Table 1. Instructions for Completion of the Long-term Care Facility Component - Annual Facility Survey (CDC 57.137)

Note: Unless otherwise stated, the responses to this Annual Facility Survey should be based on the facility characteristics and practices during the previous calendar year (2023).

Data Field	Instructions for Form Completion
Facility ID	**Required**. The NHSN-assigned facility ID will be auto-populated.
Survey Year	**Required**. Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year, unless otherwise stated. For example, in 2024, a facility would complete a 2023 survey.
National Provider ID	**Required**. Enter your facility National Provider ID (10-digit number).
State Provider ID	*Optional.* If available, enter your facility State Provider ID.
Facility Characteristics	
Ownership	**Required**. Select the appropriate ownership of this facility (*check one*). ☐ For profit ☐ Not for profit, including church ☐ Government (Not Veterans Affairs [VA]) ☐ Veterans Affairs
Certification	**Required**. Select the appropriate certification of this facility (*check one*). ☐ Dual Medicare/Medicaid ☐ Medicare only ☐ Medicaid only ☐ State only
Affiliation	**Required**. Select the appropriate affiliation for this facility (*check one*): ☐ Independent, free-standing - The facility does not share a building, staff, or policies (such as infection control) with any other healthcare institution. ☐ Independent, continuing care retirement community – This facility is not affiliated with any other healthcare system but is part of a campus containing other levels of elder care services. ☐ Multi-facility organization (chain) - The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure. ☐ Hospital system attached - The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. The facility is physically connected to the hospital within the system. ☐ Hospital system, free-standing - The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. The facility is not physically connected to the hospital within the system.

Data Field	Instructions for Form Completion
Average daily census	**Required**. Enter the average daily census for your facility during the last full calendar year (12 months).
Total number of short-stay residents	**Required**. Enter the total number of unique residents who stayed **100 days or less** in the previous calendar year. **Note:** If a person starts off as short stay but converts to long-stay, then count the resident in the total number of long-stay.
Total number of long-stay residents	**Required**. Enter the total number of unique residents who stayed **more than 100** days in the previous calendar year.
Average length of stay for short-stay residents	*Optional.* Enter the average length of stay for short-stay residents for your facility during the last full calendar year.
Average length of stay for long-stay residents	*Optional.* Enter average length of stay for long-stay residents for your facility during the last full calendar year.
Total number of new admissions	**Required**. Enter the total number new admissions to your facility during the last full calendar year. A new admission is defined as a new resident entering the facility for the first time or a readmission if the resident was out of the facility more than 2 calendar days (specifically, a change to the *Current Admission Date*)
Number of beds	**Required**. Enter the total number of beds (including any pediatric beds) for your facility.
Number of pediatric (age less than 21) beds	**Required**. Enter the number of pediatric beds for your facility. Pediatric beds are defined as those beds dedicated to residents that are less than 21 years of age. If your facility has no pediatric beds report zero.
Indicate which of the following primary service types are provided by your facility. For each service indicated: ***On the day of this survey***, how many residents are receiving care in your facility by the following primary service types	**Required**. For each primary service type listed, check the box only if your facility provides this primary service type. For the primary service types your facility provides (those with boxes checked), indicate the number of residents primarily receiving that service ***on the day this survey is completed***. Only list one service type per resident and this should be the primary service (or most specialized care) the resident is receiving. For example, a resident may be admitted for skilled care while on a ventilator. That resident would be counted as "ventilator care". A resident who is long-stay but on a specialized dementia unit would be listed as "long-term dementia". The total sum of residents per service type reported should be equal to the resident census on the day the survey is completed. ☐ Long-term general nursing: ☐ Long-term dementia: ☐ Skilled nursing and/or short-term (sub-acute) rehabilitation: ☐ Long-term psychiatric (non-dementia): ☐ Ventilator: ☐ Bariatric: ☐ Hospice/Palliative: ☐ Other:

Facility Microbiology Laboratory Practices *Completion of this section may require the assistance from the microbiology laboratory.*	
1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If 'No', where is the facility's antimicrobial susceptibility testing performed? *(Check One)*	**Required**. Select 'Yes' if your laboratory performs antimicrobial susceptibility testing. Otherwise, select 'No'. *Conditionally Required*. If 'No' is selected, select the location where your facility's antimicrobial susceptibility testing is performed (*check one*): ☐ Affiliated medical center, within same health system ☐ Commercial referral laboratory ☐ Medical center, contracted locally **Note:** If multiple laboratories are used, select the laboratory that performs most of the bacterial susceptibility testing.

2. Indicate whether your facility screens new admissions for any of the following multidrug-resistant organisms (MDROs). *(Check all that apply)* For each MDRO selected, indicate the specimen type(s) sent for screening. *(Check all that apply)*	**Required.** Indicate, by checking the appropriate box(es), if your facility obtains screening cultures (Active Surveillance Testing) on newly admitted residents for the following multidrug-resistant organisms (MDROs): (*check all that apply*) ☐ **We do not screen new admissions for MDROs**: Select this box if your facility does not obtain screening cultures on new admissions for any of the MDROs listed. **NOTE:** if this box is checked, no other boxes should be selected. ☐ **Methicillin-resistant *Staphylococcus aureus* (MRSA)**: *Conditionally Required*. If checked, indicate the specimen type(s) that are sent for screening. (*Check all that apply*) ☐ Nasal swabs ☐ Wound swabs ☐ Sputum ☐ Other skin site ☐ **Vancomycin-resistant *Enterococcus* (VRE)**: *Conditionally Required*. If checked, indicate the specimen type(s) that are 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.): *Conditionally Required*. If checked, indicate the specimen type(s) that are sent for screening. (*Check all that apply*) ☐ Rectal swabs ☐ Wound swabs ☐ Sputum ☐ Urine ☐ **Candida Auris (C. Auris)**: *Conditionally Required*. If checked, indicate the specimen type(s) that are 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)*	**Required.** Select, from the choices listed, the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. ☐ Enzyme immunoassay (EIA) for toxin ☐ Cell cytotoxicity neutralization assay (CCNA): **this option is an uncommon testing method. Verify with the laboratory before selecting this method.** ☐ Nucleic acid amplification test (NAAT): Includes Polymerase Chain Reaction (PCR) and loop-mediated isothermal amplification (LAMP) ☐ NAAT plus EIA, if NAAT positive (2-step algorithm) ☐ Glutamate dehydrogenase (GDH) antigen plus EIA for toxin: two step testing method ☐ GDH plus NAAT: two step testing method ☐ GDH plus EIA for toxin, followed by NAAT for discrepant results: three step testing method ☐ Culture: **this option is an uncommon testing method. Verify with the laboratory before selecting this method.** ☐ Other: **this is an uncommon choice, as most methods can be categorized accurately by selecting from the options provided**. **Notes:** **1.** '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 or conduct a search for further guidance on selecting the correct option to report. **2.** If your facility uses more than one laboratory, you are encouraged to contact the diagnostic laboratory where most of the resident samples/specimens are sent. In discussion with that laboratory, facilities can identify the primary diagnostic testing method for *C. difficile* used by that laboratory.
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)? If 'Yes', indicate how often this summary report is provided.	**Required.** Select 'Yes' if your laboratory provides your facility with a summary report of antibiotic resistance patterns in common bacterial organisms identified in cultures sent from your facility. This report may be called a facility antibiogram. Otherwise, select 'No'. **Note:** This summary is NOT the same as antibiotic susceptibility testing provided on culture reports for individual residents. ***Conditionally required***. If 'Yes' is selected, indicate whether the summary report or antibiogram is provided once a year, every two years, or Other. If 'Other' is selected, specify the frequency.

Infection Prevention and Control Practices	
5. Total staff hours dedicated to infection prevention and control activities in the facility.	**Required**. Enter estimated hours per week that are dedicated to ALL infection prevention and control activities in your facility. If multiple staff members are responsible for parts of the infection prevention and control program, combine the hours spent per week by each person.
a. Total hours per week performing surveillance	**Required**. Based on the total hours dedicated to all program activities, enter the estimated number of hours per week engaged in identifying and reporting healthcare-associated infections and the appropriate denominators.
b. Total hours per week for infection prevention activities other than surveillance	**Required.** Based on the total hours dedicated to all program activities, enter the estimated number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
6. Is it a policy in your facility to routinely use gown/gloves for care of residents infected or colonized with a multidrug-resistant organism (MDRO)? □ Yes □ No (If "No", continue to question #7) If yes, please select the option that is applicable to your facility for each MDRO. ("No" should only be selected if your facility does not have a policy for the MDRO listed.)	**Required.** Select the MDRO option/s from the choices listed that are applicable to your facility's policy of routinely using gowns/gloves for care of residents infected or colonized with a multidrug-resistant organism (MDRO) at your facility. Select 'No' if your facility does not have a policy that requires the use of gowns/gloves during care of residents infected or colonized with the listed MDRO. **Note:** For further information regarding barrier precaution, please visit the CDC's Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities.
7. Is it a policy in your facility to use gowns/gloves for care of residents with certain characteristics that make them high-risk for transmission or acquisition of an MDRO (e.g., wounds, presence of an indwelling device) regardless of MDRO status?	**Required.** Select 'Yes' if your facility has a policy to use gowns/gloves during the care for residents with certain characteristics that make them high-risk for transmission or acquiring a MDRO regardless of MDRO status. Otherwise, select 'No' if your facility does not have a policy that requires the use of gowns/gloves during care of residents with certain characteristics that make them high-risk for transmission or acquisition of an MDRO regardless of MDRO status. **Note:** For further information regarding barrier precaution, please visit the CDC's Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities.

8. 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?	**Required.** Select 'Yes' if your facility **routinely** communicates the status of a patient known to be colonized or infected with a multidrug-resistant organism (MDRO) to the receiving facility at the time of patient transfer; otherwise, select 'No'.
9. 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?	**Required.** Enter the estimated percentage of the time that your facility receives information from a transferring facility about the status of a resident known to be colonized or infected with a multidrug-resistant organism (MDRO).
Antibiotic Stewardship Practices. *Completion of this by section may require assistance from the consultant pharmacist, director of nursing, and/or medical director who focus on efforts to improve antimicrobial use and monitoring (known as Stewardship) for your facility.*	
10. Are there one or more individuals responsible for the impact of activities to improve use of antimicrobials at your facility?	**Required.** Select 'Yes' if there are one or more individuals who have been identified as being responsible for antimicrobial stewardship activities as evidenced by responsibility for improving antimicrobial use in the job description or performance review, authority to coordinate activities of staff from multiple departments (for example, laboratory, pharmacy, information technology), and/or responsibility to report to facility administration/senior leaders on the antimicrobial stewardship program planning and outcomes. Select 'No' if the facility leadership has not specifically given one or more individuals the responsibility, support, and authority to oversee antimicrobial use and stewardship efforts in the facility.
If 'Yes', what is the position of the individuals? *(select all that apply)*	***Conditionally required***. If 'Yes', specify the qualification or job title of the leader(s). More than choice one may be selected. If 'Other' is selected, please specify the position.

11. Does your facility have a policy that requires prescribers to document an indication for all antimicrobials in the medical record or during order entry? If 'Yes', has adherence to the policy to document an indication been monitored?	**Required.** Select 'Yes' if your facility has a policy requiring documentation of an indication for all antimicrobials in the medical record or during order entry; otherwise, select 'No'. ***Conditionally required.*** If 'Yes' to question 13, select 'Yes' if charts or other medical record documentation are routinely reviewed to confirm documentation of an indication; otherwise, select 'No'.
12. Does your facility provide treatment recommendations for common infections based on national guidelines to assist with antimicrobial decision making? If 'Yes', has adherence to facility-specific treatment recommendations been monitored?	**Required.** Select 'Yes' if there are facility-specific recommendations for antimicrobial treatment selection based on national guidelines for ANY common clinical infections diagnosed and treated (for example, urinary tract infections, community required pneumonia, or skin and soft tissue infections); otherwise, select 'No'. ***Conditionally required.*** If 'Yes' to question 14, indicate if charts have been audited to confirm adherence to facility-specific treatment guidelines for ANY of the common clinical conditions listed above by selecting 'Yes' or ' No'.
13. Is there a formal procedure for performing a follow-up assessment 2-3 days after a new antimicrobial start to determine whether the antimicrobial treatment is still indicated and appropriate (for example, antibiotic time out)?	**Required.** Select 'Yes' if your facility has developed a standardized way for clinicians or nurses caring for a resident to reassess the continuing need and choice of antimicrobial treatment when the clinical picture is clearer and more diagnostic information is available in order to determine the following: confirm indication, review microbiology results, and review antibiotic choice, dose, and duration; Otherwise, select 'No'.

14. 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?	**Required.** Select 'Yes' if your facility has a physician, nurse or pharmacist knowledgeable in antimicrobial use, review courses of antimicrobial therapy **and** provides suggestions to optimize use to the providers caring for the resident; otherwise, select 'No'.
15. Does your facility have a system for tracking antimicrobial use? If 'Yes', what is the source of the antimicrobial use report provided? (select all that apply)	**Required.** Select 'Yes' if your facility tracks antimicrobial use measures (e.g., antimicrobial courses, days of therapy, antimicrobial starts) a; Antimicrobial use measurement is critical to identify opportunities for improving antimicrobial use and to assess the impact of stewardship interventions. Select 'No' if the facility does not track antimicrobial use. ***Conditionally required***. If 'Yes', specify the source of the antimicrobial use report provided. Facilities can use different data sources to track antimicrobial prescribing practices. More than one choice may be selected. If 'Other' is selected, please specify the source.
16. Has your facility provided education to clinicians and other facility staff on improving antimicrobial use in past 12 months?	**Required.** Select 'Yes' if your facility has provided specific education on ways to improve antimicrobial use to prescribers, nurses, and other facility staff (for example, in-service training, workshops, direct instruction, etc.); Otherwise, select 'No'.
17. Does your facility have a written statement of support from leadership that supports efforts to improve antimicrobial use?	**Required.** Select 'Yes' if your facility has a written statement of support from leadership that supports efforts to improve antimicrobial use; Otherwise, select 'No'.
18. Are antimicrobial use and resistance data reviewed by leadership in quality assurance / performance improvement committee meetings?	**Required.** Select 'Yes' if antimicrobial use and resistance data are reviewed by leadership in quality assurance/performance improvement committee meetings; Otherwise, select 'No'.

19. Does your facility have access to individual(s) with antimicrobial stewardship expertise (for example, consultant pharmacist trained in antimicrobial stewardship, stewardship team at referral hospital, external infectious disease/stewardship consultant)?	**Required.** Select 'Yes' if your facility has access to individual(s) with antimicrobial stewardship expertise (for example, consultant pharmacist trained in antimicrobial stewardship, stewardship team at referral hospital, external infectious disease/stewardship consultant); Otherwise, select 'No'.
Electronic Health Record Utilization	
20. Indicate whether any of the following are available in an electronic health record. (*Check all that apply*)	**Required***.* Indicate by checking the appropriate box(es) whether any of the following are available in an electronic health record at your facility. (*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	
21. Have you ever conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grow and spread in the facility water system?	*Optional.* Select 'Yes' if your facility has conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No'
If Yes, when was the most recent assessment conducted? *(Check one)*	***Conditionally required***. If 'Yes', specify the time period in which the most recent assessment was conducted. If 'Other' is selected, please specify the time period.
22. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens?	*Optional.* Select 'Yes' if your facility has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No'
If Yes, who is represented on the team? *(Check all that apply)*	***Conditionally required***. If 'Yes', specify the roles of the team members represented on the water management program team. If 'Other' is selected, please specify the role of the team member.
23. Do you regularly monitor the following parameters in your building's water system? *(Check all that apply)*	*Optional.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No' ☐ Disinfectant (such as residual chlorine) ☐ Temperature ☐ Heterotrophic plate counts ☐ Specific tests for *Legionella*
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?	***Conditionally required***. For each parameter, if 'Yes', specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program?