

## Patient Safety Component—Annual Facility Survey for IRF

Instructions for this form are available at: <http://www.cdc.gov/nhsn/forms/instr/TOI-57.151-IRF.pdf>

\*required for saving

Tracking #:

Facility ID:

\*Survey Year:

### Facility Characteristics (completed by Infection Preventionist)

\*Ownership (check one):

For profit

Not for profit, including church

Government

Veterans Affairs

\*Affiliation (check one):

Hospital System

Independent

Multi-facility organization (specialty hospital network)

\*How would you describe your licensed inpatient rehabilitation facility? (check one)

Free-standing

Healthcare facility based

In the previous calendar year, indicate the following counts for the Rehabilitation Facility:

\*Total number of rehab beds: \_\_\_\_\_

\*Average daily census: \_\_\_\_\_

\*Number of patient days: \_\_\_\_\_

\*Average length of stay: \_\_\_\_\_

\*Indicate the number of admissions with the primary diagnosis for each of the following rehabilitation categories (*must sum to the total number of admissions listed below*)

a. Traumatic spinal cord dysfunction: \_\_\_\_\_

b. Non-traumatic spinal cord dysfunction: \_\_\_\_\_

c. Stroke: \_\_\_\_\_

d. Brain dysfunction (non-traumatic or traumatic): \_\_\_\_\_

e. Other neurologic conditions (for example, multiple sclerosis, Parkinson's disease, etc.): \_\_\_\_\_

f. Orthopedic conditions (incl. fracture, joint replacement, other): \_\_\_\_\_

g. All other admissions: \_\_\_\_\_

\*Total number of admissions: \_\_\_\_\_

\*Number of admissions on a ventilator: \_\_\_\_\_

\*Number of pediatric ( $\leq 18$  years old) admissions: \_\_\_\_\_

### Facility Microbiology Laboratory Practices (completed with input from Microbiology Laboratory Lead)

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- \*1. Does your facility have its own on-site laboratory that performs antimicrobial bacterial susceptibility testing?  Yes  No
- 1a. If No, where is your facility's antimicrobial susceptibility testing performed? (check one)
- Affiliated medical center  Commercial referral laboratory  Other local/regional, non-affiliated reference laboratory
- 1b. If Yes, do you also send out any antimicrobial susceptibility testing (check one)  Yes  No
- \*2. For the following organisms, indicate which methods are used for:
- (1) Primary susceptibility testing and  
(2) Secondary, supplemental, or confirmatory testing (if performed).

**Facility Microbiology Laboratory Practices (continued)**

If your laboratory does not perform susceptibility testing, indicate the methods used at the outside laboratory.  
Use the testing codes listed below the table.

Pathogen	(1) Primary	(2) Secondary	Comments
<i>Enterobacteriales</i>	_____	_____	_____
<i>Pseudomonas aeruginosa</i>	_____	_____	_____
<i>Acinetobacter baumannii</i> complex	_____	_____	_____

1 = Kirby-Bauer disk diffusion    4 = Sensititre    7 = Agar dilution method  
2 = Vitek (Legacy)    5.1 = MicroScan WalkAway    10 = Gradient Dilution Strip (for example E test)  
2.1 = Vitek 2    5.2 = MicroScan autoSCAN    13 = Other (describe in Comments section)  
3.1 = BD Phoenix    6 = Other broth microdilution method

- \*3. Does either the primary of secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply):

Drug	Organism tested:		
	<i>Enterobacteriales</i>	<i>Pseudomonas aeruginosa</i>	<i>Acinetobacter baumannii</i>
Cefiderocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftazidime-Avibactam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftolozane-Tazobactam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colistin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Delafloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eravacycline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imipenem-Relebactam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meropenem-Vaborbactam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- \*4. Has the laboratory implemented revised breakpoints recommended by CLSI for the following:
- a. Third Generation Cephalosporin and monobactam (that is, aztreonam) breakpoints for *Enterobacteriales* in 2010  Yes  No
  - b. Carbapenem breakpoints for *Enterobacteriales* in 2010  Yes  No
  - c. Ertapenem breakpoints for *Enterobacteriales* in 2012  Yes  No
  - d. Carbapenem breakpoints for *Pseudomonas aeruginosa* in 2012  Yes  No
  - e. Fluroquinolone breakpoints for *Pseudomonas aeruginosa* in 2019  Yes  No
  - f. Fluroquinolone breakpoints for *Enterobacteriales* in 2019  Yes  No
- \*5. Does the laboratory test bacterial isolates for presence of carbapenemase? (this does not include automated testing instrument expert rules)  Yes  No
- 5a. If Yes, indicate what is done if carbapenemase production is detected: (check one)
- Change susceptible carbapenem results to resistant

**Facility Microbiology Laboratory Practices (continued)**

- Report carbapenem MIC results without an interpretation
- No changes are made in the interpretation of carbapenems, the test is used for epidemiological or infection control practices

5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

- NAAT (for example, PCR)       MLB Screen       mCIM/CIM
- Modified Hodge Test       Carba NP       CARBA 5
- Rapid CARB Blue       Cepheid, BioFire, Verigene, Genmark, etc.
- E test       Other (specify): \_\_\_\_\_

5c. If Yes, which of the following are routinely tested for the presence of carbapenemases: (check all that apply)

- Enterobacteriales* spp.       *Pseudomonas aeruginosa*       *Acinetobacter baumannii*

- \*6. Does your facility use commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections? Examples of commercially available systems include BioFire FilmArray, Luminex Verigene, etc.
- Yes

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- No [if checked, skip questions 7 and 8]

6a. If Yes, which test panel(s) does your facility use? (check all that apply)

- Accelerate PhenoTest BC       BioFire FilmArray BCID       BioFire FilmArray BCID II  
 Cepheid Xpert MRSA/SA BC       GenMark ePlex BCID-GP       GenMark ePlex BCID-GN  
 GenMark ePlex BCID-FP       Luminex Verigene BC-GP       Luminex Verigene BC-GN  
 MALDI-TOF MS directly from positive blood culture (e.g., Sepsityper)  
 MALDI-TOF MS based antimicrobial resistance detection  
 T2Biosystems T2Bacteria       T2Biosystems T2Candida       T2Biosystems T2Resistance  
 Other Commercial Test(s) (Leave Comment) \_\_\_\_\_  
 Other Laboratory Developed Test(s) (Leave Comment) \_\_\_\_\_

\*7. In a scenario where the *mecA* resistance marker and *Staphylococcus aureus* are detected by rapid molecular testing in a blood specimen, select the procedure(s) your facility conducts. (check one)

- Our laboratory does not perform *mecA* testing using rapid molecular methods. [If checked, skip question 7a.]  
 Culture based phenotypic antimicrobial susceptibility testing is not performed. [If checked, skip question 7a.]  
 Culture based phenotypic antimicrobial susceptibility testing is performed. A text indicating results of the corresponding rapid molecular testing and/or the interpretation of the rapid molecular testing result is added to the phenotypic test result.  
 Culture based phenotypic antimicrobial susceptibility testing is performed. No text indicating corresponding rapid molecular testing and/or interpretation is added.

7a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed for a blood specimen to detect drug resistance in *Staphylococcus aureus*, and discordance is found between their results, how are results reported? (check one)

- Further testing is not pursued. Results are reported separately.  
 Further testing is not pursued. The phenotypic result is overridden by the rapid molecular test result when an antimicrobial resistance marker is detected.

#### Facility Microbiology Laboratory Practices (continued)

- Further testing is performed to identify the reason for the discordance. Results are modified based on the further analysis.

\*8. In a scenario where the *bla<sub>CTX-M</sub>* (CTX-M) resistance marker and *Escherichia coli* are detected by rapid molecular testing in a blood specimen, select the procedure(s) your facility conducts. (check one)

- Our laboratory does not perform *bla<sub>CTX-M</sub>* (CTX-M) testing using rapid molecular methods. [If checked, skip questions 8a]

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- Culture based phenotypic antimicrobial susceptibility testing is not performed. [If checked, skip question 8a.]
- Culture based phenotypic antimicrobial susceptibility testing is performed. A text indicating results of the corresponding rapid molecular testing and/or the interpretation of the rapid molecular testing result is added to the phenotypic test result.
- Culture based phenotypic antimicrobial susceptibility testing is performed. No text indicating corresponding rapid molecular testing and/or interpretation is added.

8a. If both rapid and culture based phenotypic antimicrobial susceptibility testing are performed for a blood specimen to detect drug resistance in *Escherichia coli* and discordance is found between their results, how are results reported? (check one)

- Further testing is not pursued. Results are reported separately.
- Further testing is not pursued. The phenotypic result is overridden by the rapid molecular test result when an antimicrobial resistance marker is detected.
- Further testing is performed to identify the reason for the discordance. Results are modified based on the further analysis.

\*9. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli*, *Klebsiella oxytoca* or *Proteus mirabilis* routinely or using a testing algorithm?  Yes  No

9a. If Yes, indicate what is done if ESBL is detected: (check one)

- Change susceptible Cefotaxime/Ceftriaxone/Cefepime results to resistant
- No changes are made in the interpretation of cephalosporins with a note of ESBL
- Suppress cephalosporin susceptibility results

\*10. Where is yeast identification performed for specimens collected at your facility? (check one)

- On-site laboratory
- Affiliated medical center
- Commercial referral laboratory
- Other local/regional, non-affiliated reference laboratory
- Yeast identification not available (specifically, yeast identification is not performed onsite or at any affiliate/commercial/other laboratory) [If checked, skip questions 11-15]

**Answer questions 11-15 for the laboratory that performs yeast identification for your facility:**

\*11. Which of the following methods are used for yeast identification? (check all that apply)

- MALDI-TOF MS System (Vitek MS)
- MicroScan
- MALDI-TOF MS System (Bruker Biotyper)
- Non-automated Manual Kit (for example, API 20C, RapID, Germ Tube, PNA-FISH, etc.)

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Vitek-2

DNA sequencing

BD Phoenix

Other (specify): \_\_\_\_\_

**Facility Microbiology Laboratory Practices (continued)**

\*12. Does the laboratory routinely use chromogenic agar for the identification or differentiation of *Candida* isolates?

Yes

No

Unknown

\*13. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)

Blood

Respiratory

Other normally sterile body site (for example, CSF)

Other (specify): \_\_\_\_\_

Urine

None are fully identified to the species level

\*14. Does the laboratory employ any molecular tests to identify *Candida* from blood specimens?

Yes

No

Unknown

14a. If Yes, which molecular tests are used to identify *Candida* from blood specimens?

T2Candida Panel

BioFire BCID

GenMark ePlex BCID

Other, specify: \_\_\_\_\_

Unknown

14b. If yes and you get a positive result, does this lab culture the blood to obtain an isolate?

Yes, always

Yes, with clinical order

No

Unknown

\*15. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check one)

On-site laboratory

Other local/regional, non-affiliated reference laboratory

Affiliated medical center

AFST not available (specifically, AFST is not performed onsite or at any affiliate/commercial/other laboratory) [if selected, skip questions 16 -19]

Commercial reference laboratory

**Answer questions 16-19 for the laboratory that *performs AFST for your facility*:**

\*16. What method is used for antifungal susceptibility testing (AFST), ***excluding Amphotericin B***? (check all that apply)

Broth microdilution with laboratory developed plates

YeastOne (Thermo Scientific™ Sensititre™)

Gradient diffusion (E test)

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Vitek (bioMerieux)                       Other (specify): \_\_\_\_\_  Unknown

\*17. What method is used for antifungal susceptibility testing (AFST) of **Amphotericin B**? (check all that apply)

Broth microdilution with laboratory developed plates                       YeastOne (Thermo Scientific™ Sensititre™)                       Gradient diffusion (E test)

Vitek (bioMerieux)                       Other (specify): \_\_\_\_\_  Unknown

\*18. AFST is performed for which of the following antifungal drugs? (check all that apply)

Fluconazole                       Voriconazole                       Itraconazole

Posaconazole                       Micafungin                       Anidulafungin

Caspofungin                       Amphotericin B                       Flucytosine

Other, specify: \_\_\_\_\_  Unknown

**Facility Microbiology Laboratory Practices (continued)**

\*19. AFST is performed on fungal isolates in which of the following situations? (check only one box per row)

	Performed automatically	Performed with a clinician's order	Not performed	Unknown
Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other normally sterile body site (for example, CSF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*20. Is this laboratory developing antibiograms or other reports to track susceptibility trends for *Candida* spp. isolates tested in this laboratory?

Yes                       No                       Unknown

\*21. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)

- Enzyme immunoassay (EIA) for toxin
- Cell cytotoxicity neutralization assay
- Nucleic acid amplification test (NAAT) (for example, PCR, LAMP)
- NAAT plus EIA, if NAAT positive (2-step algorithm)
- Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm)
- GDH plus NAAT (2-step algorithm)

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- GDH plus EIA for toxin, followed by NAAT for discrepant results
- Toxigenic culture (*C. difficile* culture followed by detection of toxins)
- Other (specify): \_\_\_\_\_

\*22. Indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (check one)

- MALDI-TOF MS System (Vitek MS)
- MALDI-TOF MS System (Bruker Biotyper)
- Automated Instrument (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)
- Non-automated Manual Kit (for example, API, Crystal, RapID, etc.)
- Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)
- 16S rRNA Sequencing
- Other (specify): \_\_\_\_\_
- None

\*23. Indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (for example, a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). (check all that apply)

- MALDI-TOF MS System (Vitek MS)
- MALDI-TOF MS System (Bruker Biotyper)
- Automated Instrument (for example, Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)
- Non-automated Manual Kit (for example, API, Crystal, RapID, etc.)

**Facility Microbiology Laboratory Practices (continued)**

- Rapid Identification (for example, Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)
- 16S rRNA Sequencing
- Other (specify): \_\_\_\_\_
- None

**Infection Control Practices (completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)**

\*24. Number or fraction of infection preventions (IPs) in facility:

- a. Total hours per week performing surveillance: \_\_\_\_\_
- b. Total hours per week for infection control activities other than surveillance: \_\_\_\_\_

\*25. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility: \_\_\_\_\_

\*26. Is it a policy in your facility that patients infected or colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)

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- Yes
- No
- Not applicable: my facility never admits these patients

26a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- All infected and all colonized patients
- Only all infected patients
- Only infected or colonized patients with certain characteristics (check all that apply)
  - Patients admitted to high risk settings
  - Patients at high risk for transmission

\*27. Is it a policy in your facility that patients infected or colonized with VRE are routinely placed in contact precautions while these patients are in your facility? (check one)

- Yes
- No
- Not applicable: my facility never admits these patients

27a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- All infected and all colonized patients
- Only all infected patients
- Only infected or colonized patients with certain characteristics (check all that apply)
  - Patients admitted to high risk settings
  - Patients at high risk for transmission

\*28. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)

- Yes
- No
- Not applicable: my facility never admits these patients

### Infection Control Practices (continued)

28a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- All infected and all colonized patients

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- Only all infected patients
- Only infected or colonized patients with certain characteristics (check all that apply)
  - Patients admitted to high risk settings
  - Patients at high risk for transmission

\*29. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant *Enterobacteriales* are routinely placed in contact precautions while these patients are in your facility? (check one)

- Yes
- No
- Not applicable: my facility never admits these patients

29a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility (check one):

- All infected and all colonized patients
- Only all infected patients
- Only infected or colonized patients with certain characteristics (check all that apply)
  - Patients admitted to high risk settings
  - Patients at high risk for transmission

\*30. Does your facility routinely perform screening testing (culture or non-culture) for CRE? *This includes screening for patients at your facility performed by public health laboratories and commercial laboratories.*

Yes  No

30a. If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)

- Surveillance testing at admission for all patients
- Surveillance testing of epidemiologically-linked patients of newly identified CRE patients (for example, roommates)
- Surveillance testing at admission of high-risk patients (for example, admitted from LTAC or LTCF)
- Surveillance testing at admission of patients admitted to high-risk setting (for example, ICU)
- Surveillance testing of all patients in the facility or in a specific high-risk settings (for example, ICU) at pre-specified intervals (for example, weekly point prevalence survey)
- Other (specify): \_\_\_\_\_

30b. If Yes, what method is routinely used by the lab conducting CRE testing of screening swabs from your facility? (check all that apply)

- Culture-based methods

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PCR

Other (specify): \_\_\_\_\_

\*31. Does the facility routinely perform screening testing (culture or non-culture) for *Candida auris*? *This includes screening for patients at your facility performed by public health laboratories and commercial laboratories.*

Yes

No

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**Infection Control Practices (continued)**

31a. If Yes, in which situations does the facility routinely perform screening testing for *Candida auris*? (check all that apply)

- Surveillance testing at admission for all patients
- Surveillance testing of epidemiologically-linked patients of newly identified *Candida auris* patients (for example, point prevalence surveys in response to a case, patients in the same room or unit as a case)
- Surveillance testing at admission of high-risk patients (check all that apply)
  - Patients admitted from long-term acute care (LTAC) or long-term care facility (LTCF)
  - Patients with recent (for example, within 6 months) overnight hospital stay outside the United States
  - Patients admitted to high-risk settings (for example, ICU)
  - Other (specify): \_\_\_\_\_
- Surveillance testing of all patients in the facility or in a specific high-risk settings (for example, ICU) at pre-specified intervals (for example, weekly point prevalence survey)
- Other (specify): \_\_\_\_\_

31b. If Yes, what method is routinely used by the lab conducting *Candida auris* testing of screening swabs from your facility?

- Culture-based methods
- PCR
- Other (specify): \_\_\_\_\_

\*32. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted?  Yes  No

32a. If Yes, in which situations does the facility routinely perform screening testing for MRSA? (check all that apply)

- Surveillance testing at admission for all patients
- Surveillance testing at admission of high-risk patients (for example, admitted from long-term acute care [LTAC] or long-term care facility [LTCF], or dialysis patients)
- Surveillance testing at admission of patients admitted to high-risk setting (for example, ICU)
- Surveillance testing of pre-operative patients to prevent surgical site infections
- Other (specify): \_\_\_\_\_

\*33. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients to prevent infection or transmission of MDROs at your facility?

Yes  No

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\*34. Does the facility have a policy to routinely use a combination of topical chlorhexidine AND an intranasal anti-staphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens?

Yes

No

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**Antibiotic Stewardship Practices**  
**(completed with input from Physician and Pharmacist Stewardship Leaders)**

\*35. Did the antibiotic stewardship leader(s) participate in responding to these questions? (check one)

- Yes, pharmacist lead
- Yes, physician lead
- Yes, both pharmacist and physician leads
- Yes, other lead
- No

\*36. Facility leadership has demonstrated commitment to antibiotic stewardship efforts: (check all that apply)

- Providing stewardship program leader(s) dedicated time to manage the program and conduct daily stewardship interventions.
- Allocating resources (for example, IT support, training for stewardship team) to support antibiotic stewardship efforts.
- Having a senior executive that serves as a point of contact or “champion” to help ensure the program has resources and support to accomplish its mission.
- Presenting information on stewardship activities and outcomes to facility leadership and/or board at least annually.
- Ensuring the stewardship program has an opportunity to discuss resource needs with facility leadership and/or board at least annually.
- Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues.
- Providing opportunities for hospital staff training and development on antibiotic stewardship.
- Providing a formal statement of support for antibiotic stewardship (for example, a written policy or statement approved by the board).
- Ensuring that staff from key support departments and groups (for example, IT and hospital medicine) are contributing to stewardship activities.
- None of the above

\*37. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes.

Yes  No

37a. If Yes, what is the position of this leader? (check one)

- Physician
- Pharmacist
- Co-led by both Pharmacist and Physician
- Other (for example, RN, PA, NP, etc.; specify): \_\_\_\_\_

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37b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (check all that apply)

- Has antibiotic stewardship responsibilities in their contract, job description or performance review
- Is physically on-site in your facility (either part-time or full-time)
- Completed an ID fellowship
- Completed a certificate program on antibiotic stewardship
- Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship
- None of the above

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**Antibiotic Stewardship Practices (continued)**

37c. If 'Has antibiotic stewardship responsibilities in their contract or job description' is selected (for physician (co) leader): What percent time of antibiotic stewardship activities is specified in the **physician (co) leader's contract or job description?** (check one)

- 1-10%                       11-25%                       26-50%  
 51-75%                       76-100%                       Not specified

37d. If Physician or Co-led is selected: **In an average week**, what percentage of time does the **physician (co) leader spend** on antibiotic stewardship activities in your facility? (check one)

- 1-10%                       11-25%                       26-50%  
 51-75%                       76-100%

37e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (check all that apply)

- Has antibiotic stewardship responsibilities in their contract, job description or performance review
- Is physically on-site in your facility (either part-time or full-time)
- Completed a PGY2 ID residency and/or ID fellowship
- Completed a certificate program on antibiotic stewardship
- Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship
- None of the above

37f. If 'Has antibiotic stewardship responsibilities in their contract or job description' is selected (for pharmacist (co) leader): What percent time for antibiotic stewardship activities is specified in the **pharmacist (co) leader's contract or job description?** (check one)

- 1-10%                       11-25%                       26-50%  
 51-75%                       76-100%

37g. If 'Pharmacist' or 'Co-led' is selected: **In an average week**, what percentage of time does the **pharmacist (co) leader spend** on antibiotic stewardship activities in your facility? (check one)

- 1-10%                       11-25%                       26-50%  
 51-75%                       76-100%

37h. If Pharmacist or Other is selected: Does your facility have a designated physician who can serve as a point of contact and support for the non-physician leader?

- Yes                       No

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37i. If a pharmacist is **not** the leader or co-leader for the program, is there at least one pharmacist responsible for improving antibiotic use at your facility?

Yes  No

\*38. Our facility has the following priority antibiotic stewardship interventions: (check all that apply)

Prospective audit and feedback for specific antibiotic agents

38a. If Prospective audit and feedback is selected: For which categories of antimicrobials? Answer for the following categories of antimicrobials, *whether or not* they are on formulary. (check all that apply)

Cefepime, ceftazidime, or piperacillin/tazobactam

Vancomycin (intravenous)

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**Antibiotic Stewardship Practices (continued)**

- Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, imipenem-cilastatin/relebactam, or cefiderocol
- Fluoroquinolones
- Daptomycin, linezolid, or other newer anti-MRSA agents
- Ertapenem, imipenem/cilastatin, or meropenem
- Eravacycline or omadacycline
- Lefamulin
- Aminoglycosides
- Colistin or polymyxin B
- Anidulafungin, caspofungin, or micafungin
- Isavuconazole, posaconazole, or voriconazole
- Amphotericin B and/or lipid-based amphotericin B
- None of the above

38b. If Prospective audit and feedback is selected: Our antibiotic stewardship program monitors prospective audit and feedback interventions (for example, by tracking antibiotic use, types of interventions, acceptance of recommendations).

Yes  No

Preauthorization for specific antibiotic agents

38c. If Preauthorization is selected: For which categories of antimicrobials? Only answer for categories of antimicrobials that are *on formulary*. (check all that apply)

- Cefepime, ceftazidime, or piperacillin/tazobactam
- Vancomycin (intravenous)
- Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, imipenem-cilastatin/relebactam, or cefiderocol
- Fluoroquinolones
- Daptomycin, linezolid, or other newer anti-MRSA agents
- Eravacycline or omadacycline
- Lefamulin
- Aminoglycosides
- Colistin or polymyxin B

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- Anidulafungin, caspofungin, or micafungin
- Isavuconazole, posaconazole, or voriconazole
- Amphotericin B and/or lipid-based amphotericin B
- None of the above

38d. If Preauthorization is selected: Our antibiotic stewardship program monitors preauthorization interventions (for example, by tracking which agents are requested for which conditions).

Yes  No

Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions (for example, community-acquired pneumonia, urinary tract infections, skin and soft tissue infection).

38e. If Facility-specific treatment recommendations is selected: For which common clinical conditions?

**Antibiotic Stewardship Practices (continued)**

- Community-acquired pneumonia,
- Urinary tract infection
- Skin and soft tissue infection
- None of the above

38f. If Facility-specific treatment recommendations is selected: Our stewardship program monitors adherence to our facility's treatment recommendations for antibiotic selection for common clinical conditions (for example, community-acquired pneumonia, urinary tract infection, skin and soft tissue infection).

Yes  No

38g. If Yes: For which common clinical conditions?

- Community-acquired pneumonia,
- Urinary tract infection
- Skin and soft tissue infection
- None of the above

None of the above

\*39. Our facility has a policy or formal procedure for other interventions to ensure optimal use of antibiotics: (check all that apply)

- Early administration of effective antibiotics to optimize the treatment of sepsis
- Treatment protocols for *Staphylococcus aureus* bloodstream infection
- Stopping unnecessary antibiotic(s) in new cases of *Clostridioides difficile* infection (CDI)
- Review of culture-proven invasive (for example, bloodstream) infections

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- Review of planned outpatient parenteral antibiotic therapy (OPAT)
- The treating team to review antibiotics 48-72 hours after initial order (specifically, antibiotic time-out)
- Assess and clarify documented penicillin allergy
- Using the shortest effective duration of antibiotics at discharge for common clinical conditions (for example, community- acquired pneumonia, urinary tract infections, skin and soft tissue infections)
- None of the above

39a. If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' is selected: Our stewardship program monitors adherence in using the shortest effective duration of antibiotics at discharge for common clinical conditions (for example, community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.

Yes  No

\*40. Our facility has in place the following specific 'pharmacy-based' interventions: (check all that apply)

- Pharmacy-driven changes from intravenous to oral antibiotics without a physician's order (for example, hospital-approved protocol)
- Alerts to providers about potentially duplicative antibiotic spectra (for example, multiple antibiotics to treat anaerobes)
- Automatic antibiotic stop orders in specific situations (for example, surgical prophylaxis)
- None of the above

\*41. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use.

Yes  No

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**Antibiotic Stewardship Practices (continued)**

41a. If Yes is selected: Our facility has in place the following specific 'nursing-based' interventions: (check all that apply)

- Nurses receive training on appropriate criteria for sending urine and/or respiratory cultures.
- Nurses initiate discussions with the treating team on switching from intravenous to oral antibiotics.
- Nurses initiate antibiotic time-out discussions with the treating team.
- Nurses track antibiotic duration of therapy.
- None of the above

41b. If 'Nurses track antibiotic duration of therapy' is selected: Is that information available at the bedside (for example, on a whiteboard in the room)?

Yes  No

\*42. Our stewardship program monitors: (check all that apply)

- Antibiotic resistance patterns (either facility- or region-specific), at least annually
- Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually
- Antibiotic use in days of therapy (DOT) per 1000 patient days or day present, at least quarterly
- Antibiotic use in defined daily doses (DDD) per 1000 patient days, as least quarterly
- Antibiotic expenditures (specifically, purchasing costs), at least quarterly
- Antibiotic use in some other way, at least annually (specify): \_\_\_\_\_
- None of the above

\*43. Our stewardship team provides the following antibiotic use reports to prescribers, at least annually: (check all that apply)

- Individual, prescriber-level reports
- Unit- or service-specific reports
- None of the above

43a. If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' is selected: Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.

Yes  No

\*44. Our facility distributes an antibiogram to prescribers, at least annually.

Yes  No

\*45. Information on antibiotic use, antibiotic resistance, and stewardship efforts is reported to hospital staff, at least annually.

Yes  No

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\*46. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, an antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) at least annually? (check all that apply)

- Prescribers
- Nursing staff
- Pharmacists
- None of the above

\*47. Are patients provided education on important side effects of prescribed antibiotics?

Yes  No

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**Antibiotic Stewardship Practices (continued)**

47a. If 'Yes' is selected: How is education to patients on side effects shared? (check all that apply)

- Discharge paperwork                       Verbally by physician  
 Verbally by nurse                               None of the above  
 Verbally by pharmacist

**Optional Antibiotic Stewardship Practices**

Responses to the following questions are not required to complete the annual survey.

Provide additional information about your facility's antibiotic stewardship activities and leadership.

48. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.

- Yes                       No

49. Our facility accesses targeted remote stewardship expertise (for example, tele-stewardship to obtain facility-specific support for antibiotic stewardship efforts.

- Yes                       No

50. Our stewardship program works with the microbiology laboratory to implement the following interventions: (check all that apply)

- Selective reporting of antimicrobial susceptibility testing results  
 Placing comments in microbiology reports to improve prescribing  
 None of the above

51. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (check all that apply)

- Pharmacy director                               Executive leadership (for example, CEO, CMO)  
 Pharmacy & therapeutics                       Hospital board  
 Patient safety                                       Other (specify): \_\_\_\_\_  
 Quality improvement                               None

**Facility Water Management Program (WMP) (Completed with input from WMP team members.)**

\*52. Does your facility have a water management program (WMP) to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi)?

- Yes                       No

52a. If Yes, who is represented on your facility WMP team? (check all that apply):

- Hospital Epidemiologist/Infection Preventionist                       Compliance/Safety Officer

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- |  |  |
|--|--|
| <input type="checkbox"/> Hospital Administrator/Leadership       | <input type="checkbox"/> Risk/Quality Management Staff |
| <input type="checkbox"/> Facilities Manager/Engineer             | <input type="checkbox"/> Infectious Disease Clinician  |
| <input type="checkbox"/> Maintenance Staff                       | <input type="checkbox"/> Consultant                    |
| <input type="checkbox"/> Equipment/Chemical Acquisition/Supplier | <input type="checkbox"/> Laboratory Staff/Leadership   |
| <input type="checkbox"/> Environmental Services                  | <input type="checkbox"/> Other (specify): _____        |

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**Facility Water Management Program (WMP) (continued)**

\*53. Has your facility ever conducted an environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure)? This may include a description of building water systems using text or basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points.

Yes  No

53a. If Yes, when was the most recent assessment conducted? (check one)

Within the most recent year (<1 year ago)       Between 1 and 3 years ago (≥1 year and ≤3 years)       More than 3 years ago (>3 years)

\*54. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and/or program preparedness? An example WICRA tool can be accessed at <https://www.cdc.gov/hai/pdfs/prevent/water-assessment-tool-508.pdf>.

Yes  No

54a. If Yes, when was the most recent assessment conducted? (check one)

Within the most recent year (<1 year ago)       Between 1 and 3 years ago (≥1 year and ≤3 years)       More than 3 years ago (>3 years)

\*55. Does your facility regularly monitor the following parameters in the building water system(s)?

Disinfectant (such as residual chlorine):  Yes  No

55a. If Yes, Does your facility have a plan for corrective actions when disinfectant(s) are not within acceptable limits as determined by the water management program?

55b. If Yes, where and how frequently does your facility monitor disinfectant(s)? (Check all that apply)

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Water temperature:  Yes  No

55c. If Yes, does your facility have a plan for corrective actions when water temperatures are not within acceptable limits as determined by the water management program?  Yes  No

55d. If Yes, where and how frequently does your facility monitor water temperature? (check all that apply)

**Facility Water Management Program (WMP) (continued)**

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Water pH:  Yes  No

55e. If Yes, does your facility have a plan for corrective actions when water pH is not within acceptable limits as determined by the water management program?  Yes  No

55f. If Yes, where and how frequently does your facility monitor water pH? (check all that apply)

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Heterotrophic plate count (HPC) testing:  Yes  No

55g. If Yes, does your facility have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by the water management program?  Yes  No

55h. If Yes, where and how frequently does your facility perform HPC testing? (check all that apply)

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**Facility Water Management Program (WMP) (continued)**

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific environmental *Legionella* testing:  Yes  No

55i. If Yes, does your facility have a plan for corrective actions when environmental tests for *Legionella* are not within acceptable limits as determined by the water management program?  Yes  No

55j. If Yes, where an how frequently does your facility perform *Legionella* testing? (check all that apply)

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific environmental *Pseudomonas* testing:  Yes  No

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- 55k. If Yes, does your facility have a plan for corrective actions when environmental tests for *Pseudomonas* are not within acceptable limits as determined by the water management program?
- 55l. If Yes, where and how frequently does your facility perform *Pseudomonas* testing? (check all that apply)

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**Facility Water Management Program (WMP) (continued)**

	Entry Points	Cold Potable Water Storage Tank(s)	Hot Potable Water Storage Tank(s)	Hot Water Supply	Hot Water Return	Representative Locations Throughout Cold Potable Building Water System(s)	Representative Locations Throughout Hot Potable Building Water System(s)	Other (specify): _____
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*56. Does your facility water management program address measures to prevent transmission of pathogens from wastewater premise plumbing to patients?

- Yes                       No                       N/A, my facility does not have a water management program

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