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]