Table 1. Instructions for Completion of the Long Term Care Facility Component - Annual Facility Survey (CDC 57.137) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2011, a facility would complete a 2010 survey.
National Provider ID	*Required.* Enter your facility National Provider ID (10-digit number)
State Provider ID	*Optional.* If available, enter your facility State Provider ID
Facility Characteristics	
Ownership	*Required*. Select the appropriate ownership of this facility from the drop-down menu. (check one) • P - For profit • NP - Not for profit, including church • GOV – Government (not VA) • VA - Veteran's Affairs
Certification	*Required*. Select the appropriate certification of this facility from the drop-down menu. (check one) • Dual Medicare/Medicaid • Medicare only • Medicaid only • State only
Affiliation	*Required*. Select the appropriate affiliation of this facility from the drop-down menu. (check one) • Independent, free-standing • Independent, continuing care retirement community • Multi-facility organization (chain) • Hospital system, attached • Hospital system, free-standing
Average daily census	*Required.* Enter the average daily census for your facility during the last full calendar year (12 months).
Number of Short-stay residents (≤90 days)	*Required.* Enter the total number of short stay residents for your facility during the last full calendar year.
Number of Long-stay residents (>90 days)	*Required.* Enter the total number of long stay residents for your facility during the last full calendar year.
Average Length of Stay for Short-stay residents (≤90 days)	*Optional.* Enter the average length of stay for short stay residents for your facility during the last full calendar year.
Average Length of Stay for Long-stay residents (>90 days)	*Optional.*. Enter average length of stay for long stay residents for your facility during the last full calendar year.
Number of New Admissions	*Required.* Enter the total number new admissions to your facility during the last full calendar year.
Total Number of Beds:	*Required.* Enter the total number (including any pediatric beds) of beds for your facility

Data Field	Instructions for Form Completion
Number of Pediatric (age < 21) Beds	*Required.* Enter the number of pediatric beds for your facility. Pediatric beds are defined as those beds dedicated to residents that are less than 21 years of age. If you have no pediatric beds at your facility report zero.
To determine the percentage of beds for each of the categories below, divide the number of beds for that category by the Total number of beds at your facility (reported above) and multiple by 100. If you facility has no beds in any categories listed below report 0% for that category. The sum of items a through h should total 100%	
a. Long-term General Nursing:	*Required.* Percentage of beds that are Long-term General Nursing beds
b. Long-term Dementia	*Required.* Percentage of beds that are Long-term Dementia beds
c. Skilled nursing/Short-term (subacute) rehabilitation	*Required.* Percentage of beds that are Skilled nursing/Short-term (subacute) rehabilitation beds
d. Long-term psychiatric (non dementia)	*Required.* Percentage of beds that are Long-term psychiatric (non dementia) beds
e. Ventilator	*Required.* Percentage of beds that are Ventilator beds
f. Bariatric	*Required.* Percentage of beds that are Bariatric beds
g. Hospice/Palliative	*Required.* Percentage of beds that are Hospice/Palliative care beds
h. Other	*Required.* Percentage of beds that are "Other" beds (i.e., those that do not fit into one of the categories listed above)
Infection Control Practices	
Number of staff hours dedicated to infection control activities in the facility	*Required.* Enter the total number of staff hours dedicated to performing infection control activities at your facility each week
a. Total hours per week performing surveillance	*Required.* Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection prevention activities other than surveillance	*Required.* Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory.*	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Y - Yes' if your laboratory performs antimicrobial susceptibility testing. Otherwise, select 'N -No'. If 'N - No' is selected, must answer the second part of this question. *Conditionally Required.* Select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center or Commercial referral laboratory. If multiple laboratories are used include the laboratory which performs the majority of the bacterial susceptibly testing.
2. Indicate whether your facility screens new admissions for any of the	*Required.* Indicate by checking the appropriate boxes if your facility obtains screening cultures (Active Surveillance Testing) on newly admitted residents for the following multidrug resistance organisms (MDROs) (check all that apply).

Data Field	Instructions for Form Completion
following multidrug-resistant organisms (check all that apply)?	If your facility <u>does not</u> obtain screening cultures on new admissions for any of the MDROs listed check the box indicating "We do not screen new admissions for MDROs" only. • We do not screen new admissions for *MDROs* • Methicillin-resistant Staphylococcus aureus (MRSA) • Vancomycin-resistant Enterococcus (VRE) • Multidrug-resistant gram-negative rods (includes carbapenemase resistant • Enterobacteriaceae; multidrug-resistant Acinetobacter, etc.)
For the MDROs checked, indicate the specimen types sent for screening (check all that apply)?	*MRSA: Conditionally required.* • Nasal swabs • Wound swabs • Sputum • Other skin site *VRE: Conditionally required.* • Rectal swabs • Wound swabs • Urine Multidrug-resistant gram-negative rods*: Conditionally required.* • Rectal swabs • Wound swabs • Sputum • Urine
Electronic Health Record Utilization	
3. Indicate whether any of the following are available in an electronic health record (check all that apply)	*Required.* Indicate by checking the appropriate boxes whether any of the following are available in an electronic health record at your facility (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