

COVID-19 Module Long Term Care Facility: Ventilator Capacity and Supplies

CMS Certification Number (CCN): Facility Name: *Do you have ventilator dependent unit(s) and/or beds in your facility? □ YES □ NO If, NO, Skip this form *Date for which responses are reported:	NHSN Facility ID:			
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**For the following questions, please collect data at the same time at least once a week (for example, 7 AM) **For the following questions, please collect data at the same time at least once a week (for example, 7 AM) MECHANICAL VENTILATORS: Total number available in your facility MECHANICAL VENTILATORS IN USE: Total number of mechanical ventilators in use for residents who have suspected or laboratory positive COVID-19 Ventilator Supplies Supply Item Do you currently have any supply? Do you have enough for one week? Ventilator supplies (any, including tubing) NO Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in struct confidence, will be used only for the purposes sitated, and will not otherwise be addicased or released without the consent of the individual, or the institution in accordance with Sections 304. 306 and 306(d) of the Public Health Service Act (42 USC 2420, 2452,	Facility Name:			
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