**Long Term Care Facility Component—Annual Facility Survey**

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| \*required for saving | Tracking #: |
| Facility ID: | \*Survey Year: |
| \*National Provider ID: | State Provider #: |
| **Facility Characteristics** |
| \*Ownership (check one): |
| □ For profit | □ Not for profit, including church | □ Government (not VA) | □ 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, |
| \*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: \_\_\_\_\_\_\_\_\_\_\_ | \*Number of Pediatric Beds (age <21): \_\_\_\_\_\_\_\_\_ |
| \*Indicate 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. Hospice/Palliative: | \_\_\_\_\_\_\_\_ |
|  | h. Other: | \_\_\_\_\_\_\_\_ |
| **Infection Control Practices** |
| \*Total staff hours per week 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: | \_\_\_\_\_\_\_\_ |
|  |  |
|  | *Continued >>* |
| 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).CDC 57.137 (Front) Rev 1 v6.6 |

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| **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 health 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, 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 |
|  | □ None of the above |