CUYAHOGA COUNTY BOARD OF HEALTH

YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Date:

- 1. Name of Facility:
- 2. Address:
- 3. Contact person (name and title):
- 4. Contact information:
- 5. Type of Facility (SNF, LTAC, Assisted Living, Rehab, Hospice, mixed, group home, waiver group home etc:
- **6. Total bed capacity:** Current Occupancy:
- 7. If the facility is mixed, bed capacity & occupancy of each unit(add additional rows as needed)

	Bed Capacity	Current Occupancy
SNF		
LTAC		
AL		
REHAB		
HOSPICE		
MEMORY CARE		
OTHER(SPECIFY)		

- 8. Is this facility part of a large chain (Y/N?):
 - If yes, please specify (include name and contact info of local locations):
- 9. Affiliated with local health system (Y/N?):
- 10. Able to create isolation units (Y/N?):
 - Bed capacity of isolation unit:
- 11. Total number of staff members:
 - Admin:
 - Healthcare workers (includes all staff members who have any contact with patients):
- 12. Does your facility utilize agency staff? (Y/N if yes specify)

- 13. Last date of updated hygiene training for staff:
- 14. Personal protective equipment status currently (how long will current supplies last?):
- 15. Occupational Health Unit (Y/N?):
- 16. Infection Control Practitioner (Y/N?):
- 17. Name of Director of Nursing:
 - o Cell phone number:
- 18. Name of ICP if applicable:
 - o Cell phone number:
- 19. Name of Medical Director:
 - Cell phone number:
- 20. Hospital partner (if applicable):
- 21. Mechanism for admitting patients to the hospital if needed (direct admit/ ER):
- 22. Hospitals where patients are usually transported to:
- 23. Transportation mode of EMS (Public vs Private):
 - If private specify company:
- 24. Name of laboratory for COVID testing (patients):
- 25. Turnaround time for COVID testing:
- 26. Name of laboratory for COVID testing (staff):
- 27. The number of current positive cases include date:
 - Patients:
 - I. Disposition- No. Admitted: No In-house: No. transferred/discharged in last 2 weeks:
 - o Staff:
- I. No Home: Admitted: