



NHSN Long Term Care Facility Component—Annual Facility Survey

Page 1 of 6

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): <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> <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"/> _____
<p>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)).</p> <p>Public reporting burden of this collection of information is estimated to average 135 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).</p>	
<p>CDC 57.137 (Front) Rev 13.0 Release- January 2025 Continued >></p>	



Long Term Care Facility Component—Annual Facility Survey

Infection Prevention and Control Practices

*5. In addition to the Infection Preventionist (IP) role, how many other roles is the IP responsible for? Select all that apply:

- Director of Nursing
- Assisted Director of Nursing
- Floor Nurse (clinical)
- Administrator
- Other _____

*6. What formal training has your Infection Preventionist received? Select all that apply:

- None
- Infection Prevention Training Course through CDC
- Infection Prevention Training Course through State Health Department
- Other

*7. What certification has your infection preventionist obtained? Select all that apply:

- None
- Certification in Infection Control (CIC)
- Long-Term Care Certification in Infection Prevention (LTC-CIP)
- Other _____

*8. How many times in the past year have you had to find a new employee to take over the Infection Preventionist (IP) role? In other words, how many times has this position "turned over"? (check one)

- Did not turn over the IP role in the past year
- Once
- Twice
- Three
- Four or more

*9. Total infection preventionist 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: _____

*10. 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

*11. 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

*12. 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

*13. 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

*14. 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)	
*15. 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	
*16. Are there one or more individuals responsible for the impact of activities to improve use of antimicrobials at your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, what is the position of the individual(s)? (select all that apply)	
<input type="checkbox"/> Medical director	<input type="checkbox"/> Director of Nursing
<input type="checkbox"/> Consultant Pharmacist	<input type="checkbox"/> Infection Preventionist
<input type="checkbox"/> Other (please specify): _____	
*17. Does your facility have a policy that requires prescribers to document an indication for all antimicrobials in the medical record or during order entry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, has adherence to the policy to document an indication been monitored?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*18. Does your facility provide treatment recommendations for common infections based on national guidelines to assist with antimicrobial decision making?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, has adherence to facility-specific treatment recommendations been monitored?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*19. 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*20. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*21. Does your facility have a system for tracking antimicrobial use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the source of the antimicrobial use report provided?	
<input type="checkbox"/> Pharmacy services	<input type="checkbox"/> Electronic Health Records
<input type="checkbox"/> Manual reporting (i.e., facility infection control log)	<input type="checkbox"/> Other (please specify): _____
*22. Has your facility provided education to clinicians and other facility staff on improving antimicrobial use in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*23. Does your facility have a written statement of support from leadership that supports efforts to improve antimicrobial use?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Long Term Care Facility Component—Annual Facility Survey

Page 5 of 6

Antibiotic Stewardship Practices (continued)

- *24. Are antimicrobial use and resistance data reviewed by leadership in quality assurance/performance improvement committee meetings? Yes No
- *25. 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

*26. 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 |

Facility Water Management and Monitoring Program

27. 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)

- | | |
|--|---|
| <input type="checkbox"/> ≤ 1 year ago | <input type="checkbox"/> >1 and ≤ 3 years ago |
| <input type="checkbox"/> > 3 years ago | |

28. 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)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Facility Administrator | <input type="checkbox"/> Nursing Leadership (e.g., DON or ADON) | <input type="checkbox"/> Consultant | <input type="checkbox"/> Facilities Manager/Engineer |
| <input type="checkbox"/> Maintenance Staff | <input type="checkbox"/> Infection Preventionist | <input type="checkbox"/> Risk/Quality Management Staff | <input type="checkbox"/> Medical Director |
| <input type="checkbox"/> Equipment/ Chemical | <input type="checkbox"/> Other (specify): _____ | | |

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

- | | | |
|---|------------------------------|-----------------------------|
| Disinfectant (such as residual chlorine) | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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Long Term Care Facility Component—Annual Facility Survey

- 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