OMB No. 0920-0666
Exp. Date: xx-xx-xxxx
www.cdc.gov/nhsn

NHSN Long Term Care Facility Component—Annual Facility Survey

*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: _____

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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