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

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

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

CURRENT EXEMPTIONS

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

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 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.

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

Notes: Request for Documentation	**Attachment B**

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

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

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

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

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ESF Resident Characteristic Roster and Sample Selection

Attachment D

TOTAL CENSUS	Visit Type: ☐ Full ☐ Follow up ☐ Complaint

ESIDENT 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

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

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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

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.
	Mark the box:
Pay Status: Private = **P** State = **S**	**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

ESF Inspection Packet

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

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

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 Resident Review

Attachment E

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

BRIEF REVIEW OF PERSON CENTERED SERVICE PLAN

The questions in Sections B through K below are intended as a guide and should not prevent the interview from asking more questions or obtaining more data if concerns are identified. If you are concerned about the answers, please investigate further.

SELECT ONE

☐ **Resident Interview** ☐ **Representative Interview**

A. The following are **required** questions and **must** be asked 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.

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

B. Care and Service Needs

☐ What kind of help do you get from the staff?	☐ Other:
☐ How well does staff meet your needs?	☐ No concerns

ESF Inspection Packet

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

C. Support of Personal Relationships (if the resident has family or significant others)	
☐ Does staff give you time and space to meet / visit with friends and family who come to visit? ☐ Are you able to make personal phone calls without being overheard?	☐ Other: ☐ No concerns
D. Reasonable House Rules	
☐ Tell me about the rules of the facility. ☐ What have you been told about how long you can stay up at night or how early or late you can watch TV?	☐ Other: ☐ No concerns
E. Respect of Individuality, Independence, Personal Choice, Dignity	
☐ Does the staff here know about your preferences? ☐ What kinds of things do you make choices about? ☐ How does the staff treat you? Speak to you? ☐ Do you have any concerns about how you are treated?	☐ Other: ☐ No concerns
F. Homelike Environment	
☐ What is your room like? ☐ Are you comfortable there? ☐ What personal items were you allowed to bring when you came here? ☐ Is the temperature here comfortable to you?	☐ Other: ☐ No concerns
G. Response to Concerns	
☐ Do you feel like you can tell someone if you don't like it here? ☐ Who would you talk to if you had concerns? ☐ What do you think they would do about it?	☐ Other: ☐ No concerns
H. Sense of Well-Being and Safety	
☐ Do you feel safe here? ☐ Does anything make you feel uncomfortable here?	☐ Other: ☐ No concerns

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

I. Meals / Snacks / Preferences	
☐ How is the food here? ☐ If you can't eat something or don't like something, what kind of replacement does the home offer you? ☐ How often do you get the foods you like to eat?	☐ Other: ☐ No concerns
J. Activities	
☐ What activities are offered to you by the facility? ☐ What kinds of things did you do for fun and relaxation before you came here? ☐ Are there activities you would like to do that you are not offered? ☐ Is there anything you wanted to do and the facility helped you do it?	☐ Other: ☐ No concerns
K. Notice	
☐ Do you handle your own finances or does someone help you with that?	☐ Other: ☐ No concerns

Provide the resident with the CRU Hotline Information.

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 Other Contact Interview

Attachment F

Visit 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	

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

NOTES

Notes: Other Contact Interview **Attachment F**

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

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

ESF Environmental Observations

Attachment G

Visit Type: ☐ Full ☐ Follow up ☐ Complaint

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 75º 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)
- ☐ ☐ Safe water temperature in resident rooms and sinks utilized by residents (0970)
- ☐ ☐ Cleanliness of resident equipment maintained in good repair (0170)

NOTES

YES NO **Safety**

- ☐ ☐ Prevention of resident access to storage of:
  - Cleaning supplies
  - Cleaning carts
  - Storage closet
  - Toxic materials
  - Medication

ESF Inspection Packet

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

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

NOTES

ESF Inspection Packet

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

NOTES

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

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.

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 Other Resident Record Review

Attachment H

Visit Type: ☐ Full ☐ 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

NOTES

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

ESF Inspection Packet

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

☐ ☐ ☐ 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

Modified / Therapeutic Diet

YES NO N/A

☐ ☐ ☐ Receiving Food Services as ordered
☐ ☐ ☐ Receiving eating assistance

NOTES

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

Notes: Resident Record Review

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 Staff and Administration Record Review

Attachment I

PROVIDER / LICENSEE'S NAME

STAFF	ADMINISTRATOR	STAFF A	STAFF B	STAFF C	STAFF D	STAFF E	STAFF F
NAME							
DATE OF HIRE							
DATE OF BIRTH							
BGI EXPIRE DATE							
FINGERPRINT CHECK (IF NOT REQUIRED, MARK N/A)	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
CCS EVALUATION (IF NOT REQUIRED, MARK N/A)	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
ORIENTATION TO THE FACILITY							
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	☐ EXEMPT
FIRST AID / CPR							
TRAINING BY PHARMACIST							
DOH TYPE							
EXPIRATION DATE							
FOOD SAFETY / HANDLER							
12 HOURS CONTINUING EDUCATION							
THREE (3) HOURS OF CE PER QUARTER (ALL STAFF)							
Liability Insurance (WAC 388-107-1110)			**Professional Liability Insurance (WAC 388-107-1130)**				

B

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

Expiration date:	Expiration date:

Pharmacy Services (WAC 388-107-0330)
(4)(a) Education and training for enhanced services facility staff by the licensed pharmacist on medication-related subjects;
Date of last training:

SPECIALTY TRAINING ESF ADMINISTRATOR	TRAINING NOT AVAILABLE AT THIS TIME	[redacted]					
DEMENTIA*							
MENTAL HEALTH*							
DDA*							
DE-ESCALATION*							

* 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.

TB TESTING							
STAFF	ADMINISTRATOR	STAFF A	STAFF B	STAFF C	STAFF D	STAFF E	STAFF F
DATE TESTED AND TYPE OF TEST	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA	DATE: TYPE: ☐ TST ☐ IGRA
DATE FIRST READ AND RESULT. IF TESTING METHOD IS TST, RECORD MM OF INDURATIN.	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM
SECOND TEST (TST ONLY): DATE OF SECOND TEST	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
DATE SECOND READ AND RESULT.	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM	DATE: RESULT: ☐ POSITIVE ☐ NEGATIVE INDURATION: MM
COVID VACCINATION STATUS							
STAFF	ADMINISTRATOR	STAFF A	STAFF B	STAFF C	STAFF D	STAFF E	STAFF F
VACCINATED	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

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

EXEMPT (IF YES ABOVE, THIS AUTOMATICALLY BECOMES N/A)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

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 (IF NOT REQUIRED, PUT N/A)	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
CCS EVALUATION (IF NOT REQUIRED, MARK N/A)	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

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

Notes: Staff and administrative Record Review

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 Notes / Worksheets

Attachment K

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint

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

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 Exit Preparation Worksheet

Attachment L

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint

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

Washington State Department of Social & Health Services
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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

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

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 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 165ºF, ground meat at least 155ºF, fish and other meats 145ºF)
- ☐ Person in charge or designee describes how food items are properly reheated (03400)

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

☐ No bare hand contact with ready to eat foods, except during the washing of fruits and vegetables (03300)
☐ Proper hand hygiene and glove use (see above)
☐ Fruits and vegetables are thoroughly rinsed (washed) (03318)
☐ Hot foods help at ≥135ºF 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 ≥41ºF 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 ≥41ºF (internal temperature of potentially hazardous food must be at ≥41ºF) (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 135ºF to 70ºF and then to ≥41ºF 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 ≥41ºF 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

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

- ☐ 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 this 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)

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

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

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 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:			

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

ADDITIONAL NOTES

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

ESF Staff Schedule Worksheet

Attachment O

Inspection Type: ☐ Full ☐ 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)

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

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)

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

If an ESF serves on 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.

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).

Look at prior two-week staffing schedule.

Number of residents in home:

Minimum staffing level per shift:

Facility Shift Schedule:

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

Licensed Nurses Staffing Levels

STAFF NAME AND TITLE	SHIFT	DATES
LPN OR RN		
ON CALL RN		

ESF Inspection Packet

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

Mental Health Professionals (MHPs) Staffing Levels		
STAFF NAME AND TITLE	SHIFT	DATES
ON CALL MHP		
Caregivers and Other Staff Staffing Levels		
STAFF NAME AND TITLE	SHIFT	DATES

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

NOTES

ESF Staff Schedule Worksheet

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

12 AM	1 AM	2 AM	3 AM	4 AM	5 AM	6 AM	7 AM	8 AM	9 AM	10 AM	11 AM	COMMENT
12 PM	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM	7 PM	8 PM	9 PM	10 PM	11 PM	COMMENT

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

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12 PM	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM	7 PM	8 PM	9 PM	10 PM	11 PM	COMMENT

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

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12 PM	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM	7 PM	8 PM	9 PM	10 PM	11 PM	COMMENT

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

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Washington State Department of Social & Health Services
Transforming lives

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

ESF Inspection Packet

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