

# NHSN Long Term Care Facility Component—Annual Facility Survey

Page 1 of 2

*required for saving	Tracking #:
Facility ID:	*Survey Year:
*National Provider ID:	State Provider #:
<b>Facility Characteristics</b>	
*Ownership (check one):	
<input type="checkbox"/> For profit <input type="checkbox"/> Not for profit, including church <input type="checkbox"/> Government (not VA) <input type="checkbox"/> Veteran's Affairs	
*Certification (check one):	
<input type="checkbox"/> Dual Medicare/Medicaid <input type="checkbox"/> Medicare only <input type="checkbox"/> Medicaid only <input type="checkbox"/> State only	
*Affiliation (check one):	
<input type="checkbox"/> Independent, free-standing <input type="checkbox"/> Independent, continuing care retirement community <input type="checkbox"/> Multi-facility organization (chain) <input type="checkbox"/> Hospital system, attached <input type="checkbox"/> 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:	_____
<b>Infection Control Practices</b>	
*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).

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Page 2 of 2

### 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