RESIDENTIAL CARE SURVEYOR NOTES

State Form 53716 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of surveyor	Identification number of surveyor	Date(s) of survey *(month, day, year)*
Primary diagnosis		

STATE RULES	DOCUMENTATION

RESIDENTIAL CARE SURVEYOR NOTES *(continued)*

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STATE RULES	DOCUMENTATION