Pre-Survey Checklist

STATE EVALUATION: ASSISTED LIVING PROVIDERS (144G)

Provider Information

Provider: HFID:

License Type:

Issued: Expired: Capacity:

Facility Address:

Business Address (if different):

Phone:

County #: District #:

Agent: Email:

CNS/RN: Email:

LALD: Email:

☐ LALD listed as Director of Record on BELTSS?

Date notification to MDH of providing services (within 2 days of start of services):

☐ Website address/reviewed:

Comments:

☐ Advertising/social media reviewed:

Comments:

Survey Information

Team Member(s):

Projected entrance date:

Survey project #:

Complaint #:

ACO #:

Follow up #1: Follow up #2:

Previous Surveys

Date of previous survey:

Correction orders issued:

Date(s) of follow up survey(s):

Status of correction orders upon follow up:

Complaint investigations:

Results:

Ombudsman Notification

☐ Email Ombudsman for Long Term Care

Contact: Date:

Comments:

☐ Email Ombudsman for Mental Health and Developmental Disabilities

Contact: Date:

Comments:

Minnesota Department of Health
Health Regulation Division
PO Box 3879
St. Paul, MN 55101-3879
651-201-4200
health.assistedliving@state.mn.us
www.health.state.mn.us

12/21/2022

To obtain this information in a different format, call: 651-201-4200.