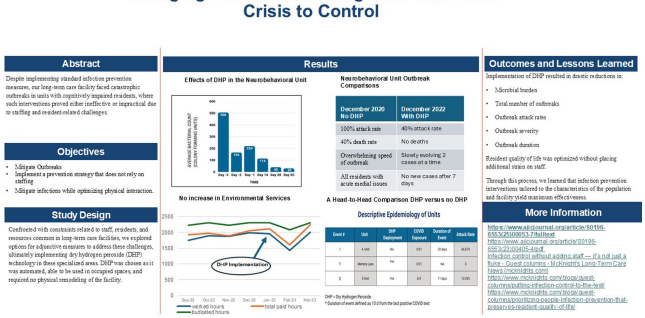
Presentation Type:
Poster Presentation
Subject Category: Long Term Care
Norovirus-Associated Acute Gastroenteritis Clusters in an Electronic Health Record System for Long-Term Care Facilities.‡
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Background: Long-term care facilities (LTCFs) are a leading setting of norovirus acute gastroenteritis (AGE) outbreaks in the United States. While illness from norovirus infection is typically considered mild and self-limiting, residents in LTCFs are especially vulnerable to more severe outcomes such as hospitalization and, in rare instances, death. Norovirus typically spreads rapidly through LTCFs due to the high infectivity of the virus and the congregate nature of these facilities. Despite the high burden of norovirus outbreaks in the U.S., limited data exist in these settings. Our objective was to characterize clusters of AGE likely associated with a norovirus outbreak among LTCF residents in a large cohort of U.S. LTCFs. **Methods:** We analyzed electronic health records from the PointClickCare (PCC) database of residents in 14,588 LTCFs across 50 states, D.C., and 1 US territory from 2016 through 2023. We identified AGE episodes using ICD-10-CM diagnosis codes and defined AGE clusters as three or more residents of the same facility with AGE episodes within seven days of one another; norovirus-associated AGE clusters were defined as clusters with at least one norovirus or unspecified viral intestinal infection ICD-10-CM code (A08.1, A08.4). **Results:** From January 1, 2016 through December 31, 2023, there were 306,683 AGE episodes from 10,653 LTCFs. Among these LTCFs, there were 17,852 AGE clusters of 86,687 (29%) episodes; 648 were norovirus-associated AGE clusters comprising 3,548 AGE episodes. The median norovirus-associated AGE cluster size was 4 residents (interquartile range [IQR]) 3-6; maximum=36). The number of norovirus-associated AGE clusters was lowest in June, July, August, September, and October (average of 3 clusters each month) and was highest in February and March (average of 13 clusters each month). The median (IQR) length of norovirus-associated AGE clusters was 9 (6-13) days from the AGE onset of the first resident to the AGE onset of the last resident in the cluster. Norovirus-associated clusters occurred in 492 facilities: 141 (29%) facilities of <100 residents, 288 (58%) facilities of 100-199 residents, and 63 (13%) facilities of 200+ residents. **Conclusions:** AGE episodes were commonly reported among LTCF residents in PCC, and approximately 30% were associated with an AGE cluster. Norovirus-associated AGE clusters ranged in size, occurred in all sizes of facilities, and were more common in winter months. Identifying individual-level and facility-level risk factors for norovirus-associated AGE is a next step to inform prevention efforts, including infection control measures and target populations for future norovirus vaccines.

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Changing Outbreaks in Long Term Care from Crisis to Control‡
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Background: Despite implementing standard infection prevention measures, our long-term care facility faced catastrophic outbreaks in units with cognitively impaired residents, where such interventions proved either ineffective or impractical due to staffing and resident-related challenges. Project Design: Confronted with constraints related to staff, residents, and resources common in long-term care facilities, we explored options for adjunctive measures to address these challenges, ultimately implementing dry hydrogen peroxide technology in these specialized areas. Outcomes and Lessons Learned: This intervention resulted in drastic reductions in microbial burden, the total number of outbreaks, outbreak attack rates, severity, and duration, while optimizing resident quality of life without placing additional strain on staff. Through this process, we learned that infection prevention interventions tailored to the characteristics of the population and facility yield maximum effectiveness.



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Longitudinal trends in MDRO admission prevalence at Arizona hospitals among transfers from long-term care facilities: 2015-2023‡
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Background:?Residents of long-term care facilities (LTCFs) are particularly vulnerable to infection and colonization with multidrug-resistant organisms (MDROs) due to immunologic vulnerability and prolonged healthcare exposure. Interfacility transfers (IFT) of these residents between LTCFs and acute care hospitals are common. Understanding trends in MDRO admission prevalence among LTCF transfers is important for hospitals considering targeted screening and implementation of protocols to prevent transmission. While the COVID-19 pandemic stalled national progress in MDRO prevention, it is unclear how MDRO admission prevalence trends among LTCFs transfers shifted. We aimed to (1) identify longitudinal trends in MDRO admission prevalence and (2) analyze shifts in these trends relative to the pandemic onset. Methods:?Hospital discharge data from the Healthcare Cost and Utilization Project Arizona State Inpatient Databases were evaluated from Oct 2015–Dec 2023. Acute care admissions for patients over 18 years old with LTCF identified as the admission source were included in the study; 12 epidemiologically important MDROs were identified via ICD-10 codes for each admission. The annual frequency and proportion of patients transferred to hospitals from LTCFs with evidence of MDRO prevalence at admission were described. Longitudinal trends in MDRO admission prevalence among all LTCF-hospital transfers were evaluated using the Cochran-Armitage trend test. Multivariable logistic regression was used to model the odds of MDRO admission prevalence – defined as documented colonization, history, or infection POA – by year, adjusting for age, sex, race, ethnicity, and rurality of patient residence. Results:?Among 14,195 Arizona IFTs from LTCFs to acute care hospitals during the 8.25-year study period, the mean age was 62.6 years, 53.1% were female, and 12.3% contained an ICD-10 diagnosis code indicating MDRO admission prevalence. Of these (n=1,741), 1,341 were documented as MDRO-POA infections, and 256 were documented as carriers or individuals with a known history of

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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