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|  | | | RESIDENTIAL CARE EXIT CONFERENCE CHECKLIST AND ATTENDANCE RECORD State Form 53739 (R / 4-21)  INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE | | | |
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| Name of facility | | | | Facility number | | |
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|  | Reintroduce survey team members. | | | | | |
|  | State that this is an exit conference and identify the type of survey, i.e., annual licensure, complaint, etc. If any complaints were investigated during the survey, give the complaint numbers. | | | | | |
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|  | Complete the information at the top of the Residential Exit Conference Record and ask that each person print their name, title, and sign their name. *(The Administrator or person in charge from facility may sign for everyone in attendance.)* | | | | | |
| **State the Following:** | | | | | | |
|  |  | The confidentiality of all resident will be maintained throughout this conference by using Resident identifier numbers.  *(You have a copy of the identifier list for your reference.)* | | | | |
|  |  | **For complaints only** – The confidentiality of all residents will be maintained throughout this exit conference. Because this is a complaint investigation, you will not be provided a copy of the resident identifier list. We do this inform to comply with state law IC 16-28-4-5, which requires us to protect the identity and privacy of the complainant. | | | | |
|  |  | Thank you for your cooperation and assistance. | | | | |
|  |  | The purpose of this exit conference is to inform you of the survey team’s (my) observations and preliminary findings. If you have any question or additional information you feel is pertinent to the identified findings, please present at the end of the exit conference. | | | | |
| **With Findings State:** | | | | | | |
|  |  | Review all preliminary licensure findings, by giving enough example for each area to allow the facility the ability to clearly understand the concern. If during the survey, this concern was shared with other staff, please identify who and what was shared, i.e., Food service concerns were shared with the Food Service manager in detail on *(date)*. | | | | |
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|  |  | Within ten (10) business days, the Division of Long-Term Care will e-mail you a message direction you to the ISDH Survey Report System.  The following can be reviewed on the ISDH Gateway.   * The survey report (2567) that contains the written official deficiencies. * Guidelines for writing an acceptable Plan of Correction; due date of the Plan of Correction, which must be after the survey exit date.   The Plan of Correction is the day you expect to have all the deficiencies corrected. Some deficiencies should be corrected immediately or as soon as possible. It is suggested the deficiencies be corrected within thirty (30) days.   * Information regarding the Informal Dispute Resolution (IDR). | | | | |
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|  |  | Are there any questions or additional information you would like to provide for review? | | | | |
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| **Without Findings State:** | | | | | | |
|  |  | Within ten (10) business days, the Division of Long-Term Care will e-mail you a message direction you to the ISDH Survey Report System.  The survey report 2567 and corresponding letter stating you are in substantial compliance can be viewed on the ISDH Gateway. | | | | |

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|  | RESIDENTIAL CARE EXIT CONFERENCE ATTENDANCE RECORD Part of State Form 53739 (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)* | | | | | | |
| Date *(month, day, year)* and time of exit conference | | | Ombudsman present?  Yes  No | | | Resident(s) present?  Yes  No |
|  | | | | | | |
| **PRINTED NAME OF ATTENDEE** | | **TITLE** | | **SIGNATURE** | | |
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| **AREAS OF CONCERN COMMUNICATED TO THE FACILTIY** | | | | | | |
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| **QUESTIONS / CONCERNS** | | | | | | |
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