ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

Attachment A

ESF Pre-Inspection Preparation

Team Coordinator: ; Team member(s):

Review facility history to include:

- Prepare licensee summary from tracking system
- Compliance history of previous inspection and past / current complaint investigations since the last full inspection, expand up to 36 months if needed
- Past SODs, uncorrected deficiencies, enforcement, and quality review complaints since the last full inspection
- Resident and staff list from last licensing inspection
- Current exemptions
- Other relevant documents

Consider conferring with staff regarding concerns about facility to include:

- Nurse, Licensor, Complaint Investigator, FM
- Case Managers

CONTRACT EXPIRATION	LICENSED BEDS	ADMINISTRATOR

CURRENT EXEMPTIONS (IF APPLICABLE)

FACILITY CHANGES SINCE LAST INSPECTION

OMBUDS QUARTERLY MEETINGS SINCE LAST FULL INSPECTION

☐ No Concerns

STATE FIRE MARSHALL'S OFFICE REPORTS SINCE LAST FULL INSPECTION

☐ No Concerns

HCS CASE MANAGER CONTACT	CONTACT DATE (IF APPLICABLE)

COMMENTS / CONCERNS

OTHER CONTACT(S)	CONTACT DATE (IF APPLICABLE)

COMMENTS / CONCERNS

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

Attachment A

ESF Pre-Inspection Preparation

Notes: Pre-Inspection Preparation

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

Attachment B

ESF Request for Documentation

☐ **The field office has contacted the Ombuds.**

Copy of form provided to: NAME _____ at TIME _____

Documentation due to licensor within two (2) hours of entrance	**Received**
Resident Characteristic Roster, DSHS 15-574* or Resident List, DSHS 15-573 or facility list of all licensed rooms (occupied and vacant), and all residents, room number, and those with limited English proficiency. Provide one copy for each inspection team member.	☐
Complete list of staff, position title, shift, date of birth, and hire date (first date worked for pay). Provide one copy for each inspection team member.	☐
Prior two weeks of staffing schedules as actually worked, including nursing, Mental Health Professional, on call staff, dietary staff, and housekeeping / laundry staff.	☐
System for and access to personnel files and resident records (requests for specific resident and staff records will occur during the inspection).	☐
Name and contact information of administrator / designee.	☐
* Note: Maintaining a Resident Characteristic Roster, DSHS 15-574, expedites inspection time. This form can be located here.	
Applicable documentation due to licensor by the end of entrance day	**Received**
Admissions Agreement	☐
Proof of general and professional liability insurance coverage.	☐
Four weeks of menus as served, available group activity opportunities.	☐
Emergency disaster plan, policies and procedures for: Infection Prevention Control, mandated reporting records for abuse / neglect, crisis prevention and response protocol, functional program.	☐
Valid Medical Test Site Certificate of Waiver License (MTSW) / Clinical Laboratory Improvement Amendment (CLIA) (☐ Not applicable).	☐
Changes in physical environment and approved Construction Review projects since last full inspection (☐ Not applicable).	☐
Copies of any waivers / exceptions / exemptions to rules (☐ Not applicable).	☐
List of residents discharged in the last three months and reason for discharge (if deceased, write deceased) (☐ Not applicable).	☐
Copy of the signed Risk Assessment (☐ Not applicable).	☐
Documentation required	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Confidential Information – Do not disclose. Not for public disclosure.

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment C

ESF Resident List

Not required if facility uses its own list or Attachment D, DSHS 15-574, is used.

ROOM NUMBER	RESIDENT NAME	NOTES

Confidential Information – Do not disclose. Not for public disclosure.

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

ESF Resident Characteristic Roster and Sample Selection

Attachment D

TOTAL CENSUS

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE

LICENSOR'S NAME	VISIT TYPE
	☐ Full ☐ Follow up ☐ Complaint Number: _____

RESIDENT ROOM	ADMIT DATE	RESIDENT ID NUMBER	RESIDENT NAME	PAY STATUS: PRIVATE = P STATE = S	NURSING SERVICES	MEDICALLY FRAGILE	MEDICATION: IND. (I), ASSIST (A); ADM. (AD)	MOBILITY / FALLS / AMBULATION DEIVICES	BEHAVIOR / PSYCHOSOCIAL ISSUES	DEMENTIA / COGNITIVE IMPAIRMENT	EXIT SEEKING / WANDERNG	SMOKING	DEVELOPMENTAL DISABILITIES	LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES	VISION DEFICIT / BLINDNESS	DIABETIC: INSULIN / NON-INSULIN	ASSIST WITH ADLS	WOUNDS / SKIN ISSUE	INCONTINENT / APPLIANCE (CATHETER) DIALYSIS	SPEICAL DIETARY NEEDS / SCHEDULED SNACKS	WIEIGHT LOSS / WEIGHT GAIN	MEDICAL DEVICES	RECENT HOSPITALIZATIONS	OXYGEN / RESPIRATORY THERAPY	HOME HEALTH / HOSPICE / PRIVATE CAREGIVER	OTHER

Confidential Information – Do not disclose. Not for public disclosure.

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

ESF Resident Characteristic Roster and Sample Selection

Attachment D

TOTAL CENSUS

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE

LICENSOR'S NAME	VISIT TYPE
	☐ Full ☐ Follow up ☐ Complaint Number: _____

RESIDENT ROOM	ADMIT DATE	RESIDENT ID NUMBER	RESIDENT NAME	PAY STATUS: PRIVATE = P STATE = S	NURSING SERVICES	MEDICALLY FRAGILE	MEDICATION: IND. (I), ASSIST (A); ADM. (AD)	MOBILITY / FALLS / AMBULATION DEIVICES	BEHAVIOR / PSYCHOSOCIAL ISSUES	DEMENTIA / COGNITIVE IMPAIRMENT	EXIT SEEKING / WANDERNG	SMOKING	DEVELOPMENTAL DISABILITIES	LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES	VISION DEFICIT / BLINDNESS	DIABETIC: INSULIN / NON-INSULIN	ASSIST WITH ADLS	WOUNDS / SKIN ISSUE	INCONTINENT / APPLIANCE (CATHETER) DIALYSIS	SPEICAL DIETARY NEEDS / SCHEDULED SNACKS	WIEIGHT LOSS / WEIGHT GAIN	MEDICAL DEVICES	RECENT HOSPITALIZATIONS	OXYGEN / RESPIRATORY THERAPY	HOME HEALTH / HOSPICE / PRIVATE CAREGIVER	OTHER

NOTES

Coding: In order to assist in more accurate communication of resident characteristics, the following coding legend has been provided. If characteristics do not apply, leave box blank.

Pay Status: Private = **P** State = **S**	Mark the box: **P** – all or part of a resident's care is paid by the resident or their family; **S** – all or part of a resident care is paid for by the State
Nursing Services (services only a licensed nurse can provide)	**O** – resident receiving **O**stomy care; **T** – resident receiving **T**ube feeding; **I** – resident receiving **I**njections
Medically Fragile	**Y** – **Y**es. Resident assessed as meeting the definition of medically fragile per WAC: A chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled nursing interventions. If these medically necessary interventions are interrupted or denied, the resident may experience irreversible damage or death. **N** – **N**o. Resident not assessed as meeting the definition of medically fragile.
Medication: Independent (**I**); Assistance (**A**); Administration (**AD**)	**I** – resident assessed as **I**ndependent with their medication; **A** – resident assessed as needing medication assistance; **AD** – resident assessed medication administration.
Mobility / Falls / Ambulation Devices	**A** – resident requires **A**ssistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; **F** – resident experienced a **F**all within the last 30 days; **D** – resident uses a **D**evice to assist with ambulation.
Behavior / Psychosocial Issues	**X** – resident shows or has behaviors such as those requiring special training or assistance increasing the amount of time staff needs to assist resident.
Dementia / Cognitive Impairment	**X** – resident shows or has behaviors such as those requiring special training or assistance increasing the amount of time staff needs to assist resident.
Exit Seeking / Wandering	**ES** – resident has shown **E**xit **S**eeking behaviors; **W** – resident has shown **W**andering behaviors
Smoking	**S** – Resident **S**mokes
Developmental Disabilities	**DD** – resident has a diagnosis of a **D**evelopmental **D**isability
Language / Communication Issue / Deafness / Hearing Issues	**X** – resident has a language or communication issue which requires additional staff support; **HI** resident is **H**earing **I**mpaired; **D** – resident is **D**eaf
Vision Deficit / Blindness	**X** – resident is blind or has severe vision deficit which requires additional staff support
Diabetic: Insulin / Non-Insulin	**I** – resident if **I**nsulin dependent; **N** – resident is **N**on-insulin dependent diabetic
Assist with ADL's	**I** – resident assessed as **I**ndependent; **MIN** – resident assessed as needing **MIN**imal assistance with ADL's such as curing reminders, supervision, and/or encouragement; **MOD** – resident assessed as needing **MOD**erate assistance with ADL's such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; **MAX** – resident assessed as needing **MAX**imum assistance with ADL's such as needing a one person or two person transfer, resident was incontinent of bowel or bladder and required staff to assist with care; resident needed assistance with turning, sitting up or laying down, staff must physically turn the resident every two hours.
Wounds / Skin Issue	**P** – resident has a **P**ressure ulcer; **S** – resident has a **S**tasis wound; **W** – resident has a **W**ound or skin issue other than pressure of stasis ulcer
Incontinent / Appliance (catheter) Dialysis	**UI** – resident **I**ncontinent of bladder and/or bowel; **C** – resident has **C**atheter; **D** – resident requires **D**ialysis
Special Dietary Needs / Scheduled Snacks	**X** – resident requires a special prescribed diet
Weight Loss / Weight Gain	**WL** – resident had more than a 3-pound to 5-pound **W**eight **L**oss within last 60 days; **WG** - resident had more than a 3-pound to 5-pound **W**eight **G**ain within last 60 days
Medical Devices	**X** – resident received dialysis treatments; **M** – if part of a resident's care is the use of side rails, transfer poles, chair / bed alarms, belt restraints
Recent Hospitalization	**X** – resident has been hospitalized within the last 60 days
Oxygen / Respiratory Therapy	**X** – resident receives oxygen and/or respiratory therapy or treatments
Home Health / Hospice / Private Caregiver	**HH** – resident receives **H**ome **H**ealth services; **HOS** – resident receives **HOS**pice services; **P** – resident received care from **P**rivate caregiver

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment E

ESF Resident Interview

Representative's Name	Resident's Identifier	Resident Room Number
Representative's Name		Representative's Phone Number

Brief Review of Negotiated Service Agreement prior to Interview

Water Temperature (check for all resident bathrooms):
☐ None Temperature: °F Date: Time: ☐ am / ☐ pm

Interview Type
☐ Resident Interview ☐ Representative Interview Date: Time: ☐ am / ☐ pm

Instructions: The interview must address each category (A through J) and include a documented response. For each question asked, document the interviewee response by checking the box next to the corresponding answer or writing in the response. A decline response indicates the question was asked and the interviewee declined to respond. Not applicable (N/A) indicates the question does not pertain to the resident.

Document on the form if the interviewee ends the interview before all questions are asked.

HCBS questions are bolded and denoted with ** before each question. For each HCBS question, that question is **required** and **must** be asked as **written** during the interview. For categories with required **HCBS questions, the additional example questions are optional.

If there is no ** HCBS question for that category (Category G-J), use one of the example questions or write your own question related to the category in the alternate question cell. **You must ask at least one question in each category.**

If you are concerned about any response, please investigate further.

A. Care and Service Needs (required ** HCBS question in this category)

**** Can you make choices about the care and services you receive here at the facility?**

☐ Yes ☐ No ☐ Decline	

Who helps you with your medications?

☐ Decline ☐ N/A	

What do staff help you with?

☐ Decline	

B. Response to Concerns Support of Personal Relationships (required ** HCBS question in this category)

**** Do they pay attention to what you have to say?** Include any means of communication such as verbal, sign language, gestures.

☐ Yes ☐ No ☐ Decline	

Who would you talk to if you had concerns about your care?

☐ Decline	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment E

ESF Resident Interview

C. Support of Personal Relationships (Required ** HCBS question in this section)	
** **Can you choose who visits you and when?**	
☐ Yes ☐ No ☐ Decline	
D. Meals / Snacks / Preferences (required ** HCBS question in this category)	
** **Do you have access to food anytime?**	
☐ Yes ☐ No ☐ Decline	
E. Respect of Individuality, Independence, Personal Choice, Dignity (required ** HCBS question in this category)	
** **Can you choose to lock your door?**	
☐ Yes ☐ No ☐ Decline	
Are you allowed to make choices, and if so, are staff respectful of your choices?	
☐ Yes ☐ No ☐ Decline	
F. Activities (<u>two</u> required ** HCBS question in this category)	
** **Do you have an opportunity to participate in community activities** (outside the facility such as employment, banking, community activities)**?**	
☐ Yes ☐ No ☐ Decline	
** **Do you receive services in the community** (outside the facility such as doctor appointments, therapies)**?**	
☐ Yes ☐ No ☐ Decline	
Do you participate in activities while in the facility? How often? Include activities inside the ESF such as movie night.	
☐ Yes ☐ No ☐ Decline	
G. Homelike Environment	
Tell me about your room. Did you help decorate it?	
☐ Yes ☐ No ☐ Decline	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment E

ESF Resident Interview

Is the temperature comfortable to you?
Alternate question:

☐ Yes
☐ No
☐ Decline

H. Reasonable Facility Rules

Does anyone tell you that you cannot do the things you want to do?
Alternate question:

☐ Yes
☐ No
☐ Decline

I. Sense of Well-Being and Safety

Do you feel safe here?
Alternate question:

☐ Yes
☐ No
☐ Decline

J. Financial

Does anyone tell you how to spend your money?
Alternate question:

☐ Yes
☐ No
☐ Decline

K. Optional Questions and Notes

Other:

Other:

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment F

ESF Other Contact Interview

RESIDENT'S NAME	RESIDENT NUMBER	INTERVIEW DATE	INTERVIEW TIME ☐ AM ☐ PM
CONTACT NAME AND NUMBER		RELATIONSHIP TO RESIDENT	
NOTES			

RESIDENT'S NAME	RESIDENT NUMBER	INTERVIEW DATE	INTERVIEW TIME ☐ AM ☐ PM
CONTACT NAME AND NUMBER		RELATIONSHIP TO RESIDENT	
NOTES			

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment F

ESF Other Contact Interview

Notes

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Attachment J

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

ESF Staff Interview

SHIFT	NAME	DATE	TIME	
☐ Caregiver				☐ AM ☐ PM

This form is **optional** and includes sample questions for individual categories. Expand questions to obtain more data if concerns are identified.

RESIDENT RIGHTS • What do you do to promote resident dignity, quality of life, and privacy? What do you do if you see or discover resident rights being violated?	
RESIDENT GRIEVANCES What do you do if you have a resident who says they are unhappy about the care in this facility?	
CARE AND SERVICES • What decisions and choices do you allow the resident to make? How do you help residents feel comfortable here?	
ABUSE / NEGLECT / EXPLOITATION • Please give an example of abuse, neglect, or exploitation. What do you do if you discover abuse, neglect, or exploitation?	
RESIDENT BEHAVIOR / FACILITY PRACTICE • What do you do if a resident elopes or is missing? • How do you manage challenging behaviors? Where do you access the facilities policies and procedures?	
ACCIDENT / INJURY / PREVENTION • What is your training for facility policy on resident-to-resident assaultive behavior? • How do you know what each resident needs? Who do you notify if a resident is injured?	
STAFFING • Do you work alone? • How do you get help? How do staff contact the administrator?	
EMERGENCY MANAGEMENT • When did you participate in an evacuation drill? What do you do if there was an emergency or disaster?	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Attachment J

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

ESF Staff Interview

Notes

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment G

ESF Environmental Observations

Observations of the environment occur throughout the inspection. Interviews with facility staff and residents are an important source of information to include.

A. Quality of Life / Resident Rights

YES	NO	
☐	☐	Staff to resident interaction(s), responsiveness and meeting resident needs (0170, 0190)
☐	☐	Appropriate staff communication with residents (0170, 0200)
☐	☐	Adaptive equipment available, clean and in good repair (0210, 0310, 0800)
☐	☐	Resident nutrition, grooming, personal and oral hygiene and/or delivery of care completed (0200)
☐	☐	Recognition of cultural diversity and preferences (0120, 0170, 0210)
☐	☐	Recognition of dignity, privacy, and resident rights (i.e., shades in room, knocking before entering room (0170)
☐	☐	Presence of restraints (0420)
☐	☐	Communication system (1005 and 1010)
☐	☐	Homelike (0170,0880)
☐	☐	Facility electronic monitoring equipment must not include audio and focus on entrance or exit doorways (0780)
☐	☐	Resident requested electronic monitoring equipment is only used in sleeping room of the resident (0790)

NOTES

B. Physical Environment – Interior (if two buildings and one license, postings in both buildings)

YES	NO	INFORMATION POSTED:
☐	☐	Current ESF license including limits or conditions on the license (1100)
☐	☐	CRU Hotline (0590)
☐	☐	Ombudsman Information (1100)
☐	☐	Appropriate Resident Advocacy Groups, if applicable
☐	☐	Copy of report, cover letter and plan of correction of most recent full licensing inspection (1100)
☐	☐	Resident Rights (0190(6)(a-o))
☐	☐	Emergency evacuation routes (1600)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment G

ESF Environmental Observations

C. Maintenance and Housekeeping

YES	NO	
☐	☐	Furnishing, floors, walls, and ceilings (0170)
☐	☐	Presence of lingering objectionable odors (0170)
☐	☐	Housekeeping supply area (0910)
☐	☐	Laundry – handled according to acceptable methods of infection control (0900)
☐	☐	Infection control practices of staff (0440)
☐	☐	Hand washing (0440)
☐	☐	Temperature (capable of maintaining 75º in areas occupied by residents and 70º for non-resident areas) (0980 / 0990)
☐	☐	Adequate ventilation in resident rooms and common areas (0810, 0880, 1000)
☐	☐	Adequate lighting in resident rooms and common areas (0880 / 1001)
☐	☐	Cleanliness of resident equipment maintained in good repair (0170)

NOTES

D. Safety

YES	NO	
☐	☐	Prevention of resident access to storage of:

- Cleaning supplies
- Cleaning carts
- Storage closet
- Toxic materials
- Medication

☐	☐	Emergency / disaster preparedness

- Emergency disaster plan reviewed annually (1600)
- Emergency behavioral crisis response plan (1590)
- Staff responsibility

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment G

ESF Environmental Observations

E. Common Bathrooms (0820 / 0830)

YES NO

☐ ☐ Common bathrooms are:
- Safe / clean / adequate lighting / grab bars (if applicable for resident needs)
- Doors swing out
- Accessible for all resident / privacy available
- Equipped with keyed locks that allow access for staff (if applicable for resident needs)
- Access to at least one bathtub / bathing device for immersion

☐ ☐ Safe water temperature in resident bathrooms and sinks utilized by residents(0970)

Water temperature: _____ºF ; _____ (date and time); _____ (place)

Water temperature: _____ºF ; _____ (date and time); _____ (place)

Water temperature: _____ºF ; _____ (date and time); _____ (place)

NOTES

F. Physical Environment - Outdoors

YES NO

☐ ☐ Stairs / steps / ramps in good repair with non-skid surfaces (0950)
☐ ☐ Handrails (0950)
☐ ☐ Sanitary collection of garbage / refuse (0924)
☐ ☐ Presence of pests (0170)
☐ ☐ General maintenance of sidewalks / walkways (0980)
- Has areas protected from direct sunshine and rain throughout the day
- Can be accessed by the resident
- Has walking surfaces that are firm, stable, and free from cracks and abrupt changes with a maximum of 1 inch between the sidewalk and adjoining landscape areas)
- Has sufficient space and outdoor furniture provided with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids
- Surrounded by walls or fences at least 72" high
- If used a resident courtyard, must not be used for public or service deliveries

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Use this form and Attachment M, Food Service Observations (DSHS 15-583) for all full inspections.

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment H

ESF Resident Record Review

ENHANCED SERVICES FACILITY NAME			LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	Inspection Type: ☐ Full ☐ Complaint: Number _____			
NAME	ID NUMBER	DATE OF BIRTH	ROOM NUMBER	MOVE-IN DATE
FAMILY / MEMBER / RESIDENT'S REPRESENTATIVE'S NAME	REPRESENTATIVE'S PHONE NUMBER		REASON FOR SAMPLE SELECTION	

PERTINENT MEDICAL HISTORY / DIAGNOSES

A. Assessment

YES	NO	N/A	
☐	☐	☐	Preadmission Assessment (0040) – prior to admission (review if admitted within the last six months, expand if needed).
☐	☐	☐	Comprehensive Assessment (0070) – completed within14 days from admission (review if admitted within the last six months, expand if needed).
☐	☐	☐	Ongoing Comprehensive Assessment (0080) – completed after a significant change or every 180 days.

NOTES

B. Monitoring Resident's Well-Being / Rights

YES	NO	N/A	
☐	☐	☐	Documented
☐	☐	☐	Action taken as needed
☐	☐	☐	Signed Residency Agreement (Medicaid residents only)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment H

ESF Resident Record Review

C. Person-Centered Service Plan (PCSP)

YES	NO	N/A	
☐	☐	☐	Initial PCSP (0110) – completed prior to admission (review if admitted within the last six months, expand if needed).
☐	☐	☐	Initial Comprehensive PCSP (0120) – 14 days from admission
☐	☐	☐	Ongoing Comprehensive PCSP (0130) – updated after a significant change, resident request, following CARE assessment, or every 180 days.
☐	☐	☐	PCSP planning team meets at least monthly (or more often as needed) to review or modify plan (0100)
☐	☐	☐	Contents meet resident's assessed needs and preferences (0120 and 0130) to include: • Care and Services provided • Documented modification to resident rights (if applicable)
☐	☐	☐	Signed by Person Centered Service Planning Team (0100) to include: resident, resident representative (if applicable), Mental Health Professional, nursing staff, and Medicaid department case manager (0120)(3)(c)
☐	☐	☐	Contains a Behavioral Support Plan that: • Documents interventions for behavioral support in response to a resident's de-escalation • Documents resident strengths that support preventative and intervention strategies • Documents steps to be taken by each of the facility staff if intervention strategies are unsuccessful

NOTES

D. Medication Services: ☐ Independent ☐ Assistance ☐ Administration

YES	NO	N/A	
☐	☐	☐	Medication services provided by family (review plan)
☐	☐	☐	Medication services provided by facility (review plan)
☐	☐	☐	Appropriate for resident abilities and needs
☐	☐	☐	Review of medication record
☐	☐	☐	Documentation of refusal (if applicable) (0350, 0360)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment H

ESF Resident Record Review

E. Modified / Therapeutic Diet

YES	NO	N/A	
☐	☐	☐	Receiving Food Services as ordered
☐	☐	☐	Receiving eating assistance
☐	☐	☐	Residents can make or select snacks and beverages without staff assistance as indicted on PCSP.

NOTES

Notes

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	INSPECTION DATE
PROVIDER / LICENSEE'S NAME	LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment I

ESF Staff and Administrative Record Review

Complete each box not greyed out. When additional staff require review, use another copy of this form. See Page 4 for additional instructions.

STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (>TWO YEARS)	STAFF (>TWO YEARS)
NAME						
IDENTIFIER						
DATE OF BIRTH						
DATE OF HIRE*						
BGI CHECK DATE*					PREVIOUS CURRENT	PREVIOUS CURRENT
FINGERPRINT CHECK	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING		
CCS EVALUATION*	☐ N/A, NOT REQUIRED	☐ N/A, NOT REQUIRED	☐ N/A, NOT REQUIRED	☐ N/A, NOT REQUIRED	☐ N/A, NOT REQUIRED	☐ N/A, NOT REQUIRED
DOH CREDENTIALS	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
DOH EXPIRE DATE						
12 HOURS CE*						
FACILITY ORIENTATION						
ORIENTATION AND SAFETY (5 HOURS)						
70 HOUR BASIC / POPULATION SPECIFIC **OR**						
EXEMPT **	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT		
FIRST AID / CPR EXPIRATION						
FOOD WORKER'S CARD EXPIRATION						

* Date of Hire - first date worked for pay. BGI - Background Inquiry; CCS - Character, Competency, and Suitability; DOH - Department of Health; CE - Continuing Education.

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	INSPECTION DATE
PROVIDER / LICENSEE'S NAME	LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment I

ESF Staff and Administrative Record Review

** Could include documentation employee worked in 2011 and met training requirements at that time or documentation employee has worked in current home since 2011. Has Fundamentals or Basics of Caregiving Certificate.

Specialty Training						
DEMENTIA*						
MENTAL HEALTH*						
DE-ESCALATION*						
☐ **N/A DEVELOPMENTAL DISABILITY***						
Facility Specific Training						
QUARTERLY STAFF EDUCATION – THREE HOURS						
DE-ESCALATION POLICY AND PROCEDURE TRAINING						
TRAINING BY PHARMACIST						
TB Testing Review (See option worksheet on Page 3)						
TB TESTING MET	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO		

GENERAL LIABILITY INSURANCE (WAC 388-107-1120)	PROFESSIONAL LIABILITY INSURANCE (WAC 388-107-1130)
Expiration date:	Expiration date: ☐ N/A

Notes

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	INSPECTION DATE
PROVIDER / LICENSEE'S NAME	LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment I

ESF Staff and Administrative Record Review

OPTIONAL WORKSHEET FOR TB TESTING REVIEW. This section can be used to assist in determining compliance with TB testing requirements. TB testing must be given no later than the first day of employment or the first day the staff person starts providing services. Once determined, indicate compliance status on Page 2.

STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (>TWO YEARS)	STAFF (>TWO YEARS)
DATE OF HIRE						
DATE TESTED						
TYPE OF TEST	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*		
DATE FIRST READ						
RESULT	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE		
INDURATION IF TST	MM	MM	MM	MM		
DATE OF SECOND TST TEST	☐ N/A, NOT TST	☐ N/A, NOT TST	☐ N/A, NOT TST	☐ N/A, NOT TST		
DATE SECOND READ						
RESULT	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE		
INDURATION IF TST	MM	MM	MM	MM		
CHEST X-RAY						
X-RAY RESULT	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE		

TST - Tuberculin Skin Test; IGRA - Interferon Gamma Release Assays

Notes

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	INSPECTION DATE
PROVIDER / LICENSEE'S NAME	LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment I

ESF Staff and Administrative Record Review

Item	Instructions. WACs referenced below are intended as a guide and may not be all inclusive of applicable statues and regulations.
General	• **Each box not greyed out must have data in it.** Check N/A box, write N/A, or draw a line through the box for any areas on this form which are not relevant. If there is no data, the reviewer of the record does not know if it was missed by the licensor or if it was a finding for the facility. • Minimally, review the following facility records and expand as needed based on areas of concern: Emergency Disaster Plan, Abuse / Neglect Policy, Risk Assessment, Menus, and Activity Calendar
Sample Selection	Review administrator's records if new since the previous inspection. Conduct a full review of three staff hired since the last inspection. If fewer than three were hired, review all new staff. Conduct a targeted review of one or two staff with a >2-year work history to verify a system is in place for all required renewals (e.g., BGI, CE). When there are not enough current staff with >2 years employment, use former staff that were employed at least two years. Document the reason for any substitutions.
BGI Check Date	Enter the date BGI was submitted to the department's background check central unit, or the date found on the background check results letter (WAC 388-78A-2466). The submit date and the results date on the background check letter are the same. BGI must be conducted every two years from the date of the previous submission.
Fingerprint Check Date	Staff hired after 01/07/2012 are required to have a national fingerprint background check. Common data for this box includes a date, the N/A box being checked, the pending box being checked, a line drawn through the box, or words that clearly describe the result of the fingerprint check review (such as "not found" if the facility will be cited for lack of fingerprint check documentation).
CCS Determination	Required when BGI returns with criminal convictions or pending charges that are not disqualifying (WAC 388-113). CCS must be completed before working unsupervised. A second CCS review is required when the FP results indicate additional, non-disqualifying criminal convictions or pending charges not already reflected in the BGI. The facility may use RCS CCS Determination form (DSHS 15-456). If an alternative format is used, reviews must include all information found in WAC 388-113-0060. Enter date of review.
DOH Credentials	Record type of license, certification, or credential. Examples may include registered nurse (RN), licensed practical nurse (LPN), home care aide certification (HCA). Provider credential search is found on the Department of Health website. Check N/A if not applicable.
DOH Expiration Date	Enter the date of expiration for staff credential.
12 Hours CE	When reviewing CE credits, record the number of hours the person received in the time period between their last two birthdays. For example, a review conducted on December 1, 2024, of a person born on January 1 would need to have all hours between January 1, 2023, and January 1, 2024, reviewed. Registered nurses and licensed practical nurses are exempt from this requirement, unless voluntarily certified as a home care aide (HCA). The field staff may use the number of credits found at the last inspection only if less than a year has passed since the last inspection, the staff member was reviewed during that inspection, and the staff member has not had a birthday since the last inspection. For newly credentialed HCA workers, initial CE requirement is due before their birthdate following their first HCA credential renewal date. See Continuing Education Requirements for more information. • Only DSHS-approved courses may be used to meet the CE requirements. Field staff may verify individual CE courses were DSHS-approved by verification of CE course number. Verification of individual courses may be reviewed by logging into the Instructor and Curriculum Tracking System (ICTS). • Ten of their twelve CE hours must cover relevant education regarding the population served within the ESF (388-107-0660 and 0670).
Facility Orientation	Required before having routine interactions with residents (388-107-0630 and 388-112A-0200). Record date of completion.

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	INSPECTION DATE
PROVIDER / LICENSEE'S NAME	LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment I

ESF Staff and Administrative Record Review

Orientation and Safety	Two hours of orientation and three hours of safety training is required before providing care to residents (388-107-0630 and 388-112A-0200 and 0220). Record date of completion.
70-Hour Basic	All long-term care workers hired after 01/07/2012 must complete within 120 days of hire (WAC 388-78A-2474 and WAC 388-112A-0300). See additional regulations within WAC 388-112A for staff hired before 01/07/2012. RNs, LPNs, CNAs, and persons who are in an approved CNA program are exempt from LTC training requirements (WAC 388-112A-0090 and 388-107-0630). Enter date completed.
Specialty Training	Staff must complete mental health and dementia specialty training before working in the facility. Staff must complete developmental disabilities training when applicable (388-107-0650). Check N/A if DD Training is not applicable. Record date of completion.
Quarterly staff education (3 hours)	All ESF staff must receive three hours of training relevant to the needs of the population served. This is in addition to annual CE requirements required for their DOH credential (388-107-0680). Record date completed.
Training by a pharmacist	Staff have received education and training by a licensed pharmacist on medication-related subjects (388-107-0330). Record date of completion.
TB Testing Requirement	Indicate yes or no if TB testing has been met (388-107-0450 through 0540). Page three optional section may be used to help determine compliance.
Liability Insurance	General liability insurance or business liability covers general coverage for premises, operations, etc. Professional liability insurance is only required when the ESF has a professional license or employs professionally licensed staff. Each insurance type must minimally cover one million each occurrence and two million aggregate. WAC 388-107-1110 through 1130)

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILITY (ESF)

Attachment K

ESF Notes / Worksheets

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment L

ESF Exit Preparation Worksheet

ISSUES	RESIDENT / STAFF NUMBER	SCOPE / CONCERNS	WAC / RCW (CONSULTATION, CITATION)

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment L

ESF Exit Preparation Worksheet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment M

ESF Food Service Observations and Interviews

Kitchen on site: ☐ Yes ☐ No; if not, location of contracted kitchen:

A. Food Services: General observation of kitchen and staff (wear a hair restraint per regulation and facility policy).

- Overall cleanliness of kitchen area (06505)
- Free from rodents and pests (06550)
- Proper hand hygiene and glove use (02305 and 02310) during food preparation and service
- Staff cleanliness, use of hair restraints, and hygienic practices (02325, 02335, 02410)
- Food from approved sources (03200) (for example, food from known providers, no home prepared items)
- Chemicals labeled and properly stored (07200)
- Person in charge to provide a copy of the food handlers' cards for meal preparation staff observed during the meal observed in this inspection (02120)
- No ill food workers present (02220)
- Person in Charge describes process for staff to report illnesses and procedures used when an ill food worker reports an illness (02205, 02220, 02225)
- Person in charge or designee describes proper dishwashing procedure that follow manufacture guidelines for temperature or chemical controls (04555, 04560)

NOTES

B. Food Preparation: Observe for proper food preparation, sanitation, and storage.

- Person in charge or designee describes how food contact surfaces are thoroughly cleaned / rinsed / sanitized (04645, 04700)
- Person in charge or designee describes steps taken to prevent cross-contamination of food items (03306)
- No bare hand contact with ready to eat foods, except during the washing of fruits and vegetables (03300)
- Fruits and vegetables are thoroughly rinsed (washed) (03318)
- Raw meats stored below or away from ready to eat food (03306)
- Stored food is date marked (03526) (resource: Department of Health Date Marking Toolkit)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment M

ESF Food Service Observations and Interviews

C. Food Storage: Observe for proper time / temperature controls.

- Food stored with proper temperature controls (for example, no potentially hazardous foods such as beef, chicken, pork thawing at room temperature) (03510)
- Refrigerator temperature is maintained at <40°F (internal temperature of potentially hazardous food must be at <40°F) (03525)
- Foods are frozen in freezer (no specific temperature requirement) (03500)
- Potentially hazardous foods are properly cooled (within two hours of going from 135°F to 70°F and then to <41°F within a total of six hours or following the rapid cooling procedure of continuous cooling in a shallow layer of two inches or less, uncovered, protected from cross contamination, in cooling equipment maintaining an ambient air temperature of <41°F or other methods as described in regulation) (03515)
- Person in charge or designee identifies proper cooking time and temperatures for potentially hazardous foods (for example, poultry 165°F [instantaneous], ground meat at least 158°F [instantaneous], fish and other meats 145°F [15 seconds])
- Person in charge describes process to check food temperatures
- Person in charge or designee describes how food items are properly reheated (03400)
- Licensors may ask the facility to check food temperature, or licensor may check temperature of food with a sanitized thermometer
  - Hot foods held at ≥135°F prior to serving (03525)
  - Cold foods held at ≤ 41°F prior to serving (03525)

Food Temperature: _____°F; _____(Date and time); _____(location)

Food Temperature: _____°F; _____(Date and time); _____(location)

Food Temperature: _____°F; _____(Date and time); _____(location)

NOTES

D. Menus: Review current and past menus.

Menus (0340):

- Written one week in advance(1)(e)(i)
- Indicate the date, day of week, month, and year (1)(e)(ii)
- Include all food and snacks served that contribute to nutritional requirements (1)(e)(iii)
- Are kept at least six months (1)(e)(iv)
- Provide variety (1)(e)(ii)
- Are not repeated for at least three weeks, except breakfast as outlined in (1)(i)(vii)
- Document on current day's menu and record on original menu when changes in current days menu are necessary (1)(h)
- If an alternate choice in entrees is served, alternate entrees must be recorded on the menu (1)(i)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

ESF Food Service Observations and Interviews

E. Meals and Snacks: Observe meal planning to meet resident's dietary needs

Meals and snacks (0430):

- Minimum of three meals provided (1)(a)
- Snacks between meals and in evening are provided at regular intervals (1)(b)
- Provide access to fluids and snacks at all times (1)(c)
- When person centered service plan indicates, resident must have ability to select own snacks and beverages without having to ask staff member for assistance (4)
- Provide sufficient time and staff support for residents to consume meals (1)(d)
- Serve nourishing, palatable and attractively presented meals for age, gender and activities (1)(g)
- Substitute foods of equal nutrient value when changes in current days menu are necessary (1)(h)
- Delivered to resident's room or posted except as specified (1)(e)(i)
- Alternate choices for entrees are available (1)(i)
- Are nutritious, meets the residents' dietary needs (1)(g)
- Are palatable and served at proper temperature (if issues with food temperature and/or palatability, consider obtaining a meal sample) (1)(e)(i)

Meals and snacks served as ordered (0430):

- Prescribed general low sodium general diabetic and mechanical soft food diets according to a diet manual (2)(a)
- Diet manual is available to and used by staff persons responsible for food preparation (2)(i)
- Diet manual is approved by a dietitian (2)(ii)
- Diet manual is reviewed and updated as necessary or at least every five years (2)(iii)
- Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner (2)(b)
- At resident's request provide nonprescribed modified / therapeutic diet and nutritional concentrates or supplements (3)(a)(b)

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment M

ESF Food Service Observations and Interviews

F. Dining Service: Observe mealtime dining service

- Residents who need assistance for eating or swallowing concerns receive it timely, appropriately, and in a dignified manner
- Meals are distributed in a timely manner
- For each sampled resident being observed, identify and special needs and interventions planned to meet their needs
- Tables adjusted to accommodate wheelchairs
- Residents prepared for meals, dentures, glasses, and/or hearing aides are in place
- Adoptive equipment is available per need
- Residents at the same table are served and assisted concurrently
- Sufficient staff are available for the distribution of meals and assistance
- Sufficient time is allowed for residents to eat
- Sufficient dining space available in all dining areas (0430)(1)(k)
- Dining atmosphere is pleasant
- Family members are accommodated for dining with their resident
- Meals are provided as written on posted menu
- Meals provided in resident rooms are served promptly to ensure proper temperature

NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Attachment Q

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Enhanced Services Facility Medication Observation Worksheet

Date Time: ☐ AM ☐ PM

This form is **optional** and includes **sample** cues for observation, interview, and record review.

WAC	Subject
388-107-0320 and 388-107-0330	Medication Services
• Observe: Medication cart • Ask: What pharmacy is used? Do they do monthly cycle fill? Do you renew and process orders or does the nurse? What information is on the MAR? How is the MAR laid out? • Review: MAR	
388-107-0340	Prescribed Medication Authorization
• Observe: Medication bottle or bingo cards • Ask: If someone didn't have an order for Tylenol but had a bad headache, what would you do?	
388-107-0350 and 388-107-0360	Medication Refusal
• Ask: What do you do if someone doesn't want their medications? When would you notify the physician of a refusal? • Review: Records of sample residents for medication refusal.	
388-107-0330	Non-Availability of Medications
• Ask: What is your process for new medications or residents returning from the hospital? • What happens if medications do not arrive timely?	
388-107-0320	Alteration of Medications
• Observe: Medication alterations (such as crushing) • Ask: Tell me more about how you are altering the medications. How does the resident know they are receiving medication in an altered form? • Review: Pharmacist orders approving altered form.	
388-107-0334	Medication Organizers
• Observe: Medication cart, proper labels • Ask: Who fills the medication organizer?	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

Attachment Q

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Enhanced Services Facility Medication Observation Worksheet

388-107-0332	Storing, Securing, and Accounting for Medications
• Observe: Narcotics storage, spot check the med cart by pulling the drawer to ensure it is locked, look for any unsecured pills. • Ask: How do you account for narcotics? What would you do if you arrived on shift and there were narcotics missing? How do you store refrigerated medications? What is your medication disposal procedure? Review: Narcotics book for any missing signatures.	
388-107-0334	Resident Controlled Medications
• Ask: What is your facility policy on residents controlling their own medications? (Compare answer to Resident Characteristics Roster to ensure it is up to date.) How do you assess residents' ability to manage their own medications? • Ask relevant residents: How are your medications stored and locked? Review: Resident Characteristics Roster	
388-107-0240	Nursing Services
• Review: Nurse staffing schedules, RN on-call procedures Ask: What do you do if you need to consult with an RN and they are not on duty?	
388-107-0440	Infection Control
Observe: Handwashing or sanitizer use, or proper glove use between residents while delivering medications.	
388-107-0190	Resident Rights
• Observe: Knocking on the door when delivering medications to resident rooms, staff to resident interactions. Ask: Do residents have the right to refuse medications?	
NOTES	

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment N

ESF Medication Pass Worksheet

This form is completed **only** if a problem with medications has been identified.

RESIDENT NAME AND ID NUMBER	DRUG PRESCRIPTION NAME, DOSE, AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS (WHEN DIFFERENT FROM OBSERVATION)
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	INSPECTION TYPE ☐ Full ☐ Follow up	COMPLAINT NUMBER ☐

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment N

ESF Medication Pass Worksheet

This form is completed **only** if a problem with medications has been identified.

ATTACHMENT N NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	Inspection Type: ☐ Initial ☐ Full ☐ Complaint:	

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM S
UPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment O

ESF Staff Schedule Worksheet

Staffing Levels: 388-107-0240 and 388-107-0260

The enhanced services facility must ensure that sufficient numbers of appropriately qualified and trained staff are available to safely provide necessary care and services consistent with residents' person-centered service plans under routine conditions, as well as during fire, emergency, and disaster situations; (1)(a)

NUMBER OF RESIDENTS IN HOME	Are staffing sheets attached or stored electronically? ☐ Yes ☐ No Were minimum staffing levels met based on the criteria below? ☐ Yes ☐ No

Review the prior two-week staffing schedule to answer the following questions:

Minimum Staff (0240): At least two staff are awake and on duty in the facility at all times if there are any residents in the facility. (1)(b)

Facility Contract with HCS: One staff for every four residents.

Was there one staff on duty for every four residents with a minimum of two staff awake and on duty at all times? ☐ Yes ☐ No

Licensed Nursing Staff (0240): A registered licensed nurse must be available to meet the needs of the residents as follows:

- On duty in the facility at least 20 hours per week (2)(a); and
- When not present, available on-call and able to respond within 30 minutes by phone or in person. (2)(b)

Was there at least one registered licensed nurse staff on duty for at least 20 hours a week? ☐ Yes ☐ No

Was a registered licensed nurse available on call and able to respond within 30 minutes when one was not on duty? ☐ Yes ☐ No

Licensed Nursing Staff – Staffing for Medically Fragile (0260):

If an ESF serves one or more medically fragile residents, the facility must ensure that a registered nurse is on site for at least 16 hours per day. A registered nurse or a doctor must be on call the remaining eight hours.

☐ **N/A, no medical fragile residents. If this box is checked, skip the next two questions.**

If servicing a medical fragile resident, was a registered nurse on site at least 16 hours per day? ☐ Yes ☐ No

If serving a medically fragile resident, was a registered licensed nurse or doctor on call for the remaining eight hours? ☐ Yes ☐ No

Mental Health Professional: A mental health professional must be available to meet the needs of the residents as follows:

- On duty in the facility at least eight hours per day (4)(a); and
- When not present, available on-call and able to respond within 30 minutes by phone or in person (4)(b).

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE

LICENSOR'S NAME	Inspection Type: ☐ Initial ☐ Full ☐ Complaint:

Was an MHP on duty in the facility at least eight hours per day? ☐ Yes ☐ No

Was an MHP available on call and able to respond within 30 minutes when one was not on duty? ☐ Yes ☐ No

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE

LICENSOR'S NAME	Inspection Type: ☐ Initial ☐ Full ☐ Complaint:

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment O[2]

ESF Staff Schedule Worksheet: 8-hour Shifts

Instructions: List the number of Licensed Nurses (LN), Mental Health Professionals (MHP), and Other Staff (OS) on duty and on call for the two weeks prior to the start of the inspection.

	LN	MHP	OS
Day			
Evening			
Night			
On-Call			

Scheduled: Number of staff for that discipline scheduled that shift.

Actual: Number of staff for that discipline who worked or were on call for that shift.

Week leading up to inspection, beginning with the day prior to the inspection of the survey team. Please use actual numbers, not scheduled numbers.

Date																				
Shift	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS
Day																				
Evening																				
Night																				
On-Call																				

Two weeks leading up to inspection. Begin this grid with the eighth day prior to the entry of the inspection team.

Date																				
Shift	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS
Day																				
Evening																				
Night																				
On-Call																				

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	Inspection Type: ☐ Initial ☐ Full ☐ Complaint:	

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
ENHANCED SERVICES FACILTY (ESF)

Attachment O[3]

ESF Staff Schedule Worksheet: 12-hour Shifts

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME	Inspection Type: ☐ Initial ☐ Full ☐ Complaint:	

Instructions: List the number of Licensed Nurses (LN), Mental Health Professionals (MHP), and Other Staff (OS) on duty and on call for the two weeks prior to the start of the inspection.

	LN	MHP	OS
Shift 1			
Shift 2			
On-Call			

Scheduled: Number of staff for that discipline scheduled that shift.

Actual: Number of staff for that discipline who worked or were on call for that shift.

Week leading up to inspection, beginning with the day prior to the inspection of the survey team. Please use actual numbers, not scheduled numbers.

Date																				
Shift	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS
Shift 1																				
Shift 2																				
On-Call																				

Two weeks leading up to inspection. Begin this grid with the eighth day prior to the entry of the inspection team.

Date																				
Shift	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS	LN	MHP	OS
Shift 1																				
Shift 2																				
On-Call																				