Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
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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) ☐ Veterans 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 calendar year:

*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):

Primary Service Type	Service provided?	Number of residents
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:	☐	_____

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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 1 hour 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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NHSN National Healthcare Safety Network

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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 (MDROs): (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

☐ Cell cytotoxicity neutralization assay

☐ Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP)

☐ Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm)

☐ GDH plus NAAT (2-step algorithm)

☐ GDH plus EIA for toxin, followed by NAAT for discrepant results

☐ Toxigenic culture (*C. difficile* culture followed by detection of toxins)

☐ 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.)

*4. Does your laboratory provide a report summarizing the percent of antibiotic resistance seen in common organisms identified in cultures sent from your facility (often called an antibiogram)?

☐ Yes ☐ No

If Yes, how often is this summary report or antibiogram provided to your facility? (check one)

☐ Once a year ☐ Every 2 years ☐ Other (specify): _____

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Infection Control Practices

*5. 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: _____

*6. Does the facility routinely require use of gowns/gloves for care of residents infected or colonized with MRSA? (check one)

- ☐ Yes, all infected and colonized residents
- ☐ Yes, only residents with active infection
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ No

*7. Does the facility routinely require use of gowns/gloves for care of residents infected or colonized with VRE? (check one)

- ☐ Yes, all infected and colonized residents
- ☐ Yes, only residents with active infection
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ No

*8. Does the facility routinely require use of gowns/gloves for care of residents infected or colonized with CRE? (check one)

- ☐ Yes, all infected and colonized residents
- ☐ Yes, only all residents with active infection
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ No

*9. Does the facility routinely require use of gowns/gloves for care of residents infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae in contact precautions? (check one)

- ☐ Yes, all infected and colonized residents
- ☐ Yes, only residents with active infection
- ☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, diarrhea, presence of an indwelling device)
- ☐ No

*10. When a resident colonized or infected with an MDRO is transferred to another facility, does your facility communicate the resident's MDRO status to the receiving facility at the time of transfer? ☐ Yes ☐ No

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Infection Control Practices (continued)

*11. Among residents with an MDRO admitted to your facility from other healthcare facilities, what percentage of the time does your facility receive information from the transferring facility about the resident's MDRO status? _____%

Antibiotic Stewardship Practices

*12. Is there a leader responsible for the impact of activities to improve use of antibiotics at your facility? ☐ Yes ☐ No

If Yes, what is the position of this leader?

☐ Medical director ☐ Director of Nursing

☐ Consultant Pharmacist ☐ Other (please specify): _____

*13. Does your facility have a policy that requires prescribers to document in the medical record or during order entry, a dose, duration, and indication for all antibiotics? ☐ Yes ☐ No

If Yes, has adherence to a documentation policy (dose, duration, and indication) been monitored? ☐ Yes ☐ No

*14. Does your facility provide facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic decision making for common clinical conditions? ☐ Yes ☐ No

If Yes, has adherence to facility-specific treatment recommendations been monitored? ☐ Yes ☐ No

*15. Is there a formal procedure for performing a follow-up assessment 2-3 days after a new antibiotic start to determine whether the antibiotic is still indicated and appropriate (e.g. antibiotic time out)? ☐ Yes ☐ No

*16. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with feedback) at your facility? ☐ Yes ☐ No

*17. Does the pharmacy service provide a monthly report of antibiotic use (e.g., new orders, number of days of antibiotic treatment) for the facility? ☐ Yes ☐ No

*18. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use in the past 12 months? ☐ Yes ☐ No

Electronic Health Record Utilization

*19. 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