Form Approved
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Long Term Care Facility Component—Annual Facility Survey

Instructions for this form can be accessed: https://www.cdc.gov/nhsn/forms/instr/57.137-toi-annual-facility-survey.pdf

*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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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

☐ Candida Auris (C.Auris)

If checked, indicate the specimen types sent for screening: (check all that apply)

☐ Skin (axilla/groin) ☐ Nares ☐ Other site

*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)

☐ NAAT plus EIA, if NAAT positive (2-step algorithm)

☐ 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

☐ 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 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 with MRSA

☐

☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, , 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 with VRE

☐

☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, , 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 with CRE

☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, , 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 with ESBL

☐ Yes, only those with certain characteristics that make them high-risk for transmission (e.g., wounds, , 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 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 antimicrobials at your facility? ☐ Yes ☐ No

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

☐ Medical director ☐ Director of Nursing ☐ Infection Preventionist

☐ Consultant Pharmacist ☐ Other (please specify): _____

*13. Does your facility have a policy that requires prescribers to document an indication for all antimicrobials 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 treatment recommendations for common infections based on national guidelines to assist with antimicrobial decision making ? ☐ 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 antimicrobial start to determine whether the antimicrobial is still indicated and appropriate (e.g. antibiotic time out)? ☐ Yes ☐ No

*16. Is there a formal procedure for reviewing courses of antimicrobial therapy and communicating with prescribers on antimicrobial selection, dosing, or duration of therapy (i.e., audit and feedback) at your facility? ☐ Yes ☐ No

*17.Does your facility have a system for tracking antimicrobial use? ☐ Yes ☐ No

If yes, what is the source of the antimicrobial use report provided?

☐ Pharmacy services ☐ Electronic Health Records

☐ Manual reporting (i.e., facility infection control log) ☐ Other (please specify): _____

*18. Has your facility provided education to clinicians and other facility staff on improving antimicrobial 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 antimicrobial use? ☐ Yes ☐ No

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Antibiotic Stewardship Practices (continued)

*20. Are antimicrobial 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 antimicrobial stewardship expertise (e.g., consultant pharmacist trained in antimicrobial 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):

- ☐ 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

Facility Water Management and Monitoring Program

23. Have you ever conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (e.g. *Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? ☐ Yes ☐ No

If Yes, when was the most recent assessment conducted? (Check one)

- ☐ ≤ 1 year ago
- ☐ >1 and ≤ 3 years ago
- ☐ > 3 years ago

24. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens? ☐ Yes ☐ No

If Yes, who is represented on the team? (Check all that apply)

- ☐ Facility Administrator
- ☐ Nursing Leadership (e.g., DON or ADON)
- ☐ Consultant
- ☐ Facilities Manager/ Engineer
- ☐ Maintenance Staff
- ☐ Infection Preventionist
- ☐ Risk/Quality Management Staff
- ☐ Medical Director
- ☐ Equipment/ Chemical
- ☐ Other (specify): _____

25. Do you regularly monitor the following parameters in your building's water system? (Check all that apply)

Disinfectant (such as residual chlorine) ☐ Yes ☐ No

If Yes, do you have a plan for corrective actions when disinfectant levels are not within acceptable limits as determined by your water management program? ☐ Yes ☐ No

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Temperature	☐ Yes	☐ No		
If Yes, do you have a plan for corrective actions when temperatures are not within acceptable limits as determined by your water management program?			☐ Yes	☐ No
Heterotrophic plate counts	☐ Yes	☐ No		
If Yes, do you have a plan for corrective actions when heterotrophic plate counts are not within acceptable limits as determined by your water management program?			☐ Yes	☐ No
Specific tests for *Legionella*	☐ Yes	☐ No		
If Yes, do you have a plan for corrective actions when specific tests for *Legionella* are not within acceptable limits as determined by your water management program?			☐ Yes	☐ No