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|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ENHANCED SERVICES FACILITY (ESF)  **ESF Request for Documentation** | | | | Attachment B |
| ENHANCED SERVICES FACILITY NAME | | | LICENSE NUMBER | ENTRANCE DATE | |
| LICENSOR’S NAME | | Inspection Type:  Full | | | |
| **The field office has contacted the Ombuds.**  NAME TIME  Copy of form provided to:  at | | | | | |
| **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](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=15-574&title=). | | | | | |
| **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** | | | | | |
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