



NHSN 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):	
<input type="checkbox"/> For profit <input type="checkbox"/> Not for profit, including church <input type="checkbox"/> Government (not VA) <input type="checkbox"/> Veterans 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	
<i>In the previous calendar year:</i> *Average daily census: _____ *Total number of short-stay residents: _____ Average length of stay for short-stay residents: _____ *Total number of long-stay residents: _____ Average length of stay for long-stay residents: _____ *Total number of new admissions: _____	
*Number of Beds: _____ *Number of Pediatric Beds (age <21): _____ *Indicate which of the following primary service types are provided by your facility. On the day of this survey, indicate the number of residents receiving those services (list only one service type per resident, i.e. total should sum to resident census on day of survey completion):	
<u>Primary Service Type</u>	<u>Service provided?</u>
a. Long-term general nursing:	<input type="checkbox"/> _____
b. Long-term dementia:	<input type="checkbox"/> _____
c. Skilled nursing/Short-term (subacute) rehabilitation:	<input type="checkbox"/> _____
d. Long-term psychiatric (non dementia):	<input type="checkbox"/> _____
e. Ventilator:	<input type="checkbox"/> _____
f. Bariatric:	<input type="checkbox"/> _____
g. Hospice/Palliative:	<input type="checkbox"/> _____
h. Other:	<input type="checkbox"/> _____
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:	_____
<i>Continued >></i>	
<small>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)).</small>	
<small>Public reporting burden of this collection of information is estimated to average 45 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).</small>	
<small>CDC 57.137 (Front) Rev 1 v7.0</small>	

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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

*3. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)

- Enzyme immunoassay (EIA) for toxin GDH plus NAAT (2-step algorithm)
- Cell cytotoxicity neutralization assay GDH plus EIA for toxin, followed by NAAT for discrepant results
- Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP) Toxigenic culture (*C. difficile* culture followed by detection of toxins)
- Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm) Other (specify): _____

("Other" should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory, refer to the Tables of Instructions for this form, or conduct a search for further guidance on selecting the correct option to report.)

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