



# 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):  
 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):

<u>Primary Service Type</u>	<u>Service provided?</u>	<u>Number of residents</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"/>	_____

*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 1.08 hours 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).  
 CDC 57.137 (Front) Rev 5 v8.6

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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

\*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)

- |  |   |
|--|---|
| <input type="checkbox"/> Enzyme immunoassay (EIA) for toxin  | <input type="checkbox"/> GDH plus NAAT (2-step algorithm)   |
| <input type="checkbox"/> Cell cytotoxicity neutralization assay                                      | <input type="checkbox"/> GDH plus EIA for toxin, followed by NAAT for discrepant results                  |
| <input type="checkbox"/> Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP)                    | <input type="checkbox"/> Toxigenic culture ( <i>C. difficile</i> culture followed by detection of toxins) |
| <input type="checkbox"/> NAAT plus EIA, if NAAT positive (2-step algorithm)                          | <input type="checkbox"/> Other (specify): _____   |
| <input type="checkbox"/> Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm) |   |

("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 Prevention and Control Practices

\*5. Total staff hours per week dedicated to infection prevention and control activity in facility: \_\_\_\_\_

a. Total hours per week performing surveillance: \_\_\_\_\_

b. Total hours per week for infection prevention and control activities other than surveillance: \_\_\_\_\_

\*6. Is it a policy in your facility that use of gowns/gloves are required 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. Is it a policy in your facility that use of gowns/gloves are required 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. Is it a policy in your facility that use of gowns/gloves are required 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. Is it a policy in your facility that use of gowns/gloves are required for care of residents infected or colonized with ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae? (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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## Long Term Care Facility Component—Annual Facility Survey

### Infection Prevention and 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. Are there one or more individuals responsible for the impact of activities to improve use of antibiotics at your facility?  Yes  No

If Yes, what is the position of the individual(s)? (select all that apply)

- Medical director       Director of Nursing  
 Consultant Pharmacist       Other (please specify): \_\_\_\_\_

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

If Yes, has adherence to the policy to document an 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, nurse, 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

If Yes, What type of feedback is provided to prescribers? (check all that apply)

- Feedback on antimicrobial route and/or dosing  
 Feedback on the selection of antimicrobial therapy and/or duration of therapy  
 Other (please specify): \_\_\_\_\_

\*17. Does the pharmacy service provide a monthly report tracking 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

\*19. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use?  Yes  No

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### Antibiotic Stewardship Practices (continued)

\*20. Are antibiotic use and resistance data reviewed by leadership in quality assurance/performance improvement committee meetings?  Yes  No

\*21. Does your facility have access to individual(s) with antibiotic stewardship expertise (e.g., consultant pharmacist trained in antibiotic stewardship, stewardship team at referral hospital, external infectious disease/stewardship consultant)?  Yes  No

### Electronic Health Record Utilization

\*22. Indicate whether any of the following are available in an electronic health record (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Microbiology lab culture and antimicrobial susceptibility results | <input type="checkbox"/> Medication orders       |
| <input type="checkbox"/> Medication administration record                                  | <input type="checkbox"/> Resident vital signs    |
| <input type="checkbox"/> Resident admission notes  | <input type="checkbox"/> Resident progress notes |
| <input type="checkbox"/> Resident transfer or discharge notes                              | <input type="checkbox"/> None of the above       |