

Patient Safety Component –Annual Facility Survey for LTCF

* required for saving	Tracking #:
Facility ID:	*Survey Year:
*National Provider #:	*CMS certification #:
	State Provider #:

Facility Characteristics

*Ownership (check one):

For profit
 Not for profit, including church
 Government
 Veteran’s Affairs

*Certification (check one):

Dual Medicare/Medicaid
 Medicare only
 Medicaid only
 State only

*Affiliation (check one):

Independent, free-standing
 Independent, continuing care retirement community
 Multi-facility organization (chain)
 Hospital system, attached
 Hospital system, free-standing

In the previous 12 months, No LTCF or not operational in this survey year

*Average daily census: _____

*Number of Short stay residents (<90 days): _____
 *Number of Long-stay residents (>90 days): _____

Average Length of Stay for Short stay residents (<90 days): _____
 Average Length of Stay for Long-stay residents (>90 days): _____

*Number of New Admissions: _____

* Total Number of Beds: _____

*Indicate the percentage of beds represented by the following service types: (must sum to 100%)

a. Long-term General Nursing: _____

b. Long-term Dementia: _____

c. Skilled nursing/Short-term (subacute) rehabilitation: _____

d. Long-term psychiatric (non dementia): _____

e. Ventilator: _____

f. Bariatric: _____

g. Other: _____

Infection Control Practices

*Number of FTE dedicated to infection control activity in facility: _____

a. Total hours per week performing surveillance: _____

b. Total hours per week for infection control activities other than surveillance: _____

c. Total hours per week performing other duties, not related to infection control: _____

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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 strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

Facility Microbiology Laboratory Practices

*1. Does your facility have its own laboratory that performs microbiology/antimicrobial susceptibility testing?

- Yes No

If No, where is your facility's antimicrobial susceptibility testing performed? (check one)

- Affiliated medical center, within same healthcare system
 Medical center, contracted locally
 Commercial referral laboratory
 Other (specify): _____

*2. Indicate whether your facility screens new admissions for any of the following multidrug-resistant organisms: (check all that apply)

- We do not screen new admissions for MDROs
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
If checked, indicate the specimen types sent for screening:(check all that apply)
 Nasal swabs Wound swabs Sputum Other skin site
- Vancomycin-resistant *Enterococcus* (VRE)
If checked, please indicate the specimen types sent for screening :(check all that apply)
 Rectal swabs Wound swabs Urine
- Multidrug-resistant gram-negative rods (includes carbapenemase resistant *Enterobacteriaceae*; multidrug-resistant *Acinetobacter*, etc.)
If checked, indicate the specimen types sent for screening:(check all that apply)
 Rectal swabs Wound swabs Sputum Urine

Electronic Health Record Utilization

*Indicate whether any of the following are available in an electronic health record (check all that apply)

- Microbiology lab culture and antimicrobial susceptibility results
 Medication orders
 Medication administration record
 Resident vital signs
 Resident admission notes
 Resident progress notes
 Resident transfer or discharge notes