strain of norovirus was associated with abnormally high outbreak activity in the 2024-25 winter season. We describe changes to trends in norovirus outbreaks in LTCFs reported to the National Outbreak Reporting System (NORS) and CaliciNet, a strain surveillance platform, during the last decade. **Methods:** State and territorial health departments voluntarily report foodborne, waterborne, and other enteric outbreaks to the Centers for Disease Control (CDC) and Prevention through NORS. Public health laboratories report laboratory-confirmed norovirus outbreaks and genotypes to CDC through CaliciNet. Merged data from both systems were analyzed across four time periods: pre-pandemic, August 2015 – March 2020; pandemic, April 2020 – July 2021; post-pandemic, August 2021 – July 2024; and the 2024-25 season, August 2024 – July 2025. Both laboratory-confirmed (positive specimens from ≥2 case-patients or as defined by the reporting site) and suspected (<2 positive specimens) etiology outbreaks were included. **Result:** In total, 16,196 enteric LTCF outbreaks were reported to NORS and/or CaliciNet from August 2015 – July 2025, of which 12,905 (80%) outbreaks with 342,712 associated cases were attributed to norovirus. The average number of outbreaks reported over 12 months was 1,505 (7,022 total) during the pre-pandemic period, 256 (341 total) during the pandemic period, and 1,085 (3,256 total) during the post-pandemic period. The predominant genotype during these periods, GII.4 Sydney[P16], caused 42% of outbreaks with genotype data available. During the 2024-25 season, 2,286 LTCF norovirus outbreaks were reported (52% higher than the pre-pandemic period) and the predominant genotype (76%) was GII.17[P17]. Outbreak size (median [IQR]: 21 cases [11–35]) and duration (median [IQR]: 8 days [5–14]) were consistent across periods. Hospitalization rates were lowest during the pandemic period (1.8%) and highest during the 2024-25 season (3.2%). **Conclusion:** The low burden of LTCF norovirus outbreaks during the COVID-19 pandemic highlights the impact of non-pharmaceutical interventions in preventing outbreaks in this setting. The increased norovirus activity in the 2024-25 season associated with a new predominant strain suggests that more proactive laboratory testing in response to outbreaks is needed in this at-risk population to monitor trends in norovirus

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Poster Presentation
Subject Category: Long Term Care

Assessing guideline concordance of antimicrobials used in Australian long-term care using a national point prevalence audit‡

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Background: There is increasing awareness of the importance of antimicrobial stewardship in long-term care settings internationally. Despite this, there is little robust surveillance data on the quality of prescribing in this setting to help target interventions. In Australia, nursing homes are known as residential aged care homes (RACHs). The Aged Care National Antimicrobial Prescribing Survey (Aged Care NAPS) is a national, standardized audit program enabling Australian RACHs to monitor antimicrobial use and provide feedback on prescribing practices. Since 2016, the program has collected detailed prescribing data but has not made an explicit assessment on prescribing quality. With revision to Australian national prescribing guidelines, we now have the potential to use this data to assess concordance with guidelines. **Methods:** All Australian RACHs are eligible and invited annually to participate in the Aged Care NAPS. A single-day point prevalence audit is the primary methodology adopted. Antimicrobial prescribing data are collected by auditors at participating RACHs and entered into an online platform. All residents present on the survey day were included in the audit. Retrospective analysis of Aged Care NAPS data collected between 1 January 2020 and 31 December 2024 was undertaken. Guideline concordance was evaluated for the five most common indications (cystitis, tinea, non-surgical wound infection, pneumonia and cellulitis), using the Therapeutic Guidelines: Antibiotic 16th edition and Dermatology 4th and 5th editions. **Results:** A total of 41,786 prescriptions from 1,408 RACHs were audited during the study period. The five most common indications accounted for 37.4% of all prescriptions. Incorrect antimicrobial choices were common, such as cefalexin and roxithromycin for pneumonia, and amoxicillin-clavulanic acid and doxycycline for cellulitis. Prevalence of dosing errors ranged from 3.4% (trimethoprim for cystitis) to 78.0% (amoxicillin for pneumonia). Cefalexin was frequently prescribed and commonly incorrectly dosed (70.3% in cystitis, 72.8% in non-surgical wound infections, 68.2% in cellulitis). Over 40% of prescriptions for the top five antimicrobials for each indication exceeded recommended treatment durations, ranging from 41.7% (amoxicillin for cystitis) to 96.8% (ketoconazole for tinea). Prescribing for tinea often exceeded six months and included non-recommended pro re nata (PRN) prescriptions. **Conclusion:** The Aged Care NAPS shows promise as a tool to monitor the quality of antimicrobial prescribing in long-term care facilities. This analysis has identified targets for improving antimicrobial prescribing, focusing on choice, dosing and duration.

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Qualitative Analysis of Infection Preventionists' Experiences Implementing Enhanced Barrier Precautions in Long-Term Care Facilities‡

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Background Enhanced Barrier Precautions (EBP) aim to reduce multidrug-resistant organism transmission in long-term care settings. Infection preventionists play a critical role in implementing EBP, yet their experiences navigating operational challenges, staff adherence, and resident safety remain underexplored. Understanding these perspectives informs strategies for effective infection control and policy development. Methods A 42-item electronic survey was distributed via Qualtrics to 578 Florida nursing homes between May and September 2024, addressed to "Infection Control." Ninety valid responses were received. Thirty-seven respondents provided 58 comments across seven prompts—six linked to specific survey questions and one to an open-ended prompt to share questions or thoughts about EBP. Comments were coded into nine categories and analyzed using MAXQDA Analytics Pro. Results The coding categories were: 1) Citation or Feedback, 2) Clarity and Scope of Criteria, 3) Cost and Resource Burden, 4) Effect on Infection Control Practice, 5) Effectiveness of EBP, 6) Resident Experience, 7) Staff Confusion, 8) Staffing, Workload, and Compliance, and 9) Support for EBP. Fourteen coded comments fell under Citation or Feedback, mostly related to corrective feedback or citations during F880 survey experiences, including, "Facility interpreted an action to be low contact and therefore not needing EBP while surveyor considered action to be high contact requiring full EBP". Staffing, Workload, and Compliance had 13 coded comments, including six responses to a survey prompt asking about challenges in implementing EBP. One respondent wrote, "Non compliance in donning. No one wants to take the time to don when they are strapped for time." Clarity and Scope of Criteria had ten coded comments, with four specifically mentioning wounds. One wrote, "I think that small skin tears should not be included into the EBP, so there is such a gray area on who should be on EBH [sic] and who doesn't need to be. So maybe clarify skin tears." Seven comments addressed Resident Experience, with mixed views on resident reactions. Cost and Resource Burden, Support for EBP, and Effectiveness of EBP each had four comments; Staff Confusion had two,

‡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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and Effect on Infection Control Practices had one. Conclusions Infection preventionists reported significant challenges in implementing EBP, particularly staffing limitations, unclear criteria, and resource constraints. While many supported EBP's intent, concerns about feasibility and resident impact persist. Addressing these barriers through clearer guidance, staff education, and resource allocation is essential for successful adoption and sustained infection control in long-term care settings.

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Vaccine effectiveness of Bivalent RSVpreF against laboratory-confirmed RSV stratified by age and comorbidities in nursing home resident‡

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Background RSV vaccine effectiveness (VE) has not been described among nursing home (NH) residents, despite their increased risk for severe disease related to age and chronic heart and lung disease. We assessed bivalent RSVpreF VE in Veterans Affairs (VA) NH residents, overall and stratified by age and comorbidities. Methods We conducted a retrospective cohort study of NH residents over two RSV seasons (October 2023–April 2024; October 2024–April 2025). Inclusion criteria were a confirmed RSVpreF vaccination status (received RSVpreF or no RSV vaccine; other formulations and unconfirmed status excluded) and residing in a NH with RSV testing during the study period. Vaccination status was a three-level time-varying exposure: unvaccinated, vaccinated in current season, or vaccinated in the prior season. Time-at-risk for RSV was limited to continuous stays in VA NH or acute care settings. The primary outcome was laboratory-confirmed RSV infection; severe infections were defined as those requiring transfer to acute care or escalation within acute care. VE was calculated as 1 minus the hazard ratio from Cox models stratified by age and cardiopulmonary disease defined by diagnoses of congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD), adjusted for demographics, calendar year, and conditional on calendar month. Results Among 15,078 unique residents, those aged 60-74 had similar VE when vaccinated in the prior season vs current season, while those aged ≥Figure 1). Similarly, current-season model-adjusted VE was similar for those with and without cardiopulmonary disease. VE for vaccination in the prior season declined modestly among those with cardiopulmonary disease (76% [51–89] to 54% [4–78]). Of 220 total laboratory-confirmed RSV infections, 15 were severe (Table 1). Of the infections, 29 occurred among vaccinated residents of which 1(3%) was severe. Among unvaccinated residents, 14/191 infections (7%) were severe. Residents with severe infections were more likely to be ? Conclusion In this first RSV Vaccine VE study among NH residents, a frail population at high risk for severe RSV disease, bivalent RSVpreF vaccination was associated with a meaningful reduction in laboratory-confirmed RSV infection risk that persisted across two seasons, but with some diminished second-season protection for those with advanced age or cardiopulmonary disease. These subgroups were also overrepresented among those with severe disease and remain an important target for disease prevention.

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Figure 1. Estimated vaccine effectiveness for RSVpreF among residents of VA nursing homes, stratified by age (A) and cardiopulmonary disease (B). "Vaccinated in current season" means patients received the vaccine and had VE assessed within the same season (e.g., 2023-2024 or 2024-2025). "Vaccination in prior season" refers to those vaccinated in 2023-2024 with VE evaluated in 2024-2025. Cardiopulmonary disease includes individual diagnosed with congestive heart failure and/or chronic obstructive pulmonary disease.

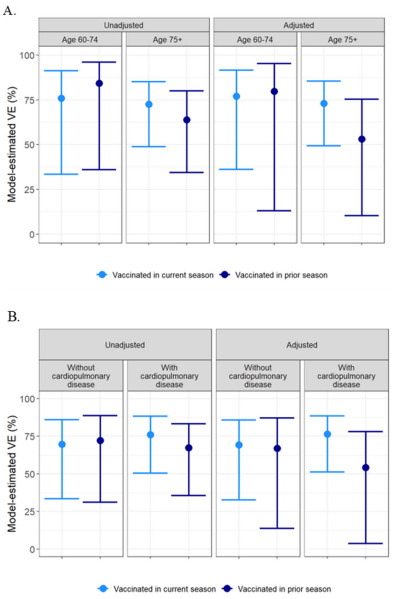
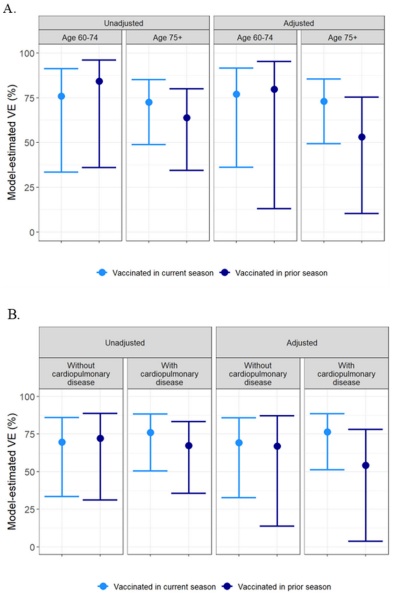


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