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|  | RESIDENTIAL CARE OFFSITE SURVEY PREPARATION State Form 53722 (R / 4-21)  INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE | | |
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| Name of facility | | | Facility number |
| Address of facility *(number and street, city, state, and ZIP code)* | | | |
| Name of ombudsman | | Identification number of ombudsman | Date of ombudsman contact *(month, day, year)* |
| Total number of beds | | Date of offsite review *(month, day, year)* | Beginning date of survey *(month, day, year)* |
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| **SURVEYOR NOTES** | | | |
| *List potential facility areas of concern and any potential residents to be reviewed during the survey. List any current complaints to be investigated onsite.* | | | |
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| **SURVEYORS / DISCIPLINE** | | | |
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