Instructions for Completion of the Patient Safety Annual Facility Survey for LTAC (CDC 57.150)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2022, a facility would complete a 2021 survey.
Facility Characteristics	
Ownership (check one)	*Required.* Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
Setting/Classification: If classified as "Free-standing", does your LTAC hospital share physical housing with one or more of the following on-site facilities or units? (check all that apply)	*Required.* Select the physical setting of the facility: free-standing or within a hospital. *Conditionally Required.* If facility is classified as free-standing, select one or more of the following facility or unit types that share physical housing with your LTAC: • No (none) • Skilled nursing facility (SNF)/nursing home • Residential facility (assisted living) • Inpatient rehabilitation facility • Neuro-behavioral unit or facility • Other: specify
If classified as "Within a hospital", is your LTAC hospital located:	*Conditionally Required.* If facility is classified as within a hospital, indicate 'Yes' or 'No' if it is: • In a building that does not provide acute care services (for example, psychiatric hospital) • Near (but not within) an acute care hospital
Number of Patient Days	*Required.* Enter the total number of patient days for your hospital during the last full calendar year.
Number of Admissions	*Required.* Enter the total number of inpatient admissions for your hospital during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day during the last full calendar year. Round to the nearest whole number.

Numbers of LTAC beds in the following categories (categories should equal total number of beds)	*Required.* Enter the total number of LTAC beds in each on the following categories during the last full calendar year: • Intensive care unit (ICU) or critical care beds • High observation/special care/high acuity beds (not ICU) • General LTAC beds
Total number of LTAC beds (licensed capacity)	*Required.* The total number of LTAC beds in the facility during the last full calendar year will be automatically summed based on the above counts.
Number of single occupancy rooms	*Required.* Enter the total number of single occupancy rooms during the last full calendar year.
Number of double occupancy rooms	*Required.* Enter the total number of double occupancy rooms (specifically, rooms with capacity to care for two patients) during the last full calendar year.
Number of triple occupancy rooms	*Required.* Enter the total number of triple occupancy rooms (specifically, rooms with capacity to care for three patients) during the last full calendar year.
Number of quadruple occupancy rooms	*Required.* Enter the total number of quadruple occupancy rooms (specifically, rooms with capacity to care for four patients) during the last full calendar year.
Total number of admissions with one of the following conditions identified on admission	*Required.* Enter the total count of patients identified on admission or upon initial assessment and review of patient during admission with the following conditions (Note: these categories are not mutually exclusive). • Ventilator dependence • Hemodialysis For a list of ICD-10 and DRG codes associated with these conditions review this spreadsheet: http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx

Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing?	*Required.* Select 'Yes' if your facility has its own onsite laboratory that performs antimicrobial susceptibility testing; otherwise, select 'No'.
1a. If No, where is your facility's antimicrobial susceptibility testing performed? (check one)	*Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used, indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.
1b. If Yes, do you also send out any antimicrobial susceptibility testing? (check one)	*Conditionally Required*. If your facility has its own laboratory that performs antimicrobial susceptibility testing, select 'Yes' to indicate if additional antimicrobial susceptibility testing is also sent out, or 'No' if all routine susceptibility testing is performed onsite.

2. For the following organisms, indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
3. Does either the primary of secondary/supplemental antimicrobial susceptibility testing (AST) include the following (check all that apply):	*Required.* For each 'Organism tested', select the 'Drug(s)' evaluated as part of the primary or secondary/supplemental susceptibility testing described in 2.
4. Has the laboratory implemented the revised breakpoints for recommended by CLSI as of 2010?	
a. Third Generation Cephalosporin and monobactam (i.e., aztreonam) breakpoints for *Enterobacterales* in 2010	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
b. Carbapenem breakpoints for *Enterobacterales* in 2010	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
c. Ertapenem breakpoints for *Enterobacterales* in 2012	Required. Select 'Yes' if your laboratory has implemented the revised ertapenem breakpoints for *Enterobacterales* recommended by CLSI as of 2012; otherwise, select 'No'.
d. Carbapenem breakpoints for *Pseudomonas aeruginosa* in 2012	Required. Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2012; otherwise, select 'No'.
e. Fluroquinolone breakpoints for *Pseudomonas aeruginosa* in 2019	Required. Select 'Yes' if your laboratory has implemented the revised fluroquinolone breakpoints for *Pseudomonas aeruginosa* recommended by CLSI as of 2019; otherwise, select 'No'.
f. Fluroquinolone breakpoints for *Enterobacterales* in 2019	Required. Select 'Yes' if your laboratory has implemented the revised fluroquinolone breakpoints for *Enterobacterales* recommended by CLSI as of 2019; otherwise, select 'No'.
5. Does the laboratory test bacterial isolates for the presence of carbapenemase?	*Required.* Select 'Yes' if your laboratory tests bacterial isolates for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify how laboratory results are managed if carbapenemase production is detected.
5a. If Yes, indicate what is done if carbapenemase production is detected (check one).	*Conditionally Required.* If 'Yes', specify how laboratory results are managed if carbapenemase production is detected.
5b. If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)	*Conditionally Required.* If 'Yes', specify which test(s) are routinely used to detect carbapenemase.

5c. If Yes, which of the following are routinely tested for the presence of carbapenemases.	*Conditionally Required.* If 'Yes', specify which pathogen(s) are tested for the presence of carbapenemase. It is not required that the lab test all species within the pathogen group (for example, select "*Pseudomonas* spp." even if the only carbapenem-resistant *Pseudomonas aeruginosa* are tested for the presence of a carbapenemase). It is not required that labs test all isolates in each group (for example, select "*Enterobacterales*" even if the lab tests only a subset of *Enterobacterales* isolates that are carbapenem-resistant).
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. 6a. If Yes, which test panel(s) does your facility use? (check all that apply)	*Required.* Select 'Yes' if your laboratory uses commercial or laboratory developed tests for rapid molecular detection of antimicrobial resistance markers in bacterial bloodstream infections; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the test panel(s) that your facility uses. If the test panel(s) your facility uses are not listed, select 'Other Commercial Test(s)' if the other test(s) used is/are commercially available or select 'Other Laboratory Developed Test(s)' if the other test used is laboratory developed, then indicate which test is used by entering in the test name in the blank field corresponding to your answer.
7. In a scenario where the *mecA* resistance marker and *Staphylococcus aureus* are detected by rapid molecular testing, select the procedure(s) your facility conducts. (check one) 7a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus*, and discordance is found between their results, how are results reported? (check one)	*Required.* Select your facilities' procedure(s) after detecting the *mecA* resistance marker and *Staphylococcus aureus* using rapid molecular testing. If the *mecA* resistance marker is not tested for *Staphylococcus aureus* in your facility, select the first answer choice and skip to question 3a. *Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Staphylococcus aureus,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 3a.
8. In a scenario where the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* are detected by rapid molecular testing, select the procedure(s) your facility conducts. (check one) 8a. If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli* and discordance is found between their results, how are results reported? (check one)	*Required.* Select your facilities' procedure(s) after detecting the *bla*$_{CTX-M}$ (CTX-M) resistance marker and *Escherichia coli* using rapid molecular testing. If the *bla*$_{CTX-M}$ (CTX-M) resistance marker is not tested for *Escherichia coli* in your facility, select the first answer choice and skip to question 9. *Conditionally Required.* If both rapid molecular and culture based phenotypic antimicrobial susceptibility testing are performed to detect drug resistance in *Escherichia coli,* specify how your facility reports results when discordance is found between rapid molecular antimicrobial susceptibility testing result and culture based antimicrobial susceptibility testing result. If either type of antimicrobial testing is not performed, skip this question and continue to question 9.

9. Does your facility perform extended-spectrum beta-lactamase (ESBL) testing for *E. coli, Klebsiella pneumoniae, Klebsiella oxytoca* or *Proteus mirabilis* routinely or using a testing algorithm? 9a. If Yes, indicate what is done if ESBL is detected.	*Required.* Select 'Yes' if your facility performs extended-spectrum beta-lactamase (ESBL) testing for E. coli or Klebsiella spp. or through an algorithm; otherwise, select 'No'. *Conditionally Required.* If 'Yes', indicate how laboratory results are managed if ESBL is detected.
10. Where is yeast identification performed for specimens collected at your facility? (check one)	*Required.* Select where yeast identification is performed for specimens collected at your facility.
11. Which of the following methods are used for yeast identification? (check all that apply)	*Required.* Select from the choices listed, one or more method (s) used for yeast identification
12. Does the laboratory routinely use chromogenic agarfor the identification or differentiation of *Candida* isolates?	*Required.* Select 'Yes' if the laboratory routinely uses chromogenic agarfor the identification or differentiation of *Candida* isolates; otherwise, select 'No'. Select 'Unknown' if not known.
13. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)	*Required.* Select from the choices listed, one or more body sites from which *Candida* is routinely identified to the species level without a specific request from a clinician. If 'Other' is selected, specify.
14. Does the laboratory employ any molecular tests to identify *Candida* from blood specimens? 14a. If yes, which molecular tests are used to identify *Candida* from blood specimens? (check all that apply) 14b. If yes and you get a positive result, does this lab culture the blood to obtain an isolate?	*Required.* Select 'Yes' if the laboratory employs any molecular tests to identify *Candida* from blood specimens; otherwise, select 'No'. Select 'Unknown' if not known. *Conditionally Required.* If 'Yes', select the molecular tests used to identify *Candida* from blood specimens. If 'Other' is selected, specify. Select 'Unknown' if not known. *Conditionally Required.* If Yes and you get a positive result on the molecular test, indicate whether this lab cultures the blood to obtain an isolate.
15. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check one)	*Required.* Select where antifungal susceptibility testing (AFST) is performed for specimens collected at your facility.

16. What method is used for antifungal susceptibility testing (AFST), excluding Amphotericin B? (check all that apply)	*Required.* Select from the choices listed, one or more method(s) used for antifungal susceptibility testing of antifungals except for Amphotericin B If 'Other' is selected, specify.
17. What method is used for antifungal susceptibility testing (AFST) of Amphotericin B? (check all that apply)	*Required.* Select from the choices listed, one or more method(s) used for antifungal susceptibility testing of Amphotericin B. If 'Other' is selected, specify.
18. AFST is performed for which of the following antifungal drugs? (check all that apply)	*Required.* Select the antifungal drugs for which AFST is performed.
19. AFST is performed on fungal isolates in which of the following situations:	*Required.* For each of the body sites listed select the most appropriate response for when antifungals susceptibility testing is performed. Chose "Performed automatically" if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient. Chose "Performed with a clinician's order" if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing. If 'Other' body site is selected, specify.
20. Is this laboratory developing antibiograms or other reports to track susceptibility trends for *Candida* spp. isolates tested in this laboratory?	*Required.* Select from the choices listed to indicate if this laboratory develops reports (for example, antibiograms) to track antifungal susceptibility trends for *Candida* spp. isolates tested in this laboratory.
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)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, specify. **Note**: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of C. *difficile* tests; most methods can be categorized accurately by selecting from the options provided. Ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
22. Indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (check one)	*Required.* Select from the choices listed to indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility.

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)	*Required.* Select from the choices listed to 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).
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
24. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals who work full-time in the infection prevention department of the hospital as infection prevention professionals. If an individual works part-time, indicate what proportion of full-time hours they work (for example, if full time is considered 40 hours and an individual works 16 hours per week, their work is counted as 16/40 = 0.4). Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the combined total number of hours per week performed by all employees engaged in activities designed to find and report healthcare-associated infections (in the hospital). The total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the combined total number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, providing education, ensuring infection prevention measures are implemented, attending meetings, etc.
25. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility:	*Required.* Enter the total number or fraction of individuals who work full-time performing the functions of a hospital epidemiologist in the facility. If an individual works part-time, include the proportion of full-time hours they work (for example, if they work 20 hours of a standard 40-hour workweek, include them as 0.5). An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
For detailed description about the use of Contact Precautions, refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html).	
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) 26a. If Yes, check the type of patients that are routinely placed in Contact Precautions while in your facility (check one):	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with methicillin-resistant Staphylococcus aureus (MRSA). Select 'No' if your facility does not have this policy. If your facility never admits patients with MRSA, select 'Not applicable'. *Conditionally Required.* If Yes, indicate which type of patients the policy requires are routinely placed in Contact Precautions for MRSA while in your facility: all patients with MRSA, regardless of whether the MRSA is associated with infection or colonization; only those patients with MRSA infections (specifically, patients with only MRSA colonization are not subject to this policy); or a subset of patients with either MRSA infection or colonization with certain characteristics.

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) 27a. If Yes, check the type of patients that are routinely placed in Contact Precautions while in your facility	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with vancomycin-resistant Enterococci (VRE). Select 'No' if your facility does not have this policy. If your facility never admits patients with VRE, select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions for VRE while in your facility.
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) 28a. If Yes, check the type of patients that are routinely placed in Contact Precautions while in your facility (check one)	*Required*. Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with carbapenem-resistant *Enterobacterales* (CRE). Select 'No' if your facility does not have this policy. If your facility never admits patients with CRE, select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions for CRE while in your facility.
29. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant *Enterobacterales* are routinely placed in contact precautions while these patients are in your facility? (check one) 29a. If Yes, check the type of patients that are routinely placed in contact precautions while in your facility (check one)	*Required.* Select 'Yes' if your facility has a policy to routinely use Contact Precautions for any patients because of the patient's colonization or infection with extended spectrum beta-lactamase (ESBL) producing *Enterobacterales* or extended spectrum cephalosporin-resistant *Enterobacterales*. Select 'No' if your facility does have this policy. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant *Enterobacterales*, select 'Not applicable'. *Conditionally Required.* If Yes, select the type of patients that are routinely placed in Contact Precautions while in your facility
30. Does the facility routinely perform screening testing (culture or non-culture) for CRE? 30a. If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** (specifically, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select 'No' if either testing is not routinely performed or is not performed at all. *Conditionally required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which CRE screening is performed. **Note**: 'Epidemiologically-linked' patients refer to healthcare contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.

30b. If Yes, what method is routinely used by the lab conducting CRE testing of screening swabs from your facility? (check all that apply)	*Conditionally Required*. If 'Yes', select the method(s) that are routinely used by the lab conducting screening. If 'Other' is selected, please specify the methods(s) in which CRE screening is performed.
31. Does the facility routinely perform screening testing (culture or non-culture) for *Candida auris*?	*Required.* Select 'Yes' if the facility routinely (specifically, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for *Candida auris*; select 'No' if either testing is not routinely performed or not performed at all.
31a. If Yes, in which situations does the facility routinely perform sceening testing for *Candida auris*? (check all that apply)	*Conditionally Required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which *Candida auris* screening is performed.
31b. If Yes, what method is routinely used by the lab conducting *Candida auris* testing of screening swabs from your facility?	*Conditionally Required*. If 'Yes', select the method that's routinely used by the lab conducting screening. If 'Other' is selected, specify the methods(s) in which *Candida auris* screening is performed. Note: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified *Candida auris*. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
32. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted?	*Required.* Select 'Yes' if the facility **routinely** (specifically, it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select 'No' if either screening testing is not routinely performed or is not performed at all.
32a. If yes, in which situation does the facility routinely perform screening testing for MRSA? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, specify the situation(s) in which MRSA screening is performed.
33. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients?	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any adult patient in any ward or unit as an intervention to prevent the infection or transmission of any MDRO; otherwise, select 'No'.
33a. If yes, indicate which patients	If 'Yes', indicate which patients are subject to this policy.
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?	*Required.* Select 'Yes' if the facility has 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. Select 'No' if the facility does not have this policy.

Antibiotic Stewardship Practices. Completion of this section should involve the leader(s) of the Antibiotic Stewardship Program (ASP), such as a pharmacist and/or physician; if your facility does not have an ASP program leader, completion should involve other leaders of the work, such as a pharmacist or physician who focuses on antibiotic stewardship or infectious diseases and/or members of the Pharmacy and Therapeutics Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to the updated 2019 Core Elements of Hospital Antibiotic Stewardship Programs (https://www.cdc.gov/antibiotic-use/core-elements/hospital.html). For additional implementation guidance for small and critical access hospitals, see https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements-small-critical.html.

35. Did the antibiotic stewardship leader(s) participate in completing these questions? (Check one.)	*Required.* Indicate which antibiotic stewardship leader(s), if any, participated in completing the 'Antibiotic Stewardship Practices' portion of the survey. If no antibiotic stewardship leader participated, either because your facility does not have an appointed leader or the appointed leader(s) did not participate, select 'No.'
36. Facility leadership has demonstrated commitment to antibiotic stewardship efforts by: (Check all that apply.)	*Required*. Select, from the choices listed, the ways in which facility leadership demonstrated their commitment to antibiotic stewardship efforts in your facility during the past calendar year. Clarification on some of the response options can be found below. Select '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' if a senior executive, such as a clinical administrator, Chief Medical Officer, or other senior-level management, at your facility supports your program and is responsible for ensuring availability of necessary resources. Select 'Information on stewardship activities and outcomes is presented to facility leadership and/or board at least annually' if your program reports stewardship activities and outcomes to senior leadership and/or the facility board at least once per year (for example, including stewardship measures in facility quality dashboard reports). This presentation may be during a meeting, or otherwise sharing reports or information up the chain to leadership. Select 'Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues' if there is evidence of broad-reaching communication from senior-level management to facility staff about antibiotic stewardship efforts within the past calendar year. Examples include written communication to facility staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility's stewardship efforts. Select 'Providing opportunities for facility staff training and development on antibiotic stewardship' if facility leadership or management has provided staff antibiotic stewardship education in-house (for example, workshops, lectures) or access to antibiotic stewardship trainings (for example, by approving time and/or providing funds to attend stewardship conferences, webinars) within the past calendar year. Select 'Providing a formal statement of support for antibiotic stewardship (for example, a written policy or statement approved by the board)' if there is evidence of senior-level management support focused on antibiotic use, prescribing, and/or stewardship (for example, formal letter of support for antibiotic stewardship efforts,

	written support in an annual report, communication of support in executive-level meetings notes). Select 'Ensuring that staff from key support departments and groups (for example, IT) are contributing to stewardship activities' if your facility ensures other groups and departments in the facility are aware of stewardship efforts and collaborate with the stewardship program.
37. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes. 37a. If Yes, what is the position of this leader? (Check one.) 37b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)	*Required*. Select 'Yes' if at least one individual has been identified to lead antibiotic stewardship activities, as evidenced by responsibility for improving antibiotic use in their job description or performance review, authority to coordinate activities of staff from multiple departments (for example, laboratory, pharmacy, information technology), and/or responsibility to report to senior-level management on antibiotic stewardship planning and outcomes; otherwise, select 'No.' *Conditionally Required*. If 'Yes', specify the qualification or job title of the leader(s). If 'Other' is selected, specify the position. *Conditionally Required*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected, specify, from the choices listed, the qualities of your facility's **physician** leader. Clarification on some of the response options can be found below. Select 'Has antibiotic stewardship responsibilities in their contract, job description, or performance review' if the **physician** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the **physician** stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **physician** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging remotely in your facility's stewardship activities. Select 'Completed an ID fellowship' if the **physician** stewardship leader completed an ID fellowship, specifically, a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program on antibiotic stewardship' if the **physician** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or commensurate level of continuing education credit(s). Select 'Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship' if the physician stewardship leader completed other antibiotic stewardship trainings, exclusive of other response options, such as CDC's online training course on antibiotic stewardship that offers participants over 10 hours of free continuing education: https://www.cdc.gov/antibiotic-use/training/continuing-education.html.

37c. What percentage of time for antibiotic stewardship activities is specified in the **physician** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract, job description, or performance review' was selected for the physician lead, specify the percent time (or equivalent) stipulated in the **physician** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select 'Not specified.' This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked.
37d. **In an average week**, what percentage of time does the **physician** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected, specify the percent time (or equivalent) that the **physician** stewardship leader, on average, actually spends on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in their contract or job description. An estimate is fine.
37e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected, specify, from the choices listed, the qualities of your facility's **pharmacist** leader. Clarification on some of the response options can be found below. Select 'Has antibiotic stewardship responsibilities in their contract, job description, or performance review' if the **pharmacist** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the pharmacist stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **pharmacist** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed a PGY2 ID residency and/or ID fellowship' if the **pharmacist** stewardship leader completed a PGY2 ID residency and/or ID fellowship, specifically, a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program on antibiotic stewardship' if the **pharmacist** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or commensurate level of continuing education credit(s). Select 'Completed other training(s) (for example, conferences or online modules) on antibiotic stewardship' if the pharmacist stewardship leader completed other antibiotic stewardship trainings, exclusive of other response options, such as CDC's online training course on antibiotic stewardship that offers participants over 10 hours of free continuing education: https://www.cdc.gov/antibiotic-use/training/continuing-education.html.

37f. What percentage of time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for the pharmacist lead, specify the percent time (or equivalent) stipulated in the **pharmacist** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select "Not specified." This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked.
37g. **In an average week**, what percentage of time does the **pharmacist** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected, specify the percent time (or equivalent) that the **pharmacist** stewardship leader, on average, actually spends on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in their contract or job description. An estimate is fine.
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?	*Conditionally Required*. If 'Pharmacist' or 'Other' was selected, select 'Yes' if your facility has at least one **physician** who dedicates time distinct from general physician duties to provide antibiotic stewardship support to the non-physician leader and serve as a point of contact for antibiotic stewardship efforts; otherwise, select 'No'.
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?	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was not selected, select 'Yes' if your facility has at least one **pharmacist** who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
38. Our facility has the following priority antibiotic stewardship interventions: (Check all that apply.)	*Required*. Select the intervention(s), from the choices listed, that your facility has implemented over the past calendar year. Clarification on some of the response options can be found below. Select 'Prospective audit and feedback for specific antibiotic agents' if the stewardship team (or physicians or pharmacists knowledgeable in antibiotic use and who are overseen by the stewardship team and are not part of the treating team) conducts a prospective review of the appropriateness of antibiotic use for any antibiotic (whether or not it is on formulary) and then provides feedback in real-time to the front-line clinicians with recommendations based on the culture results, clinical status of the patient, and other important factors. Facilities may implement prospective audit and feedback in different ways, depending on the level of expertise available (for example, on a limited number of floors/units, for a limited number of agents, on limited days, or across the entire facility). Select 'Preauthorization for specific antibiotic agents' if an approval is required prior to using certain antibiotics that are on formulary. Facilities may implement preauthorization in different ways. Examples include: -your facility has at least one antibiotic agent that requires the stewardship team, or a physician or pharmacist overseen by the stewardship team, to review and approve administration of the drug due to its spectrum of activity or associated toxicities before the agent can be dispensed; - preauthorization is required immediately, or within a specified short timeframe such a 24 hours;

	- there are specific indications or restrictive criteria in the computer entry process. *Note:* It is assumed that non-formulary drugs already require preauthorization. Select 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions' if your facility has or accesses (for example, via your health system or a neighboring facility), and uses guidelines or recommendations for antibiotic treatment selection that are based on national guidelines and take into account facility-specific factors such as formulary, resistance patterns, etc. for ANY common clinical conditions.
38a. For which categories of antimicrobials? answer for the following categories of antimicrobials, *whether or not* they are on formulary. (Check all that apply.)	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected, specify for which categories of antimicrobials the stewardship team reviews courses of therapy for specified agents and provides feedback and recommendations to the treating team (specifically, prospective audit and feedback). Select all categories containing at least one relevant antimicrobial that undergoes prospective audit and feedback <u>regardless of whether or not it is on formulary</u> in your facility.
38b. Our antibiotic stewardship program monitors prospective audit and feedback interventions (for example, by tracking antibiotic use, types of interventions, acceptance of recommendations).	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected, select 'Yes' if your antibiotic stewardship program monitors prospective audit and feedback interventions through means such as tracking antibiotic use, the types of interventions implemented, and/or the acceptance of recommendations; otherwise, select 'No'.
38c. For which categories of antimicrobials? *only* answer for categories of antimicrobials that are *on formulary*. (Check all that apply.)	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. <u>Only</u> select categories containing at least one relevant antimicrobial requiring preauthorization that is <u>on formulary</u>.
38d. Our antibiotic stewardship program monitors preauthorization interventions (for example, by tracking which agents are requested for which conditions).	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected, select 'Yes' if your antibiotic stewardship program monitors preauthorization interventions through means such as tracking which agents are being requested for which conditions; otherwise, select 'No'.
38e. For which common clinical conditions?	*Conditionally Required*. If 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilites, to assist with antibiotic selection for common clinical conditions' was selected, specify which common clinical conditions listed this applies to. If your facility does not have such recommendations for those listed, select 'None of the above.'
38f. 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).	*Conditionally Required*. If 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilites, to assist with antibiotic selection for common clinical conditions' was selected, select 'Yes' if audits have been conducted to confirm adherence to facility-specific treatment guidelines or recommendations for ANY common clinical conditions; otherwise, select 'No'.

38g. For which common clinical conditions?	*Conditionally Required*. If 'Yes,' specify which common clinical conditions the stewardship program monitors adherence to the facility's treatment recommendations for antibiotic selection. If your facility does not monitor for the conditions listed, select '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.)	*Required*. Select, from the choices listed, the policies or formal procedures that your facility had in place during the past calendar year. Clarification on some of the response options can be found below. Select 'Early administration of effective antibiotics to optimize the treatment of sepsis' if your antibiotic stewardship program works with sepsis experts in the facility, as well as pharmacy and microbiology lab, to optimize the treatment of sepsis. Select 'Stopping unnecessary antibiotic(s) in new cases of *Clostridioides difficile* infection (CDI)' if your facility reviews antibiotics in patients with new diagnoses of CDI infection to identify opportunities to stop unnecessary antibiotics. Select 'Review of culture-proven invasive (for example, bloodstream) infections' if your facility conducts prospective audit and feedback of new culture or rapid diagnostic results to reduce the time needed to discontinue, narrow, or broaden antibiotic therapy as appropriate. Select 'Review of planned outpatient parenteral antibiotic therapy (OPAT)' if OPAT is reviewed by your antibiotic stewardship program to determine if it is necessary and optimize therapy. Select 'The treating team reviews antibiotics 48-72 hours after initial order (specifically, antibiotic time-out)' if providers at your facility reassess the continuing need and choice of antibiotics after more data (including clinical results) become available.
39a. 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.	*Conditionally Required.* If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' was selected, select 'Yes' if your facility's antibiotic stewardship program reviews how often patients are discharged on antibiotics for the shortest effective duration; these are retrospective reviews of patterns within the facility. Otherwise, select 'No'.
40. Our facility has in place the following specific 'pharmacy-based' interventions: (Check all that apply.)	*Required*. Select, from the choices listed, the interventions that your facility had in place, over the past calendar year, that are initiated by pharmacists and/or embedded into pharmacy sections of electronic health records.
41. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use.	*Required*. Select 'Yes' if your facility engaged bedside nurses in actions to optimize antibiotic use over the past calendar year; otherwise, select 'No'.
41a. Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)	*Conditionally Required*. If 'Yes', select from the choices listed, the interventions that your facility had in place to engage nurses in antibiotic stewardship efforts.

41b. Is that information available at the bedside (for example, on a whiteboard in the room)?	*Conditionally Required*. If "Nurses track antibiotic duration of therapy" was selected, select 'Yes' if the information about antibiotic duration of therapy was available at the patient's bedside (for example, on a whiteboard in the room, on a clipboard, etc.); otherwise, select 'No.'
42. Our stewardship program monitors: (Check all that apply.)	*Required*. Select, from the choices listed, the measures that your facility's stewardship team monitored over the past calendar year. Clarification on some of the response options can be found below. For 'Antibiotic resistance patterns (either facility- or region-specific), at least annually': Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (for example, receiving local data from a neighboring facility); or use of the NHSN AR Option. For '*Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually': Monitoring *Clostridioides difficile* includes infection rates or LabID events in your facility. If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at the unit-, service-, and/or facility-wide level, select 'antibiotic use in some other way' and specify the metric.
43. Our stewardship program provides the following antibiotic use reports to prescribers, at least annually: (Check all that apply.) 43a. Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.	*Required*. Specify the reports on antibiotic use that the program shared with prescribers over the past calendar year, from the choices listed. These reports are intended to be targeted towards specific prescribers, units, or services rather than generic facility-wide reports. *Conditionally Required*. If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' was selected, select 'Yes' if your facility's stewardship program provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (for example, academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select 'No.'
44. Our facility distributes an antibiogram to prescribers, at least annually.	*Required*. Select 'Yes' if your facility distributed an antibiogram (a facility cumulative antibiotic resistance report that presents data from lab reports in a way that supports optimal antibiotic use and is consistent with facility guidelines) to prescribers at least once in the past calendar year; otherwise, select 'No.'
45. Information on antibiotic use, antibiotic resistance, and stewardship efforts is presented to facility staff, at least annually.	*Required*. Select 'Yes' if your facility's stewardship program shared updates with facility staff on antibiotic use, antibiotic resistance, and stewardship efforts either via in-person presentations or distribution of written materials, at once in the past calendar year; otherwise, select 'No.'
46. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) at least annually? (Check all that apply.)	*Required*. Select, from the choices listed, the groups in your facility that received education specifically about appropriate antibiotic use, adverse reactions, and antibiotic resistance (for example, Grand Rounds, in-service training, direct instruction) within the past calendar year. 'Prescribers' includes both prescribers employed by the facility and licensed independent practitioners.

47. Are patients provided education on important side effects of prescribed antibiotics? 47a. How is education to patients on side effects shared? (Check all that apply.)	*Required*. Select 'Yes' if patients received education on important side effects of prescribed antibiotics; otherwise, select 'No.' *Conditionally Required*. If 'Yes', specify, from the choices listed, how education on side effects of prescribed antibiotics is regularly provided to patients.
Optional Antibiotic Stewardship Practices Questions **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.	*Optional*. Select 'Yes' if your facility's antibiotic stewardship activities are developed or implemented in conjunction with quality improvement and/or patient safety initiatives in the facility (for example, the stewardship team works with the quality improvement or patient safety team to implement stewardship interventions, the stewardship team participates in quality improvement meetings regarding sepsis core measures); otherwise, select 'No.'
49. Our facility accesses remote stewardship expertise (for example, tele-stewardship) to obtain support for our antibiotic stewardship efforts.	*Optional*. Select 'Yes' if, over the past calendar year, your facility ever accessed remote stewardship expertise that was specifically targeted for your facility's antibiotic stewardship efforts. This typically occurs when antibiotic stewardship expertise is not otherwise available at the facility to provide specific feedback or recommendations needed. This does *not* include generic stewardship resources (for example, webinars) or using remote methods (for example, telephone) to contact an antibiotic steward who otherwise works onsite at the facility; otherwise, select 'No.'
50. Our stewardship program works with the microbiology laboratory to implement the following interventions: (Check all that apply.)	*Optional*. Select, from the choices listed, the ways in which your stewardship program worked with your facility's microbiology laboratory to implement antibiotic stewardship interventions over the past calendar year. Select 'Selective reporting of antimicrobial susceptibility testing results' if your facility tailors facility susceptibility reports to show antibiotics that are consistent with facility treatment guidelines or recommendations by the stewardship program. Select 'Placing comments in microbiology reports to improve prescribing' if, for example, information is included to help providers know which pathogens might represent colonization or contamination.
51. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship program? (Check all that apply.)	*Optional*. Select, from the choices listed, the group(s) that provide(s) oversight of your facility's antibiotic stewardship efforts and to whom the antibiotic stewardship leader is accountable. If 'Other' is selected, specify the committee or job title. Select 'None' if no further oversight is provided to the antibiotic stewardship leader(s).

Facility Water Management Program (WMP) (Required section. Complete with input from facility water management team.)	
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)? 52a. If Yes, who is represented on your WMP team? (Check all that apply)	*Required.* Select 'Yes' if your has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No' *Conditionally Required.* If 'Yes', specify the roles of the team members represented on the water management program team. If 'Other' is selected, specify the role of the team member.
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 diagrams that map all water supply sources, treatment systems, processing steps, control measures, and end-use points. 53a. If Yes, when was the most recent assessment conducted? (Check one)	*Required*. Select 'Yes' if your facility has conducted a facility environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted.
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 54a. If Yes, when was the most recent assessment conducted? (Check one)	*Required.* Select 'Yes' if your facility has ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness; Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted.
55. Does your facility regularly monitor the following parameters in the building water system(s)? *(Check all that apply)*	*Required.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No' • Disinfectant (such as residual chlorine) • Water temperature • Water pH • Heterotrophic plate counts (HPC) testing • Specific *Legionella* testing • Specific *Pseudomonas* testing

If Yes, do you have a plan for corrective actions when specific parameters are not within acceptable limits as determined by your water management program? If Yes, where and how frequently does your facility monitor the parameters?	*Conditionally Required*. For each parameter, if 'Yes', specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program? *Conditionally Required*. For each parameter, if 'Yes', specify the location of monitoring. If 'Other' is selected, specify the location. (Check all that apply) • Entry point(s) • 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 *Conditionally Required*. For each parameter location, if 'Yes', specify the frequency of monitoring. If 'Other' is selected, specify the frequency. (Check one) • Daily • Weekly • Monthly • Quarterly • Annually • Other
56. Does your Water Management Program address measures to prevent transmission of bacterial pathogens from wastewater premise plumbing to patients?	*Required.* Select 'Yes' if your facility's Water Management Program addresses measures to prevent transmission of bacterial pathogens from wastewater premise plumbing to patients; select 'No' if it does not; select 'N/A, my facility does not have a Water Management Program' if your facility does not have a Water Management Program.