NATIONAL HEALTHCARE
SAFETY NETWORK
NHSN

OMB Approved
OMB No. 0920-1317
Exp. Date 1/31/2024
www.cdc.gov/nhsn

COVID-19 Module
Long Term Care Facility: Resident Impact and Facility Capacity

Page 1 of 2	*Required to save; **Conditional

NHSN Facility ID:	CMS Certification Number (CCN):

Facility Name:	Facility Type:

*Date for which counts/responses are reported:_____/____/_____   *Date Created:_____/____/_____

*Counts should be reported on the correct calendar day and include only the new counts for the calendar day (specifically, since counts were last collected). If the count is zero, a "0" must entered as the response. A blank response is equivalent to missing data. **NON**-count questions should be answered one calendar day during the reporting week.*

Facility Capacity	
	**ALL BEDS (*enter on first survey only, unless the total bed count has changed*)
	*CURRENT CENSUS: Total number of beds that are occupied on the reporting calendar day

Resident Impact for COVID-19 (SARS-CoV-2)	
	ADMISSIONS: Number of residents admitted or readmitted from another facility who were previously diagnosed with COVID-19 and continue to require transmission-based precautions. *Excludes* recovered *residents*.
	POSITIVE TESTS (*previously called "Confirmed"*)**:** Number of residents newly positive for COVID-19 based on a viral test result.
	TEST TYPE: Based on the number of reported *Positive Tests*, indicate how many were tested using each of the following: _____**Positive SARS-CoV-2 antigen test only** [no other testing performed] _____****Positive SARS-CoV-2 NAAT (PCR) only** [no other testing performed] _____****$^{\pm}$Positive SARS-CoV-2 antigen test and** negative SARS-CoV-2 NAAT (PCR) _____****$^{\pm}$Any other combination of SARS-CoV-2 NAAT (PCR) and/or antigen test(s) with at least one positive test $^{\pm}$ Only include if the two tests were performed **within 2 days of each other**. Otherwise, count first test only. **Important:** The total for *Test Type* should equal the total for *Positive Tests*
	CALCULATED TOTAL CONFIRMED (*not editable by user*):
	** VACCINATION STATUS: For positives in each test type category, indicate how many residents received COVID-19 vaccination before the positive test: **Positive SARS-CoV-2 antigen test only [no other testing performed]:** ☐ Not vaccinated with COVID-19 vaccine: _____ ☐ Pfizer-BioNTech COVID-19 vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____ ☐ Moderna vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____

OMB Approved
OMB No. 0920-1317
Exp. Date 1/31/2024
www.cdc.gov/nhsn

NHSN
NATIONAL HEALTHCARE
SAFETY NETWORK

| Page 2 of 3 | *Required to save; **Conditional |

Positive SARS-CoV-2 NAAT (PCR) only [no other testing performed]:

☐ Not vaccinated with COVID-19 vaccine: _____

☐ Pfizer-BioNTech COVID-19 vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____

☐ Moderna vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____

Any other combination of SARS-CoV-2 NAAT (PCR) and/or antigen test(s) with at least one positive test:

☐ Not vaccinated with COVID-19 vaccine: _____

☐ Pfizer-BioNTech COVID-19 vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____

☐ Moderna vaccine: Only 1 dose: _____; Dose 1 and dose 2: _____

_____**RE-INFECTIONS:** Based on the number of reported *Positive Tests*, indicate how many met NHSN definition for re-infection.

_____**SYMPTOMATIC:** Based on the number of reported *Re-Infections*, indicate how many had signs and/or symptoms consistent with COVID-19.

_____**ASYMPTOMATIC:** Based on the number of reported *Re-Infections*, indicate how many did **not** have signs and/or symptoms consistent with COVID-19.

TOTAL DEATHS: Number of residents who have died *for any* reason in the facility or another location:_____

_____**COVID-19 DEATHS:** Based on the number of reported *Total Deaths*, indicate the number of residents with COVID-19 who died in the facility or another location.

Resident Impact for Non-COVID-19 (SARS-CoV-2) Respiratory Illness

INFLUENZA: Number of Residents with new influenza (flu).

RESPIRATORY ILLNESS: Number of Residents with acute respiratory illness symptoms, excluding COVID-19 and/or influenza (flu).

Resident Impact for Co-Infections

INFLUENZA and COVID-19: Number of residents with a confirmed co-infection with influenza (flu) and SARS-CoV-2 (COVID-19).

Since the last date of data entry in the Module, has your LTCF performed SARS-CoV-2 (COVID-19) viral testing? ☐ YES ☐ NO

** If YES, indicate counts of COVID-19 viral testing that were performed:

_____**POCRESIDENT:** Since the last date of data entry in the Module, how many COVID-19 point-of-care tests has the LTCF performed on residents?

_____**POCSTAFF:** Since the last date of data entry in the Module, how many COVID-19 point-of-care tests has the LTCF performed on staff and/or facility personnel?

_____**NONPOCRESIDENT:** Since the last date of data entry in the Module, how many COVID-19 NON point-of-care tests has the LTCF performed on residents?

_____**NONPOCSTAFF:** Since the last date of data entry in the Module, how many COVID-19 NON point-of-care tests has the LTCF performed on staff and/or facility personnel?

OMB Approved
OMB No. 0920-1317
Exp. Date 1/31/2024
www.cdc.gov/nhsn

SARS-CoV-2 TESTING

During the past two weeks, on average how long did it take your LTCF to receive SARS-CoV-2 (COVID-19) viral test results from NON point-of-care tests? (Check one)

☐ Less than one day
☐ 1-2 days
☐ 3-7 days
☐ More than 7 days
☐ No testing performed in the past two weeks on residents or staff and/or facility personnel

TESTINGSTAFF: Does the LTCF have the ability to perform or to obtain resources for performing SARS-CoV-2 viral testing (NAAT [PCR] or antigen) on all staff and facility personnel within the next 7 days, if needed?

TESTINGRESIDENT: Does the LTCF have the ability to perform or to obtain resources for performing SARS-CoV-2 viral testing (NAAT [PCR] or antigen) on all current residents within the next 7 days, if needed?