LTC NHSN Survey for Pennsylvania

1. Demographics
   a. NHSN Facility ID: [please enter your NHSN number if you have it; leave blank otherwise]
   b. CMS Certification Number (CCN): [please enter your CMS Certification Number]
   c. Facility Name: [Please select your facility name from the list]
   d. Date for which responses are reported: [enter the date for which you are reporting data – should be today’s date]

2. Resident Impact and Facility Capacity
   a. Resident Impact
      i. ADMISSIONS: Residents admitted or readmitted who were previously hospitalized and treated for COVID-19: [enter the total number of COVID-19 positive individual who were admitted or readmitted from a hospital back into your facility since January 1, 2020]
      ii. CONFIRMED: Residents with new laboratory positive COVID-19: [enter the total number of residents who have tested positive in your facility since January 1, 2020, regardless of where they acquired the disease]
      iii. SUSPECTED: Residents with new suspected COVID-19: [enter the total number of COVID-19 positive individual who have been suspected of being COVID-19 positive since January 1, 2020. This number may go down if lab results return and confirm either COVID-19 positive or negative.]
      iv. TOTAL DEATHS: Residents who have died in the facility or another location: [enter the total number of deaths, regardless of where they died, of residents in your facility since January 1, 2020]
      v. COVID-19 DEATHS: Residents with suspected or laboratory positive COVID-19 who died in the facility or another location: [enter the total number of deaths, regardless of where they died, of residents in your facility who have COVID-19 since January 1, 2020]

   b. Facility Capacity and Laboratory Testing
      i. ALL BEDS: [enter the current number of licensed beds]
      ii. CURRENT CENSUS: Total number of beds that are currently occupied [enter the current census/occupied beds]
      iii. TESTING: Does your facility have access to COVID-19 testing while the resident is in the facility? [Yes/No]
      iv. If YES, what laboratory type? Select all that apply. [select from the 3 check boxes below]
         1. State health department lab
         2. Private lab (hospital, corporation, academic institution)
         3. Other

3. Staff and Personnel Impact
   a. CONFIRMED: Staff and facility personnel with new laboratory positive COVID-19 [enter the total number of staff who have tested positive in your facility since January 1, 2020]
b. **SUSPECTED**: Staff and facility personnel with new suspected COVID-19 who are being managed as though they have it [enter the total number of staff who are being treated as if they have COVID-19, but have not been tested, in your facility since January 1, 2020]

c. **COVID-19 DEATHS**: Staff and facility personnel with new suspected or laboratory positive COVID-19 who died [enter the total number of deaths of staff in your facility who have COVID-19 since January 1, 2020]

d. Does your organization have a shortage of staff and/or personnel?
   i. **Nursing Staff**: registered nurse, licensed practical nurse, vocational nurse [yes/no]
   ii. **Clinical Staff**: physician, physician assistant, advanced practice nurse [yes/no]
   iii. **Aide**: certified nursing assistant, nurse aide, medication aide, and medication technician [yes/no]
   iv. **Other staff or facility personnel**, regardless of clinical responsibility or resident contact not included in the categories above (for example, environmental services) [yes/no]

4. Supplies and Personal Protective Equipment – for each supply item answer the following
   a. **N95 Masks**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]
   b. **Surgical masks**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]
   c. **Eye protection, including face shields or goggles**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]
   d. **Gowns**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]
   e. **Gloves**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]
   f. **Alcohol-based hand sanitizer**
      i. Do you currently have any supply? [yes/no]
      ii. Do you have enough for one week? [yes/no]

5. Ventilator Capacity and Supplies
   a. Do you have ventilator dependent unit(s) and/or beds in your facility? [yes/no]
   b. **MECHANICAL VENTILATORS**: Total number available in your facility [number]
   c. **MECHANICAL VENTILATORS IN USE**: Total number of mechanical ventilators in use for residents who have suspected or laboratory positive COVID-19 [number]
   d. **Ventilator supplies** (any, including tubing)
      i. Do you currently have any supply? [yes/no]
ii. Do you have enough for one week? [yes/no]