Washington State Department of Social & Health Services
Transforming lives

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

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Pre-Inspection Preparation

Attachment A

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

Review facility history to include:

- Past and current complaint investigations
- Past SODs and uncorrected deficiencies
- Past three consecutive years compliance with all inspections and investigations
- Resident and staff list from last licensing inspection
- Current exemptions
- Other relevant documents

Consider conferring with staff regarding concerns about facility to include:

- Complaint Investigator
- Case Managers
- Other relevant staff

CASE MANAGER'S / HCS NAME	CONTACT DATE

COMMENTS / CONCERNS

OMBUD'S NAME	CONTACT DATE

COMMENTS / CONCERNS

CONTRACT TYPE	CONTRACT DATE AND EXPIRATION

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CURRENT EXEMPTIONS

Notes: Pre-Inspection Preparation **Attachment A**

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Request for Documentation

Attachment B

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

Copy of form provided to: NAME _____ at TIME _____

Licensee / Administrator: Please provide the following information / documentation to the licensors:

At the beginning of the inspection:

- ☐ Complete list of residents, room number, and language spoken if not fluent in English (facility list of residents)
- ☐ Identify residents in the building today
- ☐ Residents discharged in the last three months, if applicable

Prior to the end of the tour:

- ☐ A completed resident characteristic list (Attachment D, DSHS 15-574). Include all licensed rooms and all residents
- ☐ Complete list of staff, position title, birthdate, shift, and hire date
- ☐ Working schedule of care staff, nursing staff. MHPs and on-call RN and MHPs for prior two weeks
- ☐ Disclosure of Admission Agreement
- ☐ Location of the resident records
- ☐ Location of personnel files
- ☐ Request for specific resident and staff records will occur during the inspection
- ☐ Copy of evidence of liability insurance coverage
- ☐ Pet records, menu calendar, changes in physical environment since the last inspection
- ☐ Approved construction review projects since the last full inspection
- ☐ Copies of any waivers / exceptions to rule

Further records and information may be requested by the licensor during the inspection process.

Thank you for your assistance.

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Notes: Request for Documentation	**Attachment B**

ESF Inspection Packet

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

ESF Resident List

Attachment C

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

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

ROOM NUMBER	RESIDENT NAME	NOTES

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

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

ESF Resident Characteristic Roster and Sample Selection

Attachment D

TOTAL CENSUS	Inspection Type: ☐ Full ☐ Follow up ☐ Complaint	FACILITY GENERATED ROSTER ATTACH ☐ **IF THIS BOX IS NOT CHECKED, SKIP NUMBER OF PAGES ATTACHED.**	PAGES ATTACHED

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 / PSYCHO SOCIAL ISSUES	DEMENTIA / COGNITIVE IMPAIRMENT	EXIT SCREENING / WANDERNG	SMOKING	DEVELOPMENTAL DISABILITIES	LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES	VISION DEFICIT / BLINDNESS	DIABETIC: INSULIN / NON-INSULIN	ADDIST WITH ADL' S	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

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

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 / PSYCHO SOCIAL ISSUES	DEMENTIA / COGNITIVE IMPAIRMENT	EXIT SCREENING / WANDERNG	SMOKING	DEVELOPMENTAL DISABILITIES	LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES	VISION DEFICIT / BLINDNESS	DIABETIC: INSULIN / NON-INSULIN	ADDIST WITH ADL' S	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

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

Coding for Attachment D:	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 / Psycho Social 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 – 5 pound **W**eight **L**oss within last 60 days; **WG** - resident had more than a 3 – 5 pound **W**eight **G**ain within last 60 days
Medical Devices	**X** – resident received dialysis treatments; **M** – if part of a residents 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

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Resident Interview

Attachment E

RESIDENT'S NAME	RESIDENT NUMBER	ROOM NUMBER	PAY STATUS ☐ Private ☐ State

BRIEF REVIEW OF PERSON-CENTERED SERVICE PLAN

The six (6) questions in Section A are **required** questions and **must** be asked as written during the interview. Check "Y" if the answer is yes; check "N" if the answer is no and document the interviewee's response; or check "D" if the interviewee declined to answer the question.

A. Select one.

☐ Resident Interview ☐ Representative Date of interview: Time of interview:

Y	N	D		Y	N	D	
☐	☐	☐	Can you make choices about the care and services you receive here at the facility?	☐	☐	☐	Can you choose who visits you and when?
☐	☐	☐	Do you have an opportunity to participate in community activities?	☐	☐	☐	Do they pay attention to what you have to say?
				☐	☐	☐	Can you choose to lock your door?
				☐	☐	☐	Do you have access to food anytime?

Document clients' answers for questions or declination to answer. Ask at least one question or a related question for Sections B – K.

B. Care and Service Needs ☐ **Declined to answer.**

Do you get the help you need?

C. Support of Personal Relationships (if the resident has family or significant others) ☐ **Declined to answer.**

Do you have friends or family in the community that you visit with?

D. Reasonable House Rules ☐ **Declined to answer.**

Does anyone tell you that you can't do the things you want to do?

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

E. Respect of Individuality, Independence, Personal Choice, Dignity ☐ **Declined to answer.**

Can you make your own choices?

F. Homelike Environment ☐ **Declined to answer.**

Tell me about your room. Did you help decorate it?

G. Response to Concerns ☐ **Declined to answer.**

Who would you talk to if you had concerns?

H. Sense of Well-Being and Safety ☐ **Declined to answer.**

Do you feel safe here?

I. Meals / Snacks / Preferences ☐ **Declined to answer.**

How is the food here?

J. Activities ☐ **Declined to answer.**

What kinds of things do you like to do for fun?

K. Notice ☐ **Declined to answer.**

Does anyone tell you how you can spend your money?

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Other Contact Interview

Attachment F

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

RESIDENT'S NAME	RESIDENT NUMBER	INTERVIEW DATE

CONTACT NAME AND NUMBER	RELATIONSHIP TO RESIDENT

NOTES

RESIDENT'S NAME	RESIDENT NUMBER	INTERVIEW DATE

CONTACT NAME AND NUMBER	RELATIONSHIP TO RESIDENT

NOTES

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

Notes: Other Contact Interview **Attachment F**

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Environmental Observations

Attachment G

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

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

YES	NO	**Quality of Life / Resident Rights**
☐	☐	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)

NOTES

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

YES NO **Physical Environment – Interior (if two buildings and one license, postings in both buildings)**

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 inspection conducted by department (1100)
- ☐ ☐ Resident Rights (0190(6)(a-o))
- ☐ ☐ Emergency evacuation routes (1600)

NOTES

YES	NO	**Maintenance and Housekeeping adequate**
☐	☐	Furnishing, floors, walls, and ceilings (0170)
☐	☐	Presence of 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 75° areas occupied by residents and 70° 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)
☐	☐	Safe water temperature in resident rooms and sinks utilized by residents (0970)
☐	☐	Cleanliness of resident equipment maintained in good repair (0170)

NOTES

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

YES NO **Safety**

☐ ☐ Prevention of resident access to storage of:

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

☐ ☐ Emergency / disaster preparedness
☐ ☐ Emergency disaster plan (1600)
☐ ☐ First Aid
☐ ☐ Staff responsibilities
☐ ☐ Emergency response teams (1590)

NOTES

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

YES NO **Common Bathrooms (0820 / 0830)**

Common bathrooms are:

☐ ☐ Safe / clean / adequate lighting / grab bars (if applicable for resident needs)
☐ ☐ Doors swing out
☐ ☐ Accessible for all resident / privacy available

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

YES NO **Bathtub or immersion tub (0830)**

☐ ☐ Access to at least one bathing device for immersion

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

YES NO **Physical Environment - Outdoors**

- ☐ ☐ Stairs / steps / ramps in good repair (0950)
- ☐ ☐ Hand rails (0950)
- ☐ ☐ Garbage / refuse (0924)
- ☐ ☐ Presence of pests (0170)
- ☐ ☐ General maintenance of sidewalks / walkways (0980)

YES NO **Outdoor recreations space and walkway (0890)**

- ☐ ☐ 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)
- ☐ ☐ Accessible to residents without staff
- ☐ ☐ 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

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

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Resident Record Review

Attachment H

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

NAME	ID NUMBER	DATE OF BIRTH	ROOM NUMBER	MOVE-IN DATE	PAY STATUS

FAMILY / MEMBER / RESIDENT'S REPRESENTATIVE NAME — PHONE NUMBER (INCLUDE AREA CODE)

PERTINENT MEDICAL HISTORY / DIAGNOSES

Assessment

YES	NO	N/A	
☐	☐	☐	Preadmission Assessment (0040) – prior to admission. (Look at residents admitted in last six months.)
☐	☐	☐	Comprehensive Assessment (0070) – 14 days from admission
☐	☐	☐	Ongoing Comprehensive Assessment (0080) – significant change or every 180 days

NOTES

Monitoring Resident's Well-Being

YES	NO	N/A	
☐	☐	☐	Documented
☐	☐	☐	Action taken as needed

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Person-Centered Service Plan (PCSP)

YES	NO	N/A	
☐	☐	☐	Initial PCSP (0110) – prior to admission. (Look at residents admitted in last six months.)
☐	☐	☐	Initial Comprehensive PCSP (0120) – 14 days from admission
☐	☐	☐	Ongoing Comprehensive PCSP (0130)
☐	☐	☐	Monthly Plan Reviews by PCSP team (0100)
☐	☐	☐	Updated as necessary – resident needs, resident request, following CARE assessment, or every 180 days
☐	☐	☐	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), MHP, 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

Medication Services: ☐ Independent ☐ Administration

YES	NO	N/A	
☐	☐	☐	Facility
☐	☐	☐	Appropriate for resident abilities and needs
☐	☐	☐	Review of medication record
☐	☐	☐	Documentation of refusal (if applicable) (0350, 0360)

NOTES

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Modified / Therapeutic Diet

YES	NO	N/A	
☐	☐	☐	Receiving Food Services as ordered
☐	☐	☐	Receiving eating assistance

NOTES

Notes: Resident Record Review

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Staff and Administration Record Review

Attachment I

PROVIDER / LICENSEE'S NAME

STAFF	ADMINISTRATOR	STAFF A (NEW)	STAFF B (NEW)	STAFF C (NEW)	STAFF D (>TWO YEARS)	STAFF E (>TWO YEARS)
NAME						
DATE OF BIRTH						
DATE OF HIRE*						
BGI EXPIRE DATE*						
FINGERPRINT CHECK	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING	☐ N/A ☐ PENDING
CCS EVALUATION*	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
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 PER WAC 388-112A-0090 AND 388-107-0630**	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT	☐ EXEMPT
FIRST AID / CPR						
TRAINING BY PHARMACIST						
FOOD SAFETY / HANDLER						
THREE (3) HOURS OF CE PER QUARTER (ALL STAFF)						

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

** 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.

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LIABILITY INSURANCE (WAC 388-107-1110)	PROFESSIONAL LIABILITY INSURANCE (WAC 388-107-1130)
Expiration date:	Expiration date:

SPECIALTY TRAINING ESF ADMINISTRATOR	TRAINING NOT AVAILABLE AT THIS TIME					
DEMENTIA*						
MENTAL HEALTH*						
DE-ESCALATION*						
☐ **N/A** **DDA***						

TB TESTING REVIEW FOR STAFF

STAFF	ADMINISTRATOR	STAFF A	STAFF B	STAFF C	STAFF D	STAFF E
DATE TESTED						
TYPE OF TEST	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	
DATE FIRST READ						
RESULT	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE
INDURATION IF TST	MM	MM	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	☐ N/A, NOT TST	☐ N/A, NOT TST
DATE SECOND READ						
RESULT	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE	☐ POSITIVE ☐ NEGATIVE
INDURATION IF TST	MM	MM	MM	MM	MM	MM
CHEST X-RAY	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

* TST = Tuberculin Skin Test; IGRA = Interferon Gamma Release Assays.

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PET RECORDS	IF MORE THAN THREE (3), PLEASE DOCUMENT REMAINDER IN NOTES
PET 1	
PET 2	
PET 3	

ADMINISTRATIVE RECORDS REVIEW – BACKGROUND CHECKS / FORMER STAFF

Instructions: Document background check results for former staff here.

STAFF	STAFF G	STAFF H	STAFF I	STAFF J	STAFF L	STAFF M	STAFF N
NAME							
DATE OF HIRE							
DATE OF BIRTH							
BGI EXPIRE DATE							
FINGERPRINT CHECK	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
CCS EVALUATION	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

NOTES: STAFF AND ADMINISTRATIVE RECORD REVIEW

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ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Notes / Worksheets

Attachment K

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Exit Preparation Worksheet

Attachment L

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

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

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Food Service Observations and Interviews

Attachment M

Food Service must meet the requirements of WAC Food Code Chapter 246-215 and WAC 388-107-0430 and WAC 388-107-0920

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

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

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

- ☐ Overall cleanliness of kitchen area (06505)
- ☐ 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 stored with proper temperature controls (for example, no potentially hazardous foods, such as beef, chicken, pork thawing at room temperature) (03510)
- ☐ Food from approved sources (03200) (for example, food from known providers, no home prepared items)
- ☐ No ill food workers present (02220)
- ☐ 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)
- ☐ Person in charge or designee describes proper dishwashing procedure that follow manufacture guidelines for temperature or chemical controls (04555, 04560)
- ☐ Person in charge or designee describes step taken to prevent cross-contamination of food items (03306)

NOTES

Food Preparation and Service: Observe for proper food preparation, thawing of frozen items, areas used for food preparation, and proper temperature controls, for example.

- ☐ Person in charge or designee describes how food contact surfaces are thoroughly cleaned / rinsed / sanitized (washing, 04645 rinsing, 04700 sanitization)
- ☐ Person in charge describes process to check food temperatures
- ☐ Person in charge or designee identifies proper cooking time and temperatures for potentially hazardous foods (for example, poultry 165°F, ground meat at least 155°F, fish and other meats 145°F)
- ☐ Person in charge or designee describes how food items are properly reheated (03400)
- ☐ No bare hand contact with ready to eat foods, except during the washing of fruits and vegetables (03300)

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

- ☐ Proper hand hygiene and glove use (see above)
- ☐ Fruits and vegetables are thoroughly rinsed (washed) (03318)
- ☐ Hot foods help at ≥135°F prior to serving (03525) (facility can check food temperature in your presence or you can check temperature of food with your sanitized thermometer)
- ☐ Hot foods help at ≥41°F prior to serving (03525) (facility can check food temperature in your presence or you can check temperature of food with your sanitized thermometer)

NOTES

Food Storage: Observe for food storage to prevent contamination and to promote proper temperature controls.

- ☐ Store rooms free from rodents and pests (06550)
- ☐ Refrigerator temperature is maintained at ≥41°F (internal temperature of potentially hazardous food must be at ≥41°F) (03525)
- ☐ Foods are frozen in freezer (no specific temperature requirement) (03500)
- ☐ Raw meats stored below or away from ready to eat food (03306)
- ☐ Potentially hazardous foods are properly cooled (within two hours 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)

NOTES

Menus: Review current and past menus.

- Menus (0430)
  - ☐ Written one week in advance
  - ☐ Delivered to resident's room or posted except as specified in 0430(1)(h)
  - ☐ Indicate the date, day of week, month, and year
  - ☐ Include all food and snacks served that contribute to nutritional requirements
  - ☐ Are kept at least six months
  - ☐ Provide variety
  - ☐ Are not repeated for at least three weeks, except breakfast as outlined in (1)(i)(vii)

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- ☐ 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 the alternate entrees must be recorded on the menu (1)(i)

NOTES

Meals and Snacks: Observe meal time and during interviews and facility tour ensure the following.

- 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)
  - ☐ Alternate choices for entrees are available
  - ☐ Are nutritious, meets the residents' dietary needs
  - ☐ Are palatable and served at proper temperature (if issues with food palatability temperature and/or palatability, consider obtaining a meal sample)

NOTES

- 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)

ESF Inspection Packet

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NOTES

- Dining Observation:

☐ 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	INSPECTION DATE	LICENSOR'S NAME

ESF Medication Pass Worksheet

Attachment N

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

This form is completed only after 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:			

ESF Inspection Packet

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ADDITIONAL NOTES

ENHANCED SERVICES FACILITY NAME	LICENSE NUMBER	INSPECTION DATE	LICENSOR'S NAME

ESF Staff Schedule Worksheet

Attachment O

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint:

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).

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

Was a 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	INSPECTION DATE	LICENSOR'S NAME

ESF Staff Schedule Worksheet: 8-hour Shifts

Attachment O[2]

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	INSPECTION DATE	LICENSOR'S NAME

ESF Staff Schedule Worksheet: 12-hour Shifts

Attachment O[3]

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																				