct or treatment of juveniles, and the Unit Managers will monitor the conduct or treatment of staff. The auditor interviewed a juvenile who reported sexual abuse, and she stated that there was no retaliation. She did not feel safe at first but did later. Both the DHHS Facilities Director and the Facility Administrator stated that they provide appropriate training to staff regarding protective measures against retaliation and ensure that, if necessary, the parties are separated to prevent retaliation.

115.367 (b): The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.8 which states, “Protection measures, such as removal of housing changes/ transfers for juvenile victims or abusers, removal of alleged staff or juvenile abusers from contact with the victim, as well as emotional support services for the juvenile and/or staff who fear retaliation for reporting sexual abuse or sexual harassment will be implemented". The Unit Manager stated when monitoring staff who may have reported another staff, she would check in with them right away and then every two weeks. The YSS assigns the work location. Higher seniority bids for jobs. There is a process and only the unit managers are allowed to give disciplinary action. The Case Manager interviewed stated that their measures would depend on the severity of the incident. The resident who was the alleged perpetrator would always be moved to a different unit, and she would check in with the resident at least every other week. She would watch for bullying.

115.367 (c): The staff interviewed and SOP #1251 both stated that monitoring would continue for a minimum of 90 days but would continue beyond that if needed.

115.367 (d): The staff interviewed stated that they would visit with the juvenile or staff regarding any threats, comments, or actions against them.

115.367 (f): The auditor reviewed SOP #1251—PREA Prevention in paragraph 6.14.10 which states, “Monitoring for retaliation shall terminate if it is determined the allegation is unfounded”.

The auditor determined compliance through a review of the pre-audit questionnaire,

	a review of SOP #1251, a review of the documents listed above, and through interviews with the administrators, the PREA Compliance Manager, a youth Case Manager, and a juvenile who reported sexual abuse.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. 6 Investigative Reports **Interviews Conducted:** 1. Facility Administrator 2. Nurse 3. 12 random staff **Findings by Provision:** **115.368:** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.2.2.5.1 which states, “Juveniles may be confined from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged”. The auditor interviewed the Facility Administrator, the nurse, and staff who all consistently stated that they do not use isolation as protection to keep residents safe from sexual abuse or who suffered from sexual abuse. They will ensure that a resident who is alleged to have suffered sexual abuse will be watched continuously through close staff supervision There have been no juveniles placed in isolation from other residents for protective measures against sexual abuse.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. SOP #1252 – PREA Treatment 4. 6 Investigative Reports 5. Administrative Investigator training certificates 6. Nebraska State Patrol letter

Interviews Conducted:
1. Facility Administrator
2. PREA Coordinator
3. Facility Administrative Investigator

Findings by Provision:
115.371 (a): The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.12.3.1 which states, “To the extent that YRTC conducts its own investigations into allegations of sexual abuse and sexual harassment, shall do so promptly, thoroughly, and objectively for all allegations, inducing third-party and anonymous reports”. The auditor interviewed the Facility Administrator, the PREA Coordinator, and a Facility Administrative Investigator who stated that as soon as they receive the allegation, the investigator from compliance is assigned and immediately begins the investigation.

115.371 (b): The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.1.6 which states, “Only investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to PREA standard 115.334 will conduct the investigation”. The YRTC has six trained facility investigators to conduct administrative investigations. The auditor reviewed specialized training certificates which showed they completed specialized investigator training.

115.371 (c): The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.4 which states, “YRTC investigators shall take measures to secure the scene and protect and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data. Interviews shall be conducted with alleged victims, suspected perpetrators, and witnesses, and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator”. The auditor interviewed the PREA Compliance Specialist who has been specially trained as an administrative investigator. He stated that to the extent they would be responsible for their facility administrative investigations they are trained to gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviews of alleged victims, suspected perpetrators, and witnesses. They will review prior complaints and reports of sexual abuse involving the suspected perpetrator. They are also responsible for gathering, preserving, and reviewing camera footage. The auditor reviewed the investigative reports, and they documented well all evidence gathered through the investigative process.

115.371 (d): The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.8 which states, “An investigation will not be terminated solely because the source of the allegation recants the allegation”. The auditor interviewed the administrative investigator who verified that the investigation would not terminate solely because the resident later recanted the allegation.

115.371 (e): The auditor interviewed the administrative investigator who stated that when interviewing staff, we always tell them they have a right to refuse the interview and can leave at any time. When it is a criminal case, the Nebraska State

	Patrol handles the consultation with the prosecutor before conducting compelled interviews. **115.371 (f):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.6 which states, “The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person’s status as a juvenile or staff. YRTC shall not require a juvenile who alleges sexual abuse to submit to a polygraphy examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation”. The auditor interviewed a facility administrative investigator who stated that he doesn’t base credibility on whether they are a resident or a staff member. During each investigation, credibility is judged on a case-by-case depending on the evidence. He read the Credibility Assessment training document in the PREA Resource Center library for further understanding. They do not use polygraphy examination. The auditor reviewed investigative reports that verify that they look for consistent statements and evidence that supported the credibility of the people interviewed. **115.371 (g):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.10 which states, “Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse. 16.12.11 Administrative investigations shall be documented in a written report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings”. The facility administrative investigator stated that the big factor is looking at camera coverage and looking at who is where. The other items are what is said in the interviews by the residents, what is said by the staff, what does the policy say, and do they all line up. he looks at what the staff were doing at the time of the incident. The auditor reviewed investigative reports. The reports include information on what staff were doing when they review the camera footage and make a statement regarding proper supervision or lack of supervision. The investigator stated that if they find staff’s actions or failures to act during the investigation, they refer them to the Facility Administrator. **115.371 (h):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.2.2 which states, “Criminal investigations conducted by the NSP shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence when feasible”. The auditor interviewed the PREA Coordinator who stated that they will request criminal investigative reports from NSP. **115.371 (i):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.2 which states, “YRTC shall ensure that all allegations of abuse, neglect, sexual harassment, sexual abuse/assault are referred for criminal investigation to the Nebraska State Patrol to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior". Paragraph 6.12.2.3 states, “Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution”. The auditor interviewed the administrative investigator who stated that they will defer to law enforcement when the criminal case is substantiated and referred for

	prosecution. They have had no cases at this facility that were referred for prosecution. **115.371 (j):** The auditor reviewed SOP #1252— PREA Treatment in paragraph 6.4.1 which states, “Each YRTC shall retain written reports from all criminal and administrative investigations for as long as the alleged abuser is incarcerated or employed by a YRTC, plus five years, unless the abuse was committed by a juvenile and applicable law requires a shorter period of retention.” **115.371 (k):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.9 which states, “The departure of the alleged abuse or victim from a YRTC shall not provide a basis for terminating an investigation”. The Facility Administrative Investigator stated that investigations are completed regardless of whether the staff member was still employed, or the resident was still housed at the facility. **115.371 (l):** The auditor reviewed the letter from the Nebraska State Patrol, Superintendent of Law Enforcement and Public Safety which states, “Investigations will be conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Nebraska State Patrol Investigators have received specialized training in sexual abuse investigations involving juvenile victims. The Nebraska State Patrol will not terminate an investigation solely because the source of the allegation recants the allegations. Investigations conducted by the Nebraska State Patrol will continue to be mindful and consistent with the PREA standards for juvenile facilities”. **115.371 (m):** The auditor reviewed SOP #1251— PREA Prevention in paragraph 6.12.2.1 which states, “When the Nebraska State Patrol (NSP) or other outside agencies investigate sexual abuse, all staff shall cooperate with investigators and the facilities shall endeavor to remain informed about the progress of the investigation". The Facility Administrative Investigator stated that their role in any investigation led by NSP is to provide whatever assistance they may need and to keep communication open with them to remain informed of the progress of the investigation. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251, SOP #1252, a review of investigative reports, a review of specialized investigator training, and through interviews with the Facility Administrative Investigator.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire

	2. SOP #1251—PREA Prevention 3. 6 Investigative Reports **Interviews Conducted:** 1. Administrative Investigator **Findings by Provision:** **115.372:** The auditor reviewed SOP #1251 – PREA Prevention in paragraph 6.12.7 which states, “When conducting an investigation, a YRTC shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated”. The auditor interviewed the administrative investigator and reviewed investigative reports and was satisfied that this facility uses no standard higher than a preponderance of the evidence. He stated that they use a preponderance of evidence which means that more than likely to have occurred – more than 50% believed through the evidence that the incident occurred. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1251 and the administrative investigation reports, and through an interview with the administrative investigator.

115.373	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment 3. 6 Investigative Reports 4. 6 Outcome to Resident forms **Interviews Conducted:** 1. Facility Administrator 2. PREA Coordinator 3. Administrative Investigator 4. Resident who received an outcome **Findings by Provision:** **115.373 (a):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.1 that, “Following an investigation into a juvenile’s allegation of sexual abuse occurring at a YRTC, the juvenile shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded”. The auditor interviewed the Facility Administrator and an Administrative Investigator who stated that they will deliver in person a form which will have the outcome of the investigation and the resident signs, acknowledging

	that they received the outcome of the investigation. The auditor reviewed notices of the outcome to the residents. **115.373 (b):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.3.1 which states, “If the investigation was conducted by an external agency, the YRTC hall request the relevant information to inform the juvenile”. The auditor interviewed the PREA Coordinator who stated that if the Nebraska State Patrol conducts the investigation, they will obtain the information from them so that they can inform the resident as to the progress of the case and the conclusion. **115.373 (c):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.2 which states, “Following a juvenile’s allegation that a staff member has committed sexual abuse against the juvenile, the juvenile shall be informed following (unless it was determined the allegation is unfounded): 6.3.2.1 If the staff member is no longer posted within the juvenile’s living unit; 6.3.2.2 If the staff member is no longer employed at the facility. 6.3.2.3 If it is known that the staff member has been indicted or convicted on a charge related to sexual abuse within the facility". The auditor reviewed the investigative files and interviewed the Administrative Investigator. There have been no substantiated or unsubstantiated allegations of sexual abuse against staff in which these processes were required. **115.373 (d):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.3 which states, “Following a juvenile’s allegation that they been sexually abused by another juvenile, the juvenile shall be informed of the following: 6.3.3.1 If it is known that the alleged abuser has been indicted or convicted on a charge related to sexual abuse at a YRTC". The auditor reviewed the investigative files and interviewed the Administrative Investigator. There have been no substantiated or unsubstantiated allegations against residents in which the resident abuser was indicted or charged. However, there were incidents in which sexual touching was substantiated, and the resident was notified of the outcome of the investigation. **115.373 (e):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.4 that, “All such notifications or attempted notifications shall be documented”. The auditor reviewed notices to residents in which the residents signed that they received the outcome of the investigation **115.373 (f):** The auditor reviewed SOP #1252 – PREA Treatment which states in paragraph 6.3.4.1 that, “YRTC’s obligation to report shall terminate if the juvenile is released from a YRTC”. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, a review of the investigative reports, and notice of the outcomes to the residents, and through interviews with the Facility Administrator, an Administrative Investigator, and a resident who received an outcome notice.

115.376	**Disciplinary sanctions for staff**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline 3. 6 Investigative Reports **Interviews Conducted:** 1. Facility Administrator **Findings by Provision:** **115.376 (a):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.1 which states, “Employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies”. **115.376 (b):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.1.1 which states, “Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse”. **115.376 (c):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.2 which states, “Disciplinary sanctions for violations of policy relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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”. **115.376 (d):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.3 which states, “All terminations for violations of sexual abuse and sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement, unless the activity was clearly not criminal, and to any relevant licensing bodies”. The auditor interviewed the Facility Administrator who stated that discipline would be commensurate with the nature and circumstances of the allegation committed, the staff member’s disciplinary history, and comparable incidents, but that termination would be the presumptive discipline for substantiated allegations of sexual abuse. All reports of sexual abuse perpetrated by a staff will be reported to law enforcement, CPS, and any relevant licensing bodies. There were no substantiated or unsubstantiated allegations against staff. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, a review of investigative reports, and through an interview with the Facility Administrator.

115.377	**Corrective action for contractors and volunteers**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1268 – Employee Discipline 3. 6 Investigative Reports **Interviews Conducted:** 1. Facility Administrator **Findings by Provision:** **115.377 (a):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.7.1 which states, “Any contact personnel or volunteer who engages in sexual abuse shall be prohibited from contact with any juvenile and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies”. **115.377 (b):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.7.2 which states, “The OJS and the YRTCs will take appropriate remedial measures and shall consider whether to prohibit further contact with juveniles, in case of any other violation of sexual abuse or sexual harassment policies by contract personnel or volunteers”. The auditor interviewed the Facility Administrator who stated that it would depend on the situation. If it were a serious act involving sexual abuse, they would immediately be removed from the campus and if criminal, contact law enforcement to seek prosecution. There may be a less serious situation where they would always have to be with a YRTC staff. She stated that she can stop contact with residents until the investigation process is complete. Contractors and volunteers are often supervised by staff while providing services to residents within the facility. The auditor reviewed the investigative reports and there were no allegations against contractors or volunteers.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1279 – Youth Rights 3. 6 Investigative Reports **Interviews Conducted:**

1. Facility Administrator

Findings by Provision:
115.378 (a): The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6 which states, “Juveniles may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the juvenile engaged in juvenile-on-juvenile sexual abuse or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse”.

115.378 (b): The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.1 which states, “Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the juvenile’s disciplinary history, and the sanctions imposed for comparable offenses by other juveniles with similar histories. In the event a disciplinary sanction results in the confinement of a juvenile, they will receive Daily large-muscle exercise; Educational programming or special education services; and other programming and work opportunities to the extent possible”. The Facility Administrator stated that discipline would depend on the level of the abuse. Rule infractions mean that a juvenile does not progress in their program, but it could mean a loss of privileges such as loss of canteen or video games, or for criminal acts, they would pursue criminal charges. She stated that isolation is not used for disciplinary sanctions. It would only be used if they are a threat to someone’s safety because their behavior is not under control. But typically, they are placed on one-on-one staff supervision, and they have to keep a certain distance away from other residents.

115.378 (c): The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.2 which states, “The disciplinary process shall consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed”. The auditor interviewed the Facility Administrator who stated that this would always be considered. The whole team meets to discuss. In the case of a resident who may have a mental disability or mental illness, mental health staff will give suggestions for what is appropriate.

115.378 (d): The auditor reviewed SOP #1279 – Youth Rights in paragraph 6.6.6.3 which states, “The juvenile may receive counseling, therapy, or other interventions designed to address and correct underlying reasons or motivations for the abuse”. Paragraph 6.6.6.4 states, “Juveniles may be required to participate in such interventions as a condition to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access general programming or education”.

115.378 (e): The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.6.5 which states, “Juveniles may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact”. The auditor interviewed the Facility Administrator who stated there have been no incidents of this type at the facility.

115.378 (f): The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.7 which states, “A report of sexual abuse made in good faith based upon a

	reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation". **115.378 (g):** The auditor reviewed SOP #1268 -- Employee Discipline in paragraph 6.6.8 which states, "Sexual activity between juveniles is prohibited and juveniles will be disciplined for such activity; however, sexual action will not constitute sexual abuse if it is determined that the activity is not coerced." The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1268, a review of investigative reports, and an interview with the Facility Administrator.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1251 – PREA Prevention 3. Informed Consent form 4. PREA Screening **Interviews Conducted:** 1. Clinical Program Manager 2. Mental Health Staff responsible for screening 3. Resident who has sexual victimization on screening **Findings by Provision:** **115.381 (a) and (b):** The auditor reviewed SOP #1251 – PREA Prevention which states in paragraph 6.2.7 that, "If the screening for Vulnerability, Assaultive, and Sexually Aggressive Behavior tool indicates that a juvenile has experienced prior sexual victimization or previously perpetrated sexual abuse, staff will ensure that the juvenile is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake process". A mental health staff completes the screening process within the first 24 hours of a youth's arrival. If there is any previous sexual abuse history or a history of the perpetration of sexual abuse, this information becomes a part of the mental health file and is discussed with the treatment team. The auditor interviewed the clinical program manager who stated that mental health staff assess all juveniles to determine their treatment needs, and a treatment team meets with the youth during the first week after orientation to discuss their treatment plan with the youth.

	115.381 (c) and (d): The auditor reviewed SOP #1251 – PREA Prevention which states in paragraph 6.2.8 that, “Any information related to sexual victimization will be strictly limited to medical and mental health practitioners and other staff, as necessary, when decisions are made regarding treatment plans, security, and management of the juvenile”. Paragraph 6.2.9 states, “Medical and mental health practitioners shall obtain informed consent from juveniles before reporting information about prior sexual victimization that did not occur in an institutional setting unless the juvenile is under the age of 18”. The clinical program manager stated that all residents sign an informed consent form when they first meet with the mental health staff. This form advises them of their rights concerning confidential information but states that as required by law, they have to report any type of abuse to juveniles. The auditor confirmed that the screening information was either locked in an office or stored on a secure drive in which access is given only to those who need to know the information and password protected.

115.382	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #168 – Emergency Medical Care **Interviews Conducted:** 1. Clinical Program Manager 2. Nurse Administrator 3. First Responders **Findings by Provision:** **115.382 (a):** The auditor reviewed SOP #168 -- Emergency Medical Care in paragraph 6.6.1 which states, “Resident victims of sexual abuse shall 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”. **115.382 (b):** The auditor reviewed SOP #168 -- Emergency Medical Care in paragraph 6.6.2 which states, “If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to 115.362 and shall immediately notify the appropriate medical and mental health practitioners”. **115.382 (c):** The auditor reviewed SOP #168 - Emergency Medical Care in paragraph 6.6.3 which states, “Resident victims of sexual abuse while incarcerated

	shall be offered timely information and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate". **115.382 (d):** The auditor reviewed SOP #168 -- Emergency Medical Care in paragraph 6.6.4 which states, "Treatment services shall be 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". The auditor reviewed SOP #168 and interviewed the nurse, the clinical program manager, and first responders. The nurse and mental health staff can provide immediate medical care and crisis intervention services, but if more critical care is needed the resident would be transported to the hospital or an ambulance called. Both the nurse and the clinical program manager stated that their personal judgement at that facility would be followed.

115.383	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #166 – Availability of Health Care **Interviews Conducted:** 1. Nurse 2. Clinical Program Manager **Findings by Provision:** **115.383 (a):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.1 which states, "The facility shall 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". **115.383 (b):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.2 which states, "The evaluation and treatment of such victims shall 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". **115.383 (c):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.3 which states, "Staff shall provide such victims with medical and mental health services consistent with the community level of care".

	115.383 (d): YRTC-H is an all-female facility. The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.4 which states, “Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests”. **115.383 (e):** YRTC-H is an all-female facility. The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.5 which states, “If pregnancy results from conduct specified in paragraph 6.3.7.4 of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services”. **115.383 (f):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.6 which states, “Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate”. **115.383 (g):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.7 which states, “Treatment services shall be 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”. **115.383 (h):** The auditor reviewed SOP #166 – Availability of Health Care in paragraph 6.4.7.8 which states, “The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners”. The auditor reviewed SOP #166 and interviewed the nurse and clinical program manager who stated that ongoing medical and mental health evaluations and treatment are offered at no cost to sexual abuse victims and abusers. The nurse or the mental health staff would follow up to ensure that follow-up services recommended by the providers would be continued. These staff stated that the level of care provided is consistent with the community level of services, if not better than what some juveniles receive when in their home communities. The nurse stated that they are taking care of whatever needs to be don immediately.

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #1252 – PREA Treatment 3. 6 Incident Review forms 4. 6 Investigative Reports

Interviews Conducted:
1. Facility Administrator
2. PREA Coordinator
3. PREA Compliance Specialist

Findings by Provision:
115.386 (a): The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.1 which states, “A sexual abuse incident review will be conducted 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”.

115.386 (b): The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.2 which states, “Sexual abuse incident reviews will occur within 30 days of the conclusion of the investigation”.

115.386 (c): The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.1 which states, “Sexual abuse incident reviews will be conducted by a review team including upper-level management, with input from line supervisors, investigators, and medical or mental health practitioners".

115.386 (d): The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.3 which states, “The review team shall consider the following during the review: 6.5.4.1 Whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. 6.5.4.2 Whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. 6.5.4.3 Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse. 6.5.4.4 Assess the adequacy of staffing levels in that area during different shifts. 6.5.4.5 Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff".

115.386 (e) The auditor reviewed SOP #1252 – PREA Treatment in paragraph 6.5.5 which states, “The review team will prepare a report of its findings, including but not necessarily limited to the criteria listed above and any recommendations for improvement. The report will be submitted for the Facility Administrator and filed with the Compliance Specialist. 6.5.5.1 The facility shall implement the recommendations for improvement or shall document its reasons for not doing so”.

The auditor reviewed the documentation of six incident reviews. The YRTC-H uses a form to complete their incident review. The form has headings to trigger discussion on the motivation for the incident and has a required explanatory section so that it is not a “check the box” form. The form includes areas for discussion on the area where the incident occurred and changes that may be needed in policy or practice. The managers documented meaningful discussion on the incident review forms related to the specifics of the sexual abuse incidents.

	Reviews were completed within 30 days of the investigation and all the required components of the standard were considered. Although it is commendable that they would review substantiated sexual harassment incidents as well, this is not required by the standard. The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #1252, a review of 6 investigative reports, and six sexual abuse incident reviews, and through interviews with the Facility Administrator, the PREA Coordinator, and the PREA Compliance Specialist.

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information Systems 3. 6 Investigative Reports 4. 2023 Annual Report with aggregate data 5. 2024 aggregate data up to October 2024 **Interviews Conducted:** 1. PREA Coordinator **Findings by Provision:** **115.387 (a):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Accurate and uniform data will be collected for every allegation of sexual abuse at facilities using a standardized instrument and set of definitions”. **115.387 (b) and (d):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Available reports, investigation files, and sexual abuse incident reviews will be used to collect data. This data will be maintained, reviewed, and totaled at least annually”. **115.387 (c):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Data collected shall 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.” **115.387 (e):** The auditor interviewed the PREA Coordinator who stated that they do not contract for the confinement of their residents with another agency. **115.387 (f):** The auditor reviewed SOP #681 – Management of Information Systems in paragraph 6.2.1.1 which states, “Upon request, all data from the

	previous calendar year shall be reported to the Department of Justice no later than June 30th". The PREA Coordinator provided aggregate annual data for 2023 and 2024 up through the October audit date. The data included the number of allegations by type and outcome. The aggregated data for 2023 is also included in their annual report. The facility does not contract for the confinement of its residents. They have provided data to the Department of Justice in the Survey of Sexual Violence when requested.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information System 3. 2023 Annual reports with aggregate data **Interviews Conducted:** 1. DHHS Facilities Director 2. PREA Coordinator 3. OJS Compliance Manager 4. PREA Compliance Specialist **Findings by Provision:** **115.388 (a):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, "All data shall be reviewed in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. This should include identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions". **115.388 (b):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, "The annual report should include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the facility's progress in addressing sexual abuse". **115.388 (c):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, "The annual report shall be approved by the Facility Administrator and made readily available to the public through its website". **115.388 (d):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.2.1 which states, "The facility may redact specific material from the annual report when publication would present a clear and specific threat to the

	safety and security of a facility but must indicate the nature of the material redacted". The auditor interviewed the DHHS Facilities Director who stated that he reviews and approves the annual report before it is posted on the agency website where it is made readily available to the public through their website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx. The auditor discussed the aggregate data and the annual report with the PREA Coordinator, the OJS Compliance Manager, and the PREA Compliance Specialist and reviewed the annual report which has no redacted information. The YRTC-H facility's annual report is well written and meets the standard by containing information that discusses the effectiveness of their sexual abuse prevention, detection, and response policies, practices, and training, including identifying problem areas and taking corrective action on an ongoing basis.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. SOP #681 – Management of Information System 3. 2023 Annual report with aggregate data **Interviews Conducted:** 1. PREA Coordinator **Findings by Provision:** **115.389 (a):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, "All data collected will be securely retained". **115.389 (b) and (c):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, "Totaled data will be made readily available to the public at least annually through its website. All personal identifiers will be removed". **115.389 (d):** The auditor reviewed SOP #681 – Management of Information System in paragraph 6.2.3.1 which states, "Data will be maintained for at least 10 years after the date of its initial collection unless Federal, State, and local law requires otherwise". The auditor determined compliance through a review of the pre-audit questionnaire, a review of SOP #681, conversations and observation of previous information stored, and the 2023 annual report with the aggregate data and through interviews with the PREA Coordinator.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. DHHS website 3. Campus maps **Findings by Provision:** **115.401 (a) and (b):** There are three facilities operated by the Nebraska DHHS Office of Juvenile Services that require a PREA Audit – YRTC- Kearney, YRTC-Hastings, and YRTC-Lincoln. The first audit was conducted for YRTC-Kearney in October 2015, the second in October 2018, the third in October 2021, and the fourth in October 2024. The first audit for the girls' facility was for the YRTC-Geneva facility in October 2015 and the second in October 2018. The Geneva facility closed in 2019 and for a short time, some of the girls were at the Kearney facility until their new buildings on the Hastings campus could be completed. The YRTC-Hastings campus opened in 2021, and their third audit was completed in October 2021. The YRTC-Lincoln facility opened in 2020, and their first audit was completed after one year of operation in January 2021. The YRTC-Lincoln's second audit was completed in January 2024. These facilities have consistently been audited every three years since they began their compliance efforts with their first audits in 2015. The original two facilities began their compliance efforts in year three of the first audit cycle and continue to audit in year three of each audit cycle. The Lincoln facility opened in January 2020 and conducted its first audit after one year of operation in January 2021. For this reason, they do not audit one facility in each year of every three-year audit cycle. **115.401 (h):** The auditor had complete access and observed operations in every area of the facility. The auditor conducted a tour of the facility on the first day which included every area of the facility including administrative areas, the two resident housing units, the program building which includes the classrooms, and the kitchen and dining hall, the chapel/gym. **115.401 (i):** The auditor was permitted to request and receive copies of any relevant documents (including electronically stored information). The auditor requested many documents throughout the audit process. The YRTC-H facility provided numerous copies of documents to include policies, resident screenings, human resource documentation, forms, and investigative information. There organization of the information provided to the auditor was exceptional. **115.401 (m):** The auditor conducted private interviews with staff and residents in a conference room that was provided for this purpose. The YRTC-H facility staff were very cooperative throughout the audit process. **115.401 (n):** The residents were permitted to send confidential information or

	correspondence to the auditor in the same manner as if they were communicating with legal counsel. The auditor did not receive any confidential correspondence. The auditor received photographs of the audit notice posted throughout the facility with the auditor's contact information and verified it was posted while on the facility tour. The auditor determined compliance through a review of the pre-audit questionnaire, a review of previous PREA Audits, a very thorough tour, and a review of numerous documents.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Documents Reviewed: 1. Pre-Audit Questionnaire 2. DHHS website **Findings by Provision:** **115.403 (f):** This is the fourth audit for the girls' program. Their audits have always been conducted in October of 2015, 2018, 2021, and now 2024. These audits as well as those of the Kearney and Lincoln facilities are posted on the DHHS website at https://dhhs.ne.gov/Pages/YRTC-Facilities.aspx.

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	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	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	yes

	functions of the facility? (N/A for non-secure facilities)	
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	yes

	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?	
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:	yes

	Residents who have speech disabilities?	
	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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
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	**Hiring and promotion decisions**	

(c)		
	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	yes

	employees?	
	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.)	na
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 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.)	yes
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	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	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.)	yes
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	yes

	the agency attempt to ascertain information about: Age?	
	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	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
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	yes

	making facility and housing placement decisions and programming assignments?	
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	yes

	entity or office that is not part of the agency?	
	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.	yes
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.)	na
	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.)	na
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	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
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	yes

	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?	
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	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	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	yes

	accordance with these standards?	
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	yes

	of sexual abuse, does the agency: Act promptly to remedy any such 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: 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	**Criminal and administrative agency investigations**	

(f)		
	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	yes

	does not provide a basis for terminating an investigation?	
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	yes

	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?	
	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	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
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	yes

	cooperates with any investigation arising out of the incident?	
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	yes

	the confinement of its residents.)	
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	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
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.)	na

	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

American Correctional Association

ACCREDITATION REPORT

Commission on Accreditation for Corrections

Nebraska Department of Health and Human Services
Youth Rehabilitation and Treatment Center- Hastings
Hastings, Nebraska

The mission of the Commission on Accreditation for Corrections is to upgrade and improve practices and conditions in adult and juvenile correctional facilities and programs through an accreditation process which is founded on a commitment to accountability, professionalism and respect for basic human rights and which recognizes sound and effective correctional practices, while striving towards excellence in the field of corrections.

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September 11, 2025

Nebraska Department of Health and Human Services
Youth Rehabilitation and Treatment Center- Hastings
Hastings, Nebraska

Congratulations!

It is a pleasure to officially inform you that the Youth Rehabilitation and Treatment Center- Hastings was accredited by the Commission on Accreditation for Corrections at the 155th Congress of Correction on August 23, 2025, in Denver, Colorado.

Your accreditation represents the satisfactory completion of a rigorous self-evaluation, followed by an outside review by a team of experienced, independent auditors.

Every profession strives to provide a high quality of service to society. To know that you, your staff, and other officials are complying with the requirements of the accreditation process is indeed a statement of a high level of commitment to the staff and people under your care.

On behalf of the American Correctional Association and the Commission on Accreditation for Corrections, thank you for your commitment to the corrections profession and to the accreditation process.

Sincerely,

TJ Stickrath

Thomas Stickrath, Chairperson
Commission on Accreditation for Corrections

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American Correctional Association
Advance. Connect. Achieve.

FOR IMMEDIATE RELEASE

Youth Rehabilitation and Treatment Center- Hastings Awarded National Accreditation

Thomas Stickrath, Chairperson of the Commission on Accreditation for Corrections (CAC), and David Haasenritter, Director of Standards and Accreditation, American Correctional Association recently announced the accreditation of the Youth Rehabilitation and Treatment Center- Hastings. The award was presented in conjunction with the American Correctional Association 155th Congress of Correction on August 23, 2025, in Denver, Colorado.

In presenting the award, Thomas Stickrath, Chairperson of the CAC, and Ricky Dixon, President of the American Correctional Association (ACA), complimented the facility on their professional level of operation and their success in completing the accreditation process. The agency is one of over 1,265 correctional organizations currently involved in accreditation across the nation.

The accreditation program is a professional peer review process based on national standards that have evolved since the founding of the Association in 1870. The standards were developed by national leaders from the field of corrections, law, architecture, health care, and other groups who are interested in sound correctional management.

ACA standards address services, programs, health care and security operations essential to effective correctional management. Through accreditation, an agency can maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Standards set by ACA reflect practical up-to-date policies and procedures and function as a management tool for agencies and facilities throughout the world.

The three-year accreditation award granted to the Youth Rehabilitation and Treatment Center-Hastings does not signal the end of their involvement in the accreditation process. During the award period, staff will work to improve any deficiencies identified during the audit and maintain continuous compliance with the standards.

FOUNDED 1870

American Correctional Association

Advance. Connect. Achieve.

Congratulations on your accreditation award! You are now a member of the elite in achieving correctional excellence. The certificate you have received is but a small symbol of the enormous dedication and commitment demonstrated by each and every member of your staff to the accreditation process, and I urge you to display it prominently as a continual reminder of the level of professionalism achieved. This is just the beginning of your journey, however, for the true test of excellence is the test of time. It is critical that your operation be able to sustain this achievement over time and be constant through both prosperity and adversity.

Achieving American Correctional Association Accreditation means you have demonstrated your dedication to getting the job done right, and that you are holding your agency to a higher standard.

Thank you for your commitment to the American Correctional Association and the accreditation process.

David Haasenritter, Director
Standards and Accreditation Department
American Correctional Association

Overview of the American Correctional Association

The American Correctional Association (ACA) is a professional membership organization composed of individuals, agencies and organizations involved in all facets of the corrections field, including adult and juvenile services, community corrections, probation and parole and jails. It has thousands of members in the United States, Canada and other nations, as well as over 100 chapters and affiliates representing states, professional specialties, or university criminal justice programs. For more than 150 years, ACA has been the driving force in establishing national correctional policies and advocating safe, humane and effective correctional operations. Today, ACA is the world-wide authority on correctional policy and expected practices, disseminating the latest information and advances to members, policymakers, individual correctional workers and departments of correction. ACA was founded in 1870 as the National Prison Association and became the American Prison Association in 1907.

At its first meeting in Cincinnati, the assembly elected Rutherford B. Hayes, then governor of Ohio and later U.S. president, as the first president of the association. At that same meeting, a *Declaration of Principles* was developed, which became the accepted guidelines for corrections in the United States and Europe. At the 1954 annual Congress of Correction in Philadelphia, the name of the American Prison Association was changed to the American Correctional Association, reflecting the changing philosophy of corrections and its increasingly important role in society.

Since that time, ACA has continued to take a leadership role in corrections and work toward a professional unified voice in correctional policy. In recent years, one of the Association's major goals has been the development of national and international policies and resolutions of significant issues in corrections. Policies are considered for ratification at the Association's two annual conferences and ratified policies are then widely disseminated. Since its formation, ACA has also had a major role in designing professional standards, and more recently performance based standards and expected practices, for correctional organizations. Since the early 1980s ACA has been involved in a program of accreditation to recognize programs representing excellence in more than 20 different disciplines within the field, with emphasis on evidenced based practices.

Membership in ACA is open to any individual, agency, or organization interested in corrections and the purposes and objectives of the Association. Members include the majority of state, local, provincial, and territorial correctional agencies, individual correctional institutions, local jails, pretrial programs and agencies, juvenile justice programs, schools of criminal justice in colleges and universities, libraries, and various probation, parole, and correctional agencies. Many of ACA's members are employed at federal, military, private, state, and local agencies. Members also include volunteers affiliated with these agencies as service providers or as members of advisory boards and committees.

Organizational Purposes of the American Correctional Association

Among the most significant purposes of the Association as outlined in its Constitution, are:

- ➢ *To provide a professional association of persons, agencies, and organizations, both public and private, who hold in common the goal of improving the profession of corrections and enhancing their contribution to that profession.*

- ➢ *To broaden and strengthen support for the Association's goals by advocating Association policies, resolutions, positions, and standards to policymakers and the public and by forming coalitions with other professional organizations sharing these goals.*

- ➢ *To develop standards for all areas of corrections and implement a system for accreditation for correctional programs, facilities and agencies based on these standards. Where feasible, standards shall be based on performance outcome.*

- ➢ *To conduct or sponsor corrections conferences, congresses, institutes, forums, seminars and meetings.*

- ➢ *To publish and distribute journals and other informative materials relating to criminology, crime prevention, and corrections and to encourage and stimulate research of these matters.*

- ➢ *To promote recognition of corrections as a profession, and those who work in corrections as professionals, and to ensure validity of that recognition by encouraging the recruitment and development of highly qualified corrections professionals, and by developing and implementing a certification program for corrections professionals*

In carrying out these purposes, ACA supports programs for policy analysis, demonstration, effective delivery of health services to offender populations and research. ACA also provides testimony, consultation, publications, conferences, workshops, and other activities designed to stimulate constructive action regarding correctional issues.

Organizational Structure of the American Correctional Association

Executive Committee

The Executive Committee is composed of the elected officers of the Association - president, vice president, treasurer, two Board of Governors members, the immediate past president, the president-elect, and the ACA executive director. The Executive Committee meets at least quarterly and exercises most of the powers of the Board of Governors during the intervals between meetings of the board.

Board of Governors

ACA's bylaws vest control of the Association with a 19-member elected Board of Governors composed of the officers of the Association and five at-large members. The 19 elected governors shall general reflect the Association's composition. The following areas of practice shall be represented by at least one board member:

Correctional Administration	Detention
Institutions	Education
Juvenile	Health Care
Probation	Community Programs
Parole, Aftercare or Post-Release Supervision	

Delegate Assembly

The Delegate Assembly is composed of delegates from the professional affiliates, geographical chapters, membership at-large, Board of Governors, past presidents of ACA, and representatives of each military service. The Delegate Assembly can establish policy, define Association positions on broad social and professional issues, and determine major programs and legislative priorities. They meet at least twice annually, at the Winter Conference and Congress of Correction.

Committees

The majority of the Association's activities take place through committees. Each committee chair reports to the Association's Board of Governors at least twice a year. In this way, the Association collectively benefits from the involvement and contribution of the hundreds of individuals who function on the various committees. Ad-hoc committees are appointed by the president of the Association.

Affiliates and Chapters

Affiliates and state chapters are major features of the Association's structure. They represent professional, regional, and state groups across the United States and Canada. Affiliates and chapters contribute to the professional development of all members by providing consultation in their respective areas of interest and by participating in seminars and workshops at ACA's annual conferences.

Major Activities of the American Correctional Association

Standards and Accreditation

Perhaps ACA's greatest influence has been the development of Expected Practices and the accreditation process. ACA Expected Practices address services, programs, and operations essential to effective correctional management. Through accreditation, an agency is able to maintain a balance between protecting the public and providing an environment that safeguards the life, health, and safety of staff and offenders. Expected Practices set by ACA reflect practical up-to-date policies and procedures and function as a management tool for correctional agencies internationally. The Standards and Accreditation Department manage the expected practices for all standards manuals and the accreditation process.

Legislation

The American Correctional Association is involved with all major issues affecting corrections today. Members and ACA staff maintain close working relationships with committees of the U.S. Congress and all federal agencies and groups whose decisions affect correctional policy. Expert testimony on a wide range of correctional issues is prepared for congressional committee and subcommittee hearings, and recommendations are provided to federal administrative agencies.

To ensure that the concerns and issues of the corrections profession are represented in proposed legislation and public policy, ACA's legislative liaison is addressing legislative and government concerns that will impact the corrections profession. ACA has established partnerships between chapters and affiliates and other national policy making organizations to present a strong collective voice for correctional reform throughout the world.

Professional Development

The purpose of the Association's Professional Development Department is to plan, promote, and coordinate professional development through training seminars, workshops, and published materials including curriculums, resource guides, and monographs.

ACA's training plan calls for a variety of professional development activities. Nationally advertised workshops cover topics such as training for trainers, management training, community-based employment programs, and stress management. On-site workshops for state and local departments of corrections are offered in curriculum development, supervision, communications, and report-writing skills.

The *Training for Correctional Staff Trainers* workshops further the skills of correctional professionals qualified to initiate and deliver training. These workshops also enable agencies to comply with national expected practices for accreditation and ensure that training is job- related and professionally developed and presented.

The department also offers correspondence courses to further professional development. More than 6,000 correctional personnel have completed or are in the process of completing ACA's self-instruction training program for correctional officers. This program, developed under the auspices of the National Institute of Corrections, provides 40 hours of basic training in accordance with ACA expected practices. A score of at least 80 percent on the comprehensive examination must be attained to achieve certification. The Association has similar courses available for correctional supervisors, juvenile caseworkers, and food service employees. Additional courses which cover report writing skills, correctional management skills, legal issues for probation and parole officers, and legal issues for correctional officers are also available.

Office of Correctional Health

ACA's Office of Correctional Health serves ACA members, jurisdictions and its affiliates by supporting health services programs for the effective delivery of health to offender populations. We offer comprehensive services, support, and resources to help correctional facilities provide security and quality care for the offender population. The office is responsible for improving ACA's performance-based health care expected practices, trainings and the health certification program. The health certification program includes Nurse, Nurse Manager, Health Services Administrator and Correctional Behavioral Health.

Publications

As one of the leading publishers of practical correctional publications, ACA produces books, videos, and lesson plans. Among the wide ranging subjects available are management, community, security, counseling, law, history, and health. These excellent resources for career advancement appeal to practitioners and scholars alike. Directories for every major sector of corrections are also published by ACA.

The following is just a few of the many publications that ACA offers:

> *Corrections Today* is the major corrections magazine in the United States. Published seven times a year, it focuses on the interests of the professional correctional employee and administrator. Articles include reports of original research, experiences from the field, discussion of public policy, and the perspectives of prominent practitioners and academicians.
>
> *Correctional expected practices* are the most significant improvement in correctional programming. As the basis for accreditation, they give administrators a nationally recognized system for upgrading and improving their correctional services. The Association currently publishes over 20 manuals for every correctional discipline.
>
> To aid in the development of policy with relation to accreditation, *Guidelines for the Development of Policies and Procedures* are available for adult correctional institutions, adult parole authorities/adult probation and parole field services, adult local detention facilities, adult community residential services, juvenile detention facilities, and juvenile training schools.

Conventions

ACA hosts two national conventions each year that attract more than 5,000 professionals from all aspects of corrections; the Winter Conference held in January, and the Congress of Correction, held in August. These events include a variety of workshops, exhibits, and seminars devoted to addressing topics specific to the corrections profession.

Contracts and Grants

The American Correctional Association has a history of successful grant and contract management and administration. ACA has completed contracts and grants of more than $30 million. These diverse initiatives, which are funded through federal and private sources, add to the technical expertise and knowledge of the organization as well as to the total field of corrections.

Overview of the Commission on Accreditation for Corrections

The Commission on Accreditation for Corrections (CAC) is a private, nonprofit organization established in 1974 with the dual purpose of developing comprehensive, national expected practices for corrections and implementing a voluntary program of accreditation to measure compliance with those expected practices.

The Commission was originally developed as part of the American Correctional Association. In 1979, by joint agreement, the Commission separated from the Association in order to independently administer the accreditation program. Between 1978 and 1986, the organizations shared the responsibility for developing and approving expected practices and electing members of the Commission. On November 7, 1986, the Commission on Accreditation for Corrections officially realigned itself with the American Correctional Association.

The Commission is governed by a Board of Commissioners who reflect the Association's composition, including adult and juvenile components; the geographical distribution of its membership; and representation of ethnic and racial minorities, women, and management and non-management staff. The responsibility of rendering accreditation decisions rests solely with the Commission.

They represent the following specific categories:

Correctional Administration
Juvenile
Institutions
Probation
Parole, Aftercare or Post-Release Supervision
Community Programs
Detention
Education
Health Care
Legal

Association Staff

Accreditation activities are supported by the staff of the American Correctional Association, Standards and Accreditation Department, under the leadership of the director of the department. Standards and Accreditation Department staff is responsible for the daily operation of the accreditation program. Agencies in the process have contact primarily with the accreditation specialist responsible for their state or agency.

Auditors

Auditors are corrections professionals who have been selected, trained, and certified by the Association. These individuals perform the field work for the Association which includes providing assistance to agencies working toward accreditation and conducting on-site audits of agencies to assess compliance with program requirements. In certain cases, when the Commission believes it necessary, they monitor agencies to ensure maintenance of the conditions required for accreditation. Teams of auditors, referred to as Visiting Committees, are formed to conduct compliance audits of agencies seeking accreditation and reaccreditation.

Auditors are recruited through announcements in prominent criminal justice publications, online and at major correctional meetings. Affirmative action and equal employment opportunity requirements and guidelines are followed in the recruitment of auditors. All auditors have a minimum of five years of corrections experience, have received a recommendation from an agency administrator, and have demonstrated knowledge in the substantive area(s) in which they are engaged to assist the Association. In addition, all auditors must successfully complete the auditor orientation course, participate in an ACA sanctioned training every three years (check out www.aca.org for details on training dates and times) and be members of the ACA in good standing. All auditors are approved by ACA.

Performance Based Standards and Expected Practices Development

Development of the traditional ACA standards began in 1974 with an extensive program of drafting, field testing, revising, and approving them for application to all areas of corrections. Since then, local, state, national, and international correctional facilities and programs have adopted the traditional standards, performance-based standards, and expected practices as outlined in ACA's accreditation manuals, for implementation through accreditation.

In the development of expected practices, the goal was to prescribe the best possible practices that could be achieved in the United States today, while both being realistic and practical. Steps were taken to ensure that the expected practices would be representative of past standards development efforts, reflect the best judgment of corrections professionals regarding good corrections practice, recognize current case law, and be clear, relevant, and comprehensive. The expected practices development and approval process has involved participation by a wide range of concerned individuals and organizations. Twenty-five manuals of performance-based standards and expected practices are now used in the accreditation process:

Performance-Based Standards and Expected Practices for Adult Correctional Institutions,
Performance-Based Core Jail Standards
Performance-Based International Correctional Core Standards–Adult
Performance-Based International Correctional Core Standards–Juvenile
Performance-Based Standards for Adult Community Residential Services
Performance-Based Standards for Adult Local Detention Facilities
Performance-Based Standards for Adult Probation and Parole Field Services
Performance-Based Standards for Correctional Industries
Performance-Based Standards for Juvenile Correctional Facilities
Performance-Based Standards for Therapeutic Communities

Performance-Based Health Care Standards for Adult Correctional Institutions
Performance-Based Health Care Standards for Adult Local Detention Facilities
Performance-Based Health Care Standards for Juvenile Correctional Facilities
Standards for Administration of Correctional Agencies
Standards for Adult Correctional Boot Camps Programs
Standards for Adult Parole Authorities
Standards for Correctional Training Academies
Standards for Electronic Monitoring Programs
Standards for Food Service Programs
Standards for Juvenile Community Residential Facilities
Standards for Juvenile Correctional Boot Camps
Standards for Juvenile Day Treatment Programs
Standards for Juvenile Detention Facilities
Standards for Juvenile Probation and Aftercare Services
Standards for Small Juvenile Detention Facilities

Performance-based standards and expected practices establish clear goals and objectives critical to the provision of constitutional and humane correctional programs and services. The performance-based expected practices include the requirement for practices to promote sound administration and fiscal controls, an adequate physical plant, adherence to legal criteria and provision of basic services. Basic services called for by the performance-based standards and expected practices include the establishment of a functional physical plant, training of staff, adoption of sanitation and safety minimums, and provision of a safe and secure living environment. In offering specific guidelines for facility and program operations, the manuals of performance-based standards and expected practices address due process and discipline, including access to the courts, mail and visitation, searches, and conditions of confinement of special management offenders.

The expected practices are systematically revised to keep pace with the evolution of different correctional practices, case law, and after careful examination of experiences, applying them over a period of time and circumstances. The ACA Standards Committee, which includes membership from the Commission on Accreditation for Corrections, is responsible for expected practices development and revision.

Suggestions and proposals for revisions to the expected practices from the field and interested others are encouraged. The Standards and Accreditation Department has developed an on-line process specifically for this purpose. Proposals should be submitted via the ACA website.

Accreditation Process Descriptions

For over 120 years, the American Correctional Association has been the only national body involved in the development of performance-based standards and expected practices for the correctional field. ACA expected practices are supported by ACA's Standards and Accreditation Department and the Commission on Accreditation for Corrections, which is the evaluating and certifying body for accreditation. The department is responsible for the administration of accreditation and ongoing development of correctional expected practices.

The accreditation process is a voluntary program for all types of correctional agencies. For these agencies, accreditation offers the opportunity to evaluate their operations against international expected practices, to remedy deficiencies, and to upgrade the quality of programs and services. The recognized benefits of such a process include: improved management; a defense against lawsuits through documentation; demonstration of a "good faith" effort to improve conditions of confinement; increased accountability and enhanced public credibility for administrative and line staff; a safer and more humane environment for personnel and offenders; and the establishment of measurable criteria for upgrading programs, staffing, and physical plant on a continuous basis.

A major component of the accreditation process is the expected practices compliance audit conducted by a visiting committee. The purpose of the audit is to measure operations against the expected practices, based on documentation provided by the agency.

The Visiting Committee Report

The results of the compliance audit are contained in the Visiting Committee report. The finished report consists of a number of sections, which are compiled through an exchange of information between the Visiting Committee, the agency, and Standards and Accreditation Department staff. The report is sent to agency staff for review and distribution to the agency administrator. The completed Visiting Committee report is submitted to the Commission for consideration at the next regularly scheduled panel hearing.

The following information is usually contained in the visiting committee report:

> *Agency and Audit Narrative*– The agency narrative includes a description of program services, a description of physical plant, number of offenders served on the days of the audit, a summary significant incidents and consent decrees, class action lawsuits and/or judgments against the agency/facility, if applicable. The audit narrative, prepared by the visiting committee chairperson, describes audit activities and findings. The narrative examines issues or concerns that may affect the quality of life and services in an agency or facility. Quality of life issues include areas such as staff training, adequacy of medical service, sanitation, use of segregation and detention, reported and/or documented incidences of violence and crowding in institutions, offender activity levels, programming and provision of basic services. The audit narrative also contains comments as a result of staff and offender interviews, and a detailed explanation of all noncompliant and not applicable expected practices.

Agency Response– The agency has three options for expected practices found in noncompliance: a plan of action; an appeal; or a waiver for the requirement of a plan of action request.

> A **plan of action** is a detailed statement of tasks to be performed in order to achieve compliance with an expected practice found in noncompliance at the time of the audit. The plan of action designates staff responsibilities and timetables for completion.
>
> An **appeal** is the agency's attempt to change the visiting committee's decision on an expected practice. The result of a successful appeal is a change in the status of the expected practice and a recalculation of the compliance tally.
>
> A **waiver** may be requested when noncompliance with an expected practice does not adversely affect the life, health, or safety of staff and offenders and when quality of life conditions compensate for the lack of implementation of a plan of action. The granting of a waiver by the Commission waives the requirement for submitting a plan of action; however, it does not change the non-compliant finding.

Auditor's *Response*– This section contains the visiting committee's final reply to all responses received from the agency and includes comments regarding the acceptability of plans of action, appeals, and waivers.

Accreditation Hearings

The Commission on Accreditation for Corrections is solely responsible for rendering accreditation decisions and considers an agency's application at its next regular meeting following completion of the visiting committee report. The Commission is divided into panels that are empowered to reach and render accreditation decisions. These panels hear the individual application for accreditation and include a quorum of at least three Commissioners which includes the panel hearing chairperson. Agencies are notified in writing of the date, time, and location of the hearings by Standards and Accreditation Department Staff.

The panel hearing is the last step in the process. With the panel chairperson presiding, panel members discuss issues and raise questions relative to all aspects of agency operations and participation in the process. The information presented during the hearing and in the visiting committee report is considered by the panel members in rendering accreditation decisions.

The agency is invited to have a representative at the hearing and, in most cases, one or more individuals attend. When special conditions warrant, the visiting committee chairperson or a member of the visiting committee also may be asked to attend the hearings. When this occurs, the auditor provides information to help clarify controversial issues and responds to questions and concerns posed by panel members.

Attendance by any other parties (i.e. media representatives, public officials, or personnel from agencies other than the applicant) occurs only with the permission of the applicant agency. In these cases, the applicant agency representatives and panel members discuss procedures to be followed before commencement of the hearing.

Conduct of Hearings

The panel schedule provides ample time for review of each individual agency pursuing accreditation. Hearings are conducted by the panel chairperson in accordance with established procedures. Panel proceedings require that a formal vote be taken on all final actions, i.e., agency appeals, Waiver requests, and the final accreditation decision of the Commission. All panel proceedings are tape-recorded to assist in preparing minutes of the hearings. Panel activities generally occur as follows:

- Applicant agency representatives are requested by Standards and Accreditation Department staff to be on-call to allow for scheduling flexibility.
- A designated waiting area is usually provided for this purpose.
- When the panel is ready to review the agency, the Standards and Accreditation Department staff representative notifies agency representative(s)
- The hearing opens with an introduction by the panel chairperson
- The agency representative is asked to give a brief description of the program

- If a Visiting Committee member is present at the hearing, the panel chairperson may request that the auditor present an account of the visit, focusing on matters particularly pertinent to the decision or specific panel actions. In some cases, however, the panel may wish to call on the Visiting Committee member only to request additional information at different points during the hearing.

- The panel chairperson leads review of each individual non-compliance finding. The agency representative presents information relative to their requests for Waivers, Plans of Action, and appeals. The agency may also present additional materials, including photographs or documentation, for review by the panel.

- Following the agency presentation, the chairperson has the option of calling the panel into executive session to consider the information provided, determine findings, and make an accreditation decision. Whether or not panel deliberations occur in the presence of agency personnel or in executive session, varies from panel to panel, considering the preference of panel members and the sensitivity of issues to be discussed regarding the application.

In final deliberations, the Commission panel:

- Ensures compliance with all mandatory expected practices and at least 90 percent of all other expected practices

- Responds with a formal vote to all appeals submitted by the applicant agency

- Responds with a formal vote to all requests for Waivers, and Plans of Action submitted by the applicant agency

At this time, the panel also:

- Assures that an acceptable Plan of Action will be submitted for every non-compliance finding, including those for which appeals of non-compliance and Waiver requests have been denied by the panel. In judging the acceptability of Plans of Action, the panel ensures that all of the information requested on the form is provided. Furthermore, the feasibility of plans to achieve compliance is considered, including specific tasks, time frames, and resource availability (staff and funding) for implementing proposed remedies.

- Addresses to its satisfaction any concerns it has with Visiting Committee comments about the quality of life in the facility or program, patterns of non-compliance, or any other conditions reviewed by the panel relating to the life, health, and safety of residents and staff

- For each application, a roll call vote to award accreditation, extend an agency in Candidate or Correspondent Status, or deny accreditation is conducted. The options for final action available to the panel are outlined in the next chapter.

- If the panel has deliberated in executive session, agency representatives are invited back into the meeting and informed of the panel's final decision and actions or recommendations on all other issues raised by the applicant. If accreditation has not been granted, the chairperson discusses with agency personnel specific reasons for the decision and the conditions of extension in Candidate or Correspondent Status and procedures for appeal.

Accreditation Decisions

The decisions available to the Commission panel relating to the accreditation of an agency are:

- *Three-year accreditation award* based on sufficient compliance with expected practices, acceptance of adequate Plans of Action for all applicable non-compliant findings, (or approval of the Waivers of the requirement that a Plan of Action be submitted) and satisfaction of any other life, health, and safety conditions established by the panel.

- *Extension of the applicant agency in initial accreditation process* (initial accreditation only) for reasons of insufficient compliance, inadequate Plans of Action, or failure to meet other requirements as determined by the panel, the Commission may stipulate additional requirements for accreditation if, in its opinion, conditions exist in the facility or program that adversely affect the life, health, or safety of the offenders or staff. Extension of an agency is for a period of time specified by the panel and for identified deficiencies if in the panel's judgment, the agency is actively pursuing compliance.

- Continuation of accreditation in *Probationary Status* after reaccreditation hearings is considered when the panel specifies that compliance levels are marginal, there is a significant decrease in compliance from the previous audit (in the case of reaccreditation), or there are quality of life issues that would indicate continued monitoring. Probationary Status lasts for a specific period of time designated by the Commission to allow for correction of deficiencies. While an award of accreditation is granted, a monitoring visit *must* be completed, and the report presented at the next meeting of the Commission. At the end of the probationary status, another monitoring visit MAY be conducted to ensure that the deficiencies have been corrected. Following the visit, a report is prepared for review by the Commission at its next regularly scheduled meeting. The Commission again reviews the program and considers removing the probationary status or the revocation of accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted by the Commission on Accreditation of Corrections by the Commission on Accreditation of Corrections, the agency resumes its status as an accredited agency.

- *Denial of accreditation* denies initial accreditation or removes the agency from Accredited Status (in the case of reaccreditation) and withdraws the agency from the accreditation program. Situations such as insufficient compliance, inadequate Plans of Action, failure to meet other requirements as determined by the panel or quality of life issues may lead to the denial of accreditation. If an agency is denied accreditation by the panel, it is immediately appealed to the full commission. If the agency is denied accreditation by the full commission, it is withdrawn from the process and is not eligible to re-apply (as an applicant) for accreditation status for a minimum of six months from the date of that panel hearing.

The agency receives written notification of all decisions relative to accreditation after the hearing.

Appeal Process

The accreditation process includes an appeal procedure to ensure the equity, fairness, and reliability of its decisions, particularly those that constitute either denial or withdrawal of Accredited Status, or placement into probationary status. Therefore, if an agency is denied accreditation, it is immediately appealed to the full commission.

If an agency is put in probationary status by the panel, it may submit an appeal of the placement into probationary status. The basis for reconsideration of probationary status is based on grounds that the decision(s) were:

- A misinterpretation of the criteria and/or procedures promulgated by the Commission
- Based on incorrect facts or an incorrect interpretation of facts
- Unsupported by substantial evidence
- Based on information that is no longer accurate
- The reasonableness of the expected practices, criteria, and/or procedures for the process may not serve as the basis for reconsideration.

The procedures for reconsideration are as follows:

- The agency can submit a verbal appeal immediately to the Director of Standards and Accreditation or a written request for reconsideration within 30 days of the adverse decision stating the basis for the request.
- The Executive Committee of the Commission, composed of the officers of the Commission, reviews the request and decides whether or not the agency's request presents sufficient evidence to warrant a reconsideration hearing before the Commission. The agency is notified in writing of the Executive Committee's decision.

- If the decision is made to conduct a hearing, the hearing is scheduled for as soon as possible if the appeal is made verbally or if in writing, for the next full Commission meeting and the agency is notified of the date.

- The agency, at its option and expense, has the right of representation, including counsel.

- Following the hearing held before the Commission, the decision, reflecting a majority opinion, is made known to the agency immediately.

- Pending completion of the reconsideration process, the agency maintains its prior status.

- Until a final decision has been reached, all public statements concerning the agency's accredited status are withheld.

Following completion of the reconsideration process, any change in the status of an agency is reflected in the next regularly published list of accredited agencies.

Accredited Status

The accreditation period is three years, during which time the agency must maintain the level of compliance achieved during the audit and work towards compliance of those expected practices found in non-compliance. Regular contact with Standards and Accreditation Department staff should also be maintained. The Annual Report, Critical Incident Report and Significant Incident Summary forms discussed below are available on the ACA website at www.aca.org or through your Accreditation Specialist.

Annual Report

During the three year accreditation period, the agency submits an annual report to the Standards and Accreditation Department. This report is due on the anniversary of the accreditation (panel hearing) date utilizing the template provided by ACA staff (also available at www.aca.org). It contains the following information:

Current Compliance Levels - This includes any changes in compliance since accreditation, listing on a case by case basis any expected practice with which the agency has fallen out of compliance or achieved compliance.

Update of Plans of Action - A progress report is included with respect to Plans of Action submitted to the hearing panel, indicating the status of the completion of the plans. potential revision to plans reflecting the need to request additional time, funds, and/or resources to achieve compliance should also be included.

Significant Incident Report Summary - A report is made of events and occurrences at the agency during the preceding year that impact on compliance, agency operation, or the quality of services provided by the agency.

Standards and Accreditation Department staff review the annual report received from the agency and respond to clarify issues or request additional information if necessary.

Critical Incident Report

In addition to submission of the annual report, the agency is responsible for notifying Standards and Accreditation Department staff of any critical incident that has the potential to affect compliance or facility accreditation as soon as possible within the context of the event itself. This information is to be submitted to ACA as soon as possible within the context of the incident itself, using the Critical Incident Report template available at www.aca.org.

Monitoring Visits

Monitoring visits to agencies in Accredited Status are conducted by an ACA auditor(s) or staff in order to assess continuing compliance. A monitoring visit may be conducted at any time during the accreditation period with notice to the agency. The determination of need for a monitoring visit is based on:

- Compliance levels, findings, and recommendations by the Commission on Accreditation for Corrections during the hearing
- Incidents or events reported by the agency in its annual report.
- Problems indicated by adverse media reports or correspondence received by Standards and Accreditation Department staff, disturbances at the agency, or special investigations.

The length of the visit varies depending on the number of expected practices or special issues that must be addressed during the visit. The visits are conducted similar to expected practice compliance audits, but on a reduced scale. Monitoring visits are charged to the agency at a rate of cost plus twenty-five percent or as stipulated in the contract.

Activities, as a general rule, involve a review of all mandatory expected practices, all expected practices found in non-compliance at the time of accreditation, and any other concerns identified by the Commission. The visit also involves a tour of the agency and interviews with staff and offenders to ensure maintenance of the requirements of accreditation. It concludes with an exit interview during which the auditor informs the agency staff of the findings of the visit.

Following the visit, the auditor prepares a monitoring visit report that addresses findings of the visit. The report includes a list of expected reviewed, explanation of noncompliance findings, results of the tour and interviews with agency staff and offenders, and discussion of any issues believed to be relevant to the agency's accreditation. The report, as with others prepared by auditors, is reviewed and sent to the agency by Standards and Accreditation Department staff.

When a monitoring visit to the agency reveals deficiencies in maintaining compliance levels that existed at the time of accreditation, or less than 100 percent compliance with mandatory expected practices, the agency prepares a response providing explanation of the problems indicated in the report. When the agency has failed to maintain compliance with all mandatory expected practices, the monitoring visit report and the agency response are submitted to the Commission on Accreditation for Corrections for review during a regular hearing. Agency representatives are advised of the date, time, and location of the review, and are invited to attend. At the discretion of the Commission, the agency may be placed in probationary status and a revisit conducted to determine if deficiencies have been corrected.

Revocation of Accreditation

If the Commission panel believes that an agency's failure to maintain continuous compliance with certain expected practices is detrimental to life, health, and safety of residents and staff, the Commission may place an agency on probation. Probationary status last for a specific period of time designated by the Commission at its next regularly schedule meeting. The Commission again reviews the program and considers removing the probationary status or revoking accreditation. When the agency corrects the deficiencies within the probationary status period and the corrections have been verified and accepted, the agency resumes its status as an accredited agency. An agency that does not satisfactorily correct the deficiencies may be withdrawn from accreditation.

Another condition that may result in a rehearing and consideration of revocation is following a significant event in an agency (i.e. major disturbance, death from other than natural causes or allegations of physical/sexual abuse of offenders). Failure to notify the Standards and Accreditation Department in a timely manner may result in suspension of the agency's accreditation. Once ACA is notified of the major event, the Director of Standards and Accreditation may consult with the Executive Committee of the Commission, who may request a monitoring visit. If a visit is warranted, ACA will notify the agency and a date will be established with the concurrence of the facility. The monitoring visit will take place within 14 days of this notification. The monitoring visit report will be sent to the Director of Standards and Accreditation within 7 days of the monitoring visit and then forwarded to the Executive Committee of the Commission. Following review of the report, a determination will be made by the Executive Committee as to whether revocation of accreditation is warranted. Prior to any rehearing, agency representatives will be notified, so that any issues may be addressed and responded to in writing.

Accreditation is revoked for the following reasons:

- Failure on the part of the agency to adhere to the provisions on the contract.
- Failure on the part of the agency to maintain continuous compliance with the expected practices at levels sufficient for accreditation.
- Intentional misrepresentation of facts, lack of good faith, or lack of deliberate speed or a concerted effort to progress in the accreditation process, including the implementation of plans of action.
- Failure to notify ACA of significant incidents in the annual report to the Commission.
- Adverse conditions of confinement that affect the life health, and/or safety of staff and offenders.
- Failure to comply with the conditions of probation or suspension.

Standards and Accreditation Department staff notify the agency in writing of the specific reasons identified by the Commission for the revocation hearing.

Expiration of Accredited Status

Accreditation is granted for a three year period. Unless the agency has applied for reaccreditation and completed activities in the process required for reaccreditation, the Commission withdraws the agency from Accreditation Status after this three year period.

For agencies in Accredited Status that are seeking subsequent accreditation, administrative extensions of Accredited Status may be granted under certain conditions. For example, relocation of the facility, staff turnover, and major renovations often warrant an extension. In these cases, a written request to the Director of Standards and Accreditation is required, outlining the reasons for extending the accreditation period. Agencies that fail to successfully complete an audit within the three year period, or do not receive an extension prior to their expiration date, are withdrawn from Accredited Status.

Visiting Committee Report and Hearing Minutes

CONFIDENTIALITY

The American Correctional Association and the Commission on Accreditation for Corrections do not disclose to external parties specific information contained in this Accreditation Report or information discussed in the Accreditation Hearing. The Association encourages all participating agencies to provide information to the media about their accreditation activities, including disclosure of the Self-Evaluation and Accreditation Report.

Commission on Accreditation for Corrections
Standards Compliance Reaccreditation Audit

Youth Rehabilitation and Treatment Center
Hastings, Nebraska

June 23-25, 2025

VISITING COMMITTEE MEMBERS

Dave Johnson, Chairperson
ACA Auditor

Linda Osborne
ACA Auditor

Allen Peaton
ACA Auditor

A. Introduction

The reaccreditation audit of Youth Rehabilitation and Treatment Center, Hastings (YRTC-H), was conducted on June 23-25, 2025, by the following team: Dave Johnson Chairperson; Linda Osborne and Allen Peaton, Member, utilizing the ACA Standards for Juvenile Correctional Facilities, 4th Edition, 2016 Standard Supplement.

B. Facility Demographics

Rated Capacity: 24
Actual Population: 17
Average Daily Population for the last 12 months: 15
Average Length of Stay: 7 months
Security/Custody Level: low/medium
Age Range of Offenders: 14 until 18
Gender: Female
Full-Time Staff: 79
9 Administrative, 9 Support, 43 Program

C. Facility Description AND Program Description

The Hastings Regional Center (HRC) was established in 1889, located two miles west of the town of Hastings. It was originally known as the Nebraska Asylum for the Incurably Insane. The first patients arrived from the Lincoln State Hospital on August 1, 1889. The original building housed psychiatric adult patients. In 1895, the name was changed to the Nebraska Asylum for the Chronic Insane. In 1905, a post office was established on the grounds and named Ingleside. The name was then changed to the Nebraska State Hospital. In 1915, the name was again changed to Hastings State Hospital and would continue to be known as that until 1969 when it was changed to the Hastings Regional Center.

In 1999, 40 juveniles from the Youth Rehabilitation and Treatment Center (YRTC) – Kearney were transferred to HRC to start the Hastings Juvenile Chemical Dependency Program. The program dealt with juveniles with substance abuse issues and behavioral issues.

On July 1, 2007, HHSS was reorganized into the Department of Health and Human Services (DHHS). DHHS is the parent agency of nine 24-hour care facilities including three Regional Centers, three Veterans Homes, one Development Center and two YRTC's.

On October 1, 2020, the Hastings Juvenile Chemical Dependency Program was moved to Whitehall Campus in Lincoln, Nebraska.

On April 12, 2021, HRC transitioned to female youth facility Youth Rehabilitation and Treatment Center-Hastings (YRTC-H), housing female youth from YRTC-Kearney.

The rated capacity is 24. The facility reported "The ideal capacity is 20, given physical plant characteristics and preference of single youth occupancy in each sleeping room, and a preference for sick bays." The facility comprises Unit A (North Dorm) and Unit B (South Dorm). Both Unit A and B have 12 single occupancy rooms. Both units also feature an ADA room and storm shelter.

The Hastings grounds hand surrounding area is 147 acres, owned by the state of Nebraska.

D. Pre-Audit Meeting

The team met on June 22, 2025, in Hastings, Nebraska, to discuss the information provided by the agency staff and the officials from the Youth Rehabilitation and Treatment Center-Hastings. This is a back-to-back audit with the Lincoln, Nebraska facility.

The chairperson divided standards into the following groups:

Standards # 4-JCF-1A-01 through 4-JCF-3E-01 to Allen Peaton, Member
Standards # 4-JCF-4A-01 through 4-JCF-4E-07 to Linda Osborne, Member
Standards # 4-JCF-5A-01 through 4-JCF-6G-14 to Dave Johnson, Chairperson

E. The Audit Process

1. Transportation

   The team was escorted to the facility by Samuel Johnston.

2. Entrance Interview

   The audit team met in the conference room. The team expressed the appreciation of the agency for the opportunity to be involved with Youth Rehabilitation & Treatment in the accreditation process.

   The following people were in attendance:

   Camella Jacobe, Facility Administrator
   Rich Williams, Program Manager
   Lisa Ferguson, Youth Security Supervisor
   Todd Lancaster, Unit Manager
   Sara Thomas, Clinical Director
   Lucas Jones, Compliance Manager
   Samuel Johnston, Compliance Specialist
   Thomas Foster, Compliance Specialist
   Shaylee Fortner, Compliance Administrator

It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The team toured the entire facility from 8:20 a.m. to 10:00 a.m. The following people accompanied the team on the tour and responded to the team's questions concerning facility operations:

Camella Jacobe, Facility Administrator
Rich Williams, Program Manager
Sara Thomas, Clinical Director
Daniel Browitt, Maintenance Supervisor
Lucas Jones, Compliance Manager
Samuel Johnston, Compliance Specialist
Thomas Foster, Compliance Specialist

Notices of the ACA audit were posted throughout the facility.

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security

The facility is classified as a low/medium security level, the campus type environment is open without security fencing. The total site size of the facility is 147 acres. Security is maintained by tight, direct supervision by staff. All buildings are locked and sleeping rooms are locked when in use. Youth movement between buildings is accompanied by multiple security staff and a security vehicle is in the immediate proximity.

However, at 9:00 p.m. all youth are locked in their individual rooms. If a need to use the bathroom arises, they must knock on their door and security must come and unlock the door, which is in direct conflict with ACA Standard #4-JCF-1C-01.

Living units that are designed primarily for single occupancy provide:
Access to toilets and a washbasin with hot and cold running water 24 hours per day without staff assistance. Therefore, the team found Standard #4-JCF-1C-01 in noncompliance.

Security staff are classified as either Youth Security Supervisor or Youth Program Specialist II. Twelve Youth Security Supervisor positions were filled. Security staff are divided between three eight-hour shifts; 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. During sleeping hours (third shift), three security staff are assigned to each of the living units. On the third shift, security staff are responsible for laundry duty.

Additional security measures include a total of 116 cameras in five buildings and on the grounds. Video footage is retained for approximately 200 days. Counts of the youth are made numerous times during the day.

When physical restraint of the youth is required, "Handle with Care" techniques are utilized to minimize injury to both youth and staff. Security staff receive both initial and annual refresher training in "Handle with Care".

Handle with Care approach is designed for use of verbal de-escalation skills, release techniques, blocking techniques, and primary restraint techniques.

The audit team found the facility procedures and controls regarding tools and sensitive items to be effective in class A. Tools and equipment are not kept at the facility but off campus, managed by the Department of Administrative Services. The facility maintains a toolbox containing utility tools used for minor repairs. All tools at the facility were inventoried and accounted for. Adequate key control was observed.

Environmental Conditions

The entire facility was found to be in a high state of cleanliness with no evidence of pests or vermin. There were no offensive odors. Temperatures were found to be within proper comfort levels. All housing units have ample square footage, showers, toilets, sinks and natural light requirements were within standard. The residents had a sufficient amount of space available for storage of personal belongings.

The grounds of the facility were in immaculate condition. The grass was cut, flower beds were well maintained, and all exterior lighting was in proper working condition.

Sanitation

The sanitation and hygiene levels throughout the facility were clean and well organized. Daily and weekly sanitation inspections are conducted by unit staff. The residents' bathroom and shower area were clean.

The residents' living spaces were found to be clean, beds were made, personal items were stored. Housing unit furnishings were found to be clean and in good order.

Janitorial services are provided by two Department of Health and Human Services employees. However, residents and staff maintain the cleanliness of the residential building. The facility stores a minimal amount of cleaning supplies. Inspection of cleaning and other related supplies were found properly inventoried and labeled. The Safety Data Sheet and safety equipment were organized and readily available.

Fire Safety

Fire safety drills are conducted on each shift monthly. Emergency exit signs and floor plans are properly posted. Pull stations, smoke/heat and duct detectors, emergency lights, lighted exit signs, fire door alarms, and visual/audio enunciators make up a complete fire alarm system. Fire suppression includes strategically located fire extinguishers and a sprinkler system. Local and state fire codes are met as evidenced by inspection reports that are on file. The emergency evacuation plans have been both posted and provided to local fire departments and law enforcement. Furnishings comply with fire ratings.

An annual fire inspection of the facility is conducted by the Nebraska State Fire Marshall. The last fire inspection was conducted on March 20, 2025.

Food Service

All meals are prepared by state food service staff. Meals are prepared according to a five-week menu cycle which is reviewed and approved by a Registered Dietician. There was a sufficient amount of space for residents to eat in the dining room without being crowded or rushed. There were no significant concerns stated by the residents regarding meals. The team consumed lunch in the dining room with the residents and the staff, and the audit team all enjoyed the chef salad.

Special diets are provided by medical staff. Religious diets may be provided with the approval of the Facility Administrator.

The food preparation area was clean and free of clutter. All temperature logs checked were within an acceptable range. Storage areas were clean with no items stored on the floor. Boxes and canned goods were properly dated. There were no signs of vermin or pest.

Medical Care

Healthcare for the Youth Rehabilitation and Treatment Center-Hastings is provided through the Nebraska Department of Health and Human Services. Staffing for the department consists of one full-time Nursing Supervisor, one full-time Registered Nurse, one part-time Physician/Psychiatrist and Nurse Practitioner, one full-time Psychologist, and three full-time Licensed Mental Health Practitioners.

Services are provided eight hours a day, five days a week. The Nurse is on site

Monday through Friday from 8:00 a.m. to 4:30 p.m. The Nurse Practitioner is on site for four hours on Tuesdays. After normal duty hours, there are on-call staff, including a Nurse, APRN, and Licensed Mental Health Practitioner.

The Youth Rehabilitation and Treatment Center-Hastings has a clinic space in the school area that features an exam room, office, and sufficient space and storage to address the needs of the population. The area is equipped with all the necessary equipment to provide any needed service. The rooms have Needle Cases and Red Bio-Hazard bags for contaminated materials. The examining room is designed to ensure the patient's privacy and confidentiality. Any of the examination rooms can be utilized for any emergency.

There is a waiting area for youth offenders awaiting medical attention. There are bathroom facilities available as well as water and educational materials.

Minor emergencies are handled at the clinic. Emergencies that the clinic cannot handle are sent to the local emergency room for a higher level of care when indicated. This is accomplished by using the Hastings Fire and Rescue, which has a response time of approximately 5-10 minutes. Supplies available at the clinic for responding to an emergency include a Crash Bag with emergency medications, including Benadryl, Narcan, and Tylenol. The facility has five AEDs, with one located in the clinic and the others in the housing units, dining hall, and facilities office building. Additionally, several First Aid Kits are located throughout the facility, as well as in all facility vehicles. Nurses inspect the AEDs and first aid kits monthly. All staff are trained in first aid and CPR and carry one-way breathing masks.

The facility does not have an infirmary but does use individual rooms to accommodate sick offenders. These youth are housed in their rooms when needed. If they are at the infirmary level, they are kept at the local hospital until they are cleared to return to the facility and can provide self-care. Offenders requiring long-term infirmary care are transferred to another facility or the local hospital.

Diamond Pharmacy provides medications for the facility. Medications are usually delivered the day after being ordered, or within two days if ordered after noon. The facility has medication storage on-site that stocks all the necessary medications, as well as the required sharps and tools. Controlled substances are secured and inventoried by licensed staff at the end of each shift. Medical sharps were not tightly controlled and inventoried at the end of each shift due to the facility's inadequate record-keeping practices. No discrepancies were noted during spot checks of the inventories. There are currently approximately 15 offenders taking medication. Medications are dispensed to the offender at the cell door or in the standard day room. The pill times are 7:00 a.m. and 7:00 p.m. No youth can self-administer medications.
Medication distribution is documented in the electronic medical record, except for C-2 controlled substances, which are recorded on a log by the medication aid.

Offenders are not allowed to have KOP medications. Three no-shows for pill call are reported to the provider for disposition.

Psychotropic medications commonly being prescribed at the facility include Antidepressants - Celexa, Prozac, Zoloft, Lexapro, Imipramine, Paxil, Cymbalta, and Luvox, Mood Stabilization - Lamictal, Depakote, and Lithium, Antipsychotics - Risperdal, Abilify, and Antianxiety - Buspar. There are 15 patients receiving 32 doses per day.

Supplies for universal precautions are procured from McKesson with no problems being noted.

Biohazardous materials for the clinic are stored in either needle cases or red biohazard bags in a separate building and picked up every three months or sooner if indicated. All bio-hazardous materials are secured in a dedicated room. During the visit, it was noted that standard #4-JFC-4C-62 NM was found to be out of compliance due to the use of an autoclave machine to clean instruments, but no spore testing had been conducted on this equipment during the audit cycle. This was addressed with the Facility Administrator and was being rectified on our last date at the facility.

Security for the clinic is provided by security staff who are always present in the clinic.

The sick call process for the clinic involves having the offender come to the clinic between 7:15 a.m. and 7:30 a.m., fill out a sick call request form, and then wait in the waiting area to be seen. The nurse will also see patients in their housing cell if needed.

Alternatively, the offender can fill out a sick call request form in the housing unit and place it in the sick call request box for pickup by healthcare staff. All sick call requests are generally seen on the same day. The offender is seen by healthcare staff and referred to a provider if deemed necessary. The nursing staff triages all the sick call requests. Regular sick call hours are 7:00 a.m. until complete, Monday through Friday. There is no ill call on Saturdays and Sundays.

The Facility Administrator, Camella Jacobe, handles all offender complaints about the clinical services.

The medical records are stored in an Electronic Medical Record (EMR) and follow the patient to each facility if they are transferred.

The Registered Nurse is also the Communicable Diseases/Infection Control Coordinator and has received all the required training for the position. If an offender is diagnosed with a communicable or infectious disease, such as TB, she would be sent to the Emergency Room to be placed in the negative pressure room provided

for observation until a decision on disposition can be reached. Notifications would be made to the local health department, CDC, the DHHS, and the Facility Administrator. During the visit, it was noted that standard 4C-62 NM was found out of compliance due to use of an autoclave machine to clean instruments, but no spore testing had been conducted on this equipment during the audit cycle time.

All medical and security staff are certified in CPR and are required to recertify every two years.

The reception process for new arrivals includes health screening for all offenders, which provides for Medical, Dental, and Mental Health Assessments. Newly arriving offenders are given instructions on how to access medical treatment, as well as dental and mental health. The appropriate provider sees all newly arriving offenders within seven days or sooner if indicated. Instructions are provided in both English and Spanish, and a language line is available for those who do not speak English. If an offender is deemed to be illiterate, instructions are given verbally. The intake screening also identifies offenders who may be vulnerable to sexual abuse/assault, and/or offenders who may be sexually abusive/assaultive.

Radiology services are not provided on-site, and patients are sent to the Emergency Room for any x-ray orders that may be needed.

Mary Lanning Health Care provides laboratory services. Specimens are obtained on-site by the nurses. They are received and picked up five days per week as needed. Results are available the following day by computer. Any results with critical values are immediately faxed, and the facility is contacted, and the laptop is flagged for immediate readings. STAT labs can be done at the local hospital if needed.

Specialty services are not provided onsite, and the offender is transferred to all appointments for specialty services.

Disaster drills are conducted three times a month, fire drills are conducted monthly, and mock code drills are conducted quarterly, with additional sessions sometimes held more frequently. Critiques are prepared for all and are reviewed at the monthly safety team meetings.

The grievance process for healthcare is that the Facility Administrator would send any healthcare grievances to the Nurse Supervisor for review and a necessary response. The Nurse would call the grievant out and go over the grievance with them. If the grievance cannot be resolved through this process, the Nurse would complete a response and forward it to the Facility Administrator for disposition.

The clinic currently has 15 youth offenders on diets, with the only prescribed diet being a food allergy.

The clinic has a Quality Assurance team that reviews the performance of healthcare services at the facility. The QA team consists of the Facility Administrator, Nurse, Compliance department representative, and security.

The only medically significant issues at the facility was an attempted suicide since the last audit.

Dental

Off-site contracted dental providers provide dental services. There are no on-site dental services.

Mental Health

Staffing for the Mental Health Department includes: Three Licensed Mental Health Practitioners (LMHP), one Psychologist, five days a week, and one Mental Health Director and Psychiatrist.

The department offers Crisis Intervention, Individual Counseling, Individual Treatment Plans, and a Multi-Disciplinary Team.

Offenders are provided with access to Mental Health services by submitting a sick call request to the MH department, and they would be seen within 24-48 hours. In an emergent situation, the offender would be seen immediately. If it is after hours, the on-call provider would be contacted. If deemed necessary, the on-call provider would visit the facility to address the situation. In a situation where the offender has made comments about suicide or hurting herself, she would be kept under close observation until seen by Mental Health staff. The offender cells are single cells and will be made into suicide or observation cells if indicated. Offenders in these circumstances would be allowed to have a mattress, a shroud, and meals would consist of finger food.

Offenders in these circumstances receive an initial evaluation, and a treatment plan is developed. They would be seen daily by nursing and mental health for 30 days and then re-evaluated. If deemed appropriate, the offender may be transferred to a facility better equipped to address their medical or mental health needs.

Mental health rounds are conducted daily in the units by the Psychologist or the Licensed Mental Health Practitioner, who make stops at all occupied cells.

Four and five-point restraints are not used at the facility. If immediate action is necessary in an emergency, the offender is restrained in either mechanical wrist and leg restraints or leather restraints. A helmet can be utilized when offenders are presenting self-injurious behaviors while being restrained. Offenders are initially evaluated by nursing staff and mental health staff. If the placement continues for more than two hours, the Facility Administrator is notified. The Facility Administrator reviews and approved appropriate use of medical restraints.

Recreation

Recreational activity at Hastings is provided by a Recreational Specialist. Recreation programs include access to the gymnasium and outdoor recreation area. There are opportunities for both individual and group recreation.

A major portion of the YRTC-H youth sports program is structured sports. These seasonal sports include Basketball, Soccer, Dodgeball, Softball, Bowling, Badminton, Volleyball, and Kickball. Leisure activities include Yard Games, 9-Square, Frisbee, Water Activities, Nail Polishing, Puzzles, Coloring, Writing, Craft, Video Games, Crocheting, and Drawing.

Youth are required to participate in two to three hours of recreation daily unless prohibited for health reasons. One hour of this recreation is a large muscle exercise, one hour is designed for leisure time activities supervised by a full-time Activity Specialist.

Religious Programming

Religious programming is available to youth, should they decide to participate. Upon request a spiritual leader will be contacted. The religious program consists of regularly scheduled chapel services, Bible study classes, individual counseling, and special spiritual programs. Chapel services are held every Sunday afternoon in the All-Faiths Chapel for any youth expressing an interest in attending.

The YRTC-H administration encourages citizen involvement and volunteer programs. The goal of citizen and volunteer programs is to generate a variety of services and experiences for the youth. Citizen volunteers participate in youth Bible studies and other campus and off-campus activities.

Offender Work Programs

Youth Rehabilitation and Treatment Center-Hastings does not have a work program.

Academic and Vocational Education

The YRTC-H education program is provided by West Hastings School (WHS). WHS provides year-round education and Vocational services that are available at no cost to students and are consistent with the needs of the students committed to the YRTC-H. The WHS is accredited by the Nebraska Department of Education (NDE) as a Special Purpose School. Programming and school classrooms are designed to conform to this accreditation. All course offerings are provided as required by the NDE certification as a Rule 10 School.

Students attend WHS and may earn a High School diploma or may be enrolled in a GED program. Any credit earned by students attending WHS may be transferred to their home schools upon their return to the community. Extracurricular activities will be offered in compliance with the requirements of approval under the school agreement. Students may participate in intramural sports. The library services of the school include recreational reading materials.

The school will graduate seniors, promote 8th grade students, and honor those completing the GED program or achieving other significant successes. The school holds a graduation ceremony as needed. The four GED subjects are Mathematical Reasoning, Reasoning Through Language Arts, Science, and Social Studies. Elective classes include but are not limited to Business Information and Technology, Career Education, Family Life Skills, Health Education, Psychology, and Physical Education.

Vocational services are integrated with the academic program provided by a Vocational Counselor based on a youth's age, needs, and employment opportunities. Vocational testing and follow-up counseling are available, researching post high school educational opportunities, after-care vocational programming, and employment/volunteer activities.

YTRC-Hastings offers a graduate program for youth who have earned their high school diploma or GED. Youth can attend classes at the Central Community College in Hastings in areas of interest if classes are available and they have met the appropriate stage requirements to go off campus.

Social Services

YRTC-H staff provides a substance use disorders programming that includes education/intervention-based program that includes assessment, education, programing and referrals.

Clients are scheduled to meet with counseling staff for at least one individual session and two group sessions weekly. In that the average length of stay is seven months, the client receives an intense treatment program of social services, Moral Recognition Therapy (MRT), which is a cognitive behavioral program that seeks to decrease recidivism by increasing moral reasoning.

Trauma Affect Regulation: Guide for Education & Therapy (TARGET). TARGET is a psychosocial intervention that provides education about the impact of complex traumatic stress on the brain's stress response system, and strengths-based practical skills for re-setting the trauma-related alarms/survival reactions that occur in complex PTSD.

Eye Movement Desensitization and Reprocessing (EMDR) is an evidence-based psychotherapy intervention used to address distress associated with past traumatic experiences. Staff at YRTC-Hastings include one or more mental health staff who are fully trained in EMDR interventions and are incorporating this into their ongoing therapeutic services for young people determined to be appropriate for this type of intervention.

Dialectical Behavioral Therapy (DBT) is a type of cognitive therapy that is evidence-based and is used to treat many conditions. Staff at all YRT locations have gone through DBT training and are incorporating these skills into their individual, family, and group therapy interventions.

Power Source is an evidence-based program designed to empower at-risk youth with social and emotional skills necessary to forge paths of health development and disengagement from high-risk and offending behaviors. Grounded in a belief in each person's intrinsic dignity and worth, Power Source guides trauma-impacted adolescents and young adults in discovering their resilience while also building the skills associated with health, social, emotional, and identity development. Offering a wide range of tools and resources, Power Source enables facilitators to address youth's unique sociomental needs, risk factors, and protective factors through high impact, engaging exercises, role plays, discussions, games, and meditation. Staff at all YRTC locations have received Power Source training and have incorporated these skill sets into individual and family therapy interventions.

Visitation

Youth have three options for supervised staff visitation, including WEBEX, on-campus, and off-campus. Off-campus visits can also be earned through programming progress. In the youth handbook, the facility strongly encourages youth to discuss their progress with treatment goals and release planning. Meals and snacks may be brought into the facility during weekend visits

Special visits for family emergencies, funerals, weddings are permitted with the approval of the Facility Administrator.

Library Services

Hastings' library includes a variety of fiction, non-fiction, biographies, and graphic novels. Titles range in readability from emergent readers to young adult readers. YRTC-H library book count is fiction, 1400, and non-fiction, 600.

Laundry

Clothing is issued during intake and includes jeans, sweatpants, winter/summer shorts, T-shirts, polo shirts, tennis shoes, sweatshirts, underwear, sports bras, and

socks. Youth are also allowed one pair of personal tennis shoes. Each youth is also provided with a comforter, flat and fitted sheet, pillow with pillowcase and a mattress.

Two washers and two dryers and detergent are available in each unit. Staff are responsible for cleaning clothing and bedding. The laundry room was found to be well organized and clean and inventories for detergent were observed.

F. Examination of Records

Following the facility tour, the team proceeded to the conference room to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

Over the last three years, the facility had no consent decrees, class action lawsuits or adverse judgments.

2. Significant Incidents/Outcome Measures

In consideration of the Security and the mission of YRTC-H, the Significant Incident Summary numbers seem appropriate. The Outcome measures Worksheet was reviewed. The Outcome Measures seem appropriate for the security level and mission of YRTC-H.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Administrative	Camella Jacobe Lindsay McBride Samuel Johnston Rich Williams
Education	Scott English
Social Services	Dr. Aryssa Washington Danielle Redman, LMHP

4. Shifts

a. Day Shift

The team was present at the facility during the day shift which is from 6:00 a.m. to 2:00 p.m. All staff that were observed by the team acted professionally and appeared to be knowledgeable about their duties. Staff were responsive and cooperative with the team. The team observed clients participating in group sessions, eating in the dining area and classroom activities.

b. Evening Shift

The team was present at the facility during the evening shift which is from 2:00 p.m. to 10:00 p.m. There appeared to be positive interaction between the clients and staff. Staff that were observed by the team acted professionally and appeared to be knowledgeable about their duties.

c. Night Shift

The team was present at the facility during the night shift which is from 10:00 p.m. to 6:00 a.m. All staff on duty were interviewed. The staff on the shift were passionate about their jobs and knowledgeable of duties and emergency procedures.

The night shift represented the most senior staff in terms of longevity.

5. Status of Previously Non-compliant Standards/Plans of Action

The team reviewed the status of standards previously found non-compliant, for which a waiver was not granted, and found the following:

There were no non-compliant from the previous audit.

G. Interviews

During the audit, team members met with both staff and offenders to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interviews

The audit team interviewed several clients informally during the audit. The clients stated they felt safe in the facility and that staff had their best interests at heart. There were no complaints about food, living conditions or overall treatment from staff. All clients stated the facility provides adequate services to offenders

incarcerated at YRTC-Hastings.

2. Staff Interviews

The audit team spoke with several staff members during the audit. Staff spoken with stated that YRTC-H is a wonderful place to work. That can be verified by the longevity of the employees at this facility.

Staff stated that management is open to suggestions, and they are responsive to employee needs and concerns. All staff stated that they felt safe working at the facility. Morale of the staff was good.

H. Exit Discussion

The exit interview was held at 11:00 a.m. in the conference room with the Camella Jacobe, Facility Administrator, and 15 staff in attendance.

The following agency staff were also in attendance:
Dr. Sara Thomas, Clinical Director
Scott English, DHHS Facilities Superintendent
Samuel Johnston, Compliance Specialist
Thomas Foster, Compliance Specialist
Lucas Jones, DHHS Compliance Manager/Accreditation Manager
Shaylee Fortner, DHHS Compliance Administrator.

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team on the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Juvenile Correctional Facilities, 4th Edition
Supplement	2016 Standards Supplement
Facility/Program	Youth Rehabilitation & Treatment Center, Hastings, Nebraska
Audit Dates	June 23-25, 2025
Auditor(s)	Dave Johnson, Chairperson Linda Osborne and Allen Peaton, Members

	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	40	331
Number Not Applicable	2	17
Number Applicable	38	314
Number Non-Compliance	0	2
Number in Compliance	38	312
Percentage (%) of Compliance	100%	99.4

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Youth Rehabilitation and Treatment Center
Hastings, Nebraska

June 23-25, 2025

Visiting Committee Findings

Non-Mandatory Standards

Non-Compliance

STANDARD #4-JCF-1C-01

LIVING UNITS THAT ARE DESIGNED PRIMARILY FOR SINGLE OCCUPANCY PROVIDE:

- SOME DEGREE OF PRIVACY WITH AT LEAST 35 UNENCUMBERED SQUARE FEET PER OCCUPANT
- WHEN CONFINEMENT EXCEEDS 10 HOURS PER DAY, THERE ARE AT LEAST 80 SQUARE FEET PER OCCUPANT
- A BED FOR EACH JUVENILE
- ADEQUATE STORAGE SPACE FOR CLOTHING AND PERSONAL BELONGINGS FOR EACH JUVENILE
- A DESK AND CHAIR OR STOOL FOR EACH JUVENILE
- ACCESS TO TOILETS AND A WASHBASIN WITH HOT AND COLD RUNNING WATER 24 HOURS PER DAY WITHOUT STAFF ASSISTANCE

FINDINGS:

Youth must knock on the bedroom door and request staff to open the bedroom door to access toilet.

AGENCY RESPONSE:

Waiver Request

In this case, completing a Plan of Action would not be feasible for the Youth Rehabilitation and Treatment Center (YRTC) - Hastings facility. Implementing such a plan would compromise the requirements established in 28 C.F.R. 115.313 regarding juvenile supervision and monitoring, as well as certain Nebraska state statutes. Additionally, it would necessitate modifications beyond reasonable limits and potentially endanger the life, health, and safety of both offenders and staff.

When supervising and monitoring juveniles, 28 C.F.R. 115.313, Federal Prison Rape Elimination Act (PREA) requires the facility to consider generally accepted juvenile

detention and correctional/secure residential practices, as well as all components of the facility's physical plant, including "blind spots" or areas where staff or residents may be isolated.

Nebraska State Statute partially defines a Staff Secure Juvenile Facility as one in which the physical restriction of movement or activity of juveniles is provided solely through staff. This may include establishing reasonable rules restricting or controlling the movement and activities of individual juvenile residents for treatment purposes through intensive staff supervision. Furthermore, Nebraska State Statute specifically requires YRTC facilities to implement procedures to provide safe spaces for the use of showers, restrooms, and sleeping quarters.

Currently, the construction of YRTC-Hastings does not provide individual restrooms within juvenile rooms but does provide one restroom per hallway, housing six female juvenile offenders. Juvenile rooms must remain secured, as well as entry into any restroom for individual use, to ensure the safety and security of the facility, staff, and juveniles. No juvenile is ever denied 24-hour access to and use of the restrooms when requested, unless it is already occupied. Youth can exit the restroom freely without staff assistance when finished.

To comply with the standard that requires "access to toilets and a washbasin with hot and cold running water 24 hours per day without staff assistance," the facility would need a complete constructional makeover that is fiscally unattainable while remaining in operation. Additionally, the standard would require the facility to leave all youth rooms, hallway entrances, and restrooms unlocked 24 hours a day, which would also jeopardize the life, health, and safety of the juveniles.

AUDITORS' RESPONSE:

The auditors concur with the agency's request.

STANDARD #4-JCF-4C-62

MANAGEMENT OF BIOHAZARDOUS WASTE AND DECONTAMINATION OF MEDICAL AND DENTAL EQUIPMENT/INSTRUMENTS COMPLY WITH APPLICABLE LOCAL, STATE, AND FEDERAL REGULATIONS.

FINDINGS:

Facility is using autoclave but zero spore counts and used as recently as day of audit, June 23, 2025, no verification of calibration of autoclave.

AGENCY RESPONSE

Plan of Action

Please explain completely the corrective action that will be taken to comply with the Traditional Standard/Expected Practice. In the order of anticipated completion dates, list the tasks necessary to achieve compliance, the responsible agency (including parent agency), and assigned staff member.

Task
a. Discontinue any use of the autoclave immediately.
b. Removal of the autoclave device from the facility.
c. Revision of Standard Operating Procedure (SOP) to reflect not applicable status.

Responsible Agency
a. YRTC-Hastings
b. YRTC-Hastings
c. YRTC-Hastings, DHHS Office of Juvenile Services Administration, and DHHS Central Office

Assigned Staff
a. YRTC Medical staff
b. YRTC Medical staff
c. YRTC-Hastings Policy Committee

Anticipated Completion Date
a. 7/2/2025
b. 7/16/2025
c. 7/31/2025

AUDITORS' RESPONSE:

The auditors agree with the agency's request.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Youth Rehabilitation and Treatment Center
Hastings, Nebraska

June 23-25, 2025

Visiting Committee Findings

Mandatory Standards

Not Applicable

Standard #4-JCF-2A-18

FOUR-/FIVE-POINT RESTRAINTS ARE USED ONLY IN EXTREME INSTANCES AND ONLY WHEN OTHER TYPES OF RESTRAINTS HAVE PROVEN INEFFECTIVE OR THE SAFETY OF THE JUVENILE IS IN JEOPARDY. ADVANCE APPROVAL IS SECURED FROM THE FACILITY ADMINISTRATOR/DESIGNEE BEFORE A JUVENILE IS PLACED IN A FOUR-/FIVE-POINT RESTRAINT. SUBSEQUENTLY, THE HEALTH AUTHORITY OR DESIGNEE MUST BE NOTIFIED TO ASSESS THE JUVENILE'S MEDICAL AND MENTAL HEALTH CONDITION, AND TO ADVISE WHETHER, ON THE BASIS OF SERIOUS DANGER TO SELF OR OTHERS, THE JUVENILE SHOULD BE IN A MEDICAL/MENTAL HEALTH UNIT FOR EMERGENCY INVOLUNTARY TREATMENT WITH SEDATION AND/OR OTHER MEDICAL MANAGEMENT, AS APPROPRIATE. IF THE JUVENILE IS NOT TRANSFERRED TO A MEDICAL/MENTAL HEALTH UNIT AND IS RESTRAINED IN A FOUR-/FIVE-POINT POSITION, THE FOLLOWING MINIMUM PROCEDURES ARE FOLLOWED:

- DIRECT VISUAL OBSERVATION BY STAFF IS CONTINUOUS PRIOR TO OBTAINING APPROVAL FROM THE HEALTH AUTHORITY OR DESIGNEE.
- SUBSEQUENT VISUAL OBSERVATION IS MADE AT LEAST 15 MINUTES.
- RESTRAINT PROCEDURES ARE IN ACCORDANCE WITH GUIDELINES APPROVED BY THE DESIGNATED HEALTH AUTHORITY.
- ALL DECISIONS AND ACTIONS ARE DOCUMENTED.

FINDINGS:

Four/Five-point restraints are not used by facility.

Standard #4-JCF-2A-27

THE LEVEL OF AUTHORITY, ACCESS, AND CONDITIONS REQUIRED FOR THE AVAILABILITY, CONTROL, AND USE OF CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE MUST BE SPECIFIED. CHEMICAL AGENTS ARE USED ONLY WITH THE AUTHORIZATION OF THE FACILITY ADMINISTRATOR, MEDICAL DIRECTOR, OR DESIGNEE.

1. CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE ARE INVENTORIED AT LEAST MONTHLY TO DETERMINE THEIR CONDITION AND EXPIRATION DATES.
2. PERSONNEL USING CHEMICAL AGENTS TO CONTROL JUVENILES SUBMIT WRITTEN REPORTS TO THE FACILITY ADMINISTRATOR OR DESIGNEE NO LATER THAN THE CONCLUSION OF THE TOUR OF DUTY.
3. ALL PERSONS CONTAMINATED IN AN INCIDENT INVOLVING THE USE OF A CHEMICAL AGENT MUST RECEIVE AN IMMEDIATE MEDICAL EXAMINATION AND TREATMENT.

FINDINGS:

No chemical agents are used within the facility.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Youth Rehabilitation and Treatment Center
Hastings, Nebraska

June 23-25, 2025

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-JCF-1A-04

IF THE JUVENILE FACILITY IS ON THE GROUNDS OF ANY OTHER TYPE OF CORRECTIONAL FACILITY, IT IS A SEPARATED, SELF-CONTAINED UNIT.

FINDINGS:

Not on the grounds of any other facility.

Standard #4-JCF-1C-02

MULTIPLE-OCCUPANCY ROOMS TO INCLUDE OPEN-BAY DORMITORIES PROVIDE:

1. SOME DEGREE OF PRIVACY WITH AT LEAST 25 SQUARE FEET OF UNENCUMBERED SPACE PER OCCUPANT
2. WHEN CONFINEMENT EXCEEDS 10 HOURS PER DAY THERE ARE AT LEAST 80 SQUARE FEET PER OCCUPANT
3. A BED FOR EACH JUVENILE.
4. ADEQUATE STORAGE SPACE FOR CLOTHING AND PERSONAL BELONGINGS FOR EACH JUVENILE
5. A WRITING SURFACE
6. ACCESS TO TOILETS AND A WASHBASIN WITH HOT AND COLD RUNNING WATER 24 HOURS PER DAY

FINDINGS:

All facility rooms are single occupancy

Standard #4-JCF-1C-05

SECURITY ROOMS, EXCEPT PADDED SAFETY ROOMS, ARE EQUIPPED WITH TOILET, SINK, AND SECURITY FURNITURE.

FINDINGS:

The facility does not have security rooms.

Standard #4-JCF-2A-08

WHEN BOTH MALES AND FEMALES ARE HOUSED IN THE FACILITY, AT LEAST ONE MALE AND ONE FEMALE STAFF MEMBER IS ON DUTY AT ALL TIMES.

FINDINGS:

Hastings is an all-female facility.

Standard #4-JCF-2A-18-1

WRITTEN POLICY, PROCEDURE AND PRACTICE, IN GENERAL, PROHIBIT THE USE OF RESTRAINTS ON FEMALE JUVENILES DURING ACTIVE LABOR AND THE DELIVERY OF A CHILD. ANY DEVIATION FROM THE PROHIBITION REQUIRES APPROVAL BY, AND GUIDANCE ON, METHODOLOGY FROM THE MEDICAL AUTHORITY AND IS BASED ON DOCUMENTED SERIOUS SECURITY RISK. THE MEDICAL AUTHORITY PROVIDES GUIDANCE ON THE USE OF RESTRAINTS ON PREGNANT JUVENILES PRIOR TO ACTIVE LABOR AND DELIVERY.

FINDINGS:

Hastings's juvenile center does not use restraints during active labor and the delivery of a child

Standard #4-JCF-3A-04

THERE IS EQUAL ACCESS TO PROGRAMS AND SERVICES FOR MALE AND FEMALE JUVENILES.

FINDINGS:

This is a female only facility.

Standard #4-JCF-3A-05

MALE AND FEMALE JUVENILES DO NOT OCCUPY THE SAME SLEEPING ROOM.

FINDINGS:

This is a female only facility.

Standard #4-JCF-3A-27

THE AGENCY RESPONSIBLE FOR THE COMMUNITY SUPERVISION OF THE JUVENILE IS AUTHORIZED TO PETITION THE PLACING/RELEASING AUTHORITY IF IT APPEARS THAT THE JUVENILE HAS WILLFULLY FAILED TO COMPLY WITH ANY PART OF THE DISPOSITION OR RELEASE ORDER. A COPY OF THIS PETITION IS PROVIDED TO THE JUVENILE, HIS/HER ATTORNEY, PARENT, AND/OR GUARDIAN.

FINDINGS:

Community Supervision is a court responsibility.

Standard #3-JCF-3E-01

THE FACILITY PROVIDES SERVICES AND OPPORTUNITIES THAT ENCOURAGE JUVENILES TO TAKE RESPONSIBILITY FOR THEIR ACTIONS AND MAKE RESTITUTION TO THE VICTIMS OF THEIR CRIME(S) AND/OR TO THE COMMUNITY, WHEN REQUIRED. OPPORTUNITIES ARE BASED ON COMMUNITY INPUT AND ARE FASHIONED IN A WAY THAT SEEKS TO AMELIORATE THE HARM DONE.

FINDINGS:

Victim restitution is handled as a court function in this jurisdiction.

Standard #4-JCF-4B-05

PROTECTIVE CLOTHING AND EQUIPMENT ARE ISSUED TO JUVENILES ASSIGNED TO WORK IN FOOD SERVICE, THE GARAGE, THE FACILITY PHYSICAL PLANT, THE MAINTENANCE SHOPS, VOCATIONAL EDUCATION, AND OTHER SPECIAL WORK AREAS.

FINDINGS:

No youth are allowed to work in areas that require protective clothing or gear.

Standard #4-JCF-4C-55

IF VOLUNTEERS ARE USED IN THE DELIVERY OF HEALTH CARE, THERE IS A DOCUMENTED SYSTEM FOR SELECTING, TRAINING, STAFF SUPERVISING, PROVIDING FACILITY ORIENTATION, AND DEFINING OF TASKS, RESPONSIBILITIES AND AUTHORITY THAT IS APPROVED BY THE HEALTH AUTHORITY. VOLUNTEERS MAY ONLY PERFORM DUTIES CONSISTENT WITH THEIR CREDENTIALS AND TRAINING. VOLUNTEERS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

Facility does not participate in volunteers providing health services.

Standard #4-JCF-4C-57

JUVENILES ARE PROHIBITED FROM PERFORMING HEALTH CARE DUTIES IN THE FACILITY.

FINDINGS:

Juveniles do not perform health services at the facility.

Standard #4-JCF-5H-02

THE JUVENILE WORK PLAN PROVIDES FOR EMPLOYMENT FOR JUVENILES WITH DISABILITIES.

FINDINGS:

There is no work program for Juveniles at YRTC.

Standard #4-JCF-5H-03

JUVENILES EMPLOYED IN THE COMMUNITY BY PUBLIC OR PRIVATE ORGANIZATIONS IN POSITIONS NORMALLY OCCUPIED BY PRIVATE CITIZENS ARE COMPENSATED AT THE PREVAILING RATE.

FINDINGS:

YRTC does not allow juveniles to work in the community.

Standard #4-JCF-5I-04

WHERE STATUTES PERMIT, JUVENILES SHOULD BE AFFORDED OPPORTUNITIES FOR GRADUATED RELEASE AND PARTICIPATION IN EMPLOYMENT AND EDUCATION PROGRAMS.

FINDINGS:

YRTC Hastings does not provide opportunities for graduate release or participation in employment.

Standard #4-JCF-6A-03

IF SERVICES FOR ADULT AND JUVENILE OFFENDERS ARE PROVIDED BY THE SAME AGENCY, STATEMENTS OF PHILOSOPHY, POLICY, PROGRAM, AND PROCEDURE DISTINGUISH BETWEEN CRIMINAL CODES AND THE STATUTES THAT ESTABLISH, GIVE DIRECTION, AND GUIDE PROGRAMS FOR JUVENILES.

FINDINGS:

YRTC-H is a stand-alone facility for juveniles.

Standard #4-JCF-6G-07

CONSISTENT WITH JURISDICTIONAL LAWS, REGISTERED CRIME VICTIM(S) ARE NOTIFIED OF A JUVENILE OFFENDER'S RELEASE PRIOR TO ANY PLANNED RELEASE FROM CONFINEMENT AND/OR ESCAPE FROM CUSTODY. FOLLOW-UP NOTIFICATION TO VICTIMS OCCURS WHEN ESCAPEES ARE RETURNED TO CUSTODY.

FINDINGS:

There are no victim services at the facility and if needed hasting doesn't do it at their level.

Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: YRTC-Hastings Reporting Period: April 2024-March 2025

Incident Type	Months ⇨	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	Total for Reporting Period
Escapes		0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender / Offender	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender / Staff	0	0	0	0	0	1	1	1	2	0	0	0	5
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		0	1	2	1	0	0	0	0	0	0	0	0	4

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

		Safety & Security Outcomes		2024-2025
Performance Standard	Outcome Measure		Value	Calculated Outcome Measure
A		**YOUTH ON YOUTH INCIDENTS**		
		Outcome Measures		
	(1)	**Number of youth on youth assaults with a weapon (object of any description used to cause harm to another) in the past twelve months divided by the total number of youth on youth assaults in the past twelve months**		0.00%
	(2)	**Number of confirmed youth on youth sexual assaults in the past twelve months divided by the total number of youth on youth assaults in the past twelve months.**		0.00%
	(3)	**Number of confirmed youth on youth assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of youth on youth assaults prosecuted in the past twelve months.**		0.00%
	(4)	**Number of youth on youth fights resulting in injury requiring medical treatment (band-aid, ice, stitches, x-ray, emergency room, etc.) in the past twelve months divided by the total number of youth fights in the past twelve months.**		0.00%
		Data Collection		
		Number of youth on youth assaults in the past twelve months	14	
		Number of youth on youth assaults with a weapon (object of any description used to cause harm to another) in the past twelve months	0	
		Number of confirmed youth on youth sexual assaults in the past twelve months	0	
		Number of youth on youth cases prosecuted in the past twelve months	0	
		Number of guilty verdicts/convictions in cases prosecuted in the past twelve months	0	
		Number of reported incidents of youth on youth fights in the past twelve months	3	
		Number of youth on youth fights resulting in injury requiring medical treatment (band-aid, ice, stitches, x-ray, emergency room, etc.) in the past twelve months	0	
B		**YOUTH ON STAFF INCIDENTS**		
		Outcome Measures		
	(1)	**Number of youth on staff assaults with a weapon in the past twelve months divided by the total number of youth on staff assaults in the past twelve months.**		0.00%

	(2)	**Number of confirmed youth on staff sexual assaults in the past twelve months divided by the total number of youth on staff assaults in the past twelve months.**		0.00%
	(3)	**Number of confirmed youth on staff assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of youth on staff assaults prosecuted in the past twelve months.**		0.00%
		Data Collection		
		Number of youth on staff assaults in the past twelve months	46	
		Number of youth on staff assaults with a weapon in the past twelve months	0	
		Number of confirmed youth on staff sexual assaults	0	
		Number of staff assaults prosecuted in the past twelve months	0	
		Number of youth on staff assault cases resulting in guilty verdicts/convictions in the past twelve months	0	
C		**STAFF ON YOUTH INCIDENTS**		
		Outcome Measures		
	(1)	**Number of staff on youth assaults with a weapon in the past twelve months divided by the total number of staff on youth assaults in the past twelve months.**		0.00%
	(2)	**Number of confirmed staff on youth sexual assaults in the past twelve months divided by the total number of staff on youth assaults in the past twelve months.**		0.00%
	(3)	**Number of confirmed staff on youth assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of staff on youth assaults prosecuted in the past twelve months.**		0.00%
		Data Collection		
		Number of staff on youth assaults in the past twelve months	0	
		Number of staff on youth assaults with a weapon in the past twelve months	0	
		Number of confirmed staff on youth sexual assaults	0	
		Number of staff on youth assaults prosecuted in the past twelve months	0	
		Number of staff on youth assaults cases resulting in guilty verdicts/convictions in the past twelve months	0	
D		**USES OF FORCE**		
		Outcome Measures		
	(1)	**Number of uses of force incidents requiring hands on intervention without mechanical restraints (non-escort, non-transport) in the past twelve months.**		117
	(2)	**Number of use of force incidents requiring the use of mechanical restraints (non-transport) in the past twelve months divided by the total number of use of force incidents in the past twelve months**		41.21%
	(3)	**Number of use of force incidents requiring the use of four – five point restraints in the past twelve months**		0.00%

		divided by the total number of use of force incidents in the past twelve months.		
	(4)	**Number of use of force incidents requiring the use of chemical agents in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		0.00%
	(5)	**Number of use of force incidents requiring the use of some other non-lethal security device (baton, shield, tazer, etc.) in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		0.00%
	(6)	**Number of use of force incidents resulting in injury to youth in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		9.55%
	(7)	**Number of use of force incidents resulting in injury to staff in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		20.10%
	(8)	**Number of use of force incidents determined to be excessive in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		0.00%
		Data Collection		
		Number of use of force incidents in the past twelve months	199	
		Number of use of force incidents requiring hands-on intervention in the past twelve months	199	
		Number of use of force incidents requiring restraints in the past twelve months	82	
		Number of use of force incidents requiring four or five point restraints in the past twelve months	N/A	
		Number of use of force incidents requiring the use of chemical agents in the past twelve months	N/A	
		Number of use of force incidents requiring the use of some other non-lethal security device (baton, shield, tazer, etc.) in the past twelve months	0	
		Number of use of force incidents resulting in injury to youth in the past twelve months	19	
		Number of use of force incidents resulting in injury to staff in the past twelve months	40	
		Number of use of force incidents determined to be excessive in the past twelve months	0	
E		**CRITICAL INCIDENTS**		
		Outcome Measure: Events of this type as defined in this section are unique and their analysis needs to be individualized.		
	(1)	**Description of each incident of youth disturbance to include response, analysis and resulting plans of action.**		
	(2)	**Description of each incident of employee work stoppage**		

		to include response, analysis and resulting plans of action.		
	(3)	**Description of each incident involving a hostage to include response, analysis and resulting plans of action.**		
	(4)	**Description of each incident of man-made or natural disaster to include response, analysis and resulting plans of action.**		
	(5)	**Description of each incident of escape from a secure facility or during secure transport to include response, analysis and resulting plans of action.**		
	(6)	**Description of any employee deaths related to occupational injury, illness, homicide, suicide or natural causes within the past twelve months to include response, analysis and resulting plans of action.**		
	(7)	**Description of any juvenile deaths related to accidental injury, illness, homicide, suicide or natural causes for the past twelve months to include response, analysis and resulting plans of action.**		
		Data Collection		
		The dates and number of incidents of youth disturbance, i.e. 4 or more youth in an organized group engaging in violence toward other youth or staff, vandalism, and/or destruction property in the past twelve months	0	
		The dates and number of incidents of employee work stoppage	0	
		The dates and number of incidents involving a hostage situation	0	
		The dates and number of incidents of man made or natural disaster, i.e. significant weather emergency, loss of power exceeding 8 hours, environmental accident, excessive illness or infection of youth or staff impacting operations, terrorist action, etc.	0	
		Average daily population for the past twelve months	15	
		Number of attempted escapes from a secure facility in the past twelve months	0	
		Number of attempted escapes during a secure transport in the past twelve months	0	
		Number of actual escapes from a secure facility in the past twelve months	0	
		Number of actual escapes during a secure transport in the past twelve months	0	
		Number of walkaways from a nonsecure facility in the past twelve months	0	
		Number of absences from furlough during the past twelve months	0	
		Number of absences from other planned events in nonsecure settings or during nonsecure transport in the past twelve months	0	
		Total number of employees allotted to the table of		

		organization for this site		
		Average daily juvenile population for the past twelve months	15	
		Number and cause of employee deaths for the past twelve months	0	
		Number and cause of juvenile deaths for the past twelve months	0	
F		**YOUTH GRIEVANCES**		
		Outcome Measures		
	(1)	**Total number of youth grievances found in favor of the youth related to access to legal counsel or courts in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(2)	**Total number of youth grievances found in favor of the youth related to communications (mail, telephone, and visitation) in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(3)	**Total number of youth grievances found in favor of the youth related to discipline received in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(4)	**Total number of youth grievances found in favor of the youth related to food service in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(5)	**Total number of youth grievances found in favor of the youth related to personal hygiene, personal grooming or clothing divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(6)	**Total number of youth grievances found in favor of the youth related to physical or verbal abuse by other juveniles in the past twelve months divided by the total number of youth grievances filed I the past twelve months.**		0.00%
	(7)	**Total number of youth grievances found in favor of the youth related to physical or verbal abuse by staff in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(8)	**Total number of youth grievances found in favor of the youth related to professional care (medical, dental, mental health) in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(9)	**Total number of youth grievances found in favor of the youth related to programming (social services, education, library, recreation) in the past twelve months.**		0.00%
	(10)	**Total number of youth grievances found in favor of the**		0.00%

		youth related to access to religious services or programs in the past twelve months divided by the total number of youth grievances filed in the past twelve months.		
	(11)	**Total number of youth grievances found in favor of the youth related to sexual harassment or discrimination in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(12)	**Total number of all youth grievances found in favor of the youth in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		4.00%
	(13)	**Total number of individual youth grievants in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		20%
	(14)	**Total number of individual youth grievants in the past twelve months divided by the average daily population for the past twelve months**		138%
		Data Collection		
		Total number of youth grievances filed in the past twelve months	104	
		Total number of youth grievances found in favor of the youth related to access to counsel and courts in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to communications (mail, telephone, visiting) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to discipline received in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to food service in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to personal hygiene, personal grooming or clothing in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to physical or verbal abuse from other juveniles in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to physical or verbal abuse from staff in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to professional care (medical, dental, mental health) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to programming (social services, education, library, recreation) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to access to religious services or programs in the past twelve months	0	

		Total number of youth grievances found in favor of the youth related to sexual harassment or discrimination in the past twelve months	0	
		Total number of all grievances found in favor of the youth	4	
		Average daily population for the past twelve months	15	
		Number of individual youth filing grievances in the past twelve months (counted once per youth per twelve month period not per grievance and not per month)	21	
G		**STAFF GRIEVANCES**		
		Outcome Measures		
	(1)	**Total number of staff grievances found in favor of staff related to working conditions, physical environment and safety in the past twelve months divided by the total number of staff grievances filed.**		0.00%
	(2)	**Total number of staff grievances found in favor of staff related to work schedules, overtime, job duties and pay in the past twelve months divided by the total number of staff grievances filed.**		0.00%
	(3)	**Total number of all staff grievances found in favor of staff divided by the total number of staff grievances filed.**		5.00%
		Data Collection		
		Total number of staff grievances in the past twelve months	21	
		Total number of staff grievances related to working conditions, physical environment and safety found in favor of staff in the past twelve months	0	
		Total number of staff grievances related to work schedules, overtime, job duties and pay found in favor of staff in the past twelve months	0	
		Total number of all grievances found in favor of staff in the past twelve months	1	
H		**EMPLOYEE OCCUPATIONAL HEALTH & SAFETY**		
		Outcome Measures		
	(1)	**Total number of employee injuries due to youth assault at this site resulting in lost work days in the past twelve months divided by total number of employees assigned to this site.**		1.00%
	(2)	**Total number of lost work days as a result of an employee injury due to youth assault in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		29%
	(3)	**Total number of employee injuries due to accidents at this site resulting in lost work days in the past twelve months divided by total number of employees assigned to this site.**		2.00%
	(4)	**Total number of lost work days as a result of an employee injury due to accidents in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		8.00%

	(5)	**Total number of employee illnesses at this site resulting in lost work days in the past twelve months divided by the total number of employees assigned to this site.**		64.94%
	(6)	**Total number of lost work days as a result of employee illness in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		305%
		Data Collection		
		Total number of employee injuries resulting in lost work days in the past twelve months	20	
		Total number of lost work days as a result of employee injury in the past twelve months	135.95	
		Total number of employee illnesses resulting in lost work days in the past twelve months	589	
		Total number of lost work days as a result of employee illness in the past twelve months	1111.65	
		Total number of employees assigned to this site per the approved table of organization minus approved/mandated vacancies required for budgetary attrition rate	907	
		Total number of work days assigned to this site	365	
I		**JUVENILE ACCIDENTAL INJURY**		
		Outcome Measures		
	(1)	**Total number of juvenile injuries related to insect or animal bite in the past twelve months divided by the average daily population for the past twelve months.**		7.00%
	(2)	**Total number of juvenile injuries related to chemical exposure in the past twelve months divided by the average daily population for the past twelve months.**		7.00%
	(3)	**Total number of juvenile injuries related to planned recreational activity in the past twelve months divided by the average daily population for the past twelve months.**		73.00%
	(4)	**Total number of juvenile injuries related to routine physical activity, slips, trips or falls in the past twelve months divided by the average daily population for the past twelve months.**		26.00%
	(5)	**Total number of juvenile injuries related to machinery or equipment in the past twelve months divided by the average daily population.**		7.00%
		Data Collection		
		Average daily population for the past twelve months	15	
		Total number of juvenile injuries related to insect or animal bites in the past twelve months	1	
		Total number of juvenile injuries related to chemical exposure in the past twelve months	1	
		Total number of juvenile injuries related to planned recreational activity in the past twelve months	11	
		Total number of juvenile injuries related to routine physical	4	

		activity slips trips or falls		
		Total number of juvenile injuries related to machinery or equipment in the past twelve months	1	
J		**JUVENILE DISCIPLINARY HEARINGS**		
		Outcome Measures		
	(1)	**Total number of disciplinary hearing decisions appealed by the juvenile in the past twelve months divided by the total number of disciplinary hearings for the past twelve months.**		0.3%
	(2)	**Total number of disciplinary hearing appeals decided in favor of the juvenile in the past twelve months divided by the total number of disciplinary hearings appealed in the past twelve months.**		100%
	(3)	**Total number of disciplinary hearing decisions that resulted in transfer of the juvenile in the past twelve months divided by the total number of disciplinary hearings for the past twelve months.**		0.00%
		Data Collection		
		Total number of disciplinary hearings for the past twelve months	287	
		Total number of disciplinary hearings appealed by the juvenile for the past twelve months	1	
		Total number of disciplinary hearing appeals found in favor of the juvenile in the past twelve months	1	
		Total number of disciplinary hearings that resulted in transfer of the juvenile in the past twelve months	0	
K		**SECLUSION & ROOM CONFINEMENT**		
		Outcome Measures		
	(1)	**Total number of hours of seclusion of a juvenile for purposes of investigation for the past twelve months divided by the total number of juveniles confined for purposes of investigation in the past twelve months.**		0.00%
	(2)	**Total number of hours of room confinement of a juvenile for purposes of investigation for the past twelve months divided by the total number of juveniles confined for purposes of investigation in the past twelve months.**		868.00%
	(3)	**Total number of hours of seclusion disciplinary reasons for the past twelve months divided by the total number of juveniles confined for disciplinary reasons in the past twelve months.**		0.00%
	(4)	**Total number of hours of room confinement for disciplinary reasons for the past twelve months divided by the total number of juveniles confined for disciplinary reasons in the past twelve months.**		0.00%
	(5)	**Total number of hours of seclusion as part of a juvenile's special management plan for the past twelve months divided by the total number juveniles confined as part of a special management plan.**		2917.00%

	(6)	**Total number of hours of room confinement as part of a juvenile's special management plan for the past twelve months divided by the total number of juveniles confined as part of a special management plan.**		2426.00%
	(7)	**Total number of hours for unit or facility lockdown for the past twelve months divided by the number of incidents requiring unit or facility lockdown in the past twelve months.**		0.00%
		Data Collection		
		Total number of hours of seclusion of a juvenile for the purpose of investigation for the past twelve months	0	
		Total number of hours of room confinement of a juvenile for purposes of investigation for the past twelve months	60.77	
		Total number of hours of seclusion for disciplinary reasons for the past twelve months	0	
		Total number of hours of room confinement for disciplinary reasons for the past twelve months	0	
		Total number of hours of seclusion as part of a juvenile's special management plan	1721.3	
		Total number of hours of room confinement as part of a juvenile's special management plan	1431.23	
		Total number of hours for unit or facility lockdown for the past twelve months	0	
		Total number of juveniles confined for purposes of investigation in the past twelve months	7	
		Total number of juveniles confined for disciplinary reasons	0	
J		**EDUCATION AND WORK**		
		Outcome Measures		
	(1)	**Number of juveniles who receive high school diplomas or equivalent in the past twelve months divided by the average daily juvenile population in the past twelve months.**		26.00%
	(2)	**Average change in grade level of juvenile served as measured by a standardized pre and post test achievement instrument during the past twelve months.**		88.00%
	(3)	**Number of juveniles who successfully complete a vocational certification program divided by the number of juvenile enrolled in the program in the past twelve months.**		7.00%
	(4)	**Number of juveniles who, in the past twelve months, obtained and maintained work program employment divided by the number of juveniles who, in the past twelve months were eligible for work programs.**		0..00%
		Data Collection		
		Number of high school graduates in the past twelve months	4	
		Average daily population in the past twelve months	15	
		Average education pre test scores for the past twelve months	107	

		Average education post test scores for the past twelve months	120	
		Number of vocational program certificates awarded in the past twelve months	1	
		Average number of students enrolled in school	15.25	
		Average number of juveniles employed in a work program in the past twelve months	0	
		Average number of juveniles eligible for work in the past twelve months	0	

		Health Care Outcomes		
Performance Standard	Outcome Measure		Value	Calculated Outcome Measure
A		**On-Site Health Care**		
		Outcome Measures		
	(1)	**Number of juveniles seen by nursing during health call in the past 12 months divided by the number of health call requests in the past 12 months.**		100.00%
	(2)	**Number of juveniles seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months divided by the number of juvenile referred to be seen the responsible physician or health care practitioner in the past 12 months.**		887.00%
	(3)	**Number of juveniles seen by the dentist in the past 12 months divided by the number of juveniles referred to be seen by the dentist in the past 12months.**		462.00%
	(4)	**Number of juveniles seen by the psychiatrist in the past 12 months divided by the number of juveniles referred to be seen by the psychiatrist in the past 12 months.**		100.00%
	(5)	**Number of female juveniles seen by OB/GYN in the past 12 months divided by the number of female juveniles referred to be seen by the OB/GYN in the past 12 months.**		100.00%
	(6)	**Number of intake health screenings (intersystem and intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.**		100.00%
	(7)	**Number of examinations (intersystem) completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission date within the past 12 months divided by the number of admissions to the facility within the past 12 months.**		100.00%
		Data Collection		
		Number of health call requests in the past 12 months	358	
		Number of juveniles seen by nursing during health call in the past 12 months	357	
		Number of juveniles referred to be seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months	23	

		Number of juveniles seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months	204	
		Number of juveniles referred to be seen by the dentist in the past 12 months	21	
		Number of juveniles seen by the dentist in the past 12 months	97	
		Number of juveniles referred to be seen by the psychiatrist in the past 12 months	1	
		Number of juveniles seen by the psychiatrist in the past 12 months	1	
		Number of female juveniles referred to be seen by OB/GYN in the past 12 months	5	
		Number of juveniles seen by OB/GYN in the past 12 months	5	
		Number of intake health screenings completed (intersystem and intrasystem) at admission in the past 12 months	23	
		Number of examinations completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission (intersystem) date within the past 12 months	23	
		Number of intrasystem transfers within the past 12 months	0	
		Number of intersystem transfers within the past 12 months	23	
		Specialty Consultants		
		Outcome Measures		
	(8)	**Number of juvenile specialty consults completed (on-site and off-site) in the past 12 months divided by the number of specialty consults (on-site and off-site) ordered by the responsible physician, health care practitioner (N.P., P.A.) or dentist in the past 12 months.**		49.00%
		Data Collection		
		Number of referrals to specialty consults on-site and off-site ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months	39	
		Number of completed on-site and off-site specialty consults ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months	80	
		Specialty Diets		
		Outcome Measures		
	(9)	**Number of juveniles receiving special medical (therapeutic) diets in the past 12 months divided by the number of special medical**		100%

		(therapeutic) diets prescribed in the past 12 months.		
	(10)	**Number of juveniles receiving a special medical diet in the past 12 months divided by the average daily population in the past 12 months.**		29.00%
		Data Collection		
		Number of juveniles prescribed a special medical (therapeutic) diet in the past 12 months	52	
		Number of juveniles receiving a special medical (therapeutic) diet in the past 12 months	52	
		Pregnancy Testing		
		Outcome Measures		
	(11)	**Number of females juveniles with a positive pregnancy test in the past 12 months divided by the number of pregnancy test administered in the past 12 months**		4.00%
	(12)	**Number of female juveniles with a positive pregnancy test in the past 12 months divided by the average daily population (female) in the past 12 months**		7.00%
		Data Collection		
		Number of female juveniles with a positive pregnancy test in the past 12 months	1	
		Number of pregnancy test administered in the past 12 months	26	
		HIV		
		Outcome Measures		
	(13)	**Number of HIV positive juveniles who are being treated with antiretroviral treatment of for opportunistic infection in the past 12 months divided by the total number of HIV positive juveniles in the past 12 months.**		0.00%
		Data Collection		
		Number of known HIV positive status juveniles admitted to the facility in the past 12 months	0	
		Number of youth testing positive for HIV in the past 12 months	0	
		Number of HIV positive juveniles who are being treated with antiretroviral treatment or for opportunistic infection in the past 12 months	0	
		Number of AIDS cases upon admission to the facility in the past 12 months	0	
		Number of AIDS cases diagnosed by the facility in the past 12 months	0	
		Tuberculosis (TB)		
		Outcome Measures		
	(14)	**Number of juveniles with a known positive**		0.00%

		tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months divided by the number of admissions (intersystem) in the past 12 months.		
	(15)	**Number of juveniles with a positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months divided by the number of admissions (intersystem) in the past 12 months.**		0.00%
	(16)	**Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months divided by the number of tuberculin skin test given in the past 12 months.**		0.00%
	(17)	**Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.**		0.00%
	(18)	**Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.**		0.00%
		Data Collection		
		Number of juveniles with a known positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months	0	
		Number of juveniles with a positive tuberculin (TB) skin test administered upon admission (intersystem) to the facility in the past 12 months	0	
		Number of admissions (intersystem) within the past 12 months	23	
		Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months	0	
		Number of tuberculin skin tests administered in the past 12 months		
		Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months	0	
		Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months	0	
		Hepatitis A, B, and C		
		Outcome Measures		
	(19)	**Number of juveniles testing positive for Hepatitis A,B, and C in the past 12 months divided by the number of tests administered in the past 12 months.**		4400 %
	(20)	**Number of juveniles testing positive for Hepatitis A,B and C in the past 12 months divided by the average daily population in the past 12 months.**		0.00%

		Data Collection		
		Number of Hepatitis A test administered in the past 12 months	22	
		Number of Hepatitis B test administered in the past 12 months	22	
		Number of Hepatitis C test administered in the past 12 months	22	
		Number of juveniles testing positive for Hepatitis A in the past 12 months	0	
		Number of juveniles testing positive for Hepatitis B in the past 12 months	0	
		Number of juveniles testing positive for Hepatitis C in the past 12 months	0	
		Methicillin Resistant Staphylococcus Aureus (MRSA)		
		Outcome Measures		
	(21)	**Number of juveniles testing positive for MRSA in the past 12 months divided by the number of tests administered in the past 12 months**		0.00%
	(22)	**Number of juveniles testing positive for MRSA in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of MRSA test administered in the past 12 months	0	
		Number of juveniles testing positive for MRSA in the past 12 months	0	
		Health Education		
	(23)	**Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months divided by the number of admissions in the past 12 months.**		100%
		Data Collection		
		Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months	23	
		Number of juvenile admissions (intersystem and/or intrasystem in the past 12 months	23	
		Pharmaceutical Management		
		Outcome Measures		
	(24)	**Number of pharmacy dispensing errors in the past 12 months divided by the number of prescriptions dispensed by the pharmacy in the past 12 months.**		3.00%
	(25)	**Number of nursing medication administration**		0.00%

		errors in the past 12 months divided by the number of medications administered in the past 12 months.		
	(26)	**Number of juveniles on psychotropic medications in the past 12 months divided by the average daily population in the past 12 months**		8.00%
		Data Collection		
		Number of total prescriptions dispensed by pharmacy in the past 12 months	1078	
		Number of pharmacy dispensing errors in the past 12 months	28	
		Number of medications administered in the past 12 months	33697	
		Number of medication administrations errors in the past 12 months	58	
		Number of incidents involving pharmaceuticals as contraband in the past 12 months	0	
		Number of juveniles on psychotropic medication in the past 12 months	187	
B		**Quality Review**		
		Outcome Measures		
	(1)	**Number of health care issues/problems identified by internal review that were corrected in the past 12 months divided by the number of problems identified by internal review in the past 12 months.**		0.00%
		Data Collection		
		Number of issues/problems identified by internal review in the past 12 months	0	
		Number of issues/problems identified by the internal review in the past 12 months that were corrected	0	
		Grievances Related to Health Care		
		Outcome Measures		
	(2)	**Number of juvenile health related grievances found in favor of the juvenile in the past 12 months divided by the number of health related grievances filed in the past 12 months.**		0.00%
		Data Collection		
		Number of juvenile health related grievances filed in the past 12 months	1	
		Number of juvenile health related grievances found in favor of the juvenile in the past 12 months	0	
		Health Related Lawsuits		
		Outcome Measures		
	(3)	**Number of health related lawsuits filed by or**		0.00%

		on behalf of juveniles found in favor of the juvenile in the past 12 months divided by the number of lawsuits filed in the past 12 months.		
		Data Collection		
		Number of juvenile health related lawsuits filed in the past 12 months	0	
		Number of juvenile health related lawsuits found in favor of the juvenile in the past 12 months	0	
C		**Death in Custody**		
		Outcome Measures		
	(1)	**Number of juvenile deaths in custody in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of juvenile deaths that were medically expected in the past 12 months	0	
		Number of juvenile deaths that were medically unexpected other than injury, suicide and /or homicide in the past 12 months	0	
		Number of juvenile deaths due to injury in the past 12 months	0	
		Number of juvenile deaths due to suicide in the past 12 months	0	
		Sexual Assaults		
		Outcome Measures		
	(2)	**Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.**		7.00%
		Data Collection		
		Number of juvenile(s) alleging sexual assault in the past 12 months	1	
D		**Health Care Staffing**		
		Outcome Measures		
	(1)	**Number of vacant positions for full-time equivalents for each health care staff category in the past 12 month period divided by the full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months.**		0.00%
		Data Collection		
		Number of physician full-time equivalent position(s)	0	
		Number of physician vacancies in the past 12 months	0	

		Number of full-time equivalent practitioner position(s)	0	
		Number of practitioner vacancies in the past 12 months	0	
		Number of full-time equivalent dentist position(s)	0	
		Number of dentist vacancies in the past 12 months	0	
		Number of full-time equivalent nursing (RN) positions(s)	2	
		Number of nursing (RN) vacancies in the past 12 months	0	
		Number of full-time equivalent nursing (LPN, LVN) position(s)	0	
		Number of nursing (LPN, LVN) vacancies in the past 12 months	0	
		Number of full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months	3	
		Qualified Staff		
		Outcome Measures		
	(2)	**Number of staff with lapsed licensure and/or certification in the past 12 months divided by the number of licensed and/or certified staff in the past 12 months.**		0.00%
	(3)	**Number of specified health care positions with a written job description divided by the number of specified health care positions in the past 12 months.**		100.00%
		Data Collection		
		Number of staff requiring a license and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., L.P.N., psychologist, et. al. therapists requiring licensure in the past 12 months.	3	
		Number of lapsed licensure and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., dentist, psychologist, et al. therapist requiring licensure) in the past 12 months	0	
		Number of specified health care positions in the past 12 months	3	
		Number of specified health care position with a written job description in the past month	3	
		Fair Treatment of Staff		
		Outcome Measures		
	(4)	**Number of health care staff grievances**		0.00%

		decided in favor of staff in the past 12 months divided by the total number of health care staff grievances filed in the past 12 months.		
	(5)	**Number of health care staff terminations demotion hearings in which administrative decision was upheld in the past 12 months divided by the number of health care staff terminations or demotion hearings held in the past 12 months.**		0.00%
		Data Collection		
		Number of health care staff grievances filed in the past 12 months	17	
		Number of health care staff grievances decided in favor of the health care staff in the past 12 months	0	
		Number of health care staff terminations and demotion hearings in which the program decision was upheld in the past 12 months	0	
		Number of health care staff terminations or demotion hearings held in the past 12 months	0	
		Employee Health		
		Outcome Measures		
	(6)	**Number of new employees who were administered a tuberculin (TB) skin test in the past 12 months divided by the number of employees hired in the past 12 months.**		108%
	(7)	**Number of employees with a positive tuberculin skin test conversion in the past 12 months.**		0
		Data Collection		
		Number of new employees hired in the past 12 months	36	
		Number of new employees who where administered a tuberculin (TB) skin test in the past 12 months	39	
		Number of employees administered tuberculin (TB) skin test in the past 12 months	5	
		Number of employees with a positive tuberculin (TB) skin test conversion in the past 12 months	0	
E		**Mental Health**		
		Outcome Measures		
	(1)	**Number of intake mental health screenings (intersystem or intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.**		100%
	(2)	**Number of juveniles receiving a mental health appraisal in the past 12 months divided by the**		100%

		number of admissions in the past 12 months.		
	(3)	**Number of juveniles with a Mental Health Treatment Plan in the past 12 months divided by the number of youth requiring ongoing mental health intervention in the past 12 months.**		100%
	(4)	**Number of suicide attempts divided by the average daily population in the past 12 months.**		7.00%
	(5)	**Number of completed suicides divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of juveniles receiving a mental health screening at admission (intrasystem and intersystem) in the past 12 months	23	
		Number of juveniles receiving mental health appraisals within the past 12 months	23	
		Number of intrasystem transfers within the past 12 months	0	
		Number of intersystem transfers within the past 12 months	23	
		Number of juveniles requiring ongoing mental health intervention in the past 12 months	210	
		Number of juveniles with a mental health treatment plan in the past 12 months	210	
		Number of suicide attempts in the past 12 months	1	
		Number of completed suicides in the past 12 months	0	
F		**Substance Abuse**		
		Outcome Measures		
	(1)	**Number of juveniles receiving a substance abuse screening in the past 12 months divided by the number of admissions (intersystem or intrasystem) in the past 12 months.**		0.00%
	(2)	**Number of juveniles referred to a chemical dependency program divided by the number of youth identified as requiring a chemical dependency program in the past 12 months.**		0.00%
	(3)	**Number of juveniles completing an alcohol and drug abuse education program in the past 12 months divided by the number of admissions in past 12 months.**		0.00%
		Data Collection		
		Number of intersystem transfers in the past 12 months	23	
		Number of intrasystem transfers in the past 12 months	0	

		Number of juveniles identified as requiring a chemical dependency program in the past 12 months	0	
		Number of juvenile placed in a chemical dependency program in the past 12 months	0	

COMMISSION ON ACCREDITATION FOR CORRECTIONS
PANEL ACTION REPORT

ACA 155th Congress of Correction
Colorado Convention Center
Denver, Colorado

Saturday, August 23, 2025

Agency Name:	Nebraska Department of Health and Human Services
Facility Name:	Youth Rehabilitation and Treatment Center- Hastings
Facility Location:	Hastings, Nebraska
Agency Representatives:	Lucas Jones, Compliance Manager Samuel Johnston, Compliance Specialist Cammy Jacobe, Facility Administrator Uoni Suhe, RN Nursing Supervisor Shaylee Fortner, Compliance Administrator
Panel Members:	Phil Nunes, Chairperson Michelle Staples-Horne Ruby Joyner David Robinson
Staff:	Rick Albert, Senior Accreditation Specialist

Panel Action	**Result**
Standard #4-JCF-1C-01	The waiver request was denied. Submit a plan of action within 30 days.
Standard #4-JCF-4C-62	The plan of action was approved.

Accreditation Panel Decision

Moved:	Commissioner Michelle Staples-Horne
Seconded:	Commissioner Ruby Joyner
Three-Year Accreditation:	Yes

Accreditation Vote	**Yes**	**No**

Commissioner Nunes	✓
Commissioner Staples-Horne	✓
Commissioner Joyner	✓
Commissioner Robinson	✓

Final Tally

Mandatory	100%
Non-Mandatory	99.4%

Lincoln-Lancaster County Health Department
Environmental Public Health Division
3131 O Street - Lincoln, NE 68510-1514
402-441-6280 phone; 402-441-6206 FAX
lincoln.ne.gov *keyword: health*

Lincoln-Lancaster County Health Department

Food Routine Inspection Report

Establishment	LANCASTER YOUTH SERVICES	**Total of Violation**	**Date** 10/21/2025
Address	1200 RADCLIFF ST LINCOLN NE 68512	**Priority** 0 **Core** 1 **Priority Foundation** 0	**Time In** 11:20 PM **Time Out** 12:26 PM
Permitee	Lancaster Youth Services		
Facility Type	School Food Service	**Permit #/Facility #**	HF20045010
Purpose of Inspection	Routine Regular	**RBST permits**	NOT APPLICABLE
Inspection ID #	INSP-057398 **Follow-up Required** No	**Food Handler permits**	NOT APPLICABLE
		Permit Records	NOT APPLICABLE

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A)

IN = in compliance **OUT** = not in compliance **N/O** = not observed **N/A** = not applicable **COS** = corrected on-site during inspection **R** = repeat violation

Risk factors are food preparation practices and employees behaviors most commonly reported to the Centers for Disease Control and Prevention as contributing factors in foodborne illness outbreaks.

Public health interventions are control measures to prevent foodborne illness or injury

		Compliance Status	COS	R
	Supervision			
01.	Person in Charge is present, demonstrates knowledge and performs duties	IN	☐	☐
02.	Certified Food Protection Manager	IN	☐	☐
	Employee Health			
03.	Management Awareness; policy present	IN	☐	☐
04.	Proper use of reporting, restriction & exclusion	IN	☐	☐
05.	Procedures for responding to vomitting and diarrheal events	IN	☐	☐
	Good Hygienic Practices			
06.	Proper eating, tasting, drinking, or tobacco use	IN	☐	☐
07.	No discharge from eyes, nose, and mouth	IN	☐	☐
	Preventing Contamination by Hands			
08.	Hands clean & properly washed	IN	☐	☐
09.	No bare hand contact with RTE foods or approved alternate method properly followed	IN	☐	☐
10.	Adequate handwashing facilities supplied & accessible	IN	☐	☐
	Approved Source			
11.	Food obtained from approved source	IN	☐	☐
12.	Food received at proper temperature	N/O	☐	☐
13.	Food in good condition, safe & unadulterated	IN	☐	☐
14.	Required records available: shellstock tags, parasite destruction	N/A	☐	☐
	Protection From Contamination			
15.	Food separated & protected	N/A	☐	☐
16.	Food-contact surfaces: cleaned & sanitized	IN	☐	☐
17.	Proper disposition of returned, previously served, reconditioned, & unsafe food	IN	☐	☐
	Time/temperature controlled for safety Food Time/Temperature			
18.	Proper cooking time & temperatures	N/O	☐	☐

19.	Proper reheating procedures for hot holding	N/O	☐	☐
20.	Proper cooling time & temperatures	N/O	☐	☐
21.	Proper hot holding temperatures	IN	☐	☐
22.	Proper cold holding temperatures	IN	☐	☐
23.	Proper date marking & disposition	IN	☐	☐
24.	Time as a public health control: procedures & record	N/A	☐	☐
	Consumer Advisory			
25.	Consumer advisory provided for raw or undercooked foods	N/A	☐	☐
	Highly Susceptible Populations			
26.	Pasteurized foods used; prohibited foods not offered	IN	☐	☐
	Food/Color addititives and Toxic Substances			
27.	Food additives: approved & properly used	N/A	☐	☐
28.	Toxic substances properly identified, stored, & used	IN	☐	☐
	Conformance with Approved Procedures			
29.	Compliance with variance, specialized process, & HACCP plan	N/A	☐	☐

GOOD RETAIL PRACTICES

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

		Compliance Status	COS	R
	Safe Food and Water			
30.	Pasteurized eggs used where required	IN	☐	☐
31.	Water & ice from approved source	IN	☐	☐
32.	Variance obtained for specialized processing methods	N/A	☐	☐
	Food Temperature Control			
33.	Proper cooling methods used; adequate equipment for temperature control	N/O	☐	☐
34.	Plant food properly cooked for hot holding	N/O	☐	☐
35.	Approved thawing methods used	IN	☐	☐
36.	Thermometers provided & accurate	IN	☐	☐
	Food Identification			
37.	Food properly labeled; original container	IN	☐	☐
	Prevention of Food Contamination			
38.	Insects, rodents, & animals not present; no unauthorized persons	IN	☐	☐
39.	Contamination prevented during food preparation, storage, & display	IN	☐	☐
40.	Personal cleanliness	IN	☐	☐
41.	Wiping cloths: properly used & stored	IN	☐	☐
42.	Washing fruits & vegetables	N/O	☐	☐
	Proper Use of Utensils			
43.	In-use utensils: properly stored	IN	☐	☐

Lincoln-Lancaster County Health Department

Food Routine Inspection Report

Establishment: LANCASTER YOUTH SERVICES
Address: 1200 RADCLIFF ST , LINCOLN NE 68512
License #/Facility #: HF20045010

44.	Utensils, equipment & linens: properly stored, dried, & handled	IN	☐	☐
45.	Single-use & single-service articles: properly stored & used	IN	☐	☐
46.	Gloves used properly	IN	☐	☐
	Utensils, Equipment and Vending			
47.	Food & non-food contact surfaces cleanable, properly designed, constructed, & used	OUT	☐	☑
48.	Warewashing facilities: installed, maintained, & used; test strips	IN	☐	☐
49.	Non-food contact surfaces clean	IN	☐	☐
	Physical Facilities			
50.	Hot & cold water available; adequate pressure	IN	☐	☐
51.	Plumbing installed; proper backflow devices	IN	☐	☐
52.	Sewage & waste water properly disposed	IN	☐	☐
53.	Toilet facilities: properly constructed, supplied, & cleaned	IN	☐	☐
54.	Garbage & refuse properly disposed; facilities maintained	IN	☐	☐
55.	Physical facilities installed, maintained, & clean	IN	☐	☐
56.	Adequate ventilation & lighting; designated areas used	IN	☐	☐
	Non-Factored			
57.	No FDA Risk Factor Association	N/A	☐	☐
	LMC 8.20			
58.	Lincoln Municipal Code Violation	IN	☐	☐

OBSERVATIONS AND CORRECTIVE ACTIONS

Risk #	P1/P2/P3	Violations cited in this report must be corrected in the time frames below as indicated.	Repeat	Correct By
		Observations: Replace battery in the dish temp thermometer used for determining the warewashing final rinse temperature.	Yes	
47	Core	4-501.11(A) (A)EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2		

MEASURED OBSERVATIONS TEMPERATURES

Food Item	Temperature	Location
Baked beans	148 °F	Hot hold
Burgers	137 °F	Hot hold
Ambient	35 °F	Refrigerator

Final rinse	170 °F	Warewashing machine

Lincoln-Lancaster County Health Department

Food Routine Inspection Report

Establishment: LANCASTER YOUTH SERVICES
Address: 1200 RADCLIFF ST , LINCOLN NE 68512
License #/Facility #: HF20045010

Person in Charge (Signature):		**Date**	10/21/2025
Person in Charge (Print Name):	Melissa Hood		
Inspector (Signature):		**Date**	10/21/2025
Inspector (Print Name):	Dan Kahler, REHS, Professional/Technical Worker		

BUREAU OF FIRE PREVENTION
CITY OF LINCOLN
OPERATIONAL PERMIT
FOR HEALTH CARE

Permit Number: **L2500002**

Name of Facility:

Youth Services Center

Location: **1200 Radcliff ST Lincoln NE 68512-2506**

Health Type: **Institutional - Detention and Correctional Occupancy**

Number of Beds: **85**

Maximum Occupancy:

Restrictions:

Date Issued: **01/03/2025**

Date Expires: **12/31/2025**

Fire Inspector

Chief Fire Inspector

This permit does not take the place of any license required by law and is not transferable. Any change in the use, name, owner or occupancy of premises shall require a new permit.

POST IN A PROMINENT PLACE

Operational Certificate is valid from date issued to date expired or upon any change in occupancy or ownership

BLD_FP_Health_Certificate

Commission on Accreditation for Corrections
Standards Compliance Reaccreditation Audit

Youth Rehabilitation & Treatment Center
Lincoln, Nebraska

June 25-27, 2025

VISITING COMMITTEE MEMBERS

Dave Johnson, Chairperson
ACA Auditor

Linda Osborne
ACA Auditor

Allen Peaton
ACA Auditor

A. Introduction

The audit of the Youth Rehabilitation and Treatment Center, Lincoln, Nebraska (YRTC-L) was conducted on June 25-27, 2025, by the following team: Dave Johnson Chairperson; Linda Osborne and Allen Peaton, Members.

B. Facility Demographics

Rated Capacity: 20 (9 male and 11 female)
Actual Population: 12 (6 male & 6 female)
Average Daily Population for the last 12 months: 14
Average Length of Stay: 4-6 months
Security/Custody Level: maximum
Age Range of Offenders: 14-18
Gender: Male & female
Full-Time Staff: 54
2 Administrative, 10 Support, 42 Program

C. Facility Description AND Program Description

The YRTC-L is located inside the Lancaster County Youth Services Center. However, youth in the state's program are in separate programs from those in county detention.

The Lincoln Facility houses both male and female juveniles ranging in age from 14-19 years of age. It is designed to hold 11 females and nine males. They are separated by gender into different secure housing pods monitored by a security desk adjacent to the pods. Youth have typically been transferred from either Kearney or the Hasting YRTC campuses if the need arises for a higher security level.

The facility is located at 1200 Radcliff Street, Lincoln Nebraska. There are two pods, the Echo Pod for females and Foxtrot Pod for males. Each pod has individual rooms. The facility shares library and gym space with the Lancaster County Youth Service Center. Lincoln and Lancaster do not use this space at the same time.

The YRTC-Lincoln Philosophy: "At the Lincoln Facility, we work to ensuring each youth we support is provided specialized and individual treatment by utilizing scientific techniques and applying empirical approaches based on the principles of Applied Behavioral Analysis. Our focus is to change behavior or social significance and provide stabilization while skills that generalize to the community for a successful transition into community-based services. The Lincoln Facility is committed to a comprehensive treatment process including the valuable participation and input from families and external personal and professional supports for the youth."

The YRTC-Lincoln Mission: "To help live better lives through effective services affording them the opportunity to become law-abiding and productive citizens." This is accomplished through individualized programming that is based on the youth's functional behavioral assessment. Youth participate in group meetings, huddles, and therapy that help build skill building, self-regulation, and overall physical well-being. The YRTC-Lincoln Facility program includes substance use disorder, education, individual counseling, family counseling, academic education, psychiatric counseling, chemical dependency treatment, trauma counseling, problem resolution, and transitioning to the community.

D. Pre-Audit Meeting

The team met on June 25, 2025, the first day of the audit. Due to the delays in travel, we were unable to attend the ice breaker dinner. As this was a double audit, the opening with the Administrator of Compliance met with the team at the YRTC Hastings facility to discuss both Hastings and Lincoln audits. At that time the team discussed the information provided by the agency staff and the officials from the Hastings and Lincolns facilities.

The chairperson divided standards into the following groups:

Standards # 4-JCF-1A-01 through 4-JCF-3E-01 to Allen Peaton, Member
Standards # 4-JCF-4A-01 through 4-JCF-4E-07 to Linda Osborne, Member
Standards # 4-JCF-5A-01 through 4-JCF-6G-14 to Dave Johnson, Chairperson

E. The Audit Process

1. Transportation

   The team was escorted to the facility by Lucas Jones, DHHS Compliance Manager, and Samuel Johnston, Compliance Specialist.

2. Entrance Interview

   The audit team proceeded to the educational wing of the facility where the opening session was held. The team expressed the appreciation of the Association for the opportunity to be involved with the Youth Rehabilitation Treatment Center-Lincoln, Nebraska, in the accreditation process.

   The following people were in attendance:

   Sarah Brownell, Facility Administrator
   Erika Wolff, Behavioral Technician Supervisor
   Jacob Myers, Behavioral Technician Supervisor
   Joni Suhr, Registered Nurse Supervisor
   Holly Boyd, Registered Nurse
   Dr. Sara Thomas, Clinical Director
   Lucas Jones, DHHS Compliance Manager /Accreditation Manager

Samuel Johnston, Compliance Specialist
Thomas Foster, Compliance Specialist
Shaylee Fortner, DHHS Compliance Administrator

It was explained that the goal of the visiting team was to be as helpful and non-intrusive as possible during the conduct of the audit. The chairperson emphasized the goals of accreditation toward the efficiency and effectiveness of correctional systems throughout the United States. The audit schedule was also discussed at this time.

3. Facility Tour

The team toured the entire facility from 1:00 p.m. to 2:20 p.m. The following people accompanied the team on the tour and responded to the team's questions concerning facility operations:

Sarah Brownell, Facility Administrator
Lucas Jones, DHHS Compliance Manager
Erika Wolff, Behavioral Technician
Shaylee Fortner, DHHS Compliance Administrator
Joni Suhr, Registered Nurse Supervisor
Holly Boyd, Registered Nurse

Notices of the ACA audit were posted throughout the facility.

4. Conditions of Confinement/Quality of Life

During the tour, the team evaluated the conditions of confinement at the facility. The following narrative description of the relevant programmatic services and functional areas summarizes the findings regarding the quality of life.

Security

Security at the facility is accomplished by a staff of Behavior Technician Supervisors who are posted at key locations within the facility. Security operates three 8-hour shifts: 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m.

The Youth Rehabilitation and Treatment Center- Lincoln is a coed maximum-security facility located in one wing of the Lancaster Conty Juvenile Detention Center. The facility is fenced, including an outdoor recreation area with a security screen covering. Cameras are located throughout the interior and exterior of the facility. Cameras and electronically operated doors are monitored and operated from a central control room which is staffed 24/7. On the opening day of the audit (June 25, 2025), the facility population was 12, six males and six females.

Security staff conduct youth counts and maintain all data required for the daily "Morning Report". The "Morning Report" is a computer-generated document that details all the activities of the previous 24 hours. Third shift security is responsible for entering the information into the system from the logbooks completed by each shift. The completed document is shared with all staff. It is a color coded by types of events and who was involved.

The facility utilizes the handle with care approach to physical intervention. This approach utilizes verbal de-escalation skills release techniques, blocking techniques and primary restraint techniques. Mechanical restraints, including handcuffs and leg restraints are available when needed. They are properly stored and accounted for through an inventory process.

Complete post orders are maintained for each security position and are reviewed annually. Included in the post orders is the daily schedule for the residents and the expected tasks to be performed on each shift.

Key control is maintained from the central desk where keys are inventoried and checked out at each shift change.

Environmental Conditions

The grounds and flower beds inside the secure perimeter are well maintained. The county provides all the labor for the upkeep of the grounds. The county is also responsible for all maintenance and equipment on the compound. The facility appeared to be very clean and well maintained. The facility is air conditioned and the temperature levels during the audit were comfortable and the air quality was good. The facility is smoke-free. There are an adequate number of sinks, toilets and showers.

Sanitation

The facility was clean and well cared for. Bedrooms, day spaces, restrooms and showers, educational spaces, and administrative areas were all clean and in good condition. Appropriate water temperatures were available in showers and restrooms. Garbage and pest control services are provided as a part of the contractual arrangement with Lancaster County.

Fire Safety

An annual fire inspection of the Lancaster County Juvenile Detention Center is conducted by the Nebraska State Fire Marshall. The inspection was current. Visible fire extinguishers were properly inspected. Fire alarm systems are maintained by the Detention Center. All exit doors and evacuation routes are clearly posted. Routine Fire and Emergency Evacuations were reviewed and found to be in compliance with ACA standards.

There is a backup generator that is load tested and maintained by the county. The Lincoln Fire & Rescue Station #4 is 1.8 miles from the facility.

Food Service

The food service at YRTC-L is provided through a contract with Aramark Food Services. The meals are delivered by Aramark and served through the county detention services employees. All employees of the Lancaster County Youth Services that serve food are SERV Safe certified. The youth consume all their meals in their pods. There is no dining room.

Special diets are provided when prescribed by YRTC-L medical staff. Religious diets may be provided with the approval of the Facility Administrator. The team sampled the lunch meal on the second day of the audit, which consisted of Sloppy Joes, Mac & Cheese, String Beans, Lettuce, and two slices of bread. The meal was adequate in presentation, quantity and taste.

Medical Care

Healthcare for Lincoln Youth Rehabilitation and Treatment Center is provided through the Nebraska Department of Health and Human Services, in a shared facility with the Lancaster County Youth Services Center. Staffing for the clinical department consists of one full-time Registered Nurse Supervisor, one full-time Registered Nurse, one part-time Physician/Psychiatrist, one full-time Psychologist, and one full-time Licensed Mental Health Practitioner (LMHP).

The site has nine male beds and 11 female beds, and on the day of the audit, there were six males and six females being housed. The average population has been 14 for the last 12 months, and the average length of stay was four to six. The security level is considered maximum due to the complexity of the patient and charges. The full-time staff to support this population consists of 54 staff members.

Services are provided eight hours a day, seven days a week. The Nurse is on site Monday through Friday from 8:00 a.m. to 4:30 p.m. The MD Psychiatrist is on site for eight hours on Thursdays. After normal duty hours, there are on-call staff, including a Nurse, Doctor, and LMHP.

The clinic has no examining rooms in each of the two housing units [Echo Pod (females) and Foxtrot Pod (males)], and the youths are taken to the shared clinical space, known as the “Medical Unit”. The Medical Unit area is equipped with all the necessary equipment to provide any needed service. The rooms have Needle Cases and Red Bio-Hazard bags for contaminated materials. The examining room is designed to ensure the patient's privacy and confidentiality. Any of the examination rooms can be utilized for any emergency.

There is a waiting area for youth offenders awaiting medical attention. There are bathroom facilities available as well as water and educational materials.

Minor emergencies are handled at the clinic. Emergencies that the clinic cannot handle are sent to the local emergency room for a higher level of care when indicated. This is accomplished by using the Lincoln Fire and Rescue, which has a response time of approximately 5-10 minutes. Supplies available at the clinic for responding to an emergency include a Crash Bag with emergency medications, including Benadryl, Narcan, and Tylenol. The facility has three AEDs, with one located in the clinic. Additionally, several First Aid Kits are located throughout the facility, as well as in all facility vehicles. Nurses inspect the AEDs and first aid kits on a monthly basis. All staff are trained in first aid and CPR and carry one-way breathing masks.

The facility does not have an infirmary. These youth are housed in their rooms when needed to recover from an illness or an isolation-required condition. If they are at the infirmary level, they are kept at the local hospital until they are cleared to return to the facility and can provide for their care. Offenders requiring long-term infirmary care are transferred to another facility or the local hospital.

Diamond Pharmacy provides medications for the facility. Medications are usually delivered the day after being ordered, or within two days if ordered after noon. The facility has medication storage (no pharmacy) on-site that stocks all the necessary medications, as well as the required sharps and tools. Controlled substances are secured and inventoried by licensed staff at the end of each shift. Medical sharps were tightly controlled and inventoried at the end of each shift, with adequate record-keeping practices in place. No discrepancies were noted during spot checks of the inventories. There are currently approximately 11 offenders taking medication. Medications are dispensed to the offender at the cell door or in the standard day room. Pill times are 7:00 a.m. and 7:00 p.m. No youth can self-administer medications.

Medication distribution is documented in the electronic medical record; however, C-2 controlled substances are reported in both the EMR and on paper logs. Offenders are not allowed to have KOP medications. Three no-shows for pill call are reported to the provider for disposition.

Psychotropic medications commonly being prescribed at the facility include Antidepressants - Celexa, Prozac, Zoloft, Lexapro, Imipramine, Paxil, Cymbalta, and Luvox, Mood Stabilization - Lamictal, Depakote, and Lithium, Antipsychotics - Risperdal, Abilify, and Antianxiety - Buspar. During the audit, there 11 patients were prescribed medications, totaling 28 doses per day.

Chronic illness clinics are held on Wednesday by Dr. Wittry. Approximately nine offenders are enrolled in chronic care clinics. Chronic care clinic encounters are conducted as determined by the providers, but no more frequently than every six months. Most are seen every three months for diagnosis or sooner if needed. There is no backlog for the chronic care clinic. There are no insulin-dependent diabetics at the facility. Finger sticks and insulin injections are conducted at the medical clinic and cell side.

Supplies for Universal precautions are procured from McKesson with no problems being noted.

Biohazardous materials for the clinic are stored in either needle cases or red biohazard bags in the medical unit, and this storage is picked up every three months or sooner if indicated.

Security for the clinic is provided by security staff who are always present in the clinic.

The sick call process for the clinic involves having the offender come to the clinic between 7:15 a.m. and 7:30 a.m., fill out a sick call request form, and then wait in the waiting area to be seen. The nurse will also see patients in their housing unit if needed.

Alternatively, the offender can fill out a sick call request form in the housing unit and place it in the sick call request box for pickup by healthcare staff. All sick call requests are generally seen the same day. The offender is seen by healthcare staff and referred to a provider if deemed necessary. The nursing staff triages all the sick call requests. Regular sick call hours are 7:00 a.m. until complete, Monday through Friday. There is no sick call on Saturdays and Sundays.

The Facility Administrator, Sarah Brownell, handles all offender complaints about the clinic services. The grievance process for healthcare is that the Facility Administrator would send any healthcare grievances to the Nurse for review and a necessary response. The Nurse would call the grievant out and go over the grievance with them. If the grievance cannot be resolved through this process, the Nurse would complete a response and forward it to the Facility Administrator for disposition.

The medical records are stored in an Electronic Medical Record (EMR) and follow the patient to each facility if they are transferred.

The Registered Nurse is also the Communicable Diseases/Infection Control Coordinator and has received all the required training for the position. If an offender is diagnosed with a communicable or infectious disease, such as TB, he would be sent to the Emergency Room to be placed in the negative pressure room provided for observation until a decision on disposition can be reached. Notifications would be made to the local health department, CDC, the DHHS, the YRTC Department, and the Facility Administrator. All medical and security staff are certified in CPR and are required to recertify every two years.

The reception process for new arrivals includes a health screening for all offenders, which provides for medical, Dental, and Mental Health Assessments. Newly arriving offenders are given instructions on how to access medical treatment, as well as Dental and Mental Health. The appropriate provider sees all newly arriving offenders within seven days or sooner if indicated. Instructions are provided in both English and Spanish, and a language line is available for those who do not speak English. If an offender is deemed to be illiterate, instructions are given verbally.

The intake screening also identifies offenders who may be vulnerable to sexual abuse/assault, and/or offenders who may be sexually abusive/assaultive.

Radiology services are not provided on-site, and patients are sent to the Emergency Room for any x-ray orders that may be needed.

Lab-Corp provides laboratory services. Specimens are obtained on-site by the nurses. They are received and picked up five days per week as needed. Results are available the following day by computer. Any results with critical values are immediately faxed, and the facility is contacted, and the laptop is flagged for immediate readings. STAT labs can be done at the local hospital if needed.

Specialty services are not provided onsite, and the offender is transferred to all appointments for specialty services.

Disaster drills are conducted three times a month, fire drills are conducted quarterly, and mock code drills are conducted quarterly, with additional sessions sometimes held more frequently. Critiques are prepared for all and are reviewed at the monthly QA team meetings.

The clinic currently has 12 youth offenders on diets, with the only prescribed diet being a food allergy.

The clinic has a Quality Assurance team that reviews the performance of healthcare services at the facility. The QA team consists of the Facility Administrator, Nurse, Compliance department representative, and a security representative.

Medically significant issues at the facility include no suicide since the last audit.

Dental

Off-site contracted dental providers provide dental services. There are no on-site dental services.

Mental Health

Staffing for the Mental Health Department includes: One LMHP, one Psychologist, five days a week, and one Mental Health Director and Psychiatrist.

The department offers Crisis Intervention, Individual Counseling, Individual Treatment Plans, and a Multi-Disciplinary Team. Programs offered that are scientific include Moral Recognition Therapy, Applied Behavior Analysis, Trauma-Informed Care, and Love Notes. Dialectical Behavioral Therapy and Power Source

Offenders are provided access to Mental Health services by submitting a two=way communication form to the MH department, and they would be seen within 24-48 hours. In an emergent situation, the offender would be seen immediately. If it is after hours, the on-call provider would be contacted. If deemed necessary, the on-call provider would visit the facility to address the situation. In a situation where the offender has made comments about suicide or hurting himself/herself, they would be kept under close observation until seen by Mental Health staff. The offender rooms are single-occupancy and will be made into suicide or observation room if indicated. Offenders in these circumstances would be allowed to have a mattress, a shroud, and meals would consist of finger food.

Offenders in these circumstances receive an initial evaluation, and a treatment plan is developed. They would be seen daily by nursing and mental health for 30 days and then re-evaluated. If deemed appropriate, the offender may be transferred to a facility better equipped to address their medical or mental health needs.

Mental health rounds are conducted daily in the units by the Psychologist or the LMHP, who make stops at all occupied cells.

Four and five-point restraints are not used at the facility. If immediate action is necessary in an emergency the offender is restrained in either mechanical wrist and leg restraints or leather restraints. A helmet can be utilized when offenders are presenting self-injurious behaviors while being restrained. Offenders are initially evaluated by nursing staff and mental health staff. If the placement continues for more than two hours, the Facility Administrator is notified. The Facility Administrator reviews and approves appropriate use of mechanical restraints.

During this audit, I had the pleasure of speaking with a female youth to gain her perspective on the facility, her treatment, the food, and the medical department's practices to assist her. She was very positive in her response and spoke highly of the medical and correctional staff. She indicated this was her third time there, and she was doing well. The food was okay, but not the best. She revealed she has been seen promptly for all sick call requests and gets what she needs when asked.

Recreation

Youth are required to participate in two-three hours of recreation daily unless prohibited for health reasons. Activities are supervised by Behavior Technicians and Activity Specialists.

The YRTC-L offers a complete recreational and leisure time program. Recreational programs include access to the gymnasium and outdoor recreation areas. There is an opportunity for both individual and group recreation.

Religious Programming

Religious services are contracted volunteers from the local community to provide religious services. Both on a group and individual basis. The YRTC-L administration encourages citizen involvement and volunteers' programs. The goal of citizen volunteer programs is to generate a variety of services and experiences for the youth.

Offender Work Programs

Youth Rehabilitation and Treatment Center-Lincoln does not have an offender work program.

Academic and Vocational Education

The YRTC-L education program is provided by West Hastings school (WHS) for females and West Kearney School (WKS) for males. WHS and WKS provide year-round education and Vocational services that are available at no cost to students and are consistent with the needs of the students committed to the YRTC-L. WHS and WKS are accredited by the Nebraska Department of Education (NDE) as a Special Purpose School. Programming and school classrooms are designed to conform to this accreditation. All course offerings are provided as required by the NDE certification as a Rule 10 School.

Students attend WHS and WKS and may earn a High School diploma or may be enrolled in a GED program. Any credit earned by students attending WHS and WKS may be transferred to their home schools upon their return to the community.

Extracurricular activities will be offered in compliance with the requirements of approval under the school agreement. Students may participate in intramural sports. The library services of the school include recreational reading materials, part of which are on permanent loan to teach each living unit.

The school will graduate seniors, promote 8th grade students, and honor those completing the GE program or achieving other significant successes. The school holds a graduation ceremony as needed. The four GED subjects are Mathematical Reasoning, Reasoning Through Language Arts, Science, and Social Studies. Elective classes include but are not limited to Business Information and Technology, Career Education, Family Life Skills, Health Education, Psychology, and Physical Education.

Vocational services are integrated with the academic program provided by a Vocational Counselor based on a youth's age, needs, and employment opportunities. Vocational testing and follow-up counseling are available, researching post high school educational opportunities, after-care vocational programming, and employment/volunteer activities.

YTRC-Lincoln offers a graduate program for youth who have earned their high school diploma or GED.

Social Services

YRTC-L staff provides a substance use disorders programming that includes education/intervention-based program that includes assessment, education, programing and referrals.

Clients are scheduled to meet with counseling staff for at least one individual session and two group sessions weekly. In that the average length of stay is four to six months, the client receives an intense treatment program of social services, Moral Recognition Therapy (MRT), which is a cognitive behavioral program that seeks to decrease recidivism by increasing moral reasoning.

Trauma Affect Regulation: Guide for Education & Therapy (TARGET). TARGET is a psychosocial intervention that provides education about the impact of complex traumatic stress on the brain's stress response system, and strengths-based practical skills for re-setting the trauma-related alarms/survival reactions that occur in complex PTSD.

Dialectical Behavioral Therapy (DBT) is a type of cognitive therapy that is evidence-based and is used to treat many conditions. Staff at all YRTC locations have gone through DBT training and are incorporating these skills into their individual, family, and group therapy interventions.

Power Source is an evidence-based program designed to empower at-risk youth with social and emotional skills necessary to forge paths of health development and disengagement from high-risk and offending behaviors. Grounded in a belief in each person's intrinsic dignity and worth, Power Source guides trauma-impacted adolescents and young adults in discovering their resilience while also building the skills associated with health, social, emotional, and identity development. Offering a wide range of tools and resources, Power Source enables facilitators to address youth's unique socio-mental needs, risk factors, and protective factors through high impact, engaging exercises, role plays, discussions, games, and meditation. Staff at all YRTC locations have received Power Source training and have incorporated these skill sets into individual and family therapy interventions.

Visitation

Visitation for approved visitors is always scheduled. Visitation is arranged by YRTC-L staff and the treatment team. All visits are planned on an individual basis to accommodate the schedule. Special visits for family emergencies, funerals, or weddings are permitted with the approval of the Facility Administrator. Virtual visits are also possible.

There is one room for non-contact visitation and another gender separation. Visitations are held on Tuesday and Thursday, and 1/2-day visits on Saturday. All visitations are separate from Lancaster County.

Special visits for family emergencies, funerals, and attorneys are permitted with the approval of the Facility Administrator.

Library Services

Lincoln library includes a variety of fiction, non-fiction, biographies and graphic novels. The library is shared with the Lancaster County Services Center, residents. Titles range in readability from emergent readers to young adult selections.

There are also magazines and newspapers. Youth are allowed to check out two books. There is an available inter-library loan system with the public school system.

Laundry

The laundry service at YRTC-L is equipped with two commercial washers and two commercial dryers, and chemicals by Ecolab dispensed through injectors. There is an eye wash station available. The Behavior Technicians do the laundry. The youth can earn specific clothing through an incentive program from the facility. There are available security smocks and blankets.

The laundry is collected, washed, folded, and distributed by the third shift staff. Clothing and underwear are exchanged daily along with towels and washcloths. Bed linen and blankets are exchanged. The facility also has an ample supply of youth clothing and bedding for emergency purposes.

Youth are provided with pants, shirts, underclothing, sweatshirts, socks, shoes, a blanket, sheets, towels, and hygiene products such as toothbrush/holder, toothpaste, deodorant, soap, and comb. Female youth are also issued bras and personal hygiene supplies.

A copy of the clothing and personal property inventory is provided to the youth, and items are returned upon release from the facility.

F. Examination of Records

Following the facility tour, the team proceeded to the conference to review the accreditation files and evaluate compliance levels of the policies and procedures. The facility has no notices of non-compliance with local, state, or federal laws or regulations.

1. Litigation

Over the last three years, the facility had no consent decrees, class action lawsuits or adverse judgments.

2. Significant Incidents/Outcome Measures

Significant Incidents and Outcome Measures are consistent with the size and population of the facility.

3. Departmental Visits

Team members revisited the following departments to review conditions relating to departmental policy and operations:

Department Visited	Person(s) Contacted
Administrative	Sarah Brownell Lucas Jones
Medical	Joni Suhr Holly Boyd
Education	Lutz Seth
Security	Ross Merritt

Ashton Willett
Aimee Perez-Valentine
Joe Madison
Taylor Beenblossom
Labessa Williams

4. Shifts

a. Day Shift

The team was present at the facility during the day shift which is from 6:00 a.m. to 2:00 p.m. All staff that were observed by the team acted professionally and appeared to be knowledgeable about their duties. The team observed youth participating in group sessions, receiving their meals in their respective pods, and their involvement with counseling sessions.

b. Evening Shift

The team was present at the facility during the evening shift, which is from 2:00 p.m. to 10:00 p.m. All staff that were observed by the team acted professionally and appeared to be knowledgeable about their duties.

c. Night Shift

The team was present at the facility during the night shift which is from 10:00 p.m. to 6:00 p.m. All staff on the shift were passionate about their jobs and knowledgeable of their duties.

5. Status of Previously Non-compliant Standards/Plans of Action

There were no standards previously found non-compliant.

G. Interviews

During the audit, team members met with both staff and offenders to verify observations and/or to clarify questions concerning facility operations.

1. Offender Interview

The audit team interviewed several youths with three being one-on-one formal interviews. The youth stated that there were no problems with the administration nor staff. All stated that staff were really concerned about them being successful after leaving YRTC-L.

2. Staff Interviews

During the audit, 16 staff members were interviewed. They all stated that they felt safe and loved their jobs while working with the youth. Staff were positive about trying to reshape the lives of the youth they are working with at the facility.

The team observed security shift change from the evening shift to the night shift. The morale of the staff was positive.

H. Exit Discussion

The exit interview was held at 11:00 a.m. in the conference room due to the distance to the airport. The Facility Administrator, Sarah Brownell and five staff members were in attendance.

The following agency employees were also in attendance:

Fr. Sara Thomas, Clinical Director
Scott Engligh, DHHS Facilities Superintendent
Samuel Johnston, Compliance Specialist
Thomas Foster, Compliance Specialist
Lucas Jones, DHHS Compliance Manager/Accreditation Manager
Shaylee Fortner, DHHS Compliance Administrator

The chairperson explained the procedures that would follow the audit. The team discussed the compliance levels of the mandatory and non-mandatory standards and reviewed their individual findings with the group.

The chairperson expressed appreciation for the cooperation of everyone concerned and congratulated the facility team for the progress made and encouraged them to continue to strive toward even further professionalism within the correctional field.

AMERICAN CORRECTIONAL ASSOCIATION

AND THE

COMMISSION ON ACCREDITATION FOR CORRECTIONS

COMPLIANCE TALLY

Manual Type	Juvenile Correctional Facilities, 4th Edition	
Supplement	2016 Standards Supplement	
Facility/Program	State of Nebraska Youth Rehabilitation	
Audit Dates	June 25-27, 2025	
Auditor(s)	Dave Johnson, Chairperson Linda Osborn, Member Allen Peaton, Member	
	MANDATORY	**NON-MANDATORY**
Number of Standards in Manual	40	331
Number Not Applicable	3	20
Number Applicable	37	311
Number Non-Compliance	0	0
Number in Compliance	37	311
Percentage (%) of Compliance	100%	100%

- Number of Standards *minus* Number of Not Applicable *equals* Number Applicable
- Number Applicable *minus* Number Non-Compliance *equals* Number Compliance
- Number Compliance *divided by* Number Applicable *equals* Percentage of Compliance

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Youth Rehabilitation & Treatment Center
Lincoln, Nebraska

June 25-27, 2025

Visiting Committee Findings

Mandatory Standards

Not Applicable

Standard #4-JCF-2A-18

FOUR-/FIVE-POINT RESTRAINTS ARE USED ONLY IN EXTREME INSTANCES AND ONLY WHEN OTHER TYPES OF RESTRAINTS HAVE PROVEN INEFFECTIVE OR THE SAFETY OF THE JUVENILE IS IN JEOPARDY. ADVANCE APPROVAL IS SECURED FROM THE FACILITY ADMINISTRATOR/DESIGNEE BEFORE A JUVENILE IS PLACED IN A FOUR-/FIVE-POINT RESTRAINT. SUBSEQUENTLY, THE HEALTH AUTHORITY OR DESIGNEE MUST BE NOTIFIED TO ASSESS THE JUVENILE'S MEDICAL AND MENTAL HEALTH CONDITION, AND TO ADVISE WHETHER, ON THE BASIS OF SERIOUS DANGER TO SELF OR OTHERS, THE JUVENILE SHOULD BE IN A MEDICAL/MENTAL HEALTH UNIT FOR EMERGENCY INVOLUNTARY TREATMENT WITH SEDATION AND/OR OTHER MEDICAL MANAGEMENT, AS APPROPRIATE. IF THE JUVENILE IS NOT TRANSFERRED TO A MEDICAL/MENTAL HEALTH UNIT AND IS RESTRAINED IN A FOUR-/FIVE-POINT POSITION, THE FOLLOWING MINIMUM PROCEDURES ARE FOLLOWED:

- DIRECT VISUAL OBSERVATION BY STAFF IS CONTINUOUS PRIOR TO OBTAINING APPROVAL FROM THE HEALTH AUTHORITY OR DESIGNEE.
- SUBSEQUENT VISUAL OBSERVATION IS MADE AT LEAST 15 MINUTES.
- RESTRAINT PROCEDURES ARE IN ACCORDANCE WITH GUIDELINES APPROVED BY THE DESIGNATED HEALTH AUTHORITY.
- ALL DECISIONS AND ACTIONS ARE DOCUMENTED.

FINDINGS:

Four/five-point restraint not used at YRTC-Lincoln

Standard #4-JCF-2A-27

THE LEVEL OF AUTHORITY, ACCESS, AND CONDITIONS REQUIRED FOR THE AVAILABILITY, CONTROL, AND USE OF CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE MUST BE SPECIFIED. CHEMICAL AGENTS ARE USED ONLY WITH THE AUTHORIZATION OF THE FACILITY ADMINISTRATOR, MEDICAL DIRECTOR, OR DESIGNEE.

1. CHEMICAL AGENTS AND EQUIPMENT RELATED TO ITS USE ARE INVENTORIED AT LEAST MONTHLY TO DETERMINE THEIR CONDITION AND EXPIRATION DATES.
2. PERSONNEL USING CHEMICAL AGENTS TO CONTROL JUVENILES SUBMIT WRITTEN REPORTS TO THE FACILITY ADMINISTRATOR OR DESIGNEE NO LATER THAN THE CONCLUSION OF THE TOUR OF DUTY.
3. ALL PERSONS CONTAMINATED IN AN INCIDENT INVOLVING THE USE OF A CHEMICAL AGENT MUST RECEIVE AN IMMEDIATE MEDICAL EXAMINATION AND TREATMENT.

FINDINGS:

Chemical agents are not used to manage an uncontrollable juvenile and are not maintained in the facility.

Standard #4-JCF-4C-47

GUIDELINES REGARDING THE USE OF RESTRAINTS ON JUVENILES FOR MEDICAL AND MENTAL HEALTH PURPOSES AT A MINIMUM SHALL INCLUDE:

1. CONDITIONS UNDER WHICH RESTRAINTS MAY BE APPLIED
2. TYPES OF RESTRAINTS TO BE APPLIED
3. IDENTIFICATION OF A QUALIFIED MEDICAL OR MENTAL HEALTH PROFESSIONAL AND HEALTH CARE PRACTITIONER WHO MAY AUTHORIZE THE USE OF RESTRAINTS AFTER REACHING THE CONCLUSION THAT LESS INTRUSIVE MEASURES ARE NOT SUCCESSFUL
4. MONITORING PROCEDURES
5. LENGTH OF TIME RESTRAINTS ARE TO BE APPLIED
6. LESS-RESTRICTIVE-TREATMENT-PLAN ALTERNATIVES ARE DEVELOPED AND IMPLEMENTED AS SOON AS POSSIBLE
7. AFTER-INCIDENT REVIEW

FINDINGS:

YRTC-Lincoln does not use restraints on juveniles for medical or mental health purposes.

COMMISSION ON ACCREDITATION FOR CORRECTIONS

Youth Rehabilitation & Treatment Center
Lincoln, Nebraska

June 25-27, 2025

Visiting Committee Findings

Non-Mandatory Standards

Not Applicable

Standard #4-JCF-1C-02

MULTIPLE-OCCUPANCY ROOMS TO INCLUDE OPEN-BAY DORMITORIES PROVIDE:

1. SOME DEGREE OF PRIVACY WITH AT LEAST 25 SQUARE FEET OF UNENCUMBERED SPACE PER OCCUPANT
2. WHEN CONFINEMENT EXCEEDS 10 HOURS PER DAY THERE ARE AT LEAST 80 SQUARE FEET PER OCCUPANT
3. A BED FOR EACH JUVENILE.
4. ADEQUATE STORAGE SPACE FOR CLOTHING AND PERSONAL BELONGINGS FOR EACH JUVENILE
5. A WRITING SURFACE
6. ACCESS TO TOILETS AND A WASHBASIN WITH HOT AND COLD RUNNING WATER 24 HOURS PER DAY

FINDINGS:

YRTC-Lincoln does not use multiple occupancy rooms, such as open bay dormitories.

Standard #4-JCF-1C-09

FOOD SERVICE FACILITIES INCLUDING KITCHEN AND DINING AREAS MEET THE FOLLOWING DESIGN REQUIREMENTS:

1. TOILET AND SINK FACILITIES ARE AVAILABLE TO FOOD SERVICE PERSONNEL AND JUVENILES IN THE VICINITY OF THE FOOD PREPARATION AREA.
2. SPACE IS PROVIDED FOR GROUP DINING EXCEPT WHERE SECURITY OR SAFETY CONSIDERATIONS JUSTIFY OTHERWISE.

3. ADEQUATE SPACE IS PROVIDED FOR FOOD PREPARATION BASED ON THE POPULATION SIZE, TYPE OF FOOD PREPARATION, AND METHODS OF MEAL SERVICE.
4. THERE ARE PROVISIONS FOR ADEQUATE STORAGE AND LOADING AREAS AND GARBAGE DISPOSAL FACILITIES.

FINDINGS:

Food services for YRTC-Lincoln are provided by a contracted, off-site company.

Standard #4-JCF-3A-27

THE AGENCY RESPONSIBLE FOR THE COMMUNITY SUPERVISION OF THE JUVENILE IS AUTHORIZED TO PETITION THE PLACING/RELEASING AUTHORITY IF IT APPEARS THAT THE JUVENILE HAS WILLFULLY FAILED TO COMPLY WITH ANY PART OF THE DISPOSITION OR RELEASE ORDER. A COPY OF THIS PETITION IS PROVIDED TO THE JUVENILE, HIS/HER ATTORNEY, PARENT, AND/OR GUARDIAN.

FINDINGS:

YRTC does not provide community supervision. Functions of the juvenile court.

Standard #4-JCF-3C-17

AN ADMINISTRATIVE REVIEW IS PROVIDED FOR JUVENILES TRANSFERRED TO A MORE RESTRICTIVE PROGRAM OR SECURE FACILITY.

FINDINGS:

YRTC-Lincoln has the most restrictive program and facility within the office of juvenile services.

Standard #4-JCF-3E-01

THE FACILITY PROVIDES SERVICES AND OPPORTUNITIES THAT ENCOURAGE JUVENILES TO TAKE RESPONSIBILITY FOR THEIR ACTIONS AND MAKE RESTITUTION TO THE VICTIMS OF THEIR CRIME(S) AND/OR TO THE COMMUNITY, WHEN REQUIRED. OPPORTUNITIES ARE BASED ON COMMUNITY INPUT AND ARE FASHIONED IN A WAY THAT SEEKS TO AMELIORATE THE HARM DONE.

FINDINGS:

YRTC-Lincoln has no information or contact with victims and thus there is no restitution program.

Standard #4-JCF-4A-01

THE FACILITY HAS A DESIGNATED FULL-TIME STAFF MEMBER, EXPERIENCED IN FOOD SERVICE MANAGEMENT, TO MANAGE DIETARY OPERATIONS. THE DESIGNATED STAFF MEMBER'S MANAGEMENT RESPONSIBILITIES ARE OUTLINED IN A JOB DESCRIPTION, WRITTEN AGREEMENT, OR CONTRACT.

FINDINGS:

Food service is provided by an outside contractor.

Standard #4-JCF-4A-05

THE FOOD SERVICE PLAN PROVIDES FOR A SINGLE MENU FOR STAFF AND JUVENILES.

FINDINGS:

YRTC-Lincoln does not provide employees with meals from the facility contractor.

Standard #4-JCF-4A-11

THE FOOD SERVICE MANAGER, OR OTHER QUALIFIED PERSONNEL, CONDUCTS WEEKLY SANITATION INSPECTIONS OF ALL FOOD SERVICE EQUIPMENT AND AREAS, INCLUDING DINING AND FOOD-PREPARATION AREAS. WATER TEMPERATURES ARE CHECKED AND RECORDED DAILY. WATER TEMPERATURE ON THE FINAL DISHWASHER RINSE SHOULD BE 180 DEGREES FAHRENHEIT; OR BETWEEN 140 DEGREES FAHRENHEIT AND 160 DEGREES FAHRENHEIT IF A SANITIZER IS USED ON THE FINAL RINSE.

FINDINGS:

YRTC-Lincoln food service is contracted. Food is stored and maintained off-site.

Standard #4-JCF-4A-12

THE FOOD SERVICE MANAGER, OR OTHER QUALIFIED PERSONNEL, CONDUCTS DAILY INSPECTIONS OF ALL TEMPERATURE-CONTROLLED STORAGE AREAS AND APPLIANCES, INCLUDING REFRIGERATORS, FREEZERS, AND DRY STORAGE AREAS. TEMPERATURES ARE RECORDED WITH EACH INSPECTION.

1. STORED SHELF GOODS SHALL BE MAINTAINED AT 45 DEGREES TO 80 DEGREES FAHRENHEIT.
2. REFRIGERATED FOODS SHALL BE MAINTAINED AT 35 DEGREES TO 40 DEGREES FAHRENHEIT.
3. FROZEN FOODS SHALL BE MAINTAINED AT 0 DEGREES FAHRENHEIT OR BELOW, UNLESS NATIONAL OR STATE HEALTH CODES SPECIFY OTHERWISE.

FINDINGS:

Food is stored and maintained via contracted services, not located on-site.

Standard #4-JFC-4B-05

PROTECTIVE CLOTHING AND EQUIPMENT ARE ISSUED TO JUVENILES ASSIGNED TO WORK IN FOOD SERVICE, THE GARAGE, THE FACILITY PHYSICAL PLANT, THE MAINTENANCE SHOPS, VOCATIONAL EDUCATION, AND OTHER SPECIAL WORK AREAS.

FINDINGS:

YRTC-Lincoln does not offer a work program within the facility.

Standard #4-JCF-4C-56

ANY STUDENTS, INTERNS, OR RESIDENTS DELIVERING HEALTH CARE IN THE FACILITY, AS PART OF A FORMAL TRAINING PROGRAM, WORK UNDER STAFF SUPERVISION, COMMENSURATE WITH THEIR LEVEL OF TRAINING. THERE IS A WRITTEN AGREEMENT BETWEEN THE FACILITY AND TRAINING OR EDUCATIONAL FACILITY THAT COVERS THE SCOPE OF WORK, LENGTH OF AGREEMENT, AND ANY LEGAL OR LIABILITY ISSUES. STUDENTS OR INTERNS AGREE IN WRITING TO ABIDE BY ALL FACILITY POLICIES, INCLUDING THOSE RELATING TO THE SECURITY AND CONFIDENTIALITY OF INFORMATION.

FINDINGS:

YRTC-Lincoln does not use students, interns, or residents in the delivery of health care services.

Standard #4-JCF-4C-57

JUVENILES ARE PROHIBITED FROM PERFORMING HEALTH CARE DUTIES IN THE FACILITY.

FINDINGS:

Youth are prohibited from performing health care duties at YRTC-Lincoln.

Standard #4-JCF-5B-04

WHEN JUVENILES ARE TRANSFERRED TO A MORE SECURE FACILITY, THEY MUST BE PROVIDED A PLAN THAT SPECIFIES THE OBJECTIVES OF THE PLAN, DETAILS THE METHODS FOR ACHIEVING THE OBJECTIVES, PROVIDES PROCEDURAL SAFEGUARDS, AND PROVIDES A MONITORING AND EVALUATION MECHANISM. THE PLAN IS REVIEWED AT LEAST ANNUALLY AND UPDATED, IF NECESSARY.

FINDINGS:

YRTC-Lincoln is the most secure facility under the office of Juvenile services.

Standard #4-JCF-5H-02

THE JUVENILE WORK PLAN PROVIDES FOR EMPLOYMENT FOR JUVENILES WITH DISABILITIES.

FINDINGS:

YTC-Lincoln does not allow juveniles to be employed in the community.

Standard #4-JCF-5H-03

JUVENILES EMPLOYED IN THE COMMUNITY BY PUBLIC OR PRIVATE ORGANIZATIONS IN POSITIONS NORMALLY OCCUPIED BY PRIVATE CITIZENS ARE COMPENSATED AT THE PREVAILING RATE.

FINDINGS:

YRTC-Lincoln does not allow juveniles to be employed in the community.

Standard #4-JCF-51-03

TEMPORARY RELEASE PROGRAMS INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

1. WRITTEN OPERATIONAL PROCEDURES
2. SCREENING AND SELECTION CRITERIA
3. GOALS AND OBJECTIVES FOR PLANNED ACTIVITIES
4. WRITTEN RULES OF JUVENILE CONDUCT AND SANCTIONS FOR MISBEHAVIOR

5. SUPERVISION TO ENCOURAGE POSITIVE BEHAVIOR

FINDINGS:

YRTC-Lincoln does not provide temporary release programs.

Standard #4-JCF-51-04

WHERE STATUTES PERMIT, JUVENILES SHOULD BE AFFORDED OPPORTUNITIES FOR GRADUATED RELEASE AND PARTICIPATION IN EMPLOYMENT AND EDUCATION PROGRAMS.

FINDINGS:

YRTC-Lincoln has no opportunities for graduate release or participation in employment/education programs.

Standard #4-JCF-6A-03

IF SERVICES FOR ADULT AND JUVENILE OFFENDERS ARE PROVIDED BY THE SAME AGENCY, STATEMENTS OF PHILOSOPHY, POLICY, PROGRAM, AND PROCEDURE DISTINGUISH BETWEEN CRIMINAL CODES AND THE STATUTES THAT ESTABLISH, GIVE DIRECTION, AND GUIDE PROGRAMS FOR JUVENILES.

FINDINGS:

YRTC-Lincoln does not provide adult services.

Standard #4JCF-6B-11

IF A CANTEEN IS AVAILABLE WHERE JUVENILES CAN PURCHASE APPROVED ITEMS THAT ARE NOT FURNISHED BY THE FACILITY, THE CANTEEN OPERATIONS ARE STRICTLY CONTROLLED USING STANDARD ACCOUNTING PROCEDURES.

FINDINGS:

YRTC-Lincoln does not offer canteen or community purchasing.

Standard #4-JCF-6G-07

CONSISTENT WITH JURISDICTIONAL LAWS, REGISTERED CRIME VICTIM(S) ARE NOTIFIED OF A JUVENILE OFFENDER'S RELEASE PRIOR TO ANY PLANNED RELEASE FROM CONFINEMENT AND/OR ESCAPE FROM CUSTODY.

FOLLOW-UP NOTIFICATION TO VICTIMS OCCURS WHEN ESCAPEES ARE RETURNED TO CUSTODY.

FINDINGS:

Jurisdictional laws relating to this standard do not apply to juvenile offenders in the state of Nebraska, thus, making this standard not applicable.

Significant Incident Summary

This report is required for all **residential** accreditation programs.

This summary is required to be provided to the Chair of your visiting team upon their arrival for an accreditation audit and included in the facility's Annual Report. The information contained on this form will also be summarized in the narrative portion of the visiting committee report and will be incorporated into the final report. Please type the data. If you have questions on how to complete the form, please contact your Accreditation Specialist.

This report is for Adult Correctional Institutions, Adult Local Detention Facilities, Core Jail Facilities, Boot Camps, Therapeutic Communities, Juvenile Correctional Facilities, Juvenile Detention Facilities, Adult Community Residential Services, and Small Juvenile Detention Facilities.

Facility Name: YRTC-Lincoln Reporting Period: April 2024 – March 2025

Incident Type	Months ⇨	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	Total for Reporting Period
Escapes		0	0	3	0	0	0	0	0	0	0	0	0	3
Disturbances*		0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Violence		0	0	0	0	0	0	0	0	0	0	0	0	0
Homicide*	Offender Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Staff Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
	Other Victim	0	0	0	0	0	0	0	0	0	0	0	0	0
Assaults	Offender / Offender	0	0	0	0	0	0	0	0	0	0	0	0	0
	Offender / Staff	1	1	0	0	0	1	0	0	0	1	2	0	6
Suicide		0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Compliance with a Mandatory Standard*		0	0	0	0	0	0	0	0	0	0	0	0	0
Fire*		0	0	0	0	0	0	0	0	0	0	0	0	0
Natural Disaster*		0	0	0	0	0	0	0	0	0	0	0	0	0
Unnatural Death		0	0	0	0	0	0	0	0	0	0	0	0	0
Other*		0	1	3	0	2	1	0	0	0	0	0	0	7

**May require reporting to ACA using the Critical Incident Report as soon as possible within the context of the incident itself.*

		Safety & Security Outcomes		2024-2025
Performance Standard	Outcome Measure		Value	Calculated Outcome Measure
A		**YOUTH ON YOUTH INCIDENTS**		
		Outcome Measures		
	(1)	**Number of youth on youth assaults with a weapon (object of any description used to cause harm to another) in the past twelve months divided by the total number of youth on youth assaults in the past twelve months**		0.00%
	(2)	**Number of confirmed youth on youth sexual assaults in the past twelve months divided by the total number of youth on youth assaults in the past twelve months.**		0.00%
	(3)	**Number of confirmed youth on youth assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of youth on youth assaults prosecuted in the past twelve months.**		0.00%
	(4)	**Number of youth on youth fights resulting in injury requiring medical treatment (band-aid, ice, stitches, x-ray, emergency room, etc.) in the past twelve months divided by the total number of youth fights in the past twelve months.**		46.67%
		Data Collection		
		Number of youth on youth assaults in the past twelve months	20	
		Number of youth on youth assaults with a weapon (object of any description used to cause harm to another) in the past twelve months	0	
		Number of confirmed youth on youth sexual assaults in the past twelve months	0	
		Number of youth on youth cases prosecuted in the past twelve months	0	
		Number of guilty verdicts/convictions in cases prosecuted in the past twelve months	0	
		Number of reported incidents of youth on youth fights in the past twelve months	15	
		Number of youth on youth fights resulting in injury requiring medical treatment (band-aid, ice, stitches, x-ray, emergency room, etc.) in the past twelve months	7	
B		**YOUTH ON STAFF INCIDENTS**		
		Outcome Measures		
	(1)	**Number of youth on staff assaults with a weapon in the past twelve months divided by the total number of youth on staff assaults in the past twelve months.**		0.00%
	(2)	**Number of confirmed youth on staff sexual assaults in the past twelve months divided by the total number of youth**		0.00%

		on staff assaults in the past twelve months.		
	(3)	**Number of confirmed youth on staff assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of youth on staff assaults prosecuted in the past twelve months.**		0.00%
		Data Collection		
		Number of youth on staff assaults in the past twelve months	74	
		Number of youth on staff assaults with a weapon in the past twelve months	0	
		Number of confirmed youth on staff sexual assaults	0	
		Number of staff assaults prosecuted in the past twelve months	0	
		Number of youth on staff assault cases resulting in guilty verdicts/convictions in the past twelve months	0	
C		**STAFF ON YOUTH INCIDENTS**		
		Outcome Measures		
	(1)	**Number of staff on youth assaults with a weapon in the past twelve months divided by the total number of staff on youth assaults in the past twelve months.**		0.00%
	(2)	**Number of confirmed staff on youth sexual assaults in the past twelve months divided by the total number of staff on youth assaults in the past twelve months.**		0.00%
	(3)	**Number of confirmed staff on youth assaults prosecuted resulting in a guilty verdict/conviction in the past twelve months divided by the total number of staff on youth assaults prosecuted in the past twelve months.**		0.00%
		Data Collection		
		Number of staff on youth assaults in the past twelve months	0	
		Number of staff on youth assaults with a weapon in the past twelve months	0	
		Number of confirmed staff on youth sexual assaults	0	
		Number of staff on youth assaults prosecuted in the past twelve months	0	
		Number of staff on youth assaults cases resulting in guilty verdicts/convictions in the past twelve months	0	
D		**USES OF FORCE**		
		Outcome Measures		
	(1)	**Number of uses of force incidents requiring hands on intervention without mechanical restraints (non-escort, non-transport) in the past twelve months.**		20
	(2)	**Number of use of force incidents requiring the use of mechanical restraints (non-transport) in the past twelve months divided by the total number of use of force incidents in the past twelve months**		80%
	(3)	**Number of use of force incidents requiring the use of four – five point restraints in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		0.00%

	(4)	**Number of use of force incidents requiring the use of chemical agents in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		0.00%
	(5)	**Number of use of force incidents requiring the use of some other non-lethal security device (baton, shield, tazer, etc.) in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		8.00%
	(6)	**Number of use of force incidents resulting in injury to youth in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		29%
	(7)	**Number of use of force incidents resulting in injury to staff in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		34%
	(8)	**Number of use of force incidents determined to be excessive in the past twelve months divided by the total number of use of force incidents in the past twelve months.**		1.00%
		Data Collection		
		Number of use of force incidents in the past twelve months	100	
		Number of use of force incidents requiring hands-on intervention in the past twelve months	100	
		Number of use of force incidents requiring restraints in the past twelve months	80	
		Number of use of force incidents requiring four or five point restraints in the past twelve months	N/A	
		Number of use of force incidents requiring the use of chemical agents in the past twelve months	N/A	
		Number of use of force incidents requiring the use of some other non-lethal security device (baton, shield, tazer, etc.) in the past twelve months	8	
		Number of use of force incidents resulting in injury to youth in the past twelve months	29	
		Number of use of force incidents resulting in injury to staff in the past twelve months	34	
		Number of use of force incidents determined to be excessive in the past twelve months	1	
E		**CRITICAL INCIDENTS**		
		Outcome Measure: Events of this type as defined in this section are unique and their analysis needs to be individualized.		
	(1)	**Description of each incident of youth disturbance to include response, analysis and resulting plans of action.**		
	(2)	**Description of each incident of employee work stoppage to include response, analysis and resulting plans of action.**		
	(3)	**Description of each incident involving a hostage to**		

		include response, analysis and resulting plans of action.		
	(4)	**Description of each incident of man-made or natural disaster to include response, analysis and resulting plans of action.**		
	(5)	**Description of each incident of escape from a secure facility or during secure transport to include response, analysis and resulting plans of action.**		
	(6)	**Description of any employee deaths related to occupational injury, illness, homicide, suicide or natural causes within the past twelve months to include response, analysis and resulting plans of action.**		
	(7)	**Description of any juvenile deaths related to accidental injury, illness, homicide, suicide or natural causes for the past twelve months to include response, analysis and resulting plans of action.**		
		Data Collection		
		The dates and number of incidents of youth disturbance, i.e. 4 or more youth in an organized group engaging in violence toward other youth or staff, vandalism, and/or destruction property in the past twelve months	0	
		The dates and number of incidents of employee work stoppage	0	
		The dates and number of incidents involving a hostage situation	0	
		The dates and number of incidents of man made or natural disaster, i.e. significant weather emergency, loss of power exceeding 8 hours, environmental accident, excessive illness or infection of youth or staff impacting operations, terrorist action, etc.	0	
		Average daily population for the past twelve months	14	
		Number of attempted escapes from a secure facility in the past twelve months	0	
		Number of attempted escapes during a secure transport in the past twelve months	0	
		Number of actual escapes from a secure facility in the past twelve months	3	
		Number of actual escapes during a secure transport in the past twelve months	0	
		Number of walkaways from a nonsecure facility in the past twelve months	0	
		Number of absences from furlough during the past twelve months	0	
		Number of absences from other planned events in nonsecure settings or during nonsecure transport in the past twelve months	0	
		Total number of employees allotted to the table of organization for this site	702	
		Average daily juvenile population for the past twelve months	14	
		Number and cause of employee deaths for the past twelve	0	

		months		
		Number and cause of juvenile deaths for the past twelve months	0	
F		**YOUTH GRIEVANCES**		
		Outcome Measures		
	(1)	**Total number of youth grievances found in favor of the youth related to access to legal counsel or courts in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(2)	**Total number of youth grievances found in favor of the youth related to communications (mail, telephone, and visitation) in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(3)	**Total number of youth grievances found in favor of the youth related to discipline received in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(4)	**Total number of youth grievances found in favor of the youth related to food service in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(5)	**Total number of youth grievances found in favor of the youth related to personal hygiene, personal grooming or clothing divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(6)	**Total number of youth grievances found in favor of the youth related to physical or verbal abuse by other juveniles in the past twelve months divided by the total number of youth grievances filed I the past twelve months.**		0.00%
	(7)	**Total number of youth grievances found in favor of the youth related to physical or verbal abuse by staff in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(8)	**Total number of youth grievances found in favor of the youth related to professional care (medical, dental, mental health) in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(9)	**Total number of youth grievances found in favor of the youth related to programming (social services, education, library, recreation) in the past twelve months.**		0.00%
	(10)	**Total number of youth grievances found in favor of the youth related to access to religious services or programs in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(11)	**Total number of youth grievances found in favor of the youth related to sexual harassment or discrimination in**		0.00%

		the past twelve months divided by the total number of youth grievances filed in the past twelve months.		
	(12)	**Total number of all youth grievances found in favor of the youth in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		0.00%
	(13)	**Total number of individual youth grievants in the past twelve months divided by the total number of youth grievances filed in the past twelve months.**		18%
	(14)	**Total number of individual youth grievants in the past twelve months divided by the average daily population for the past twelve months**		145%
		Data Collection		
		Total number of youth grievances filed in the past twelve months	114	
		Total number of youth grievances found in favor of the youth related to access to counsel and courts in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to communications (mail, telephone, visiting) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to discipline received in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to food service in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to personal hygiene, personal grooming or clothing in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to physical or verbal abuse from other juveniles in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to physical or verbal abuse from staff in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to professional care (medical, dental, mental health) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to programming (social services, education, library, recreation) in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to access to religious services or programs in the past twelve months	0	
		Total number of youth grievances found in favor of the youth related to sexual harassment or discrimination in the past twelve months	0	
		Total number of all grievances found in favor of the youth	0	
		Average daily population for the past twelve months	14	
		Number of individual youth filing grievances in the past	20	

		twelve months (counted once per youth per twelve month period not per grievance and not per month)		
G		**STAFF GRIEVANCES**		
		Outcome Measures		
	(1)	**Total number of staff grievances found in favor of staff related to working conditions, physical environment and safety in the past twelve months divided by the total number of staff grievances filed.**		0.00%
	(2)	**Total number of staff grievances found in favor of staff related to work schedules, overtime, job duties and pay in the past twelve months divided by the total number of staff grievances filed.**		0.00%
	(3)	**Total number of all staff grievances found in favor of staff divided by the total number of staff grievances filed.**		0.00%
		Data Collection		
		Total number of staff grievances in the past twelve months	3	
		Total number of staff grievances related to working conditions, physical environment and safety found in favor of staff in the past twelve months	0	
		Total number of staff grievances related to work schedules, overtime, job duties and pay found in favor of staff in the past twelve months	0	
		Total number of all grievances found in favor of staff in the past twelve months	0	
H		**EMPLOYEE OCCUPATIONAL HEALTH & SAFETY**		
		Outcome Measures		
	(1)	**Total number of employee injuries due to youth assault at this site resulting in lost work days in the past twelve months divided by total number of employees assigned to this site.**		3.00%
	(2)	**Total number of lost work days as a result of an employee injury due to youth assault in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		32%
	(3)	**Total number of employee injuries due to accidents at this site resulting in lost work days in the past twelve months divided by total number of employees assigned to this site.**		0.00%
	(4)	**Total number of lost work days as a result of an employee injury due to accidents in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		14.00%
	(5)	**Total number of employee illnesses at this site resulting in lost work days in the past twelve months divided by the total number of employees assigned to this site.**		62.39%
	(6)	**Total number of lost work days as a result of employee illness in the past twelve months divided by the total number of work days for the past twelve months assigned to this site.**		183%
		Data Collection		

		Total number of employee injuries resulting in lost work days in the past twelve months	21	
		Total number of lost work days as a result of employee injury in the past twelve months	167.86	
		Total number of employee illnesses resulting in lost work days in the past twelve months	438	
		Total number of lost work days as a result of employee illness in the past twelve months	668.64	
		Total number of employees assigned to this site per the approved table of organization minus approved/mandated vacancies required for budgetary attrition rate	702	
		Total number of work days assigned to this site	365	
I		**JUVENILE ACCIDENTAL INJURY**		
		Outcome Measures		
	(1)	**Total number of juvenile injuries related to insect or animal bite in the past twelve months divided by the average daily population for the past twelve months.**		0.00%
	(2)	**Total number of juvenile injuries related to chemical exposure in the past twelve months divided by the average daily population for the past twelve months.**		0.00%
	(3)	**Total number of juvenile injuries related to planned recreational activity in the past twelve months divided by the average daily population for the past twelve months.**		0.00%
	(4)	**Total number of juvenile injuries related to routine physical activity, slips, trips or falls in the past twelve months divided by the average daily population for the past twelve months.**		7.00%
	(5)	**Total number of juvenile injuries related to machinery or equipment in the past twelve months divided by the average daily population.**		0.00%
		Data Collection		
		Average daily population for the past twelve months	14	
		Total number of juvenile injuries related to insect or animal bites in the past twelve months	0	
		Total number of juvenile injuries related to chemical exposure in the past twelve months	0	
		Total number of juvenile injuries related to planned recreational activity in the past twelve months	0	
		Total number of juvenile injuries related to routine physical activity slips trips or falls	1	
		Total number of juvenile injuries related to machinery or equipment in the past twelve months	0	
J		**JUVENILE DISCIPLINARY HEARINGS**		
		Outcome Measures		
	(1)	**Total number of disciplinary hearing decisions appealed by the juvenile in the past twelve months divided by the total number of disciplinary hearings for the past twelve months.**		0.21%

	(2)	**Total number of disciplinary hearing appeals decided in favor of the juvenile in the past twelve months divided by the total number of disciplinary hearings appealed in the past twelve months.**		0.00%
	(3)	**Total number of disciplinary hearing decisions that resulted in transfer of the juvenile in the past twelve months divided by the total number of disciplinary hearings for the past twelve months.**		0.00%
		Data Collection		
		Total number of disciplinary hearings for the past twelve months	478	
		Total number of disciplinary hearings appealed by the juvenile for the past twelve months	1	
		Total number of disciplinary hearing appeals found in favor of the juvenile in the past twelve months	0	
		Total number of disciplinary hearings that resulted in transfer of the juvenile in the past twelve months	0	
K		**SECLUSION & ROOM CONFINEMENT**		
		Outcome Measures		
	(1)	**Total number of hours of seclusion of a juvenile for purposes of investigation for the past twelve months divided by the total number of juveniles confined for purposes of investigation in the past twelve months.**		0.00%
	(2)	**Total number of hours of room confinement of a juvenile for purposes of investigation for the past twelve months divided by the total number of juveniles confined for purposes of investigation in the past twelve months.**		651%
	(3)	**Total number of hours of seclusion disciplinary reasons for the past twelve months divided by the total number of juveniles confined for disciplinary reasons in the past twelve months.**		0.00%
	(4)	**Total number of hours of room confinement for disciplinary reasons for the past twelve months divided by the total number of juveniles confined for disciplinary reasons in the past twelve months.**		0.00%
	(5)	**Total number of hours of seclusion as part of a juvenile's special management plan for the past twelve months divided by the total number juveniles confined as part of a special management plan.**		0.00%
	(6)	**Total number of hours of room confinement as part of a juvenile's special management plan for the past twelve months divided by the total number of juveniles confined as part of a special management plan.**		0.00%
	(7)	**Total number of hours for unit or facility lockdown for the past twelve months divided by the number of incidents requiring unit or facility lockdown in the past twelve months.**		161%
		Data Collection		
		Total number of hours of seclusion of a juvenile for purpose	0	

		of investigation for the past twelve months		
		Total number of hours of room confinement of a juvenile for purposes of investigation for the past twelve months	9365.16	
		Total number of hours of seclusion for disciplinary reasons for the past twelve months	0	
		Total number of hours of room confinement for disciplinary reasons for the past twelve months	0	
		Total number of hours of seclusion as part of a juvenile's special management plan	0	
		Total number of hours of room confinement as part of a juvenile's special management plan	0	
		Total number of hours for unit or facility lockdown for the past twelve months	49.77	
		Total number of juveniles confined for purposes of investigation in the past twelve months	1439	
		Total number of juveniles confined for disciplinary reasons	0	
J		**EDUCATION AND WORK**		
		Outcome Measures		
	(1)	**Number of juveniles who receive high school diplomas or equivalent in the past twelve months divided by the average daily juvenile population in the past twelve months.**		22%
	(2)	**Average change in grade level of juvenile served as measured by a standardized pre and post test achievement instrument during the past twelve months.**		71%
	(3)	**Number of juveniles who successfully complete a vocational certification program divided by the number of juvenile enrolled in the program in the past twelve months.**		0.00%
	(4)	**Number of juveniles who, in the past twelve months, obtained and maintained work program employment divided by the number of juveniles who, in the past twelve months were eligible for work programs.**		0.00%
		Data Collection		
		Number of high school graduates in the past twelve months	3	
		Average daily population in the past twelve months	14	
		Average education pre test scores for the past twelve months	109	
		Average education post test scores for the past twelve months	154	
		Number of vocational program certificates awarded in the past twelve months	0	
		Average number of students enrolled in school	11	
		Average number of juveniles employed in a work program in the past twelve months	0	
		Average number of juveniles eligible for work in the past twelve months	0	

		Health Care Outcomes		
Performance Standard	Outcome Measure		Value	Calculated Outcome Measure
A		**On-Site Health Care**		
		Outcome Measures		
	(1)	**Number of juveniles seen by nursing during health call in the past 12 months divided by the number of health call requests in the past 12 months.**		100%
	(2)	**Number of juveniles seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months divided by the number of juvenile referred to be seen the responsible physician or health care practitioner in the past 12 months.**		100%
	(3)	**Number of juveniles seen by the dentist in the past 12 months divided by the number of juveniles referred to be seen by the dentist in the past 12months.**		100%
	(4)	**Number of juveniles seen by the psychiatrist in the past 12 months divided by the number of juveniles referred to be seen by the psychiatrist in the past 12 months.**		100%
	(5)	**Number of female juveniles seen by OB/GYN in the past 12 months divided by the number of female juveniles referred to be seen by the OB/GYN in the past 12 months.**		80%
	(6)	**Number of intake health screenings (intersystem and intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.**		100%
	(7)	**Number of examinations (intersystem) completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission date within the past 12 months divided by the number of admissions to the facility within the past 12 months.**		100%
		Data Collection		
		Number of health call requests in the past 12 months	17	
		Number of juveniles seen by nursing during health call in the past 12 months	17	
		Number of juveniles referred to be seen by the responsible physician or health care practitioner (N.P., P.A.) in the past 12 months	141	
		Number of juveniles seen by the responsible	141	

		physician or health care practitioner (N.P., P.A.) in the past 12 months		
		Number of juveniles referred to be seen by the dentist in the past 12 months	52	
		Number of juveniles seen by the dentist in the past 12 months	52	
		Number of juveniles referred to be seen by the psychiatrist in the past 12 months	141	
		Number of juveniles seen by the psychiatrist in the past 12 months	141	
		Number of female juveniles referred to be seen by OB/GYN in the past 12 months	5	
		Number of juveniles seen by OB/GYN in the past 12 months	4	
		Number of intake health screenings completed (intersystem and intrasystem) at admission in the past 12 months	15	
		Number of examinations completed by the responsible physician or health care practitioner (N.P., P.A.) within 14 days of admission (intersystem) date within the past 12 months	15	
		Number of intrasystem transfers within the past 12 months	15	
		Number of intersystem transfers within the past 12 months	0	
		Specialty Consultants		
		Outcome Measures		
	(8)	**Number of juvenile specialty consults completed (on-site and off-site) in the past 12 months divided by the number of specialty consults (on-site and off-site) ordered by the responsible physician, health care practitioner (N.P., P.A.) or dentist in the past 12 months.**		100%
		Data Collection		
		Number of referrals to specialty consults on-site and off-site ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months	90	
		Number of completed on-site and off-site specialty consults ordered by the responsible physician health care practitioner (N.P., P.A.) or dentist in the past 12 months	90	
		Specialty Diets		
		Outcome Measures		
	(9)	**Number of juveniles receiving special medical (therapeutic) diets in the past 12 months divided by the number of special medical (therapeutic) diets prescribed in the past 12**		0.00%

		months.		
	(10)	**Number of juveniles receiving a special medical diet in the past 12 months divided by the average daily population in the past 12 months.**		160%
		Data Collection		
		Number of juveniles prescribed a special medical (therapeutic) diet in the past 12 months	0	
		Number of juveniles receiving a special medical (therapeutic) diet in the past 12 months	22	
		Pregnancy Testing		
		Outcome Measures		
	(11)	**Number of females juveniles with a positive pregnancy test in the past 12 months divided by the number of pregnancy test administered in the past 12 months**		0.00%
	(12)	**Number of female juveniles with a positive pregnancy test in the past 12 months divided by the average daily population (female) in the past 12 months**		0.00%
		Data Collection		
		Number of female juveniles with a positive pregnancy test in the past 12 months	0	
		Number of pregnancy test administered in the past 12 months	0	
		HIV		
		Outcome Measures		
	(13)	**Number of HIV positive juveniles who are being treated with antiretroviral treatment of for opportunistic infection in the past 12 months divided by the total number of HIV positive juveniles in the past 12 months.**		0.00%
		Data Collection		
		Number of known HIV positive status juveniles admitted to the facility in the past 12 months	0	
		Number of youth testing positive for HIV in the past 12 months	0	
		Number of HIV positive juveniles who are being treated with antiretroviral treatment or for opportunistic infection in the past 12 months	0	
		Number of AIDS cases upon admission to the facility in the past 12 months	0	
		Number of AIDS cases diagnosed by the facility in the past 12 months	0	
		Tuberculosis (TB)		
		Outcome Measures		
	(14)	**Number of juveniles with a known positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12**		0.00%

		months divided by the number of admissions (intersystem) in the past 12 months.		
	(15)	**Number of juveniles with a positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months divided by the number of admissions (intersystem) in the past 12 months.**		0.00%
	(16)	**Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months divided by the number of tuberculin skin test given in the past 12 months.**		0.00%
	(17)	**Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.**		0.00%
	(18)	**Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months divided by the number of juveniles with a positive tuberculin skin test in the past 12 months.**		0.00%
		Data Collection		
		Number of juveniles with a known positive tuberculin (TB) skin test upon admission (intersystem) to the facility in the past 12 months	0	
		Number of juveniles with a positive tuberculin (TB) skin test administered upon admission (intersystem) to the facility in the past 12 months	0	
		Number of admissions (intersystem) within the past 12 months	0	
		Number of juveniles with a positive tuberculin (TB) skin test conversion in the past 12 months	0	
		Number of tuberculin skin tests administered in the past 12 months	7	
		Number of juveniles diagnosed with active tuberculin (TB) in the past 12 months	0	
		Number of juveniles on prophylaxis treatment for tuberculosis (TB) in the past 12 months	0	
		Hepatitis A, B, and C		
		Outcome Measures		
	(19)	**Number of juveniles testing positive for Hepatitis A,B, and C in the past 12 months divided by the number of tests administered in the past 12 months.**		0.00%
	(20)	**Number of juveniles testing positive for Hepatitis A,B and C in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of Hepatitis A test administered in the	0	

		past 12 months		
		Number of Hepatitis B test administered in the past 12 months	0	
		Number of Hepatitis C test administered in the past 12 months	0	
		Number of juveniles testing positive for Hepatitis A in the past 12 months	0	
		Number of juveniles testing positive for Hepatitis B in the past 12 months	0	
		Number of juveniles testing positive for Hepatitis C in the past 12 months	0	
		Methicillin-Resistant Staphylococcus Aureus (MRSA)		
		Outcome Measures		
	(21)	**Number of juveniles testing positive for MRSA in the past 12 months divided by the number of tests administered in the past 12 months**		0.00%
	(22)	**Number of juveniles testing positive for MRSA in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of MRSA test administered in the past 12 months	0	
		Number of juveniles testing positive for MRSA in the past 12 months	0	
		Health Education		
	(23)	**Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months divided by the number of admissions in the past 12 months.**		100%
		Data Collection		
		Number of juveniles receiving documented health education on personal hygiene upon admission in the past 12 months	15	
		Number of juvenile admissions (intersystem and/or intrasystem in the past 12 months	15	
		Pharmaceutical Management		
		Outcome Measures		
	(24)	**Number of pharmacy dispensing errors in the past 12 months divided by the number of prescriptions dispensed by the pharmacy in the past 12 months.**		1.00%
	(25)	**Number of nursing medication administration errors in the past 12 months divided by the number of medications administered in the past 12 months.**		0.00%
	(26)	**Number of juveniles on psychotropic medications in the past 12 months divided by**		76%

		the average daily population in the past 12 months		
		Data Collection		
		Number of total prescriptions dispensed by pharmacy in the past 12 months	975	
		Number of pharmacy dispensing errors in the past 12 months	8	
		Number of medications administered in the past 12 months	31380	
		Number of medication administration errors in the past 12 months	16	
		Number of incidents involving pharmaceuticals as contraband in the past 12 months	0	
		Number of juveniles on psychotropic medication in the past 12 months	125	
B		**Quality Review**		
		Outcome Measures		
	(1)	**Number of health care issues/problems identified by internal review that were corrected in the past 12 months divided by the number of problems identified by internal review in the past 12 months.**		0.00%
		Data Collection		
		Number of issues/problems identified by internal review in the past 12 months	0	
		Number of issues/problems identified by the internal review in the past 12 months that were corrected	0	
		Grievances Related to Health Care		
		Outcome Measures		
	(2)	**Number of juvenile health related grievances found in favor of the juvenile in the past 12 months divided by the number of health related grievances filed in the past 12 months.**		0.00%
		Data Collection		
		Number of juvenile health related grievances filed in the past 12 months	0	
		Number of juvenile health related grievances found in favor of the juvenile in the past 12 months	0	
		Health Related Lawsuits		
		Outcome Measures		
	(3)	**Number of health related lawsuits filed by or on behalf of juveniles found in favor of the juvenile in the past 12 months divided by the number of lawsuits filed in the past 12 months.**		0.00%
		Data Collection		

		Number of juvenile health related lawsuits filed in the past 12 months	0	
		Number of juvenile health related lawsuits found in favor of the juvenile in the past 12 months	0	
C		**Death in Custody**		
		Outcome Measures		
	(1)	**Number of juvenile deaths in custody in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of juvenile deaths that were medically expected in the past 12 months	0	
		Number of juvenile deaths that were medically unexpected other than injury, suicide and /or homicide in the past 12 months	0	
		Number of juvenile deaths due to injury in the past 12 months	0	
		Number of juvenile deaths due to suicide in the past 12 months	0	
		Sexual Assaults		
		Outcome Measures		
	(2)	**Number of juvenile(s) alleged sexual assaults in the past 12 months divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		
		Number of juvenile(s) alleging sexual assault in the past 12 months	0	
D		**Health Care Staffing**		
		Outcome Measures		
	(1)	**Number of vacant positions for full-time equivalents for each health care staff category in the past 12 month period divided by the full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months.**		0.00%
		Data Collection		
		Number of physician full-time equivalent position(s)	1	
		Number of physician vacancies in the past 12 months	0	
		Number of full-time equivalent practitioner position(s)	0	
		Number of practitioner vacancies in the past 12 months	0	
		Number of full-time equivalent dentist position(s)	0	
		Number of dentist vacancies in the past 12 months	0	

		Number of full-time equivalent nursing (RN) positions(s)	1	
		Number of nursing (RN) vacancies in the past 12 months	0	
		Number of full-time equivalent nursing (LPN, LVN) position(s)	0	
		Number of nursing (LPN, LVN) vacancies in the past 12 months	0	
		Number of full-time equivalents of each health care staff category as determined by the designated health authority needed to provide adequate health care in the past 12 months	2	
		Qualified Staff		
		Outcome Measures		
	(2)	**Number of staff with lapsed licensure and/or certification in the past 12 months divided by the number of licensed and/or certified staff in the past 12 months.**		20%
	(3)	**Number of specified health care positions with a written job description divided by the number of specified health care positions in the past 12 months.**		100%
		Data Collection		
		Number of staff requiring a license and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., L.P.N., psychologist, et. al. therapists requiring licensure in the past 12 months.	5	
		Number of lapsed licensure and/or certification (include physician, psychiatrist, physician assistant, nurse practitioner, R.N., dentist, psychologist, et al. therapist requiring licensure) in the past 12 months	1	
		Number of specified health care positions in the past 12 months	2	
		Number of specified health care position with a written job description in the past month	2	
		Fair Treatment of Staff		
		Outcome Measures		
	(4)	**Number of health care staff grievances decided in favor of staff in the past 12 months divided by the total number of health care staff grievances filed in the past 12 months.**		0.00%
	(5)	**Number of health care staff terminations demotion hearings in which administrative decision was upheld in the past 12 months divided by the number of health care staff terminations or demotion hearings held in the past 12 months.**		0.00%

		Data Collection		
		Number of health care staff grievances filed in the past 12 months	0	
		Number of health care staff grievances decided in favor of the health care staff in the past 12 months	0	
		Number of health care staff terminations and demotion hearings in which the program decision was upheld in the past 12 months	0	
		Number of health care staff terminations or demotion hearings held in the past 12 months	0	
		Employee Health		
		Outcome Measures		
	(6)	**Number of new employees who were administered a tuberculin (TB) skin test in the past 12 months divided by the number of employees hired in the past 12 months.**		100%
	(7)	**Number of employees with a positive tuberculin skin test conversion in the past 12 months.**		0
		Data Collection		
		Number of new employees hired in the past 12 months	31	
		Number of new employees who where administered a tuberculin (TB) skin test in the past 12 months	31	
		Number of employees administered tuberculin (TB) skin test in the past 12 months	0	
		Number of employees with a positive tuberculin (TB) skin test conversion in the past 12 months	0	
E		**Mental Health**		
		Outcome Measures		
	(1)	**Number of intake mental health screenings (intersystem or intrasystem) completed at admission in the past 12 months divided by the number of admissions in the past 12 months.**		100%
	(2)	**Number of juveniles receiving a mental health appraisal in the past 12 months divided by the number of admissions in the past 12 months.**		100%
	(3)	**Number of juveniles with a Mental Health Treatment Plan in the past 12 months divided by the number of youth requiring ongoing mental health intervention in the past 12 months.**		100%
	(4)	**Number of suicide attempts divided by the average daily population in the past 12 months.**		0.00%
	(5)	**Number of completed suicides divided by the average daily population in the past 12 months.**		0.00%
		Data Collection		

		Number of juveniles receiving a mental health screening at admission (intrasystem and intersystem) in the past 12 months	15	
		Number of juveniles receiving mental health appraisals within the past 12 months	15	
		Number of intrasystem transfers within the past 12 months	15	
		Number of intersystem transfers within the past 12 months	0	
		Number of juveniles requiring ongoing mental health intervention in the past 12 months	162	
		Number of juveniles with a mental health treatment plan in the past 12 months	162	
		Number of suicide attempts in the past 12 months	0	
		Number of completed suicides in the past 12 months	0	
F		**Substance Abuse**		
		Outcome Measures		
	(1)	**Number of juveniles receiving a substance abuse screening in the past 12 months divided by the number of admissions (intersystem or intrasystem) in the past 12 months.**		0.00%
	(2)	**Number of juveniles referred to a chemical dependency program divided by the number of youth identified as requiring a chemical dependency program in the past 12 months.**		0.00%
	(3)	**Number of juveniles completing an alcohol and drug abuse education program in the past 12 months divided by the number of admissions in past 12 months.**		0.00%
		Data Collection		
		Number of intersystem transfers in the past 12 months	0	
		Number of intrasystem transfers in the past 12 months	15	
		Number of juveniles identified as requiring a chemical dependency program in the past 12 months	0	
		Number of juvenile placed in a chemical dependency program in the past 12 months	0	

DR. BRIAN L. MAHER, COMMISSIONER

TEL 402.471.2295
FAX 402.471.0117

P.O. Box 94987
Lincoln, NE 68509-4987

education.ne.gov

April 7, 2025

Administrator
Morton School
2311 N 60th St Bldg 4
Lincoln, NE 68507

Dear Administrator,

On April 4, 2025, the State Board of Education voted to grant approval to Morton School for the school year 2025-26. The decision was based upon a review of the Assurance Statement and other information indicating compliance with Title 92, Nebraska Administrative Code, Chapter 18 (Rule 18), *Interim-Program Schools in County Detention Homes, Institutions, and Juvenile Emergency Shelters*. This approved status will be in effect for the period July 1, 2025, through June 30, 2026.

We thank you for the cooperation you have extended to us and wish you well as you continue to provide educational opportunities for the young people in your school.

Sincerely,

Decua Jean-Baptiste Ed. D.
Director of Accreditation
Office of Accreditation, Certification, & Approval
Nebraska Department of Education

Certificate of Approval

The Nebraska Department of Education

Recognizes

Morton School

AS AN APPROVED INTERIM-PROGRAM SCHOOL
FOR THE SCHOOL YEAR 2025-2026

BY THE OFFICIAL ACTION OF THE STATE BOARD OF EDUCATION

Brian L. Maher, Ed.D.
Commissioner of Education

Deborah A. Frison, Ed.D.
Deputy Commissioner of Education

DR. BRIAN L. MAHER, COMMISSIONER

TEL 402.471.2295
FAX 402.471.0117

P.O. Box 94987
Lincoln, NE 68509-4987

education.ne.gov

April 7, 2025

Administrator
Nebraska Youth Academy
5900 Walker Ave
Lincoln, NE 68507

Dear Administrator,

On April 4, 2025, the State Board of Education voted to grant approval to Nebraska Youth Academy for the school year 2025-26. The decision was based upon a review of the Assurance Statement and other information indicating compliance with Title 92, Nebraska Administrative Code, Chapter 18 (Rule 18), *Interim-Program Schools in County Detention Homes, Institutions, and Juvenile Emergency Shelters*. This approved status will be in effect for the period July 1, 2025, through June 30, 2026.

We thank you for the cooperation you have extended to us and wish you well as you continue to provide educational opportunities for the young people in your school.

Sincerely,

Decua Jean-Baptiste Ed. D.
Director of Accreditation
Office of Accreditation, Certification, & Approval
Nebraska Department of Education

Certificate of Approval

The Nebraska Department of Education

Recognizes

Nebraska Youth Academy

AS AN APPROVED INTERIM-PROGRAM SCHOOL
FOR THE SCHOOL YEAR 2025-2026

BY THE OFFICIAL ACTION OF THE STATE BOARD OF EDUCATION

Brian L. Maher, Ed.D.
Commissioner of Education

Deborah A. Frison, Ed.D.
Deputy Commissioner of Education

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REPORT

INVOICE NUMBER 7197723

PAGE 1

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LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (A)
SERVICE DATE: 1/30/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX: 5.500	
CITY TAX: 1.750	
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Jared

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C09	C57	C53
						C06	C01	C07
						C11	C80	C54
						C56	C55	C05

PRODUCT CODE | PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice

SITES
C01 Kitchen Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3850
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

CONDITIONS FOUND/ACTIONS TAKEN

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (A)
SERVICE DATE: 1/30/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 1/30/2025 9:50 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Jared
01/30/2025 10:49 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392270
SERVICE SPECLST HECHT, JAMES R
LICENSE NUMBER NEB 090990
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (B)
SERVICE DATE: 2/27/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
SUB TOTAL:	248.14
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			6.00 EA	000009	C24 C11 C80
Beetles	DEMAND CS INSECTICIDE	338		.20 GA	000011	C21 C24 C53 C57 C01 C10 C11 C80 C56 C05

PRODUCT

CODE	PRODUCT USED DESCRIPTION/EPA NUMBER
338	Demand CS (0.015%) 100-1066 Lamba-cyhalothrin

METHODS
000009 Checking Traps
000011 General Surface Application

SITES
C01 Kitchen Area-Interior
C05 Storage Area-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	6
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

CONDITIONS FOUND/ACTIONS TAKEN

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392270
SERVICE SPECLST HECHT, JAMES R
LICENSE NUMBER NEB 090990
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (B)
SERVICE DATE: 2/27/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area food covered or removed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.

Pest activity found during service: (YES)
Exterior Area-Mice noted during service Activity noted in bait stations
Rodent Stations inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

James Hecht

SVSP SIGNATURE - HECHT, JAMES R
START DATE/TIME: 2/27/2025 2:10 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
02/27/2025 15:22 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (C)
SERVICE DATE: 3/31/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00 EA	000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25 GA	000002	C06 C80 C56 C05 C10 C11 C24 C21 C53 C13 C23 C02

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C23 Work Floor-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C56 Roll Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (C)
SERVICE DATE: 3/31/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists. Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 3/31/2025 2:13 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
03/31/2025 15:05 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's associate who performed today's service

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (D)
SERVICE DATE: 4/30/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00 EA	000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25 GA	000002	C10 C11 C54 C53 C24 C02 C57 C80 C23 C13 C56 C05

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C13 Vending Machines-Interior
C23 Work Floor-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

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CHICAGO, IL 60673-1262

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (D)
SERVICE DATE: 4/30/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists.
Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 4/30/2025 1:47 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
04/30/2025 14:20 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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26252 NETWORK PLACE
CHICAGO, IL 60673-1262

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (E)
SERVICE DATE: 5/29/2025

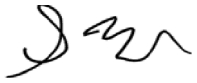
SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE



Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C54
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C55 C21 C06 C56 C53 C02 C05 C80 C07 C54 C57 C13

PRODUCT CODE — PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2650
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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1-800-325-1671

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (E)
SERVICE DATE: 5/29/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Basement-Interior-Cockroaches noted during service Treated for water bugs on the lower floor of the school
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 5/29/2025 9:29 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
05/29/2025 10:54 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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CHICAGO, IL 60673-1262

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (F)
SERVICE DATE: 6/26/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			3.00	EA 000009	C11
Cockroaches	DEMAND CS INSECTICIDE	340		.35	GA 000001	C11 C54 C01 C06 C07 C80 C57 C09 C02 C21 C55 C53

PRODUCT CODE — PRODUCT USED DESCRIPTION/EPA NUMBER
340 Demand CS (0.06%) 100-1066
Lamba-cyhalothrin

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2550
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (F)
SERVICE DATE: 6/26/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 6/26/2025 8:30 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
06/26/2025 9:16 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (G)
SERVICE DATE: 7/29/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:
TOTAL: 248.14
AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			3.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C01	C06	C07
						C80	C56	C05
						C09	C53	C57
						C21	C55	C02

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method None generated
Area/Size treated 3550
Area/Size Measurement Linear feet

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LINCOLN NE 68522 US
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ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (G)
SERVICE DATE: 7/29/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.
Application to surface type(s) Linoleum/tile
Carpet
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service:	(NO)
Structural concerns that could cause pest problems:	(NO)
Sanitation issues that could cause pest problems:	(NO)
Facility preparation issues:	(NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 7/29/2025 8:19 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
07/29/2025 9:03 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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PAGE 1

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (H)
SERVICE DATE: 8/27/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Cockroaches	DEMAND CS INSECTICIDE	340		.50	GA 000001	C11 C54 C01 C53 C05 C55 C06 C07 C80 C02 C21 C57
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
340 Demand CS (0.06%) 100-1066
Lamba-cyhalothrin

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3250
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (H)
SERVICE DATE: 8/27/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.
The area was very clean and in excellent condition!
Please thank everyone who cleaned the area!

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 8/27/2025 9:10 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
08/27/2025 9:59 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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1-800-325-1671

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (I)
SERVICE DATE: 9/25/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:

TOTAL: 248.14

AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C69	C06	C07
						C80	C11	C54
						C53	C57	C21
						C01	C02	C55

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C69 Snack Bar/Cafe-Interior
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3550
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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PAGE 2

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ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (I)
SERVICE DATE: 9/25/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Maintenance Area-Interior-Spiders noted during service Near the roll door of the maintenance shop
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 9/25/2025 8:14 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
09/25/2025 9:08 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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CHICAGO, IL 60673-1262

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:

TOTAL: 248.14

AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C02	C53	C11
						C54	C55	C06
						C07	C80	C57
						C01	C56	C05

PRODUCT

CODE	PRODUCT USED DESCRIPTION/EPA NUMBER
691	Alpine WSG Insecticide (0.3%) 499-561
	dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2925
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet
Wood
Concrete

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Maintenance Area-Interior-Crickets noted during service Near the roll doors in the maintenance area
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 10/28/2025 8:32 AM
I acknowledge that my report accurately reflects my activities and findings during today's service visit, in accordance with Ecolab's standards and regulatory requirements.

CUSTOMER'S SIGNATURE - Scott
10/28/2025 9:19 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate who carried out today's service visit.

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White Hall School #10

2320 North 57th
LINCOLN, NE 68507
402-309-3231

Building Contact: Mike Heaps
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Clint Coonrod
Title: Inspector

Quarterly Inspection **Inspection Date: Dec 18, 2024**

Tested to NFPA 25 Standards

This Inspection was performed in accordance with applicable Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

EXECUTIVE SUMMARY

Generated by: BuildingReports.com

Building Information

White Hall School #10
2320 North 57th
LINCOLN, NE 68507
United States of America

Contact: Mike Heaps
Phone: 402-450-8379
Fax:
Mobile:
Email: mike.heaps@nebraska.gov

Inspection Performed By

NIFCO Mechanical Systems
500 Blue Heron Dr
Lincoln, NE 68522-1701
United States of America

Inspector: Clint Coonrod
Phone: 402-477-0666
Fax:
Mobile: 531-220-1703
Email: ccoonrod@nifcomechanical.com

System Control Unit

System Type	System Location	Protected Area	Devices
Wet Pipe	Building-	Building-	6

Monitoring

Company: PERMAR	**Phone:** 1-800-227-9805	**Account #:**

Inspection Summary

	Total Items		Serviced		Passed		Failed/Other	
Category	Qty	%	Qty	%	Qty	%	Qty	%
Alarm	1	16.67%	1	100.00%	1	100.00%	0	0.00%
Device	1	16.67%	1	100.00%	1	100.00%	0	0.00%
Hose	1	16.67%	1	100.00%	1	100.00%	0	0.00%
Valve	3	50.00%	3	100.00%	3	100.00%	0	0.00%
Totals	**6**	**100%**	**6**	**100.00%**	**6**	**100.00%**	**0**	**0.00%**

Certification

Company: NIFCO Mechanical Systems
Inspector: Clint Coonrod
Building: White Hall School #10
Contact: Mike Heaps

Clint Coonrod Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	147096
Nebraska Grade VI Water Operator	8889

INSPECTION & TESTING

Generated by: BuildingReports.com

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.

Building: White Hall School #10

Device Type	Location	Service	Time	Date
	PASSED			
Building- Wet Pipe, Building-				
Control Valve	Basement East Mechanical	Quarterly	1:14:35 PM	12/18/2024
Control Valve	Basement East Mechanical	Quarterly	1:16:45 PM	12/18/2024
Control Valve	Basement East Mechanical	Quarterly	1:17:36 PM	12/18/2024
Drain	Basement East Mechanical	Quarterly	1:19:06 PM	12/18/2024
Fire Dep't Connection	Ground Southeast Outside	Quarterly	1:18:27 PM	12/18/2024
Waterflow Switch	Basement East Mechanical	Quarterly	1:17:22 PM	12/18/2024

WET PIPE FIRE SPRINKLER SYSTEMS

Generated by: BuildingReports.com

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.

Building: White Hall School #10 **Building-, Building-**

ALARMS

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane				2.0	1	☑	59341130

COMPONENTS

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Ball	Basement East Mechanical			☑	59341127
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Main Control		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Ball	Basement East Mechanical			☑	59341128
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Main Control		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Ball	Basement East Mechanical			☑	59341129
Position	**Size**	**Status**	**Description**		
Open	2"	Supervised	Main Control		

DEVICES

DEVICES (continued)

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Ground Southeast Outside	Wall	2"	1	Yes	Yes	12/31/1969	☑	59341131

Drain

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical	1.25"		81	74	1	☑	59341132

INVENTORY & WARRANTY REPORT

Generated by: BuildingReports.com

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.

Building: White Hall School #10

Device or Type	Category	% of Inventory	Quantity
Control Valve	Valve	50.00%	3
Drain	Device	16.67%	1
Fire Dep't Connection	Hose	16.67%	1
Waterflow Switch	Alarm	16.67%	1

Device Type	Qty	Model #	Description	Install Date
IN SERVICE - 3 YEARS TO 5 YEARS				
Building- Wet Pipe, Building-				
Control Valve	3		Ball	02/20/2020
Drain	1		Main	02/20/2020
Fire Dep't Connection	1		Wall	02/20/2020
Waterflow Switch	1		Vane	02/20/2020

White Hall Family Life

5819 Huntington
LINCOLN, NE 68507
402-309-3231

Building Contact: Mike Heaps
Title: Maint. Supervisor

Company: NIFCO Mechanical Systems
Contact: Clint Coonrod
Title: Inspector

N/A Inspection **Inspection Date: Dec 31, 2024**

Tested to NFPA 25 Standards

This Inspection was performed in accordance with applicable Standards. The subsequent pages of this report provide performance measurements, listed ranges of acceptable results, and complete documentation of the inspection. Whenever discrepancies exist between acceptable performance standards and actual test results, notes and/or recommended solutions have been proposed or provided for immediate review and approval.

EXECUTIVE SUMMARY

Generated by: BuildingReports.com

Building Information

White Hall Family Life
5819 Huntington
LINCOLN, NE 68507
United States of America

Contact: Mike Heaps
Phone: 402-450-8379
Fax:
Mobile:
Email: mike.heaps@nebraska.gov

Inspection Performed By

NIFCO Mechanical Systems
500 Blue Heron Dr
Lincoln, NE 68522-1701
United States of America

Inspector: Clint Coonrod
Phone: 402-477-0666
Fax:
Mobile: 531-220-1703
Email: ccoonrod@nifcomechanical.com

System Control Unit

System Type	System Location	Protected Area	Devices
Dry Pipe	Building-	Area-Attic	5
Service Main	Building-	Building-	4
Wet Pipe	Building-	Building-basement 1st	1
Wet Pipe	Building-	Floors-basement and 1	1

Inspection Summary

	Total Items		Serviced		Passed		Failed/Other	
Category	Qty	%	Qty	%	Qty	%	Qty	%
Alarm	3	27.27%	0	0.00%	0	0.00%	0	0.00%
Device	1	9.09%	0	0.00%	0	0.00%	0	0.00%
Hose	1	9.09%	0	0.00%	0	0.00%	0	0.00%
Valve	6	54.55%	2	33.33%	2	100.00%	0	0.00%
Totals	**11**	**100%**	**2**	**18.18%**	**2**	**100.00%**	**0**	**0.00%**

Certification

Company: NIFCO Mechanical Systems
Inspector: Clint Coonrod
Building: White Hall Family Life
Contact: Mike Heaps

Clint Coonrod Certifications

Certification Type	Number
NICET Inspection and Testing of Water-Based Systems Level I	147096
Nebraska Grade VI Water Operator	8889

INSPECTION & TESTING

Generated by: BuildingReports.com

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.

Building: White Hall Family Life

Device Type	Location	Service	Time	Date
PASSED				
Building- Service Main, Building-				
Control Valve	Basement East Mechanical Laundry	Tested	8:20:35 AM	12/31/2024
Control Valve	Basement East Mechanical Laundry	Tested	8:20:46 AM	12/31/2024
UNTESTED				
Building- Dry Pipe, Area-Attic				
Control Valve	Basement East Mechanical Laundry			
Drain	Basement East Mechanical Laundry			
Dry Pipe Valve	Basement East Mechanical Laundry			
Pressure Switch	Basement East Mechanical Laundry			
Pressure Switch	Basement East Mechanical Laundry			
Building- Service Main, Building-				
Fire Dep't Connection	Ground West			
Post Indicator Valve	Ground Southeast			
Building- Wet Pipe, Building-basement 1st				
Waterflow Switch	Basement East Mechanical Laundry			
Building- Wet Pipe, Floors-basement and 1				
Control Valve	Basement East Mechanical Laundry			

WET PIPE FIRE SPRINKLER SYSTEMS

Generated by: BuildingReports.com

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.

Building: White Hall Family Life **Building-, Building-basement 1st**

ALARMS

Waterflow Switch

Type	Manufacturer	Model #	Sec	Size	Zone/Address	OK	ScanID
Vane				2.0	1	☐	59341106

Building: White Hall Family Life **Building-, Floors-basement and 1**

COMPONENTS

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement East Mechanical Laundry			☐	54622412
Position	**Size**	**Status**	**Description**		
	3"		Isolation		

DRY PIPE FIRE SPRINKLER SYSTEMS

Generated by: BuildingReports.com

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.

Building: White Hall Family Life **Building-, Area-Attic**

ALARMS

Pressure Switch

Type	Description	Manufacturer	Low	High	Zone/Address	OK	ScanID
High	Alarm					☐	59341102
Low	Supervisory					☐	59341103

COMPONENTS

Dry Pipe Valve

Manufacturer	Model #	Location	OK	ScanID
Viking	F-2	Basement East Mechanical Laundry	☐	59341100

Type	Status	Position	Size	Serial #	Water psi	Air Pressure
Grooved			3"			

Trip Air	Trip Time	Total Timing (sec)	3 Year Leak Test	Partial Trip Date	Internal Date	Full Trip Date
			05/10/2021	06/04/2024	06/04/2024	05/10/2022

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement East Mechanical Laundry			☐	59341109

Position	Size	Status	Description
	3"		Isolation

DEVICES

Drain

DEVICES (continued)

Drain (continued)

Type	Location	Size	Supply psi	Restored psi	Residual psi	Sec	OK	ScanID
Main	Basement East Mechanical Laundry	1.25"	85	79	72		☐	59341101

PRIVATE FIRE SERVICE MAINS

Generated by: BuildingReports.com

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.

Building: White Hall Family Life **Building-, Building-**

COMPONENTS

Post Indicator Valve

Location		Manufacturer	Model #	OK	ScanID
Ground Southeast				☐	59341107
Type	**Size**	**Position**	**Status**	**# of Turns**	
Ground	6"				

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement East Mechanical Laundry			☑	96771729
Position	**Size**	**Status**	**Description**		
Open	4"	Supervised	Main Control		

Control Valve

Type	Location	Manufacturer	Model #	OK	ScanID
Butterfly	Basement East Mechanical Laundry			☑	96771730
Position	**Size**	**Status**	**Description**		
Open	4"	Supervised	Main Control		

DEVICES

Fire Dep't Connection

Location	Type	Size	Qty	BallDrip	Rotating Swivels	5-Year Hydro	OK	ScanID
Ground West	Freestanding	4"	1	Yes	Yes	02/20/2020	☐	59341108

INVENTORY & WARRANTY REPORT

Generated by: BuildingReports.com

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.

Building: White Hall Family Life

Device or Type	Category	% of Inventory	Quantity
Control Valve	Valve	36.36%	4
Drain	Device	9.09%	1
Dry Pipe Valve	Valve	9.09%	1
Fire Dep't Connection	Hose	9.09%	1
Post Indicator Valve	Valve	9.09%	1
Pressure Switch	Alarm	18.18%	2
Waterflow Switch	Alarm	9.09%	1

Device Type	Qty	Model #	Description	Install Date
IN SERVICE - 3 YEARS TO 5 YEARS				
Building- Dry Pipe, Area-Attic				
Control Valve	1		Butterfly	02/20/2020
Drain	1		Main	02/20/2020
Pressure Switch	1		High	02/20/2020
Pressure Switch	1		Low	02/20/2020
Dry Pipe Valve	1	F-2	Grooved	02/20/2020
Building- Service Main, Building-				
Control Valve	2		Butterfly	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				

Device Type	Qty	Model #	Description	Install Date
IN SERVICE - 3 YEARS TO 5 YEARS (continued)				
Building- Wet Pipe, Building-basement 1st (continued)				
Waterflow Switch	1		Vane	02/20/2020
Building- Wet Pipe, Floors-basement and 1				
Control Valve	1		Butterfly	02/20/2020

NEBRASKA
GENERATOR SERVICE LLC
308.293.5206

Customer: State of NE

Address: 2311 N 60th st. Lincoln NE 68507

Generator Model: 20A02942-S

Generator Serial: 2058112

2 HOUR LOADBANK TEST

Generator kW: **35**

Date	Time	Alternator L1-L2 Voltage (Volts)	Alternator L2-L3 Voltage (Volts)	Alternator L1-L3 Voltage (Volts)	Alternator L1 Current (Amps)	Alternator L2 Current (Amps)	Alternator L3 Current (Amps)	Generator Frequency (Hz)	Alternator Total kW (kW)	Alternator % Application Total (kW%)	Engine Speed (RPM)	Coolant Temperature (degF)	Engine Oil (PSI)	Battery Voltage (Volts)	Engine Running Time (ERT) (hours)
5/27/25	12:15 PM	240	240	240	26	26	26	60	5	14%	1800	100	70	13	437.4
	12:30 PM	240	240	240	56	56	56	60	23	67%	1800	170	65	13	437.6
	12:45 PM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	437.9
	1:00 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	438.1
	1:15 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	438.4
	1:30 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	438.6
	1:45 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	438.9
	2:00 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	439.1
	2:15 AM	240	240	240	65	65	65	60	27	77%	1800	190	65	13	439.4

NMC - Fluid Analysis Report 14648 Shepard St, Suite 500 Omaha, NE 68138 USA

PHONE: nmc-technologies.com / 844-NMC-TECH

Web: lab@nmc-technologies.com Email: lab@nmccat.com

ENGINE NATURAL GAS

EQUIP NUM: 2058112

SERIAL NUMBER: 2058112

GENERAC 30KW_GENERAC

E330-55156-0038

LABEL#: 0038

SHOP JOB NUM : 13262

SAMPLE SHIP TIME (days) : 9

STATE OF NEBRASKA - LINCOLN

WHILEHALL CAMPUS

RECEIVED DATE: 05-Jun-25

No Action Required

Interp By: Rachel Smith

Interpreted On: 06-Jun-25

UNKNOWN HOURS ON OIL. NORMAL READINGS. NO PROBLEMS PRESENTLY ASSOCIATED WITH THIS SAMPLE. SUGGEST TO RESAMPLE AT REGULAR SERVICE INTERVALS TO ESTABLISH METAL WEAR TREND.

SAMPLE INFORMATION

Sampled Date	27-May-25
Sample Id	E330-55156-0038
Lab Date	05-Jun-25
Meter [Hr]	437
Meter On Fluid	
Fluid Brand	
Fluid Weight	
Fluid Type	
Fluid Change	Y
Filter Change	Y
Kidney Loop	U
Total Fluid Added	0

For additional sample history, go to: S.O.S WEB

CONDITION / CONTAMINATION

27-May-25

VISCOSITY (CENTISTOKES) ASTM D445

V100	Viscosity at 100 C	10.10

INFRARED (UFM) ASTM E2412

ST	Soot	0
OXI	Oxidation	7
SUL	Sulfate By-Product	15
NIT	Nitration	0

WATER

W	Water	N

WEAR LEVELS / ADDITIVES

27-May-25

ELEMENTAL ANALYSIS (PPM) ASTM D5185 [OIL] / ASTM D6130 [COOLANT]

Cu	Copper	6
Fe	Iron	5
Cr	Chromium	0
Al	Aluminum	1
Pb	Lead	7
Sn	Tin	1
Si	Silicon	24
Na	Sodium	4
K	Potassium	0
Mo	Molybdenum	52
Ni	Nickel	0
Ag	Silver	0
Ti	Titanium	0
V	Vanadium	0
Cd	Cadmium	1
Ca	Calcium	1307
P	Phosphorus	682
Zn	Zinc	816
Mg	Magnesium	456
Ba	Barium	1
B	Boron	64

ANTIFREEZE

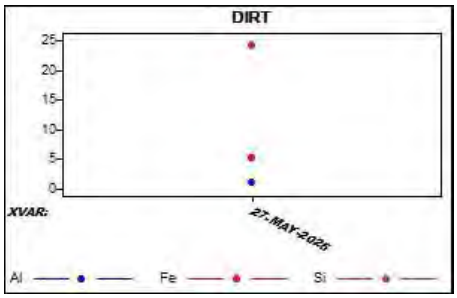
A	Antifreeze	N

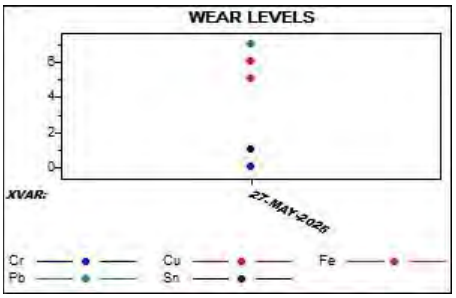
Notice: This analysis is intended as an aid in predicting mechanical wear. No guarantee, expressed or implied, is made against failure of this piece of equipment or component thereof.

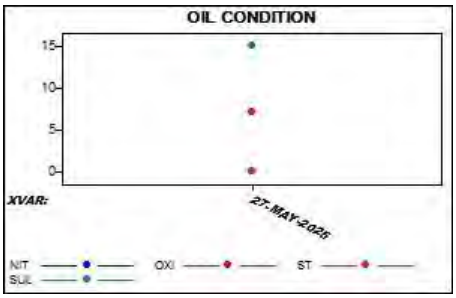
ENGINE NATURAL GAS
SERIAL NUMBER: 2058112
EQUIP NUM: 2058112
GENERAC 30KW_GENERAC

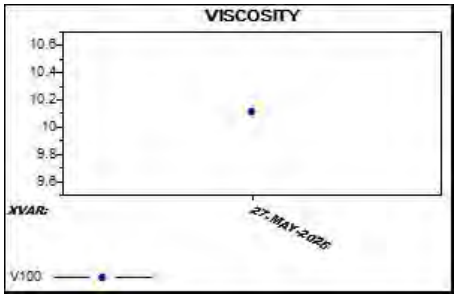
E330-55156-0038

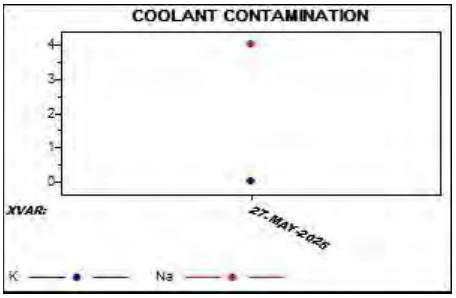
No Action Required

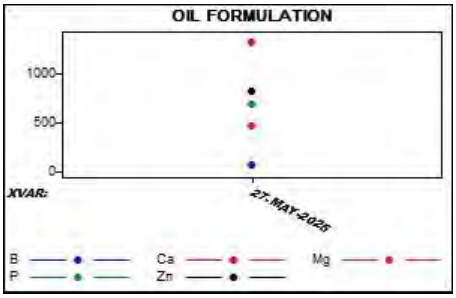












Report Comment

VisionLink® will be the new home for S·O·SSM Services fluid analysis. Begin the transition to VisionLink now - Sign up or log into vLcat.com to update your settings, manage your fleet, configure your jobsites (groups), and view your samples. The ability for users to submit samples, track samples, view and graph sample history, and download reports are coming to VisionLink soon.

Notice: This analysis is intended as an aid in predicting mechanical wear. No guarantee, expressed or implied, is made against failure of this piece of equipment or component thereof.

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 6534829

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430270
SERVICE SPECLST OPEN POSITION
LICENSE NUMBER
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2024

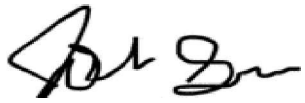
SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX: 5.500	
CITY TAX: 1.750	
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE



Josh

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			4.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	689		.20	GA 000001	C74	C24	C21
						C57	C53	C06
						C01	C10	C11
						C80	C05	C13

PRODUCT

CODE	PRODUCT USED DESCRIPTION/EPA NUMBER
689	Alpine WSG Insecticide (0.1%) 499-561 dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C57 Fire Door-Introduction Point
C74
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	4
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 6534829

PAGE 2

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430270
SERVICE SPECLST OPEN POSITION
LICENSE NUMBER
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2024

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Performed interior rodent service, checked and reset all traps.

Pest activity found during service: (YES)
Maintenance Area-Interior-Crickets noted during service Crickets noted at time of service
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

James Hecht

SVSP SIGNATURE - OPEN POSITION
START DATE/TIME: 10/28/2024 12:56 PM
I acknowledge that my report accurately reflects my activities and findings during today's service regarding recommendations and standards

CUSTOMER'S SIGNATURE - Josh
10/28/2024 13:29 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's service

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 6733849

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14

SERVICE PERIOD: MONTHLY (K)
SERVICE DATE: 11/26/2024

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:

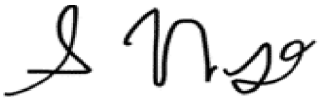
SUB TOTAL: 248.14

TOTAL: 248.14

AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE



Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25	GA 000002	C21 C24 C53 C57 C01 C80 C13 C23

PRODUCT CODE | PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C23 Work Floor-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.

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PAGE 2

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program

SERVICE PERIOD: MONTHLY (K)
SERVICE DATE: 11/26/2024

CONDITIONS FOUND/ACTIONS TAKEN
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists.
Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 11/26/2024 12:43 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
11/26/2024 13:30 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's

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INVOICE NUMBER 6964472

PAGE 1

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (L)
SERVICE DATE: 12/26/2024

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00 EA	000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25 GA	000002	C21 C38 C24 C53 C57 C06 C10 C01 C11 C80 C02 C56

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C06 Hallways-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C24 Break Room-Interior
C38 Basement-Interior
C53 Front Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 430209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (L)
SERVICE DATE: 12/26/2024

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists.
Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 12/26/2024 1:18 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
12/26/2024 14:01 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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CHICAGO, IL 60673-1262

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392270
SERVICE SPECLST HECHT, JAMES R
LICENSE NUMBER NEB 090990
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (B)
SERVICE DATE: 2/27/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
SUB TOTAL:	248.14
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			6.00 EA	000009	C24 C11 C80
Beetles	DEMAND CS INSECTICIDE	338		.20 GA	000011	C21 C24 C53 C57 C01 C10 C11 C80 C56 C05

PRODUCT

CODE	PRODUCT USED DESCRIPTION/EPA NUMBER
338	Demand CS (0.015%) 100-1066 Lamba-cyhalothrin

METHODS
000009 Checking Traps
000011 General Surface Application

SITES
C01 Kitchen Area-Interior
C05 Storage Area-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	6
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

CONDITIONS FOUND/ACTIONS TAKEN

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392270
SERVICE SPECLST HECHT, JAMES R
LICENSE NUMBER NEB 090990
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (B)
SERVICE DATE: 2/27/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area food covered or removed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.

Pest activity found during service: (YES)
Exterior Area-Mice noted during service Activity noted in bait stations
Rodent Stations inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

James Hecht

SVSP SIGNATURE - HECHT, JAMES R
START DATE/TIME: 2/27/2025 2:10 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
02/27/2025 15:22 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (C)
SERVICE DATE: 3/31/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00 EA	000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25 GA	000002	C06 C80 C56 C05 C10 C11 C24 C21 C53 C13 C23 C02

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C23 Work Floor-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C56 Roll Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (C)
SERVICE DATE: 3/31/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists.
Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 3/31/2025 2:13 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
03/31/2025 15:05 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's service

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CHICAGO, IL 60673-1262

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LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (D)
SERVICE DATE: 4/30/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00 EA	000009	C80
Cockroaches	ALPINE WSG INSECTICIDE	689		.25 GA	000002	C10 C11 C54 C53 C24 C02 C57 C80 C23 C13 C56 C05

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
689 Alpine WSG Insecticide (0.1%) 499-561
dinotefuran

METHODS
000002 Spot
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C10 Laundry/Housekeeping-Interior
C11 Maintenance Area-Interior
C13 Vending Machines-Interior
C23 Work Floor-Interior
C24 Break Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	None generated
Area/Size treated	2
Area/Size Measurement	Multi-catch traps
Application to surface type(s)	Not Applicable

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392209
SERVICE SPECLST SWIFT, DORIAN F
LICENSE NUMBER 117281
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (D)
SERVICE DATE: 4/30/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Performed interior rodent service, checked and reset all traps.
No rodent activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (YES)
Near Entry-Introduction Point--exit door doesn't close/seal properly-1/4 inch gap or greater exists.
Install/replace door sweep.

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - SWIFT, DORIAN F
START DATE/TIME: 4/30/2025 1:47 PM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
04/30/2025 14:20 PM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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INVOICE NUMBER 8091090

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (E)
SERVICE DATE: 5/29/2025

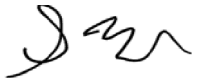
SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE



Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C54
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C55 C21 C06 C56 C53 C02 C05 C80 C07 C54 C57 C13

PRODUCT CODE — PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C13 Vending Machines-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2650
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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PAGE 2

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (E)
SERVICE DATE: 5/29/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Basement-Interior-Cockroaches noted during service Treated for water bugs on the lower floor of the school
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 5/29/2025 9:29 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
05/29/2025 10:54 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (F)
SERVICE DATE: 6/26/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Mice	REPEATER TRAP SOLID TOP			3.00	EA 000009	C11
Cockroaches	DEMAND CS INSECTICIDE	340		.35	GA 000001	C11 C54 C01 C06 C07 C80 C57 C09 C02 C21 C55 C53

PRODUCT CODE — PRODUCT USED DESCRIPTION/EPA NUMBER
340 Demand CS (0.06%) 100-1066
Lamba-cyhalothrin

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2550
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 8325565

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

1-800-325-1671

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (F)
SERVICE DATE: 6/26/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 6/26/2025 8:30 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
06/26/2025 9:16 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 8559912

PAGE 1

1-800-325-1671

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (G)
SERVICE DATE: 7/29/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:
TOTAL: 248.14
AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			3.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C01	C06	C07
						C80	C56	C05
						C09	C53	C57
						C21	C55	C02

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method None generated
Area/Size treated 3550
Area/Size Measurement Linear feet

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CUSTOMER SERVICE
REPORT

INVOICE NUMBER 8559912

PAGE 2

1-800-325-1671

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (G)
SERVICE DATE: 7/29/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.
Application to surface type(s) Linoleum/tile
Carpet
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service:	(NO)
Structural concerns that could cause pest problems:	(NO)
Sanitation issues that could cause pest problems:	(NO)
Facility preparation issues:	(NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 7/29/2025 8:19 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
07/29/2025 9:03 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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REPORT

INVOICE NUMBER 8806465

PAGE 1

1-800-325-1671

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (H)
SERVICE DATE: 8/27/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX:	5.500
CITY TAX:	1.750
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES
Cockroaches	DEMAND CS INSECTICIDE	340		.50	GA 000001	C11 C54 C01 C53 C05 C55 C06 C07 C80 C02 C21 C57
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
340 Demand CS (0.06%) 100-1066
Lamba-cyhalothrin

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3250
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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CUSTOMER SERVICE
REPORT

INVOICE NUMBER 8806465

PAGE 2

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CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
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SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (H)
SERVICE DATE: 8/27/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet
Wood

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.
The area was very clean and in excellent condition!
Please thank everyone who cleaned the area!

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 8/27/2025 9:10 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
08/27/2025 9:59 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

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INVOICE
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INVOICE NUMBER 9046172

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
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26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (I)
SERVICE DATE: 9/25/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:

TOTAL: 248.14

AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C69	C06	C07
						C80	C11	C54
						C53	C57	C21
						C01	C02	C55

PRODUCT
CODE PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C21 Bathroom/Locker Room-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C57 Fire Door-Introduction Point
C69 Snack Bar/Cafe-Interior
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3550
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

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INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 9046172

PAGE 2

1-800-325-1671

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ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
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SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (I)
SERVICE DATE: 9/25/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Maintenance Area-Interior-Spiders noted during service Near the roll door of the maintenance shop
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 9/25/2025 8:14 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Scott
09/25/2025 9:08 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate who provided today's service

Pay your invoice ONLINE through Ecolab Easy Pay - visit easypay.ecolab.com or scan QR code for access.

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg#1
5800 Leighton Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg#1	Occupancy Type:	Educational (Group E)
Address:	5800 Leighton Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19881	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	28	0 (0%)	0 (0%)	0 (0%)
Supervisory Signal Device	4	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	11/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.7
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	room 13

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP111450	Alarm Signal Tested visually Alarm Restoration Tested visually Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Tested visually Supervisory Restoration Tested visually	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / West exit by room 9	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - South / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - North / 002	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Dining room / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above stairs / 004	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 1 / 005	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 16 / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by room 16 / 007	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Office / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Clinic office / 009	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 15 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 14 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 13 / 012	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Hallway by room 13 / 013	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 11 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 10 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 6 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by room 7 / 017	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 7 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 9 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / North smoke / 020	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South smoke / 021	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above fire panel / 022	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Throughout building - 4	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes

Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Low Air Switch	Not Tested	-
Location	Type/Make/Model	Result	Number
	PIV Switch	Not Tested	-

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 3	Door Unlocking	Not Tested	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6 / 11	Audible And Visible	Not Tested	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #2
5801 Walker Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #2	Occupancy Type:	Educational (Group E)
Address:	5801 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-BOX11564	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	27	1 (4%)	1 (4%)	0 (0%)
Supervisory Signal Device	4	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SFP-2404

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	03/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.6 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP18160	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Tested visually Supervisory Restoration Tested visually	● Passed	-

Annunciator 1

Location

Location	1st / room 3

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / West exit by room 9	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - South / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - North / 002	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above fire panel / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Dining room / 004	Type/Make/Model Smoke Detector / System Sensor / 2WB	Sensitivity Range 1.0 - 4.0% Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above stairs / 005	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 1 / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 3 / 007	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 16 / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Hallway by room 3 / 009	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 15 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 14 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Storage room / 012	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by room 14 / 013	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 11 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 10 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 6 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by room 9 / 017	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 9 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 7 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Nurse office / 020	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / North smoke / 021	Type/Make/Model Smoke Detector / System Sensor	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model	Sensitivity Range	Result	Number
Basement / South smoke / 022	Smoke Detector / System Sensor / 1451	- Sensitivity Result -	Not Tested	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
	Water Flow	- Sensitivity Result -	Not Tested	-

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Control Valve Tamper Switch	Not Tested	-
Location	Type/Make/Model	Result	Number
Outside of building	PIV Switch	Not Tested	-

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 3	Door Unlocking	Passed	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6 / 11	Audible And Visible	Not Tested	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

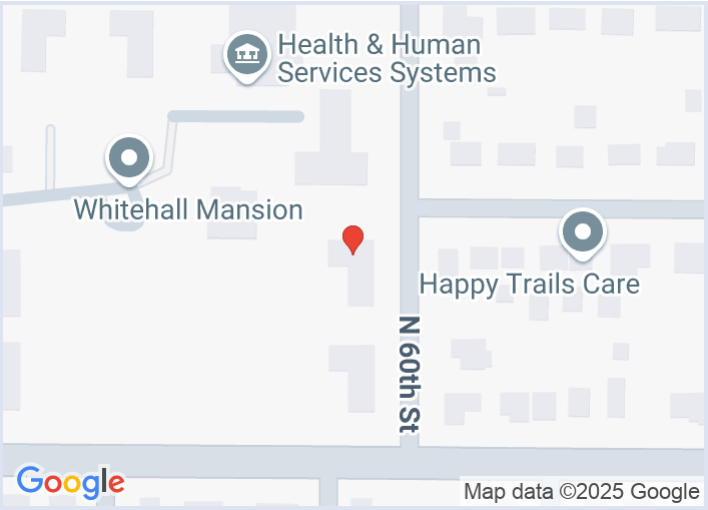
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #3
2345 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #3	Occupancy Type:	Educational (Group E)
Address:	2345 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19753	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	20	1 (5%)	1 (5%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	04/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.9 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-BOS11503	Alarm Signal Tested visually Alarm Restoration Tested visually Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / West exit in computer room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Fireplace room - South	Type/Make/Model Smoke Detector / Notifier / CP-651	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - North	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Commons area by kitchen	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above fire panel	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above stairs	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Office next to stairwell	Type/Make/Model Smoke Detector / Notifier / CP-651	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway North of stairwell	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Southeast office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Northeast office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / North storage room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by restrooms	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Northwest computer room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model	Sensitivity Range	Result	Number
Basement / North room	Smoke Detector / System Sensor / 1451	- Sensitivity Result -	Not Tested	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
Basement / South room	Smoke Detector / System Sensor / 1451	- Sensitivity Result -	Not Tested	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
Basement / Storage room	Smoke Detector / System Sensor / 1451	- Sensitivity Result -	Not Tested	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 4 / 5	Audible And Visible	Not Tested	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

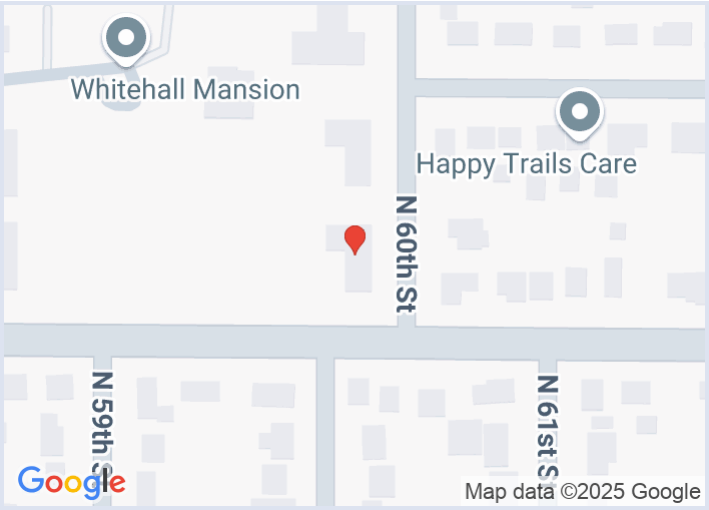
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #4
2311 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed with Deficiencies

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #4	Occupancy Type:	Not determined
Address:	2311 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19838	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	0 (0%)	0 (0%)	0 (0%)
Supervising Station Monitoring	1	0 (0%)	0 (0%)	0 (0%)
Annunciator	1	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	12	1 (8%)	1 (8%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal
M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	02/28/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	-
Amps/Hour Rating	7AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	1st / room 8

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	Not Tested

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-BOS11713	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Not Tested	-

Annunciator 1

Location

Location	1st / east exit

Specification

Type/Make/Model	Honeywell

Result

	Not Tested

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / West exit in computer room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes

Location	Type/Make/Model	Result	Number
	Door Holder	Passed	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 4 / 4	Audible And Visible	Not Tested	-

Comments

Number	COMMENT	IMAGE
1	Panel has been in trouble for a year. Customer has been aware. panel needs to be replaced	
2		

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

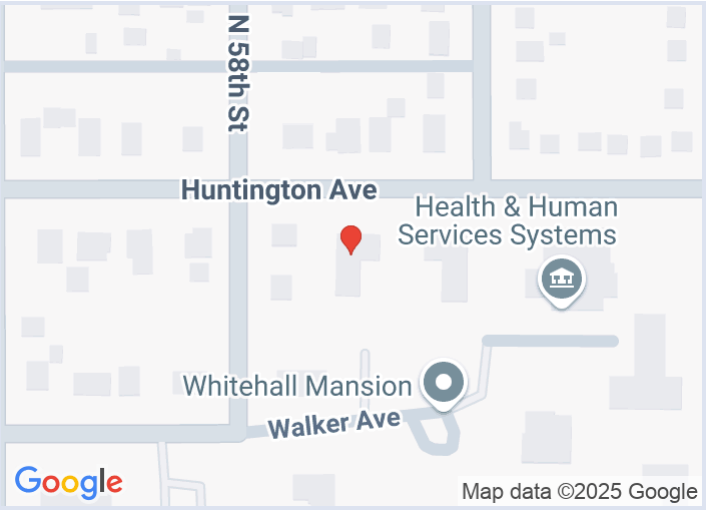
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #5
5845 Huntington Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #5	Occupancy Type:	Educational (Group E)
Address:	5845 Huntington Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP110341	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	13	1 (8%)	1 (8%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

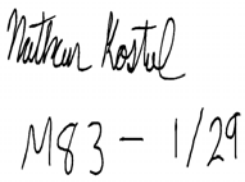
Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:



Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Southwest exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/18/2023
Battery Type	Sealed Lead Acid
Nominal Voltage	14.0 / 14.5
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	in janitor closet

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP110341	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / West exit by room 7	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room / 001	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above fire panel / 002	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Dining area / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by staff office / 004	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by janitor supplies / 005	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by room 6 / 006	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / North / 007	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South / 008	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Throughout building - 20	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location Outside doors - 3	Type/Make/Model Door Unlocking	Result ● Passed	Number -

Alarm Notification Appliance

Location	Specification	Result	Notes
Location Throughout building - 4 / 4	Type/Make/Model Audible And Visible	Result ● Passed	Number -

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #6
5819 Huntington Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #6	Occupancy Type:	Educational (Group E)
Address:	5819 Huntington Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-LN25605	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	29	1 (3%)	1 (3%)	0 (0%)
Supervisory Signal Device	3	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

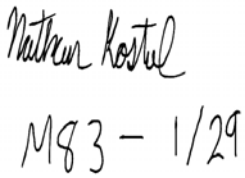
Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:



Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	Battery Load Test : 80% / East exit

Specification

Type/Make/Model	Honeywell Silent Knight® / Sk-2224

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/28/2021
Battery Type	Sealed Lead Acid
Nominal Voltage	13.6 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Battery: 7Ah - 9/21 - 13.5 / janitor closet room 13

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP18860	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	staff office

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / East exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit from main room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / East exit by room 7	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / South exit in game/ activity room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Above fire panel / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - South / 002	Type/Make/Model Smoke Detector / System Sensor	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Fireplace room - North / 003	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Dining room / 004	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Top of stairwell / 005	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Supervisor office / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 16 / 007	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by Room 16 / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Room 3 / 009	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 14 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 15 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 13 / 012	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by Room 13 / 013	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 4 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 11 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 5 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 10 / 017	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 6 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Hallway by Room 6 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 7 / 020	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Room 9 / 021	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / Storage room / 022	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / Game room - North / 023	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / Game room - South / 024	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location Outside of building	Type/Make/Model PIV Switch	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location Outside doors - 3	Type/Make/Model Door Unlocking	Result ● Passed	Number -

Alarm Notification Appliance

Location	Specification	Result	Notes
Location Throughout building - 6 / 11	Type/Make/Model Audible And Visible	Result ● Passed	Number -

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

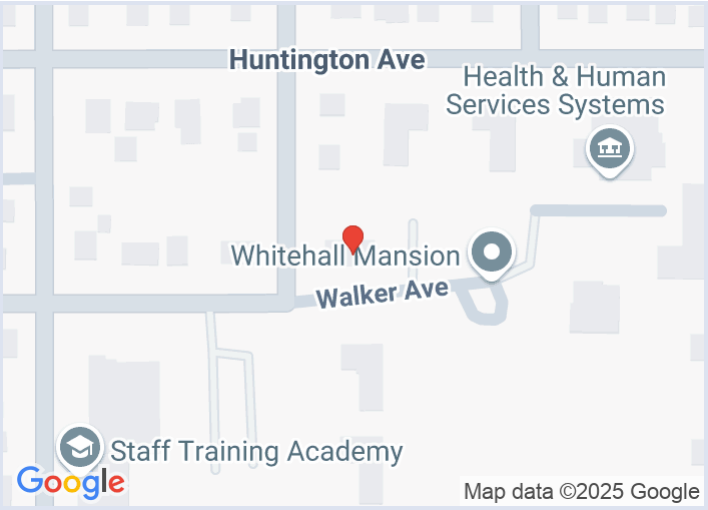
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #7
5800 Walker Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Failed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #7	Occupancy Type:	Educational (Group E)
Address:	5800 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP112860	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	0 (0%)	1 (100%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	6	1 (17%)	1 (17%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	2	2 (100%)	0 (0%)	2 (100%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

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Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal
M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Northwest exit

Specification

Type/Make/Model	Notifier / MD

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	06/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.8
Amps/Hour Rating	8AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	X Failed

Notes

Number	-

Communicator 1

Location

Location	above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP112860	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually Trouble Restoration Tested visually Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / top of stairs	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West entrance	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Commons area	Type/Make/Model Smoke Detector / System Sensor / 2WB	Sensitivity Range 1.0 - 4.0% Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / Bottom of stairs	Type/Make/Model Smoke Detector / BRK - system sensor / 1851B	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Throughout building - 5	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Alarm Notification Appliance

Location	Specification	Result	Notes
Location 1st	Type/Make/Model Bell	Result X Failed	Number -
Location Basement	Type/Make/Model Bell	Result X Failed	Number -

Deficiencies

Location	Type/Make/Model	Revision Number	Nominal Voltage	Type	Control Unit	Battery Date	Load Voltage	Result	Number
1st / Northwest exit	Notifier / MD	- Onsite Location Of Documentation -	- Amps -	- Amps - Location - Disconnecting Means Location -	Tested visually and functionally Lamps/LEDs/LCDs Tested visually and functionally Fuses Tested visually Trouble Signal Tested visually and functionally Disconnect Switch Tested visually Ground-Fault Monitoring Tested visually	06/01/2022 Battery Type Sealed Lead Acid Nominal Voltage 13.8 Amps/Hour Rating 8AH Standby Mode (hrs) 24 Alarm Mode (mins) 5	Tested visually Charge Test Tested visually Discharge Test Tested visually Battery Condition Tested visually	Failed	-

Location	Type/Make/Model	Result	Number
1st	Bell	Failed	-
Basement	Bell	Failed	-

Comments

Number	COMMENT	IMAGE
1	No audibles sound when panel is in alarm. Reccomned replacing panel.	

2			

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 9287002

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INV AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL: 248.14
STATE TAX: 5.500
CITY TAX: 1.750
CNTY TAX:

TOTAL: 248.14

AMOUNT DUE: 248.14

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Scott

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Mice	REPEATER TRAP SOLID TOP			2.00	EA 000009	C11		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C02	C53	C11
						C54	C55	C06
						C07	C80	C57
						C01	C56	C05

PRODUCT

CODE	PRODUCT USED DESCRIPTION/EPA NUMBER
691	Alpine WSG Insecticide (0.3%) 499-561
	dinotefuran

METHODS
000001 Crack & Crevice
000009 Checking Traps

SITES
C01 Kitchen Area-Interior
C02 Office Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C11 Maintenance Area-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	2925
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 9287002

PAGE 2

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (J)
SERVICE DATE: 10/28/2025

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Carpet
Wood
Concrete

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (YES)
Maintenance Area-Interior-Crickets noted during service Near the roll doors in the maintenance area
This area was inspected and serviced.

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 10/28/2025 8:32 AM
I acknowledge that my report accurately reflects my activities and findings during today's service visit, in accordance with Ecolab's standards and regulatory requirements.

CUSTOMER'S SIGNATURE - Scott
10/28/2025 9:19 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate who carried out today's service visit.

Pay your invoice ONLINE through Ecolab Easy Pay - visit easypay.ecolab.com or scan QR code for access.

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 7197723

PAGE 1

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE	QTY	INVOICE AMT
Cockroach/Rodent Program		248.14
Energy Surcharge		

SERVICE PERIOD: MONTHLY (A)
SERVICE DATE: 1/30/2025

SPECIAL INSTRUCTIONS:

TERMS: NET 30 DAYS

SUB TOTAL:	248.14
STATE TAX: 5.500	
CITY TAX: 1.750	
CNTY TAX:	
TOTAL:	**248.14**
AMOUNT DUE:	**248.14**

ADDITIONAL COMMENTS

CUSTOMER'S SIGNATURE

Jared

TARGET PEST	PRODUCT USED	PRODUCT CODE	LOT NUMBER ADD'L INFO	QUANTITY	METHOD	SITES		
Cockroaches	ALPINE WSG INSECTICIDE	691		.50	GA 000001	C09	C57	C53
						C06	C01	C07
						C11	C80	C54
						C56	C55	C05

PRODUCT CODE | PRODUCT USED DESCRIPTION/EPA NUMBER
691 Alpine WSG Insecticide (0.3%) 499-561
dinotefuran

METHODS
000001 Crack & Crevice

SITES
C01 Kitchen Area-Interior
C05 Storage Area-Interior
C06 Hallways-Interior
C07 Lobby Door-Introduction Point
C09 Dining-Interior
C11 Maintenance Area-Interior
C53 Front Door-Introduction Point
C54 Rear Door-Introduction Point
C55 Side Door-Introduction Point
C56 Roll Door-Introduction Point
C57 Fire Door-Introduction Point
C80 Near Entry-Introduction Point

This confidential report is provided to identify sanitation deficiencies, structural defects and improper storage practices contributing to pest infestations.

Pesticide Disposal Method	Applied to target site
Area/Size treated	3850
Area/Size Measurement	Linear feet
Application to surface type(s)	Linoleum/tile

CONDITIONS FOUND/ACTIONS TAKEN

ECOLAB®

INVOICE
CUSTOMER SERVICE
REPORT

INVOICE NUMBER 7197723

PAGE 2

1-800-325-1671

PLEASE REMIT PAYMENT TO:
PEST ELIMINATION
26252 NETWORK PLACE
CHICAGO, IL 60673-1262

BILLING ADDRESS
LINCOLN REGIONAL CENTER MAINTENANCE DEPT
801 W PROSPECTOR PL
LINCOLN NE 68522 US
BILL PH: 407-479-5452

ACCOUNT INFORMATION:
ACCOUNT NO. LINC0173-0002-01
SVSP # 392211
SERVICE SPECLST CENTAMORE, JOSEPH
LICENSE NUMBER NEB084367
CORP REF # 92035

SERVICE ADDRESS
WHITEHALL CAMPUS
5800 LEIGHTON AVE
LINCOLN NE 68512 US
SERV PH: 402-471-8354

SERVICE
Cockroach/Rodent Program
Energy Surcharge

SERVICE PERIOD: MONTHLY (A)
SERVICE DATE: 1/30/2025

CONDITIONS FOUND/ACTIONS TAKEN
Service related comments:
Inspected and treated selected areas.
Kitchen - Treated area closed.
Dining Room - Closed.
Performed interior rodent service, checked and reset all traps.
No rodent or insect activity was noted during the inspection and/or service.

Pest activity found during service: (NO)

Structural concerns that could cause pest problems: (NO)

Sanitation issues that could cause pest problems: (NO)

Facility preparation issues: (NO)

SVSP SIGNATURE - CENTAMORE, JOSEPH
START DATE/TIME: 1/30/2025 9:50 AM
I acknowledge that my report accurately reflects my activities and findings during today's service

CUSTOMER'S SIGNATURE - Jared
01/30/2025 10:49 AM
I acknowledge that the findings detailed in this report have been communicated to me by Ecolab's Service Associate during today's service

Pay your invoice ONLINE through Ecolab Easy Pay - visit easypay.ecolabusa.com or scan QR code for access.

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

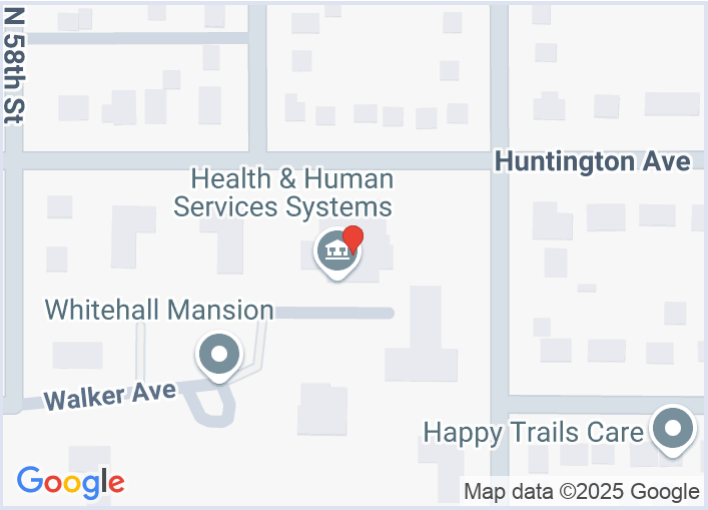
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Garage & Maintenance
2401 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Garage & Maintenance	Occupancy Type:	Educational (Group E)
Address:	2401 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP13839	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	33	1 (3%)	1 (3%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	South work shop

Specification

Type/Make/Model	Notifier / NFW-100X

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	Far North garage
Disconnecting Means Location	Disconnect labeled "Fire"

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/24/2024
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.7
Amps/Hour Rating	8AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP13839	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location South entrance - East / L1 M001	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location South entrance - West / L1 M002	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South garage - North entrance / L1 M003	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Westside - South exit / L1 M004	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - Middle / L1 M005	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - North exit / L1 M006	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - North exit / L1 M007	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - South exit / L1 M008	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North main shop / L1 M009	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northeast main shop / L1 M010	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Attic Heats / L1 M012	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Restroom hallway / L1 D012	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Restroom / L1 D013	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location work room / L1 D014	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Key room / L1 D015	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Window repair area / L1 D016	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Storage East / L1 D017	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Storage West / L1 D018	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Tool storage / L1 D019	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Breakroom / L1 D020	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - South / L1 D021	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - middle / L1 D022	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - North middle / L1 D023	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Westside - North / L1 D024	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - North / L1 D025	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - North middle / L1 D026	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - middle / L1 D027	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Eastside - South / L1 D028	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Mechanical room / L1 D029	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Wood shop / L1 D030	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Institute shop / L1 D031	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Office / L1 D032	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Above fire panel / L1 D033	Type/Make/Model Smoke Detector / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Alarm Notification Appliance

Location	Specification	Result	Notes
Location Throughout building - 8 / 15	Type/Make/Model Audible And Visible	Result ● Passed	Number -

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Mansion
5903 Walker Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Mansion	Occupancy Type:	Educational (Group E)
Address:	5903 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-BOS11550	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	72	1 (1%)	1 (1%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	2	1 (50%)	1 (50%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Hallway by North exit

Specification

Type/Make/Model	Notifier / AFP200

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	03/01/2024
Battery Type	Sealed Lead Acid
Nominal Voltage	13.9 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Basement / communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-BOS11550	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / North exit by fire panel / M 11	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Northeast exit by elevator / M 12	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / South exit / M 13	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Northwest stairs / M 14	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / West exit / M 21	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / East exit / M 22	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 3rd / West exit / M 31	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 3rd / East exit / M 32	Type/Make/Model Manual Pull Station / Notifier	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northwest office / D 01	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North hallway / D 02	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northeast office / D 03	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West stairs / D 04	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Elevator hallway / D 05	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Ballroom - Northwest closet / D 06	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Furnace room / D 07	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Restroom / D 08	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Ballroom - East / D 09	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Ballroom - West / D 10	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location East stairs / D 11	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Ballroom - SW closet / D 12	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South office / D 13	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Southeast closet / D 14	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northwest office / D 15	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North center office / D 16	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northeast office / D 17	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West stair landing / D 18	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North hallway / D 19	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West center office / D 21	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West restroom / D 22	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location West hallway / D 23	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Southwest office / D 24	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Center stair landing / D 25	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South office / D 26	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location East hallway / D 27	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Southeast office / D 28	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location East office / D 29	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location East restroom / D 30	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northwest room / D 31	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North hallway / D 32	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northeast room / D 33	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Kitchenette / D 35	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Hall by kitchen / D 36	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Restroom / D 37	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Hall by restroom / D 38	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Center hallway / D 39	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Dining room / D 40	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West center hall / D 41	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location East center hall / D 42	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Library / D 43	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Reception parlor / D 44	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Foyer / D 45	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Living room / D 46	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South entry / D 47	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Northwest stairwell / D 48	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North furnace room / D 49	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location Northeast storage / D 50	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Storage by pump room / D 51	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Center hall - West / D 52	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Center hall - East / D 53	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Vault / D 54	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Storage - West / D 55	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Corridor - East / D 56	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Storage - Southwest / D 57	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location History room / D 58	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Furnace room - East / D 59	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Storage - South / North Furnace / D 60	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Elevator lobby / D 71	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Elevator lobby / D 72	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator lobby / D 73	Smoke Detector	-	Not Tested	-
		Sensitivity Result		
		-		
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator lobby / D 74	Smoke Detector	-	Not Tested	-
		Sensitivity Result		
		-		
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator equipment room / D 75	Smoke Detector	-	Not Tested	-
		Sensitivity Result		
		-		
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator hoistway / D 76	Smoke Detector	-	Not Tested	-
		Sensitivity Result		
		-		

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6	Door Holder	Passed	-
Location	Type/Make/Model	Result	Number
Elevator Reset Key : H2389	Elevator Recall	Not Tested	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 22 / 47	Audible And Visible	Passed	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

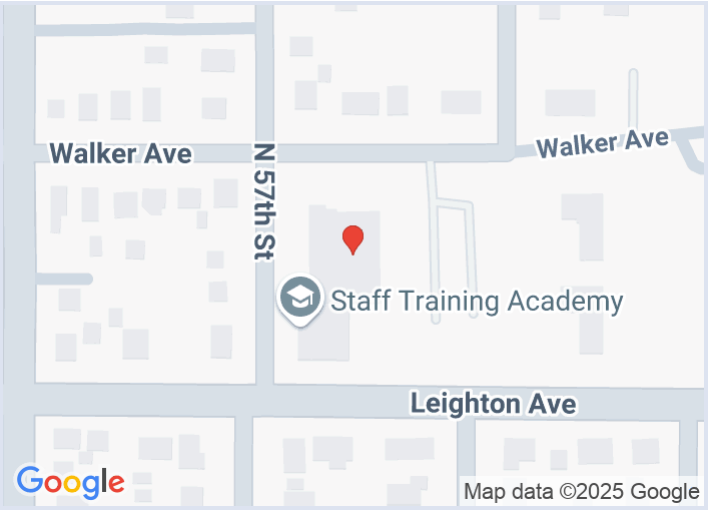
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - School/Staff Train Academy
2320 N 57th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - School/Staff Train Academy	Occupancy Type:	Educational (Group E)
Address:	2320 N 57th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-DMP1921-1	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	2	2 (100%)	2 (100%)	0 (0%)
Auxiliary Power Supply	1	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	74	1 (1%)	1 (1%)	0 (0%)
Supervisory Signal Device	3	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal

M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	West main entrance

Specification

Type/Make/Model	Fire-Lite® Alarms / MS-4024

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/01/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	Customer will replace
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	DMP panel powering communicator Battery: 8Ah - 5/20 - customer will replace / 1st / Communications room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-BOS11659	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	2nd / north exit by classroom 3

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Annunciator 2

Location

Location	1st / by front desk

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Auxiliary Power Supply 1

Location

Location	1st / custodian closet by fire panel

Specification

Type/Make/Model	Notifier / FCPS-24

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting means location	-

Visual/ Functional

Auxiliary Power Supply	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	08/01/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	Customer will replace
Amps/Hour Rating	7AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	Not Tested

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / by west main entrance under fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Passed	Number -
Location 1st / northwest entrance	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / west stairwell exit by jym	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / south exit by weight room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / north exit by classroom 3	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / west exit by conference room 3	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / boiler room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / basketball court exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South classroom	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South classroom	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South air handler mezz	Type/Make/Model Duct Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South air handler mezz	Type/Make/Model Duct Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Boiler room - West valve	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
Boiler room - East valve	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
Main water	Control Valve Tamper Switch	Not Tested	-

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6	Door Holder	Passed	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 35 / 58	Audible And Visible	Not Tested	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

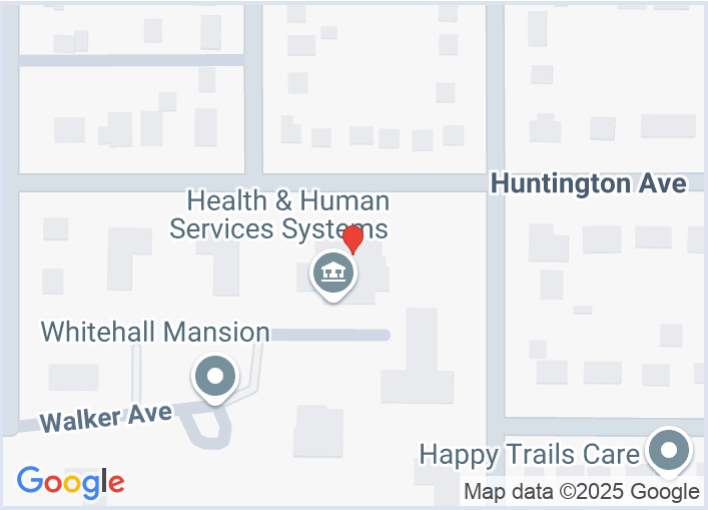
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Admin Training
5900 Walker Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, March 14, 2025

Inspection Status:
Passed

Tested By:

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Admin Training	Occupancy Type:	Business (Group B)
Address:	5900 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP110332	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	12	1 (8%)	1 (8%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Please see the end of the report for possible deficiencies.

Tested By:

Nathan Kostal
M83 - 1/29

Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	Northeast storage closet

Specification

Type/Make/Model	Potter / IPA-100

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	10/01/2024
Battery Type	Sealed Lead Acid
Nominal Voltage	13.6 / 13.6
Amps/Hour Rating	7Ah
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP110332	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	Southwest entrance

Specification

Type/Make/Model	Potter

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location Smoke above fire panel / 001	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result Not Tested	Number -
Location East entrance / 002	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Classroom East / 003	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Southeast courtyard / 004	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location North courtyard / 005	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Southwest courtyard / 006	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West office exit / 007	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West entrance / 008	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location West courtyard / 009	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Door hold West / 010	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result Not Tested	Number -
Location Door hold East / 011	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result Not Tested	Number -
Location East courtyard / 012	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes

Location	Type/Make/Model	Result	Number
West wing - 2	Door Holder	Not Tested	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 11/30	Horn/Strobe	Not Tested	-

MIDWEST ALARM SERVICES

Tech connected. Lives protected.

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.

Nathan Kostal

M83 - 1/29

Tested By:
Nathan Kostal
License: M83 - 1/29
Midwest Alarm Services
141 M St
Lincoln, NE 68508

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

Jim Pillen, Governor

August 21, 2025

Mark Labouchardiere, Administrator
2802 30th Avenue
Kearney, NE 68845

Dear Mr. Labouchardiere,

An onsite certification survey of your psychiatric residential treatment facility (PRTF) was conducted on August 11-14, 2025, by surveyors representing the Division of Public Health. This survey was conducted to determine compliance with the federal requirement in the Code of Federal Regulations at 441.151 through 441.156 and 483.354 through 483.376(h).

Enclosed on the form CMS-2567 you will find the deficiencies cited during the survey. Please type your plan of correction opposite the deficiency upon which it is based, sign and date the form. Return the original statement of deficiencies with a plan of correction to this office by .

To be acceptable, your plan of correction must include:

1. How the corrective action will be accomplished for individuals found to have been affected by the deficient practice;

2. What measures will be put into place for systemic changes made to ensure that the deficient practice will not recur;

3. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur;

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 deficiency will be corrected; and

6. Signature of the administrator or other authorized official and date.
August 21, 2025,

The plan of correction becomes part of the public record; therefore please **do not identify clients by name** on the plan of correction.

We would like to thank you for your cooperation and assistance at the time of the survey. Should you have any questions, please feel free to contact this office.

Sincerely,

Mark Luger, Program Manager
Office of DD & Behavioral Health Facilities
Division of Public Health
Ph. (402) 471-4975 FAX: (402) 742-2326
Email: mark.lugerl@nebraska.gov

cc: Margaret Van Dyke, Medicaid

EID:8YLF11

ML/fe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	EP Training Program CFR(s): 441.184(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 2	E 037		

policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: . Based on record review and interview the facility failed to document provided training of the facilty's Emergency Preparedness Plan (EPP) for staff. This had the potential to affect the health and safety of all clients residing at the facility. The facility census was 16 at the time of the survey. Findings: Record review of the Emergency Preparedness Plan revealed the plan did not show the training log completed by staff. Interview with the Youth Counselor Supervisor (person responsible for the EPP) on 8/13/2025 at 1:30 pm confirmed the system to track employee EPP training was in the process of changing and it will be implemented into the EPP soon. . .	E 037		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PRTF	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	8/14/2025
	SURVEY EVENT ID#	8YLF11
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	**PRTF032**

CITED TAG #	**PROVIDER'S PLAN OF CORRECTION** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E-037		
	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:	
E-037	In person training on the EPP will be conducted with all exsisting staff. In person training will be conducted during orientation for all new employees. An online training will be created through workday to supplement and show compliance with training on a yearly basis.	9/29/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
E-037	The Safety Coordinator will develop a training and then schedule all staff, keeping shifts in mind, for training on the plan. The Safety Coordinator and Training Specialist will coolaborate to create an online training in Workday to implement annually.	9/29/2025
	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:	
E-037	The Safety Coordinator will track progress and ensure that all staff are initially trained. The Training Specialist will ensure the online training is assigned yearly there after.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
E-037	Safety Coordinator, Training Specialist, and Facility Administrator	

	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

Jim Pillen, Governor

August 18, 2025

Mitchell Popple, Administrator
Lrc Whitehall Psychiatric Residential Treatment Facility
5845 Huntington Avenue
Lincoln, NE 68507

Dear Mr. Popple:

The enclosed report documents a finding of noncompliance with the licensure regulations for Lrc Whitehall Psychiatric Residential Treatment Facility- Mental Health Substance Use Treatment Center following the survey at your facility completed on August 14, 2025 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 94669, Lincoln, NE 68509-4669
Email: mark.luger@nebraska.gov

EID: KSV011

ML/fe

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 _____	08/14/2025

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
A 122	18-006.07(A) PROGRAM DESCRIPTION The facility must have a written program description that is available to staff, clients, and members of the public that explains the range of care and treatment activities provided. The description must include the following: (i) The mission statement, program philosophy, goals and objectives developed by the governing body; (ii) The levels of care and treatment provided, including inpatient and outpatient components, when applicable; (iii) The client population served, including age groups and other relevant characteristics; (iv) The hours and days the facility provides care and treatment; (v) Staff composition and staffing qualification requirements to sufficiently provide care and treatment to meet facility goals and objectives; (vi) Staff job responsibilities for meeting care and treatment facility goals and objectives; (vii) The admission and discharge processes, including criteria for admission and discharge; (viii) A system of referral for alternative services for those individuals who do not meet admission criteria; (ix) The client admission and ongoing assessment and evaluation procedures used by the program, including individualized service plan (ISP) process; (x) A plan for providing emergency care and treatment, including use of facility approved interventions to be used by staff in an emergency situation; (xi) Quality assurance and improvement processes, including who will be responsible for the program and how results will be utilized to improve care and treatment; (xii) A system governing the reporting, investigation, and resolution of allegations of	A 122		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	08/14/2025

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
A 122	Continued From page 1 abuse, neglect, and exploitation; and (xiii) Client rights and the system for ensuring client rights will be protected and promoted. This Standard is not met as evidenced by: . Based on record review and interview the facility failed to have a written program description that is available to staff, clients, and members of the public that accurately explains the range of care and treatment activities that are provided at the facility. This had the potential to affect all clients at the facility. The census at the time of the survey was 16. Findings: Record review of the facility's 7/26/2025 Program Description revealed the program description failed to include the following required items: 1.) The hours and days the facility provides care and treatment. 2.) The admission and discharge processes, including criteria for admission and discharge. 3.) A system of referral for alternative services for those individuals who do not meet admission criteria. 4.) The client admission and on-going assessment and evaluation procedures used by the program, including the individualized service plan (ISP) process. 5.) A plan for providing emergency care and treatment, including use of facility approved	A 122		

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 _____	08/14/2025

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
A 122	Continued From page 2 interventions to be used by staff in an emergency situation. 6.) Quality assurance and improvement process, including who will be responsible for the program and how the results will be used to improve care and treatment. 7.) A system governing the reporting, investigation, and resolution of allegations of abuse, neglect, and exploitation. 8.) Client rights and the system for ensuring client rights will be protected and promoted. Interview on 8/14/2025 at 9:30 am with the Administrator confirmed the facility's current Program Description does not include the missing required items.	A 122		
A 191	18-007.19 HOT WATER SYSTEM The facility must maintain hot and cold water to all hand washing and bathing locations with water temperatures for the comfort and safety of each individual. Hot water temperatures must not exceed 120 degrees Fahrenheit. This Standard is not met as evidenced by: . Based on observations and interviews the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit (F) at 1 out of 10 faucet locations tested. This has the potential to affect all clients at the facility. The facility census was 16 at the time of the survey.	A 191		

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 _____	08/14/2025

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
A 191	Continued From page 3 Findings: Observations completed on 8/12/2025 at 10:30 am during an environmental tour of the facility with the Administrator, Quality Assurance Specialist, Youth Counselor Supervisor, and the Maintenance Manager revealed that the temperature of the kitchen sink in the Warner Cottage was 130.3 degrees. Interview on 8/12/2025 at 11:30 am with the Maintenance Manager confirmed that the Warner Cottage has a regulator for the water temperatures to remain under the 120 degree limit, and will need to be turned down. Observations completed on 8/14/2025 at 8:45 am with the Administrator revealed that the temperature of the kitchen sink in the Warner Cottage was 123.6 degrees. Interview on 8/14/2025 at 8:50 am with the Administrator confirmed that the temperature of the kitchen sink at the Warner Cottage was still too high, and was over 120 degrees. The Administrator confirmed that the water temperature must be turned down to meet the requirements. .	A 191		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	8/14/2025
	SURVEY EVENT ID#	KSV011
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	**MHS031**

PROVIDER'S PLAN OF CORRECTION

CITED TAG #	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A-122, A-191		
	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-122	The program description will be reviewed by the administration team and rewritten so that it includes the 8 items that were noted as missing. After this edit the program description will be corrected and no longer deficient.	9/5/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
A-122	The program description will be rewritten by the Clinical Program Manager and then reviewed by the administration team to ensure compliance.	9/5/2025
	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-122	The program description will be reviewed against the current standards yearly to ensure the facility remains in copmliance with this deficiency.	9/25 and every year after
	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-122	Clinical Program Manager and Facility Administrator	

	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-191	DAS maintenance personnel will check the plumbing in WNR cottage to see if it is set up so that a mixing valve can be added to the hot water heater. Once the mixing valve is added to the hot water heater then the temperature will remain stable without having to turn down the water heater because the mixing valve accurately can hold a water temperature that is desired.	9/15/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
A-191	DAS maintenance personnel will place a work order to add a mixing valve to the WNR cottage water heater and then install the mixing valve. Once complete they will mark the work order as complete for documentation that the work has been done.	9/15/2025
	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-191	The water temperatures are currently monitored daily during 3rd shift as part of their daily nightly duties. When the water is above the 120 degree threshold the staff member is to place a work order for the temperature to be adjusted. The Facility Adminstrator or Unit Managers then make sure that work order is placed so that DAS maintenance personnel know to go adjust the water temperature. To further ensure the hot water is reported when out of compliance, the supervisors on 3rd shift will ensure that when the water is out of compliance it is added to the shift report for that cottage so that all of campus can be aware of the hot water.	8/22/2025
	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-191	Shift Supervisors, Unit Managers, and Facility Administrator	

	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).	

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 _____	08/14/2025

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
D 240	009.02 Maintenance 009. Every building or space utilized for the care and treatment of the consumer must comply with the following: 009.02. All parts of a facility or service, and all equipment, fixtures and furnishings are to be maintained in good working order and meet the following standards: (A) Surfaces must be smooth, free of sharp edges, splinters, or potential safety risks; (B) Doors, stairways, passageways, aisles and other means of exit must be maintained to prevent hazards which might pose a potential safety risk; (C) Routine and preventative maintenance must be performed in accordance with manufacturer's instructions and documentation of maintenance must be maintained; (D) Sound and lighting levels must be conducive to the care and treatment provided; (E) Maintenance equipment and supplies must be available; and (F) Hazardous materials must be secured to prevent accidental or intentional ingestion, inhalation, or consumption by the consumer. This Standard is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure all parts of the facility, facility equipment and services are maintained in good working order, safe and free of potential harm. This had the potential to affect the health and safety of all clients residing at the facility. The facility census was 16 at the time of the survey.	D 240		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	08/14/2025

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
D 240	Continued From page 1 Findings: Observations on 8/12/2025 from 10:10 am-12:00 pm during an environmental tour of the facility with the Administrator, Quality Assurance Specialist, Youth Counselor Supervisor, and the Maintenance Manager revealed the following maintenance issues: Nighthouse Outside in front of the entrance there is a metal grate over a drainage pipe that is very rusted and there places in which the metal is completely rusted through. The kitchen sink has a nozzle that controls the blockage of the drain, the metal piece of the nozzle was sitting loosely in the hole and didn't appear to be attached properly. The stopper for the drain did not appear to be functioning. In the group therapy room there was a long conference table. The conference table had a long missing piece of the wood lament missing. This exposed the table to sharp edges and an unfinished surface. In the doorway to the group therapy room, there was a chipped piece of would coming off of the doorway wood approximately 3 feet up the doorway that was that had sharp edges. Family Life Cottage There was a door that went to a maintenance room, that had a significant amount of the wood lament missing all around the door, leaving the door to have areas of sharp and exposed wood. Community Life Cottage	D 240		

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 _____	08/14/2025

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
D 240	Continued From page 2 Outside in front of the entrance there is a metal grate over a drainage pipe that is very rusted. In the kitchen, the wood trim to the counter tops is peeling away from the counter. There are large areas in which the trim is missing or left exposed and sharp. The counter top is has heat damage, resulting in a large stain to the counter top. There is a shower that has low water pressure in the large bathroom. Warner Cottage There is a toilet located in the small bathroom in which the calking is missing and pulled away from the toilet. This has has cause an orange discoloration of the bottom of the toilet and floor. Interview with the Administrator on 8/14/2025 at 9:30 am confirmed that the identified maintenance issues at Warner Cottage, Community Life Cottage, Family Life Cottage, and Nighthouse would need to be fixed and addressed.	D 240		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	8/14/2025
	SURVEY EVENT ID#	KSV011
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	**MHS031**

PROVIDER'S PLAN OF CORRECTION

CITED TAG #	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
D-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:	
D-240	There are nine items noted in this citation. Each item will have a work order placed to either fix or remove the deficient item. Once removed or fixed we will then be in compliance with the standard cited. Some items like the rusty metal grates and the conference table will take longer to replace because replacement items will need to be ordered. Any items that have sharp edges that are waiting on replacement will have temporary fixes in place to ensure the sharp edge is mitigated until it can be replaced.	9/29/2025
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
D-240	Work orders or supply requests will be placed by the Facility Administrator to ensure all deficiencies are taken care of.	8/29/2025
	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-240	The facility safety coordinator will conduct yearly environment of care walkthroughs through all spaces that youth utiliize to ensure all spaces and equipment utilized by youth are in safe working order.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
D-240	Unit Mangers and Facility Administrator	

	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

Jim Pillen, Governor

October 1, 2025

Mark Labouchardiere, Administrator
Lrc Whitehall Prtf
5845 Huntington Avenue
Lincoln, NE 68507

Dear Mr. Labouchardiere:

On September 29, 2025, DHHS representatives conducted an onsite revisit to verify that your facility had achieved and maintained compliance with the deficiencies cited during a survey conducted . During the revisit survey, the original cited deficiency E-037 was not corrected, as you will see on the enclosed CMS-2567.

PLAN OF CORRECTION (POC)

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

An acceptable POC must include:

- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction;
- **PROVIDE THE DATE WHEN CORRECTION ACTION WILL BE COMPLETED**. Correction dates should be no later than forty-five calendar days from the exit date of the survey or November 13, 2025**.**

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

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

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

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

Sincerely,

Mark Luger

Mark Luger - Program Manager II
DHHS Public Health - Licensure Unit
Office of DD and Behavioral Health
PO Box 94669, Lincoln, NE 68509-4669
Email: mark.luger@nebraska.gov

EID:8YLF12
ML/fe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	EP Training Program CFR(s): 441.184(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	{E 037}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	{E 037}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

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{E 037}	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	{E 037}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{E 037}	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	{E 037}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: . Based on record review and interview the facility failed to provide training of the facilty's Emergency Preparedness Plan (EPP) for all staff. This had the potential to affect the health and safety of all clients residing at the facility. The facility census was 13 at the time of the survey. Findings: Record review of the Emergency Preparedness Training Log revealed 47 out of 64 staff members completed Emergency Management training. Interview with the Compliance Specialist on 9/29//2025 at 11:30am confirmed that not all staff have completed Emergency Preparedness Training and it is not logged in the EPP. . .	{E 037}		

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{A 122}	18-006.07(A) PROGRAM DESCRIPTION The facility must have a written program description that is available to staff, clients, and members of the public that explains the range of care and treatment activities provided. The description must include the following: (i) The mission statement, program philosophy, goals and objectives developed by the governing body; (ii) The levels of care and treatment provided, including inpatient and outpatient components, when applicable; (iii) The client population served, including age groups and other relevant characteristics; (iv) The hours and days the facility provides care and treatment; (v) Staff composition and staffing qualification requirements to sufficiently provide care and treatment to meet facility goals and objectives; (vi) Staff job responsibilities for meeting care and treatment facility goals and objectives; (vii) The admission and discharge processes, including criteria for admission and discharge; (viii) A system of referral for alternative services for those individuals who do not meet admission criteria; (ix) The client admission and ongoing assessment and evaluation procedures used by the program, including individualized service plan (ISP) process; (x) A plan for providing emergency care and treatment, including use of facility approved interventions to be used by staff in an emergency situation; (xi) Quality assurance and improvement processes, including who will be responsible for the program and how results will be utilized to improve care and treatment; (xii) A system governing the reporting,	{A 122}	The program description will be updated to reflect all required items. Mitch, FA, will add a description regarding how we investigate + resolve allegations of abuse. Mitch will also add a description of our quality assurance + improvement process. The program description will then be turned in with this document. - MP 10/10/25	

Licensure Unit
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Facility Administrator — (X6) DATE: 10/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{A 122}	Continued From page 1 investigation, and resolution of allegations of abuse, neglect, and exploitation; and (xiii) Client rights and the system for ensuring client rights will be protected and promoted. This Standard is not met as evidenced by: Based on record review and interview the facility failed to have a written program description that is available to staff, clients, and members of the public that accurately explains the range of care and treatment activities that are provided at the facility. This had the potential to affect all clients at the facility. The census at the time of the survey was 13. Findings: Record review of the facility's updated Program Description revealed the program description failed to include the following required items: 1.) Quality assurance and improvement process, including who will be responsible for the program and how the results will be used to improve care and treatment. 2.) A system governing the reporting, investigation, and resolution of allegations of abuse, neglect, and exploitation. Interview on 9/29/2025 at 12:10 pm with the Clinical Program Manager and the Quality Assurance Specialist confirmed the facility's current program description states that quality assurance and the reporting of abuse, neglect,	{A 122}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{A 122}	Continued From page 2 and/or exploitation are the responsibility of the Compliance Coordinator. Both staff members confirmed the program description did not include how quality assurance will be used to improve care and treatment or what is the system for reporting, investigating, and resolving allegations of abuse, neglect, and exploitation.	{A 122}		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	8/14/2025
	SURVEY EVENT ID#	KSV012
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	MHSU031

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A-122		
	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-122	The program description will be updated to include the two items that were missing.	10/10/25
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
A-122	The facility administrator will update the program description and the administrative team will review for accuracy.	10/10/25
	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-122	The program description will be reveiwed yearly to ensure compliance.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
A-122	Facility Administrator and Clinical Program Manger	
	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).	

Whitehall Psychiatric Residential Treatment Facility
Program Description (391 NAC 7, 005.08)
Updated: 08/20/2025

Whitehall Psychiatric Residential Treatment Facility (PRTF) is a state-operated 24/7 residential facility that currently serves two different populations. That is, youth who have been diagnosed with a moderate to severe substance use disorder and youth who have sexually harmed and are thought to be at risk to harm again. Both programs are designed to address mental health needs as well as criminal thinking and behaviors. Both programs are trauma focused; evidence based, and take a strength-based approach to treatment. Both programs provide 40 hours per week of therapeutic activities.

Goals & Objectives: The overall goal is for youth to successfully and safely transition back into the community. Whitehall staff guide youth towards reduced incidents of acting out behaviors, especially those in which the youth may harm themselves and/or others and ultimately to have no additional criminal offenses. Whenever possible, reunification with the primary family unit is encouraged. Each Whitehall program strives to keep youth active and challenged to remain current in their academic goals and status. Clinical interventions and/or objectives are met through individual sessions, family sessions, group therapy, and education. Each youth and their primary therapist develop individualized clinical objectives and whenever possible the parent and/or guardian and the primary referral source are also consulted. Youth advance through the program through a series of phases. Phase advancement is dependent upon well-defined, achievable, and measurable indicators of emotional growth and prosocial behavior. As youth begin to gain social and emotional control, they earn additional privileges which are built into the different phases of treatment. The higher the phase, the more privileges youth are afforded.

Description of Population Being Served: Whitehall PRTF serves adolescent males 13 -18 years of age in two separate programs: youth with a history of engaging in sexually harmful behaviors and those diagnosed with moderate to severe substance use disorders. Whitehall takes into consideration the youth's developmental history, trauma history, criminal history and the severity of behaviors when creating individualized treatment plans. All staff are trained in de-escalation strategies and in recognizing trauma-related behaviors.

Admission Criteria:

- Youth must be at least 13 years of age and no older than 18.
- Youth must not require emergency medical detoxification treatment and supervision.
- All youth must have completed a community-based Substance Use Evaluation and/or a Youth Who Sexual Harm Evaluation prior to being referred.
- Youth must be diagnosed with a moderate to severe substance use disorder or must be assessed as being highly likely to continue to sexually harm others by a community-based evaluator.

All youth are interviewed by Whitehall clinical staff in order to access the youth's current responsiveness for treatment. The below criteria are **guidelines** for admission. Thus, Whitehall

evaluators take into consideration the youth's current situation, functioning, and behaviors at the time of the interview before making admission decisions.

- Youth must not be actively suicidal. That is, youth must not have attempted suicide or have been hospitalized due to suicidal ideation within a reasonable period prior to being referred/interviewed.
- Youth must not be experiencing psychotic symptoms/behaviors within a reasonable period of time prior to being referral/interview.
- Youth must not have engaged in violent behaviors within a reasonable period prior to being referred/interviewed.
- Youth must have the intellectual capacity to benefit from cognitive behavioral therapy. This is evaluated by reviewing the community-based Substance Use Evaluation and/or the Psychosexual Evaluation, school records, Individualized Educational Plans (IEPs), severity and frequency of drug and alcohol use, age of first use, and presentation during the clinical interview.

If a youth does not meet criteria, the referral source is notified of the decision. Recommendations for alternative treatment is dependent on: (1) the reason the youth was denied for admission and, (2) available treatment options in Nebraska. For example, this may include intensive outpatient treatment; immediate admission to a medically supervised detox center; a secure psychiatric treatment facility; or a secure behavioral treatment facility.

Individualized Treatment Plans: Treatment plans are developed by the youth's individual therapist at the time of admission. The initial plan identifies immediate needs and expectations such as being evaluated by the facility psychiatrist, medical doctor, and psychologist. The plan must be completed within 24-hours of admission. An updated Treatment Plan is completed within 10-days of admission and describes all treatment interventions as well as the Whitehall staff responsible for each intervention. Treatment plans include specific intervention needs and goals/objectives designed to address those needs. Youth are able to provide input to the plan and whenever possible the plan is discussed with parents/guardians. The plan is updated and reviewed with each youth every 30-days and the youth is expected to sign each updated plan.

Successful Discharge Criteria: In order to be successfully discharged, all youth must have advanced through all phases of treatment and completed all assigned work described on their individualized treatment plan. Additionally, youth must maintain good behavior as reflected by their Cottage Scores (i.e., number of progressive discipline strategies earned) in the prior 30-days. Youth must also maintain high Therapeutic Scores which reflects their behavior, participation, and treatment homework scores for all therapeutic activities. Most often youth discharge with the recommendation to return to live with their family and to continue with outpatient therapy. For youth who have sexually harmed, discharge recommendations are dependent upon the youth's relationship with victims and whether safety plans can be followed. The level of supervision and monitoring in the home is an important consideration during discharge planning.

Unsuccessful Discharge Criteria: Youth may be unsuccessfully discharged for any of the below described behaviors:

- Repeatedly engages in verbal and/or physical aggression.
- Repeatedly fails to follow Whitehall policies and procedures.
- Repeatedly fails UAs either after community and home visits or while in treatment.
- Fails to advance through phases of treatment in a reasonable amount of time.

Recommendations following unsuccessful discharges are dependent on the youth's behaviors and the youth's individual circumstances, however always includes a recommendation for continued treatment for the youth and the family.

Average Lengths of Stay: The average length of stay for the Substance Use program is approximately 110 days, however the range of days in treatment is 95 to 240 days. Youth remain in treatment as long as they continue to make progress. The average length of stay for the Youth Who Sexually Harm is 12 months. Range of stay is 6 months to 18 months. Youth remain in treatment as long as they continue to make progress unless the youth turns 19.

Emergency Events: In the event of a medical emergency, youth will either be transported to the nearest hospital by at least two staff or 911 will be called. In the event of unmanageable behavioral concerns, the Lincoln Police Department will be called for assistance. If any youth requires medical care or police interventions, parents, guardians and probation officers will be notified via phone.

Client Rights: Upon admission, all youth are given a copy of their client rights. All youth are required to read and sign a form acknowledging that they received a copy of their client rights. Included in the copy of their client rights are options for recourse if they believe their rights have been violated including facility grievance procedures and contact information for the State Ombudsman.

Allegations of Abuse, Neglect, and Exploitation:

Whitehall is monitored by an internal, 3rd party compliance team, that monitors the facilities grievance and abuse/neglect allegations. Currently youth have access to grievance forms in each cottage that they may grab themselves and turn into a lock box to the compliance team. The lock boxes are checked at a minimum three times a week by Whitehall's compliance specialist. Youth can use these grievance forms to report complaints, grievances, or instances of abuse/neglect. Additionally, in each cottage the phone numbers to the Ombudsman office and the Abuse/Neglect hotline are posted next to the phone so that youth have additional avenues for reporting abuse/neglect. If an abuse/neglect allegation is received, the compliance specialist will investigate to determine whether the allegation is substantiated or not. During the investigation process, Whitehall will work with compliance to ensure safety of the youth is maintained until the investigation is completed. If allegations are substantiated, Whitehall then works with HR to determine the level of discipline to impose, including up to immediate termination.

Discipline Model Being Followed: Whitehall staff implement a very positive strength-based approach to any discipline that is needed with our youth. Positive reinforcement has been found to be far more effective in achieving lasting behavioral change. We implement progressive statuses such as "Loss of Privileges", "Phase Freeze", and "Treatment Re-Focus", when needed as last resort options.

Academic & Vocational Education: Youth participate in school for 5 hours, 5 days per week. Youth participate in personalized curriculum to support their individualized educational needs. Our goal is to help youth advance rather than fall behind in their academic status while in treatment at Whitehall.

Library Access & Usage: Whitehall maintains a library on campus. Youth are allowed to check out two books at a time and return for two more when needed. Clinical staff, as appropriate, may recommend reading materials for specific youth's needs.

Money Management Training: Whitehall curriculum includes a Life Skills Group held twice weekly wherein youth learn to make a budget, how to save money, how to balance and keep a checkbook and how to open an account.

Religious/Spiritual Needs: A Lincoln Regional Center (LRC) Pastoral Care staff and/or representatives from a community-based church come to the Whitehall campus each Sunday and facilitate spiritual lessons and discussion. At admission each youth is asked about their spiritual preferences and are

allowed to practice their religious beliefs provided rituals or religious items do not present a risk to self or others.

Nutrition & Dietary Education: Our Whitehall nurse conducts a nutritional assessment upon admission and forwards the assessment to a dietician at LRC who determines each youth's caloric needs. We also hold a cooking and nutrition class weekly wherein youth learn to cook, learn about healthy foods, and how to make grocery lists for meal preparation.

Recreation: Recreational activities are held daily throughout the duration of treatment. Therapeutic recreational activities are designed to introduce youth to a variety of activities that are comfortable for any skill level. It is Recreational staff's intent to have youth identify activities they wish to continue to pursue post treatment.

Community Contacts: Youth are encouraged to remain in contact with identified healthy support in the community. The parent/guardian, together with the primary therapist and the primary referral source put together an approved contact list for phone calls and visitation. Youth are allowed a pass into the community with their family and other healthy support as they progress through the treatment phases.

Risk Management, Quality Assurance, and Emergency Preparedness:

Whitehall meets monthly for our risk management, quality assurance, and emergency preparedness (RQE) meeting. This meeting is comprised of the facility administrator, clinical program manager, unit managers, activity supervisor, nurse supervisor, maintenance personnel, and the school principal. This meeting's purpose is to discuss issues that have been identified in the previous month regarding any of the three subjects that the title is comprised of. Solutions discussed in these meetings are then disseminated to the appropriate parties on campus to ensure their implementation. Quality assurance is also monitored by team QDIPs on campus. QDIPs give us the ability to monitor problem areas within our areas to identify problems that can be fixed. (ex. A possible QDIP could be that 1st shift would like to monitor who on their shift is giving statuses to the youth. They then monitor the statutes given on their shift for the month and then discuss the results. If a particular staff member is the one always giving statuses, then the supervisors can work with that individual to ensure the staff member is fair in their distribution of statuses to youth.) This meetings is ran and maintained by the facility administrator.

Program Interventions / Curriculum: Unless noted, the interventions listed below are offered in both programs.

Anger Management: Anger Management class will encourage youth to develop positive coping mechanisms for their anger. This class will help youth understand their emotions, develop emotional awareness, and give youth the tools to navigate their feelings and others.

Cooking and Nutrition: Cooking and nutrition group will help youth understand the fundamentals of cooking, how to store food, and what support they have upon discharge if they are unable to afford food. This group will focus on giving youth a well-rounded understanding of meal planning, nutrition, and ensuring proper health.

Cottage Group: The group facilitates learning of behavioral expectations for the living area and the campus. Youth are encouraged to report safety concerns and learn how to demonstrate healthy personal boundaries. The cottage group helps to troubleshoot problems that develop in the living area.

Emotional Regulation: Youth will understand and change their emotional patterns that lead to regrettable or unhealthy behaviors (withdrawal, lashing out, etc.). Emotion regulation will inform youth about managing emotions in a way that allows problem-solving, feeling in-control, and communicating in healthy ways.

Fatherhood Group: Youth are taught basic skills that promote effective and safe parenting strategies and includes information on child development. The focus is on teaching prospective fathers to recognize and respond appropriately as infants and children move through the stages of development.
Future Possible Self: Future Possible Self class will encourage youth to bring awareness to positive future possibilities, while they internally develop the tools and understanding to take the appropriate next steps towards those goals. This class will increase self-awareness, self-esteem, and emotional awareness. Youth will develop an understanding of where they are at with their goals currently as a first step toward deciding their future.
Health Education: Youth will learn of changes in their bodies, their sexuality, physical and emotional health care, and various disorders such as eating disorders, substance abuse disorders, and mental health disorders. Youth will have the opportunity to ask questions regarding these health-related issues and changes.
Hobbies, Interests and Talents: Hobbies, interests and talents group will teach youth how to explore personal interests and develop a healthy lifestyle. Youth will learn about new hobbies they could take interest in, as well as explore ideas on future planning.
Keep Up the Good Work Group: Keep Up the Good Work group will promote positive behaviors using verbal and tangible reinforces. Positive behaviors include managing challenges successfully, being friendly and helpful to others, and staying on task. To encourage the use of appropriate social skills and learning to reward self appropriately after reaching goals.
Life Skills: Life skills group explores money management, independent living, employment opportunities, and traits associated with having a good work ethic. Youth participating in the life skills group learn to fill out an application for employment, manage money, learn new hobbies interests and talents, and learn simple cooking /nutrition skills, and other life skills to help him be successful.
Relapse Prevention: Youth work on learning strategies to help them stay in recovery once they leave treatment. Understanding what their personal triggers are and how people, places, and situations can be helpful or harmful to their recovery. Discovering tools for long lasting recovering, developing personal recovery tools, and the use of refusal skills and complete a recovery project and a relapse prevention plan.
Planning for Success: This group is specifically for youth who sexually harm and focuses on creating goals that will promote a healthy productive life. Youth examine beliefs that either support or impede the development of prosocial values that help to guide the youth to a healthy lifestyle.
Risk Reduction Group: This intervention is also specifically for youth who have sexually harm. Youth prepare and present a series of workbooks and assignments designed to introduce the youth to treatment and develop a better understanding of themselves including their dysfunctional behaviors. Each youth is expected to develop strategies to manage unhealthy/harmful urges and increase their understanding of the harm they have caused. Additionally, youth learn skills to enhance the adolescent's ability to connect to family and the community by making amends for their sexually harmful behaviors.
Self-Management and Recovery (SMART Recovery) Group: SMART Recovery incorporates techniques from Cognitive Behavior Therapy, Rational Emotive Behavior Therapy, and Motivational Enhancement Therapy to help youth identify and change problematic behaviors that may interfere in their recovery. Because many of the youth who have sexually harmed also have substance use difficulties, all youth are expected to participate in this group.

Social Skills: Social Skills will promote and teach utilization of appropriate social interactions listed on the Phase System, role-playing appropriate steps to each interaction. Youth will practice skills through the week with staff as evidenced by Daily Documentation Records.
Target Group: Target group is a strength-based, present-centered approach to teaching self-regulations skills for those who have experienced trauma. Target teaches a sequence of practical skills that enable individuals to safely process stressful experiences.
Teaching Tolerance: Teaching Tolerance will promote acceptance towards those different from oneself, ability to positively navigate situations out of their control, and educating youth about situations that impacted how we view other people today. This group will give youth the internal tools to respond appropriately to others in a multitude of situations and circumstances.
Therapy Group: This intervention is provided for youth in the Substance Use (SU) program. Youth in the SU program examine the facts and costs of addiction to gain competence in the use of recovery tools and practices, and restructure cognitive distortions to help him be successful in abstinence/recovery. Therapists will promote use of novel recovery tools and sober principles through personal interaction, listening to youth's life stories, working with strengths, and bolstering successes to help youth learn to live a clean and sober lifestyle.
Therapeutic Recreation: Therapeutic Recreation will teach positive coping skills for youth to utilize to express thoughts, feelings, and ideas assertively with others by discharge. To teach a variety of leisure skills and resources so youth may learn about healthy leisure lifestyle and habits.

Staff Composition, Responsibilities, & Qualifications:

Facility Administrator: Responsible for the overall administration of the facility and direct care staff. Must have a master's degree in social work, counseling, business, public administration, education, or a related field; or have a bachelor's degree and five years of experience in social work, counseling, business, public administration, education, or a related human service.
Psychiatrist: Acts as the Supervising Practitioner overseeing the psychiatric needs of our youth, to include medication management and associated medical needs.
Medical Physician: Conducts medical examinations at intake for all youth and prescribes medical interventions as needed.
Clinical Program Manager: Supervises the therapists and case managers. Oversees daily activities/scheduling and programing. The Clinical Program Manager also coordinates referrals, discharges, and the census. This individual must have a master's degree in social work, counseling, business, public administration, education, or a related human service; or have a bachelor's degree and five years of experience in social work, counseling, business, public administration, education, or a related human service.
Clinical Psychologist: Oversees the assessment processes and the clinical needs of each youth. The psychologist actively supervises our clinical team to ensure therapeutic interventions are evidenced based and appropriate for each youth and must be provisionally or fully licensed with a PhD or PsyD.
School Principal: Responsible for the overall academic needs of our youth and supervises the teachers.
Nurses: Work together with the Psychiatrist, the Medical Physician, and the Clinical Psychologist to meet the daily medical needs of the youth.
Unit Managers: Responsible for overseeing the supervisors/direct care staff and their interactions and interventions with the youth. The Unit Managers also oversee compliance checks, facility drills, trainings, and work orders. Unit Managers work closely with the clinical team to communicate youth, and facility needs to and from the direct care staff. Must have a master's degree in social work,

counseling, or a related human service; or have a bachelor's degree in social work, counseling, or a related human service with two years of experience in a human service-related field.

Compliance Specialists: Responsible for conducting a variety of investigations (including abuse, neglect, and exploitation allegations) and serves as a consultant to assure youth treatment activities are delivered in accordance with federal and State standards and regulations. Must have a high school diploma or a high school equivalency diploma and some post high school coursework/training in criminal justice, law enforcement, or a human service-related field and experience with investigations, data, or trend analysis or related area.

Youth Security Specialists (YSS) and Shift Leads: Both positions are responsible for overseeing the activities and schedules on their assigned shift. This includes making sure that schedules are followed, youth are engaged in treatment, and that there are positive interactions between direct care staff and youth. YSS staff must have a bachelor's degree in social work, counseling, or a related human service field. Shift Leads must have at least a high school diploma.

Direct Care Staff: Responsible for specific staff-to-youth supervision ratios, actively monitoring and guiding the youth through all nonclinical activities. Must be at least 21 years of age and have a high school diploma or a high school equivalency diploma.

Activity Specialists: Plan, organize, and facilitate the therapeutic recreation program.

Activity Supervisor: Plans, organizes, and facilitates holiday events, monitors youth money, oversees activity specialists, and helps facilitate the graduate program in coordination with the clinical program manager.

Therapists/Social Worker: Must be provisionally or fully licensed as a mental health practitioner or a clinical social worker. Mental health staff are responsible for the individualized clinical care for youth assigned to their caseload, ongoing assessment of youth, treatment planning, family therapy, and discharge planning.

Case Managers: Responsible for meeting the ancillary needs of the youth. Case Managers also aid in discharge planning, referral source communication, and placement planning.

Health Information Manager: Responsible for maintaining and auditing the electronic medical record and physical charts for all youth on campus. The Health Information Manager is responsible for quality assurance by ensuring all standards and regulations are being followed. Must be at least 21 years of age and have a high school diploma or a high school equivalency diploma.

Teachers: Lead and guide youth toward advancement and understanding of their assigned schoolwork and goals.

Staff Assistants/Ancillary Staff: A variety of ancillary staff assist in treatment planning, scheduling, health information management, insurance authorizations, and a wide range of other supportive roles. (All staff must be at least 21 years of age; and have a high school diploma or a high school equivalency diploma.)

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{D 240}	009.02 Maintenance 009. Every building or space utilized for the care and treatment of the consumer must comply with the following: 009.02. All parts of a facility or service, and all equipment, fixtures and furnishings are to be maintained in good working order and meet the following standards: (A) Surfaces must be smooth, free of sharp edges, splinters, or potential safety risks; (B) Doors, stairways, passageways, aisles and other means of exit must be maintained to prevent hazards which might pose a potential safety risk; (C) Routine and preventative maintenance must be performed in accordance with manufacturer's instructions and documentation of maintenance must be maintained; (D) Sound and lighting levels must be conducive to the care and treatment provided; (E) Maintenance equipment and supplies must be available; and (F) Hazardous materials must be secured to prevent accidental or intentional ingestion, inhalation, or consumption by the consumer. This Standard is not met as evidenced by: . Based on record review, observation and interview the facility failed to ensure all parts of the facility, facility equipment and services are maintained in good working order, safe and free of potential harm. This had the potential to affect the health and safety of all clients residing at the facility. The	{D 240}	metal grates have been located at another site. They will be brought over to whitehall for maintenance to adjust the pieces then replace the grates by FLC,* CLC. the door in FLC will be replaced by a new door. * This door was replaced on 10/8/25. - MP Will adjust ~~replace~~ MP the shower head in ~~WHR~~ MP CLC.	

Licensure Unit
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Facility Administrator — (X6) DATE: 10/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{D 240}	Continued From page 1 facility census was 13 at the time of the survey. Findings: Observations on 9/29/2025 from 11:10 am-11:35 pm during an environmental tour of the facility with Quality Assurance Specialist , Clincal Program Manager, and the Maintenance Manager revealed the following maintenance issues: Family Life Cottage Outside in front of the entrance there is a metal grate over a drainage pipe that is very rusted and there places in which the metal is completely rusted through. There was a door that went to a maintenance room, that had a significant amount of the wood lament missing all around the door, leaving the door to have areas of sharp and exposed wood. Community Life Cottage Outside in front of the entrance there is a metal grate over a drainage pipe that is very rusted. In the kitchen, the wood trim to the counter tops is peeling away from the counter. There are large areas in which the trim is missing or left exposed and sharp. The counter top is has heat damage, resulting in a large stain to the counter top. In the large bathroom there is a shower that has low water pressure. Interview with the Maintenance Manager on 9/29/2025 confirmed that there were current bids and the process had begun to replace the rusted grates outside of the cottages and the kitchen	{D 240}	The counter tops are currently being bidded out and are expected to be replaced in a month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHSU031	A. BUILDING: _____ B. WING _____	R 09/29/2025

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
{D 240}	Continued From page 2 counter in Warner Cottage. The Maintenance Manager confirmed that the plan is to replace the damaged door in the Family Life Cottage. Interview with the Quality Assurance Specialist and the Clinical Program Manager on 9/25/2025 at 12.10 pm confirmed that the identified maintenance issues at Community Life Cottage and Family Life Cottage would need to be fixed and addressed.	{D 240}		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	8/14/2025
	SURVEY EVENT ID#	KSV012
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	MHSU031

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
D-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:	
D-240	Metal grates have been found and used cut to replace old ones. The FLC door has been replaced. The WNR shower head has been adjusted. The counters are being bidded for.	11/24/25
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	
D-240	Work orders are placed and DHS maintenance now has to replace or fix the cited items.	11/24/25
	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-240	Facility Administrator will check with DHS weekly to ensure items cited will be fixed on time. Any changes will be relayed to public Health	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
D-240	Facility Administrator.	
	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):	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	EP Training Program CFR(s): 441.184(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	{E 037}	All staff except one has completed the training. The last staff member will complete when she returns from break in Nov.	

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

M Poppe Facility Administrator 10/10/25

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
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	{E 037}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	{E 037}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28L032	A. BUILDING _____ B. WING _____	R 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LRC WHITEHALL PRTF	5845 HUNTINGTON AVENUE LINCOLN, NE 68507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 037}	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: . Based on record review and interview the facility failed to provide training of the facilty's Emergency Preparedness Plan (EPP) for all staff. This had the potential to affect the health and safety of all clients residing at the facility. The facility census was 13 at the time of the survey. Findings: Record review of the Emergency Preparedness Training Log revealed 47 out of 64 staff members completed Emergency Management training. Interview with the Compliance Specialist on 9/29//2025 at 11:30am confirmed that not all staff have completed Emergency Preparedness Training and it is not logged in the EPP. . .	{E 037}		

PLAN OF CORRECTION

Provider/Supplier Name:	LRC WHITEHALL PRTF	Survey Date
STREET ADDRESS, CITY, ZIP:	5845 HUNTINGTON AVENUE LINCOLN, NE 68507	9/29/2025
	SURVEY EVENT ID#	8YLF12
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 28-	PRTF032

CITED TAG #	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E-037		
	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:	
E-037	All staff members except one have completed the training.	11/11/25
	The last staff member will complete when she comes	
	back from break.	
	B. THE PROCEDURE FOR IMPLEMENTING THE CORRECTIVE ACTION(S):	11/11/25
E-037	Wait until staff returns from scheduled break.	
	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 will be automatically reassigned to	
	all staff yearly.	
	D. THE TITLE OF THE PERSON RESPONSIBLE FOR ENSURING THE FACILITY REMAINS IN COMPLIANCE WITH THE CITED DEFICIENCY: (Do not put the staff names).	
	Facility Administrator and Training Specialist.	
	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).	

MIDWEST ALARM SERVICES

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg#1
5800 Leighton Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg#1	Occupancy Type:	Educational (Group E)
Address:	5800 Leighton Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19881	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

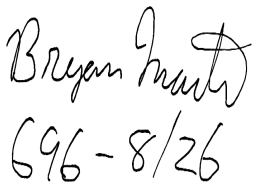
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	28	26 (93%)	26 (93%)	0 (0%)
Supervisory Signal Device	4	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	11/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.5 / 13.5
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Room 13

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP111450	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Tested visually Supervisory Restoration Tested visually	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit by room 9	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - South / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - North / 002	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Dining room / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above stairs / 004	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 1 / 005	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 16 / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by room 16 / 007	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Office / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Clinic office / 009	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 15 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 14 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 13 / 012	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Hallway by room 13 / 013	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 11 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 10 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 6 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by room 7 / 017	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 7 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 9 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location Basement / North smoke / 020	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location Basement / South smoke / 021	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above fire panel / 022	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location Throughout building -	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes

Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
	Low Air Switch	Not Tested	-
Location	Type/Make/Model	Result	Number
	PIV Switch	Not Tested	-

Auxiliary Device

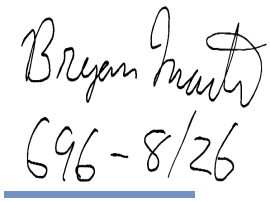
Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 3	Door Unlocking	● Passed	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6 / 11	Audible And Visible	● Passed	-

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #2
5801 Walker Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #2	Occupancy Type:	Educational (Group E)
Address:	5801 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-BOX11564	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

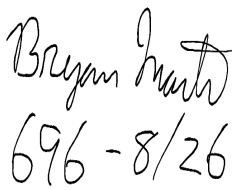
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	28	26 (93%)	26 (93%)	0 (0%)
Supervisory Signal Device	4	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SFP-2404

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	03/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP18160	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Tested visually Supervisory Restoration Tested visually	● Passed	-

Annunciator 1

Location

Location	1st / room 3

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit by room 9	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / South exit	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - South / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - North / 002	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above fire panel / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Dining room / 004	Type/Make/Model Smoke Detector / System Sensor / 2WB	Sensitivity Range 1.0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above stairs / 005	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 1 / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 3 / 007	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 16 / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Hallway by room 3 / 009	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 15 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 14 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Storage room / 012	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by room 14 / 013	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 11 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 10 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 6 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by room 9 / 017	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 9 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Room 7 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location 1st / Nurse office / 020	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location Basement / North smoke / 021	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South smoke / 022	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range 1.55 - 3.0 Volts Sensitivity Result -	Result ● Passed	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Throughout building -	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location	Type/Make/Model Control Valve Tamper Switch	Result Not Tested	Number -
Location Outside of building	Type/Make/Model PIV Switch	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location Throughout building - 3	Type/Make/Model Door Unlocking	Result ● Passed	Number -

Alarm Notification Appliance

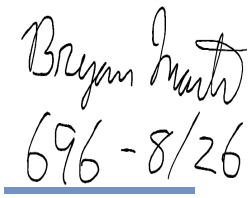
Location	Specification	Result	Notes
Location Throughout building - 6 / 11	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Comments

Number	COMMENT	IMAGE
1	Recommend replacing all smoke detectors to a system sensor 2W-B detector so all can be calibrated	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

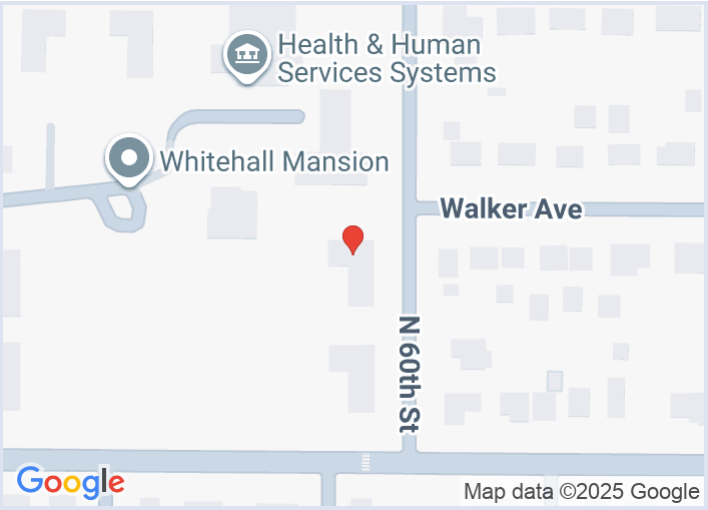
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #3
2345 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #3	Occupancy Type:	Educational (Group E)
Address:	2345 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19753	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

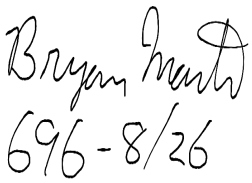
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	21	20 (95%)	20 (95%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	04/01/2022
Battery Type	Sealed Lead Acid
Nominal Voltage	13.8 / 13.7
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-BOS11503	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit in computer room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - South	Type/Make/Model Smoke Detector / Notifier / CP-651	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room - North	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Commons area by kitchen	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above fire panel	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above stairs	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Office next to stairwell	Type/Make/Model Smoke Detector / Notifier / CP-651	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway North of stairwell	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Southeast office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Northeast office	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / North storage room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by restrooms	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

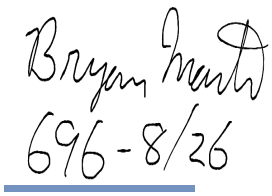
Location	Specification	Sensitivity	Result	Notes
Location 1st / Northwest computer room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / North room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / South room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / Storage room	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Throughout building -	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Alarm Notification Appliance

Location	Specification	Result	Notes
Location Throughout building - 4 / 5	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

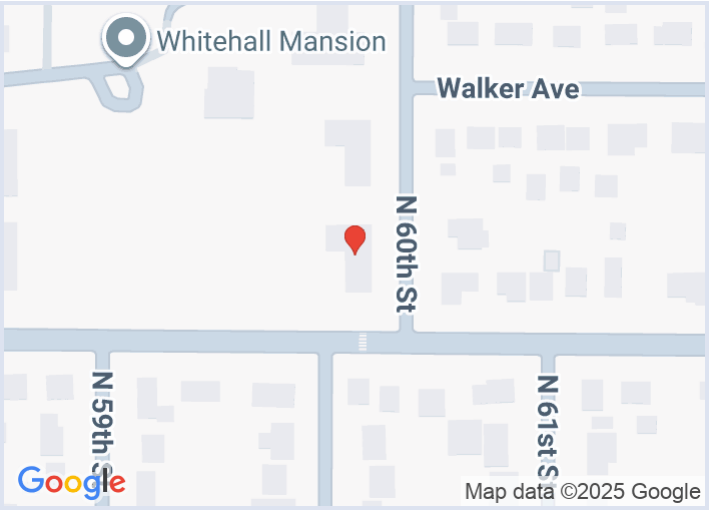
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #4
2311 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #4	Occupancy Type:	Not determined
Address:	2311 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-FA19838	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

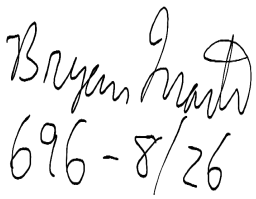
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	13	12 (92%)	12 (92%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	02/28/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	-
Amps/Hour Rating	7AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	1,2

Communicator 1

Location

Location	1st / room 8

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-BOS11713	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	1st / West exit

Specification

Type/Make/Model	Honeywell

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit in computer room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model	Sensitivity Range	Result	Number
Throughout building -	Heat Detector	-	Not Tested	-
		Sensitivity Result		
		-		

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
	Door Holder	Passed	-

Alarm Notification Appliance

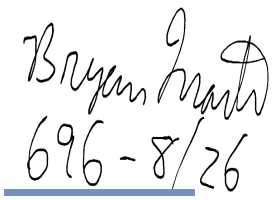
Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 4 / 4	Audible And Visible	Passed	-

Comments

Number	COMMENT	IMAGE
1	Fire panel in trouble and has been like this for a long time. Fire panel is in the works to be replaced. Hopefully replacing all old smoke detectors and pull stations along with replacing all heat detectors to a smoke detector.	
2		

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

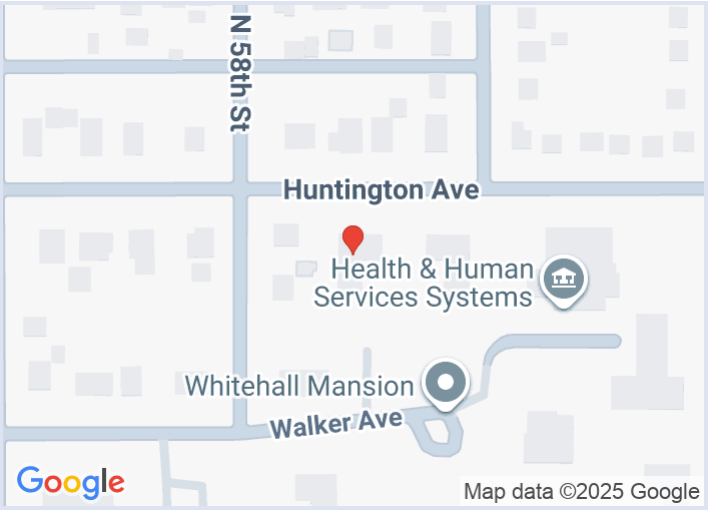
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #5
5845 Huntington Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Thursday, September 18, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #5	Occupancy Type:	Educational (Group E)
Address:	5845 Huntington Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP110341	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

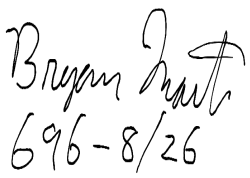
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	13	12 (92%)	12 (92%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Southwest exit

Specification

Type/Make/Model	Notifier / SGL-2000

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/18/2023
Battery Type	Sealed Lead Acid
Nominal Voltage	13.6 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	1,2

Communicator 1

Location

Location	in janitor closet

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP110341	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / West exit by fire panel	Type/Make/Model Manual Pull Station / Cerberus Pyrotechnics / MSZ-1	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit	Type/Make/Model Manual Pull Station / Notifier / BG-1	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit by room 7	Type/Make/Model Manual Pull Station / Kidde/Edwards	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / South exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Fireplace room / 001	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Above fire panel / 002	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Dining area / 003	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by staff office / 004	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by janitor supplies / 005	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Hallway by room 6 / 006	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / North / 007	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / South / 008	Type/Make/Model Smoke Detector / System Sensor / 1451	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Throughout building - 20	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location Outside doors - 3	Type/Make/Model Door Unlocking	Result ● Passed	Number -

Alarm Notification Appliance

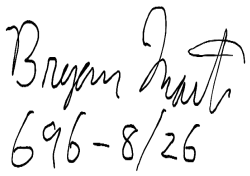
Location	Specification	Result	Notes
Location Throughout building - 4 / 4	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Comments

Number	COMMENT	IMAGE
1	This fire panel has a trouble on it from the charger and there is no fix for it. This panel will need to be replaced and upgrade all devices to bring them up to code.	
2		

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #6
5819 Huntington Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Thursday, September 18, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #6	Occupancy Type:	Educational (Group E)
Address:	5819 Huntington Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-LN25605	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

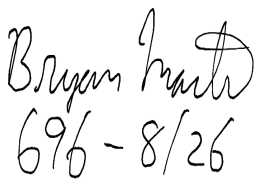
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	29	28 (97%)	28 (97%)	0 (0%)
Supervisory Signal Device	3	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	Battery Load Test : / East exit

Specification

Type/Make/Model	Honeywell Silent Knight® / Sk-2224

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/28/2021
Battery Type	Sealed Lead Acid
Nominal Voltage	13.6 / 13.6
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Battery: 7Ah - 9/21 - 13.5 / janitor closet room 13

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP18860	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	staff office

Specification

Type/Make/Model	DMP

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / East exit by fire panel	Type/Make/Model Manual Pull Station / Spectronics / SG-32SK1	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / West exit from main room	Type/Make/Model Manual Pull Station / Spectronics / SG-32SK2	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / East exit by room 7	Type/Make/Model Manual Pull Station / Spectronics / SG-32SK1	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / South exit in game/ activity room	Type/Make/Model Manual Pull Station / Spectronics / SG-32SK1	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Smoke Calibration Test : 9/ 2025 Next Test Date : 9/ 2030 / 1st / Above fire panel / 001	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location 1st / Fireplace room - South / 002	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .64 volts	Result ● Passed	Number -
Location 1st / Fireplace room - North / 003	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .64 volts	Result ● Passed	Number -
Location 1st / Dining room / 004	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .62 volts	Result ● Passed	Number -
Location 1st / Top of stairwell / 005	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result -	Result ● Passed	Number 1
Location 1st / Supervisor office / 006	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .64 volts	Result ● Passed	Number -
Location 1st / Room 16 / 007	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .85 volts	Result ● Passed	Number -
Location 1st / Hallway by Room 16 / 008	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .62 volts	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Room 3 / 009	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .84 volts	Result ● Passed	Number -
Location 1st / Room 14 / 010	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location 1st / Room 15 / 011	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location 1st / Room 13 / 012	Type/Make/Model Smoke Detector / System Sensor / 1151	Sensitivity Range .59 - 1.63 Volts Sensitivity Result .95 volts	Result ● Passed	Number -
Location 1st / Hallway by Room 13 / 013	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number 2
Location 1st / Room 4 / 014	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number 3
Location 1st / Room 11 / 015	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .41 volts	Result ● Passed	Number -
Location 1st / Room 5 / 016	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .83 volts	Result ● Passed	Number -
Location 1st / Room 10 / 017	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .84 volts	Result ● Passed	Number -
Location 1st / Room 6 / 018	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .83 volts	Result ● Passed	Number -
Location 1st / Hallway by Room 6 / 019	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .86 volts	Result ● Passed	Number -
Location 1st / Room 7 / 020	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location 1st / Room 9 / 021	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .84 volts	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / Storage room / 022	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location Basement / Game room - North / 023	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .63 volts	Result ● Passed	Number -
Location Basement / Game room - South / 024	Type/Make/Model Smoke Detector / System Sensor / 2151	Sensitivity Range .35 - 1.0 Volts Sensitivity Result .83 volts	Result ● Passed	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location	Type/Make/Model Backflow Valve	Result Not Tested	Number -
Location Outside of building	Type/Make/Model PIV Switch	Result Not Tested	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location Outside doors - 3	Type/Make/Model Door Unlocking	Result ● Passed	Number -

Alarm Notification Appliance

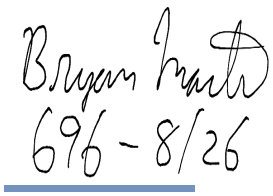
Location	Specification	Result	Notes
Location Throughout building - 6 / 11	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Comments

Number	COMMENT	IMAGE
1	Unable to Calibrate due to being above the stairs	
2	Unable to Calibrate detector 13 due to type of detector	
3	Unable to Calibrate detector 14 due to type of detector	
4	Would recommend replacing all smoke detectors due to detectors being very old	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

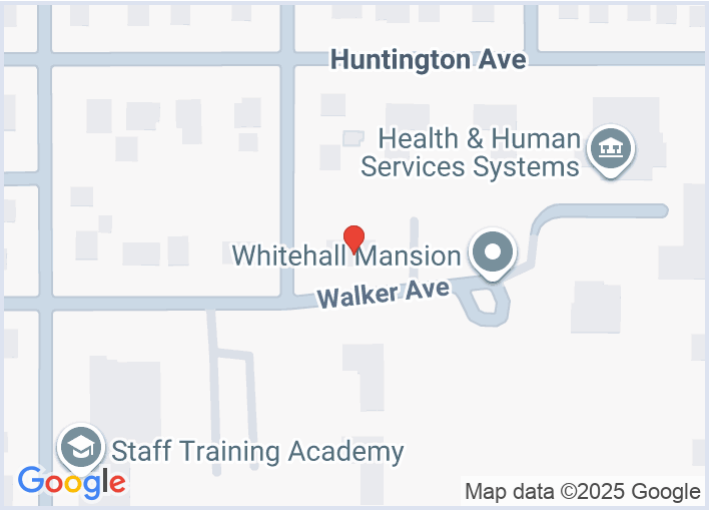
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Bldg #7
5800 Walker Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Thursday, September 18, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Bldg #7	Occupancy Type:	Educational (Group E)
Address:	5800 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP112860	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

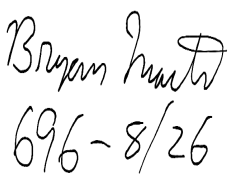
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	15	13 (87%)	13 (87%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Northwest exit

Specification

Type/Make/Model	Potter / IPA-100

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	06/01/2025
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.6
Amps/Hour Rating	7AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP112860	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	1st / South main entrance

Specification

Type/Make/Model	Potter

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location Smoke Calibration Test : 6/ 2025 (New) Next Test Date : 9/ 2027 / 1st / West office / 001	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / Conference room / 002	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / North office / 003	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / Northeast office / 004	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / Southeast office / 005	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location 1st / Breakroom / 006	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location Heat Detector Test : 6/ 2025 (New) Next Test Date : 9/ 2030 / 1st / Breakroom (kitchen) / 007	Type/Make/Model Heat Detector / Potter / PAD300-HD	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / Main entrance / 008	Type/Make/Model Manual Pull Station / Potter / PAD 100-PSDA	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / East emergency exit / 009	Type/Make/Model Manual Pull Station / Potter / PAD 100-PSDA	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Basement / Office / 010	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location Basement / Northeast office / 011	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Basement / Utility room by East exit / 012	Type/Make/Model Heat Detector / Potter / PAD300-HD	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / Furnace room / 013	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location Basement / Storage / 014	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -
Location Basement / South corner room / 015	Type/Make/Model Smoke Detector / Potter / PAD-300PD	Sensitivity Range 0 - 4.0% Sensitivity Result -	Result ● Passed	Number -

Alarm Notification Appliance

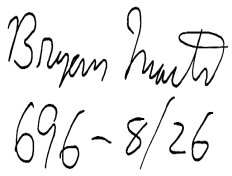
Location	Specification	Result	Notes
Location Throughout building - 5 / 7	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Comments

Number	COMMENT	IMAGE
1	New fire panel and devices were approved on 6/03/25	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

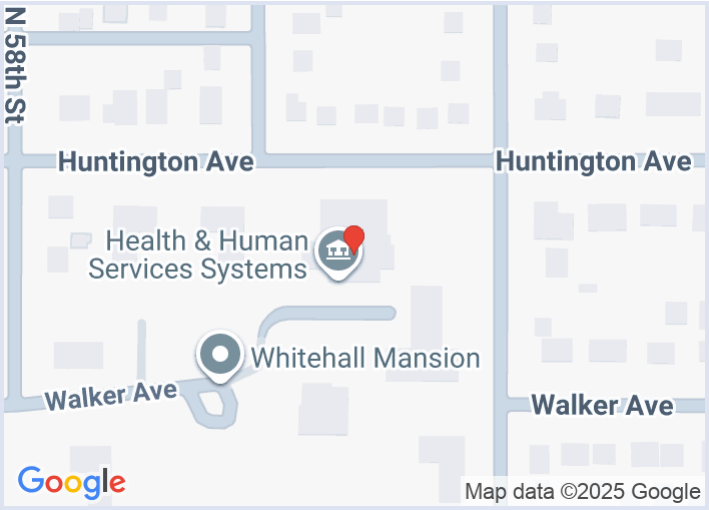
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Garage & Maintenance
2401 N 60th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Thursday, September 18, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Garage & Maintenance	Occupancy Type:	Educational (Group E)
Address:	2401 N 60th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP13839	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

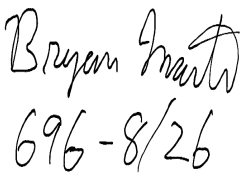
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	33	33 (100%)	33 (100%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	0	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	South work shop

Specification

Type/Make/Model	Notifier / NFW-100X

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	Far North garage
Disconnecting Means Location	Disconnect labeled "Fire"

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/24/2024
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.7
Amps/Hour Rating	8AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-RDMP13839	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location South entrance - East / L1 M001	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location South entrance - West / L1 M002	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location South garage - North entrance / L1 M003	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Westside - South exit / L1 M004	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - Middle / L1 M005	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - North exit / L1 M006	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - North exit / L1 M007	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - South exit / L1 M008	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location North main shop / L1 M009	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Northeast main shop / L1 M010	Type/Make/Model Manual Pull Station / Notifier / NOT-BG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Heat Detector Test : 9/ 2025 Next Test Date : 9/ 2030 / Attic Heats / L1 M012	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number 1
Location Restroom hallway / L1 D012	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Restroom / L1 D013	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location work room / L1 D014	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Key room / L1 D015	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Window repair area / L1 D016	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Storage East / L1 D017	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Storage West / L1 D018	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Tool storage / L1 D019	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Breakroom / L1 D020	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - South / L1 D021	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - middle / L1 D022	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - North middle / L1 D023	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Westside - North / L1 D024	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - North / L1 D025	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - North middle / L1 D026	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - middle / L1 D027	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Eastside - South / L1 D028	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Mechanical room / L1 D029	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Wood shop / L1 D030	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Institute shop / L1 D031	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Office / L1 D032	Type/Make/Model Heat Detector / Notifier / NH-200	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Smoke Calibration Test : 9/ 2025 Next Test Date : 9/ 2030 / Above fire panel / L1 D033	Type/Make/Model Smoke Detector / Notifier / NP-200	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -

Alarm Notification Appliance

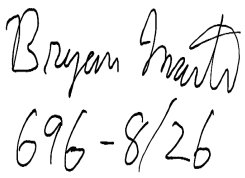
Location	Specification	Result	Notes
Location Throughout building - 8 / 15	Type/Make/Model Audible And Visible	Result ● Passed	Number -

Comments

Number	COMMENT	IMAGE
1	Tested Module 12 heats through the module due to old heat detectors in the attic and unable to reach them	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Mansion
5903 Walker Ave
Lincoln, NE 68507

This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Mansion	Occupancy Type:	Educational (Group E)
Address:	5903 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-BOS11550	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

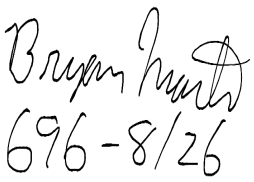
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	72	72 (100%)	72 (100%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	2	2 (100%)	2 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	1st / Hallway by North exit

Specification

Type/Make/Model	Notifier / AFP200

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/19/2025
Battery Type	Sealed Lead Acid
Nominal Voltage	12.5 / 12.5
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Basement / communication room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model Permar / MW-BOS11550	Alarm Signal Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	Result ● Passed	Number -

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / North exit by fire panel / M 11	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / Northeast exit by elevator / M 12	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 1st / South exit / M 13	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location 1st / Northwest stairs - coming from basement / M 14	Type/Make/Model Manual Pull Station / Notifier / NBG12L	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 2nd / West exit / M 21	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 2nd / East exit / M 22	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 3rd / West exit / M 31	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location 3rd / East exit / M 32	Type/Make/Model Manual Pull Station / Notifier / NBG12LX	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Smoke Calibration Test : 9/ 2025 Next Test Date : 9/ 2030 / Northwest office / D 01	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 37%	Result ● Passed	Number -
Location North hallway / D 02	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 10%	Result ● Passed	Number -
Location Northeast office / D 03	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 5%	Result ● Passed	Number -
Location West stairs / D 04	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 28%	Result ● Passed	Number -
Location Elevator hallway / D 05	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 19%	Result ● Passed	Number -
Location Ballroom - Northwest closet / D 06	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 24%	Result ● Passed	Number -
Location Furnace room / D 07	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location Restroom / D 08	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 44%	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location 3rd / Ballroom - East / D 09	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 26%	Result ● Passed	Number -
Location 3rd / Ballroom - West / D 10	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 37%	Result ● Passed	Number -
Location East stairs / D 11	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location 3rd / Ballroom - Southwest closet / D 12	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location South office / D 13	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 44%	Result ● Passed	Number -
Location Southeast closet / D 14	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Northwest office / D 15	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location North center office / D 16	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 33%	Result ● Passed	Number -
Location Northeast office / D 17	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 06%	Result ● Passed	Number -
Location West stair landing / D 18	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 10%	Result ● Passed	Number -
Location North hallway / D 19	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location West center office / D 21	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location West restroom / D 22	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 15%	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location West hallway / D 23	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 10%	Result ● Passed	Number -
Location Southwest office / D 24	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 55%	Result ● Passed	Number -
Location Center stair landing / D 25	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 07%	Result ● Passed	Number -
Location South office / D 26	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 24%	Result ● Passed	Number -
Location East hallway / D 27	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 23%	Result ● Passed	Number -
Location Southeast office / D 28	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 50%	Result ● Passed	Number -
Location East office / D 29	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 34%	Result ● Passed	Number -
Location East restroom / D 30	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 37%	Result ● Passed	Number -
Location Northwest room / D 31	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 15%	Result ● Passed	Number -
Location North hallway / D 32	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 26%	Result ● Passed	Number -
Location Northeast room / D 33	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Kitchenette / D 35	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Hall by kitchen / D 36	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Restroom / D 37	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Hall by restroom / D 38	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 06%	Result ● Passed	Number -
Location Center hallway / D 39	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Dining room / D 40	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location West center hall / D 41	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location East center hall / D 42	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location Library / D 43	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 10%	Result ● Passed	Number -
Location Reception parlor / D 44	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 03%	Result ● Passed	Number -
Location Foyer / D 45	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -
Location Living room / D 46	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 01%	Result ● Passed	Number -
Location South entry / D 47	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Northwest stairwell / D 48	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location North furnace room / D 49	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location Northeast storage / D 50	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Storage by pump room / D 51	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Center hall - West / D 52	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Center hall - East / D 53	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Vault / D 54	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Storage - West / D 55	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Corridor - East / D 56	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Storage - Southwest / D 57	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 01%	Result ● Passed	Number -
Location History room / D 58	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Furnace room - East / D 59	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Storage - South / North Furnace / D 60	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 0%	Result ● Passed	Number -
Location Elevator lobby / D 71	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 08%	Result ● Passed	Number -
Location Elevator lobby / D 72	Type/Make/Model Smoke Detector / Notifier / FSP-851	Sensitivity Range 0 - 100% Sensitivity Result 12%	Result ● Passed	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator lobby / D 73	Smoke Detector / Notifier / FSP-851	0 - 100% Sensitivity Result 10%	Passed	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator lobby / D 74	Smoke Detector / Notifier / FSP-851	0 - 100% Sensitivity Result 0%	Passed	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator equipment room / D 75	Smoke Detector / Notifier / FSP-851	0 - 100% Sensitivity Result 0%	Passed	-
Location	Type/Make/Model	Sensitivity Range	Result	Number
Elevator hoistway / D 76	Smoke Detector / Notifier / FSP-851	0 - 100% Sensitivity Result 03%	Passed	-

Auxiliary Device

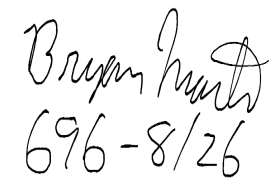
Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6	Door Holder	Passed	-
Location	Type/Make/Model	Result	Number
Elevator Reset Key : H2389	Elevator Recall	Passed	-

Alarm Notification Appliance

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 22 / 47	Audible And Visible	Passed	-

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

MIDWEST ALARM SERVICES

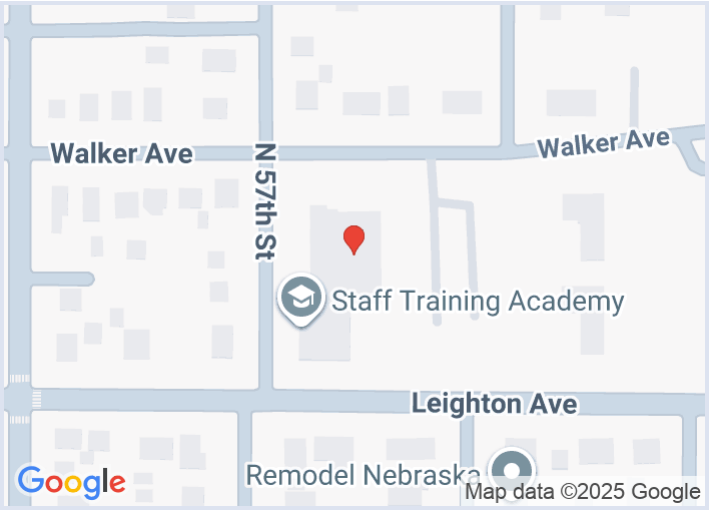
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - School/Staff Train Academy
2320 N 57th St
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Friday, September 19, 2025

Inspection Status:
Failed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - School/Staff Train Academy	Occupancy Type:	Educational (Group E)
Address:	2320 N 57th St	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-DMP1921-1	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	0 (0%)	1 (100%)
Communicator	1	0 (0%)	0 (0%)	0 (0%)
Supervising Station Monitoring	1	0 (0%)	0 (0%)	0 (0%)
Annunciator	2	0 (0%)	0 (0%)	0 (0%)
Auxiliary Power Supply	1	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	74	0 (0%)	0 (0%)	0 (0%)
Supervisory Signal Device	3	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	0 (0%)	0 (0%)	0 (0%)
Alarm Notification Appliance	1	0 (0%)	0 (0%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

DEFICIENCIES / RESOLUTIONS

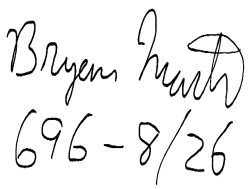
Deficiencies	1
Resolutions	0

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Deficiencies

Any deficiencies reported below outline observations and findings based on the NFPA- or UL-compliant inspection conducted by our company. It is important to note that while every effort has been made to accurately identify and document all potential issues, this report serves solely as a snapshot at the time of inspection and does not guarantee the absence of other deficiencies or hazards not visible or present during the inspection. Property owners and stakeholders are encouraged to promptly address identified deficiencies to ensure compliance with local fire safety regulations and to mitigate potential risks.

Outstanding Deficiencies

	Location	Device Type/Make/Model	Barcode	Test Date	Inspector	Comment	Photo	Status
1	West main entrance	Fire-Lite® Alarms / MS-4024		Sep 19, 2025	Bryan Martin	After pulling 3 different pull stations in the building, the panel gets the alarm but no audibles sounding in the building. Also, the alarm signal doesn't send to the central station. The DMP doesn't receive the alarm		X Open

Resolved Deficiencies

Control Unit 1

Location

Location	West main entrance

Specification

Type/Make/Model	Fire-Lite® Alarms / MS-4024

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	09/01/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	Customer will replace
Amps/Hour Rating	5AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	x Failed

Notes

Number	-

Communicator 1

Location

Location	DMP panel powering communicator Battery: 8Ah - 5/20 - customer will replace / 1st / Communications room

Specification

Type/Make/Model	Alula

Type

Type	-

Result

	Not Tested

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-BOS11659	Tested visually and functionally	Not Tested	-
	Alarm Restoration		
	Tested visually and functionally		
	Trouble Signal		
	Tested visually and functionally		
	Trouble Restoration		
	Tested visually and functionally		
	Supervisory Signal		
	Supervisory Restoration		

Annunciator 1

Location

Location	2nd / north exit by classroom 3

Specification

Type/Make/Model	DMP

Result

	Not Tested

Notes

Number	-

Annunciator 2

Location

Location	1st / by front desk

Specification

Type/Make/Model	DMP

Result

	Not Tested

Notes

Number	-

Auxiliary Power Supply 1

Location

Location	1st / custodian closet by fire panel

Specification

Type/Make/Model	Notifier / FCPS-24

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting means location	-

Visual/ Functional

Auxiliary Power Supply	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	08/01/2020
Battery Type	Sealed Lead Acid
Nominal Voltage	Customer will replace
Amps/Hour Rating	7AH
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	Not Tested

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location 1st / by west main entrance under fire panel	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / northwest entrance	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / west stairwell exit by jym	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / south exit by weight room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / north exit by classroom 3	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 1st / west exit by conference room 3	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location Basement / boiler room	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location 2nd / basketball court exit	Type/Make/Model Manual Pull Station	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
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Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South classroom	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South classroom	Type/Make/Model Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
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Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Location	Specification	Sensitivity	Result	Notes
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Heat Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South air handler mezz	Type/Make/Model Duct Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location South air handler mezz	Type/Make/Model Duct Smoke Detector	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -
Location	Type/Make/Model Water Flow	Sensitivity Range - Sensitivity Result -	Result Not Tested	Number -

Supervisory Signal Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Boiler room - West valve	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
Boiler room - East valve	Backflow Valve	Not Tested	-
Location	Type/Make/Model	Result	Number
Main water	Control Valve Tamper Switch	Not Tested	-

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 6	Door Holder	Not Tested	-

Alarm Notification Appliance

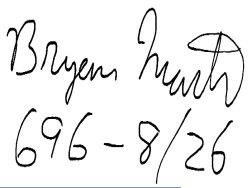
Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 35 / 58	Audible And Visible	Not Tested	-

Comments

Number	COMMENT	IMAGE
1	Highly recommend replacing this fire panel due to past problems on this panel. This seems to be an ongoing issue at this location	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

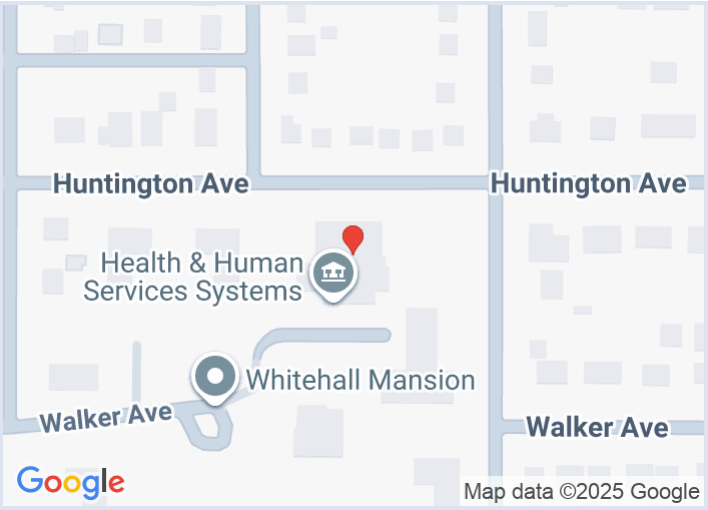
Inspection Report

Presented To

State of Nebraska-Whitehall Campus

For

Whitehall Campus - Admin Training
5900 Walker Ave
Lincoln, NE 68507



This site has been inspected and tested in compliance with applicable standards.

Completed:
Thursday, September 18, 2025

Inspection Status:
Passed

Tested By:

Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Scan Code to Access
Nspec Cloud Portal

Inspection Information

CUSTOMER INFORMATION

Name:	State of Nebraska-Whitehall Campus	Address:	801 W Prospector Pl
City:	Lincoln	State:	NE
ZIP:	68522	AR Number:	900516

BUILDING INFORMATION

Name:	Whitehall Campus - Admin Training	Occupancy Type:	Business (Group B)
Address:	5900 Walker Ave	City:	Lincoln
State:	NE	ZIP:	68507
Monitoring Company Account Number:	MW-RDMP110332	Retransmission Entity:	Per Mar
Retransmission Entity Phone:	(800) 383-7871	AR Number:	900516
Nspec Cloud Portal:	Click to Open		

COMPANY INFORMATION

Name:	Midwest Alarm Services	Address:	141 M St
City:	Lincoln	State:	NE
Zip:	68508	License:	-
Email:	inspections@mw-as.com	Phone:	(402) 474-3737

TESTING SUMMARY

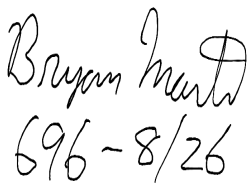
EQUIPMENT TYPE	TOTAL	TESTED	PASSED	FAILED
Control Unit	1	1 (100%)	1 (100%)	0 (0%)
Communicator	1	1 (100%)	1 (100%)	0 (0%)
Supervising Station Monitoring	1	1 (100%)	1 (100%)	0 (0%)
Annunciator	1	1 (100%)	1 (100%)	0 (0%)
Auxiliary Power Supply	0	0 (0%)	0 (0%)	0 (0%)
Alarm Initiated Device	12	12 (100%)	12 (100%)	0 (0%)
Supervisory Signal Device	0	0 (0%)	0 (0%)	0 (0%)
Auxiliary Device	1	1 (100%)	1 (100%)	0 (0%)
Alarm Notification Appliance	1	1 (100%)	1 (100%)	0 (0%)
Battery	0	0 (0%)	0 (0%)	0 (0%)

Fire Alarm System - NFPA 72 (2013) Lincoln

This inspection was conducted in accordance with NFPA 72 Standards and the codes established by the local Authorities Having Jurisdiction for the site inspected. NFPA 72 provides established guidelines for the testing of fire alarm systems, including fire detection, emergency communication and signaling. If your city has mandated it, we will upload your inspection report to the local compliance engine. If you have any questions regarding this report or require additional services. Please contact our Inspection Team at 402-970-1509 or MWLNInspections@mw-as.com.

Joel Stolley
Operations Manager
402-315-7541
Joel Stolley@mw-as.com

Tested By:



Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

Control Unit 1

Location

Location	Northeast storage closet

Specification

Type/Make/Model	Potter / IPA-100

Software Firmware

Revision Number	-
Onsite Location Of Documentation	-

Primary Power

Nominal Voltage	-
Amps	-

Overcurrent Protection

Type	-
Amps	-
Location	-
Disconnecting Means Location	-

Visual/ Functional

Control Unit	Tested visually and functionally
Lamps/LEDs/LCDs	Tested visually and functionally
Fuses	Tested visually
Trouble Signal	Tested visually and functionally
Disconnect Switch	Tested visually
Ground-Fault Monitoring	Tested visually

Batteries

Battery Date	10/01/2024
Battery Type	Sealed Lead Acid
Nominal Voltage	13.7 / 13.6
Amps/Hour Rating	7Ah
Standby Mode (hrs)	24
Alarm Mode (mins)	5

Visual/ Functional

Load Voltage	Tested visually
Charge Test	Tested visually
Discharge Test	Tested visually
Battery Condition	Tested visually

Result

	● Passed

Notes

Number	-

Communicator 1

Location

Location	Above fire panel

Specification

Type/Make/Model	DMP

Type

Type	-

Result

	● Passed

Notes

Number	-

Supervising Station Monitoring

Specification	Supervising Station Monitoring	Result	Notes
Type/Make/Model	Alarm Signal	Result	Number
Permar / MW-RDMP110332	Tested visually and functionally Alarm Restoration Tested visually and functionally Trouble Signal Tested visually and functionally Trouble Restoration Tested visually and functionally Supervisory Signal Supervisory Restoration	● Passed	-

Annunciator 1

Location

Location	Southwest entrance

Specification

Type/Make/Model	Potter

Result

	● Passed

Notes

Number	-

Alarm Initiated Device

Location	Specification	Sensitivity	Result	Notes
Location Smoke Calibration Test : 10/ 2024 (New) Next Test Date : 9/ 2026 / Smoke above fire panel / 001	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result ● Passed	Number -
Location East entrance / 002	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Classroom East / 003	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Southeast courtyard (Library) / 004	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location North courtyard / 005	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Southwest courtyard / 006	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location West office exit / 007	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location West entrance / 008	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location West courtyard / 009	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -
Location Door hold West / 010	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result ● Passed	Number -
Location Door hold East / 011	Type/Make/Model Smoke Detector / Potter / PAD300-PD	Sensitivity Range 1.1-3.5% Sensitivity Result -	Result ● Passed	Number -
Location East courtyard / 012	Type/Make/Model Manual Pull Station / Potter	Sensitivity Range - Sensitivity Result -	Result ● Passed	Number -

Auxiliary Device

Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
West wing - 2	Door Holder	Passed	-

Alarm Notification Appliance

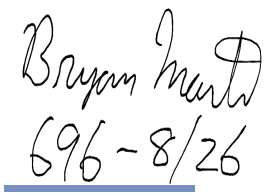
Location	Specification	Result	Notes
Location	Type/Make/Model	Result	Number
Throughout building - 11 / 30	Audible And Visible	Passed	-

Comments

Number	COMMENT	IMAGE
1	Old heat detector in North courtyard storage room. Customer will remove it and put cover plate over it	

Conclusion

We appreciate the opportunity to provide this inspection report. We are confident in the accuracy of the contents of this report. Should you require any additional services, or have questions regarding the contents of this report, please do not hesitate to contact your Midwest Alarm Services representative at 402-970-1509.



Tested By:
Bryan Martin
License: 696 Expires 8/26
Midwest Alarm Services
141 M St
Lincoln, NE 68508

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of nebraska	**DATE:** 2/27/25
ADDRESS: 2311 N. 60th St Lincoln,NE, 68507	**JOB ID:** 12254
SITE NAME: Morton School	**TECHNICIAN:** Nick
CONTACT NAME: Kris Hoover	**CONTACT TEL:** 402-479-5452

PRODUCT DETAILS	
GEN MAKE Generac	**GEN MODEL:** 20A02942-S
GEN SERIAL: 2058112	**GEN HOURS:** 430.8

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
Model: 5208420100 SN: 88115	Quarterly	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	242	B-C		C-A		A-B	243	B-C		C-A	
A-N	121	B-N	121	C-B		A-N	120	B-N	120	C-B	
A-Amps		B-Amps		C-Amps		A-Amps		B-Amps		C-Amps	
A-Temp	68	B-Temp	68	C-Temp		A-Temp	68	B-Temp	68	C-Temp	
PRE OPERATION CHECKS				Coolant temp	115	Battery Charging voltage	13				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	192	W/ or W/O Load	
✓			CONTROL DISPLAY	Oil Pressure	66	Exercise Duration	
✓			EMERGENCY STOP	Oil Temp		Day	
✓			SWITCH/CONTROLS	Battery Voltage		Week	
✓			CB OPERATION	Frequency Rate	60	Start Time	
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
	✓		FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	NG
✓			ENCLOSURE CONDITION				
		✓	BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes: 2/27/25 Nick
Arrived on site. Inspect generator and equipment. Run generator to temp. Take readings on generator and ATS. No issues found during testing.
Recommend again from last visit battery and natural gas line be replaced.
Battery 1X24 3/21

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of NE	**DATE:** 5/27/25
ADDRESS: 2311 N 60th st. Lincoln NE 68507	**JOB ID:** 13262
SITE NAME: 2311	**TECHNICIAN:** Darren
CONTACT NAME: Matt Heaps	**CONTACT TEL:** 402-450-8379
PRODUCT DETAILS	
GEN MAKE Generac	**GEN MODEL:** 20A02942-S
GEN SERIAL: 2058112	**GEN HOURS:** 439.4

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
Generac S# 88115 M# 5208420100	Quarterly	
	Semi-Annual	
	Annual	✓

Nominal Voltage Source						Emergency Voltage Source					
A-B	246	B-C	246	C-A	246	A-B	240	B-C	240	C-A	240
A-N	122	B-N	212	C-B	122	A-N	120	B-N	208	C-B	120
A-Amps		B-Amps		C-Amps		A-Amps		B-Amps		C-Amps	
A-Temp	71	B-Temp	71	C-Temp	71	A-Temp	68	B-Temp	68	C-Temp	
PRE OPERATION CHECKS				Coolant temp	101	Battery Charging voltage	13.1				

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			CONTROL LIGHTS	Engine Run temp	170	W/ or W/O Load	W/O
✓			CONTROL DISPLAY	Oil Pressure	55	Exercise Duration	30 MIN
✓			EMERGENCY STOP	Oil Temp		Day	Monday
✓			SWITCH/CONTROLS	Battery Voltage	14.1	Week	Weekly
✓			CB OPERATION	Frequency Rate	60	Start Time	8 am
✓			AUTO OPERATION	RPM	1800		
✓			COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses				
✓			EXHAUST SYSTEMS CONDITION				
✓			ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather				
✓			ALTERNATOR CONDITION				
✓			FULL SERVICE PERFORMED				
✓			FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition			Fuel Level	NG
✓			ENCLOSURE CONDITION				
✓			BATTERY CONDITION				
✓			ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger				
✓			OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM				
✓			Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs				

Notes:

5/27/2025 Darren
Arrived on site. Completed visual inspection. Checked oil level. Checked coolant level. Started generator. Changed oil. Changed filter. Connected load bank. Ran generator under load for 2 hours. Checked parameters routinely throughout test. Disconnected load bank. Put generator in auto. Left site.

NEBRASKA GENERATOR SERVICE LLC

Generator & ATS PM Checklist

CUSTOMER DETAILS	
CUSTOMER: State of Nebraska	**DATE:** 11/3/25
ADDRESS: 2311 N. 60th Street, Lincoln, NE 68507	**JOB ID:** 15765
SITE-NAME: Whitehall	**TECHNICIAN:** Nick
CONTACT NAME: Mark Huenik	**CONTACT TEL:** 402-416-3605

PRODUCT DETAILS		
GEN MAKE Generac	**GEN MODEL:** 20A02942-S	**GEN SPEC:**
GEN SERIAL: 2058112	**GEN HOURS:** 456.1	**ENGINE S/N:** A9046

AUTOMATIC TRANSFER SWITCH NOTES	Service Interval	
GENERAC Model: 5208420100 Serial: 88115	**Quarterly**	✓
	Semi-Annual	
	Annual	

Nominal Voltage Source						Emergency Voltage Source					
A-B	242	**B-C**		**C-A**		**A-B**	240	**B-C**		**C-A**	
A-N	121	**B-N**	121	**C-B**		**A-N**	120	**B-N**	120	**C-B**	
A-Amps		**B-Amps**		**C-Amps**		**A-Amps**		**B-Amps**		**C-Amps**	
A-Temp	68	**B-Temp**	68	**C-Temp**		**A-Temp**	68	**B-Temp**	68	**C-Temp**	
PRE OPERATION CHECKS				**Coolant temp**	110	**Battery voltage**	12.8	**Battery Date**	3/12/25	**Size**	Group 24

OPERATION CHECKS

PASS	N/A	NEEDS ATTN					
✓			**CONTROL LIGHTS**	**Engine Run temp**	198	**W/ or W/O Load**	
✓			**CONTROL DISPLAY**	**Oil Pressure**	55	**Exercise Duration**	
✓			**EMERGENCY STOP**	**Oil Temp**		**Day**	
✓			**SWITCH/CONTROLS**	**Battery Voltage**	28.0	**Week**	
✓			**CB OPERATION**	**Frequency Rate**	60HZ	**Start Time**	
✓			**AUTO OPERATION**	**RPM**	1800		
✓			**COOLANT SYSTEM: Radiator cap, Coolant level, Coolant Condition, Coolant filter, Coolant Heater, All Hoses**				
✓			**EXHAUST SYSTEMS CONDITION**				
✓			**ENGINE: Ignition system, Belts, Turbo, Air intake system, Air filter, Oil Leaks, Oil level, Crankcase Breather**				
✓			**ALTERNATOR CONDITION**				
	✓		**FULL SERVICE PERFORMED**				
✓			**FUEL SYSTEM: Fuel Plumbing, Fuel Filters, Fuel Condition**			**Fuel Level**	NG
✓			**ENCLOSURE CONDITION**				
✓			**BATTERY CONDITION** GOOD				
✓			**ATS: Housing Condition, Power and Control Cables, Main Connects, Operating Mechanism, Control Boards, Display, Battery Charger**				
✓			**OPERATION CHECKS: Engine Run Temp, Oil Pressure, Oil Temp, Battery Voltage, Control Lights, Control Guages, Emergency Stop, Switches/Controls, CB Operation, Auto Operation, Frequency rate, RPM**				
✓			**Before Leaving Site: Gen in Auto, Battery Charger ON, Block Heater ON, CB closed, Customer Logs**				

Notes:

11/3/25 Nick

Arrive on site, gain access to generator and equipment. Inspect generator. Record pre inspection values on gen. Start and run generator to temp. Take readings. No leaks or issues found during testing.