SKILLED NURSING FACILITY (SNF)

FACILITY		**OMBUDSMAN**	
FACILITY ADDRESS		**TOTAL RESIDENTS**	
DATE		**TOTAL VACANCIES**	

	YES	NO		YES	NO		YES	NO
ROUTINE VISIT			**WITNESSED AHCD**			**EMERGENCY GENERATOR** (REQUIRED)		
COMPLAINT VISIT			**PARTICIPATED SURVEY**			**EVACUATION PLAN** (REQUIRED)		
ATTENDED CARE PLAN MEETINGS			**ATTENDED RESIDENT OR FAMILY COUNCILS**			**DID EXIT INTERVIEW WITH:** _____		

OBSERVATIONS	SATISACTORY	UNSATISFACTORY	COMMENTS
QUALITY OF CARE			
CONDITION OF PHYSICAL PLANT			
NUTRITION/FOOD SERVICE			
SANITATION			
ACTIVITIES			
GENERAL ATMOSPHERE			
CALL LIGHTS ANSWERED IN TIMELY MANNER			
MEDICATION CARTS LOCKED WHEN NOT ATTENDED BY STAFF			
RESTRAINTS			

- **Bulleted Comments:**

COMPLAINTS

Resident Name	Complaint Handled	Rm#