



## ESF Request for Documentation

ENHANCED SERVICES FACILITY NAME		LICENSE NUMBER	ENTRANCE DATE
LICENSOR'S NAME		Inspection Type: <input type="checkbox"/> Full	
<input type="checkbox"/> <b>The field office has contacted the Ombuds.</b>			
NAME		TIME	
Copy of form provided to: _____ at _____			
<b>Documentation due to licensor within two (2) hours of entrance</b>			<b>Received</b>
Resident Characteristic Roster, DSHS 15-574* <u>or</u> Resident List, DSHS 15-573 <u>or</u> 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.			<input type="checkbox"/>
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.			<input type="checkbox"/>
Prior two weeks of staffing schedules as actually worked, including nursing, Mental Health Professional, on call staff, dietary staff, and housekeeping / laundry staff.			<input type="checkbox"/>
System for and access to personnel files and resident records (requests for specific resident and staff records will occur during the inspection).			<input type="checkbox"/>
Name and contact information of administrator / designee.			<input type="checkbox"/>
* Note: Maintaining a Resident Characteristic Roster, DSHS 15-574, expedites inspection time. This form can be located <a href="#">here</a> .			
<b>Applicable documentation due to licensor by the end of entrance day</b>			<b>Received</b>
Admissions Agreement			<input type="checkbox"/>
Proof of general and professional liability insurance coverage.			<input type="checkbox"/>
Four weeks of menus as served, available group activity opportunities.			<input type="checkbox"/>
Emergency disaster plan, policies and procedures for: Infection Prevention Control, mandated reporting records for abuse / neglect, crisis prevention and response protocol, functional program.			<input type="checkbox"/>
Valid Medical Test Site Certificate of Waiver License (MTSW) / Clinical Laboratory Improvement Amendment (CLIA) ( <input type="checkbox"/> Not applicable).			<input type="checkbox"/>
Changes in physical environment and approved Construction Review projects since last full inspection ( <input type="checkbox"/> Not applicable).			<input type="checkbox"/>
Copies of any waivers / exceptions / exemptions to rules ( <input type="checkbox"/> Not applicable).			<input type="checkbox"/>
List of residents discharged in the last three months and reason for discharge (if deceased, write deceased) ( <input type="checkbox"/> Not applicable).			<input type="checkbox"/>
Copy of the signed Risk Assessment ( <input type="checkbox"/> Not applicable).			<input type="checkbox"/>
<b>Documentation required</b>			