Presentation Type:
Oral Presentation
Subject Category: Long Term Care
Implementation Methods, Experiences, and Perceptions of Enhanced Barrier Precautions in Florida Nursing Homes‡

Sri Pulaparthi[1], AC Burke[2] and Cindy Prins[3]
[1]University of Central Florida College of Medicine; [2]RB Health Partners, Inc and [3]University of Central Florida

Background: On April 1, 2024, the U.S. Centers for Medicare and Medicaid Services mandated the implementation of Enhanced Barrier Precautions (EBP) in all nursing homes. EBP, which are intended to reduce MDRO transmission while avoiding the adverse effects associated with prolonged use of contact precautions, require the use of gowns and gloves during high-contact resident care activities for individuals with a history of MDRO colonization or infection, non-healing wounds, or indwelling medical devices. While EBP may offer important infection prevention benefits, concerns exist about increased costs, staff workload, and potential resident stigmatization. To date, there are no published data examining infection preventionists' perceptions of EBP, and few studies have looked at methods of EBP implementation. **Methods:** To address these gaps, this study assessed experiences, challenges, and perceptions related to EBP implementation in nursing homes across Florida (UCF IRB 00007601). From May through September 2025, individuals with responsibility for infection control and EBP in their facilities were invited to take a cross-sectional, 42-item Qualtrics survey. The survey invitation was mailed to 578 free-standing nursing homes in Florida with 60 or more beds, and 90 responses were received (15.6% response rate). **Results:** Among the demographic results, the majority (96.7%) of respondents worked in infection control, with most (45.3%) having 1 to 3 years of experience as an infection preventionist and approximately 25% holding a certification in infection control from the Certification Board of Infection Control and Epidemiology. Regarding implementation of EBP, the most frequently targeted pathogens were ESBL–producing Enterobacterales (87.3%), VRE (85.9%), MRSA (84.5%), and drug-resistant Streptococcus pneumoniae (84.5%). Some methods of initial staff education included posted guidelines/signage (83.3%), structured in-person sessions (77.4%), and informal staff meetings and discussions (72.6%). Facilities mainly used signage outside the resident's door (93%), documentation in the resident's care plan (79.1%), and EHR alerts (77.9%) to indicate EBP. When assessing perceptions of EBP, most respondents (47.3%) reported a somewhat or very negative perception of staff attitudes towards EBP, while (33.3%) reported a somewhat or very positive perception. Over half of respondents (58.3%) believed that EBP increases the overall cost of care in their facility. **Conclusion:** These findings provide important insight into real-world EBP implementation in nursing homes and identify perceived barriers and facilitators to adoption. Understanding infection preventionist perspectives is essential to refining EBP guidance, improving implementation strategies, and ensuring that MDRO prevention efforts in long-term care settings balance effectiveness with staff feasibility and resident-centered care.

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Breakthrough COVID-19 Infections Among Vaccinated Residents of VA Community Living Centers‡

Brigid Wilson[1], Taissa Bej[2], Corinne Kowal[3], Federico Perez and Robin Jump[4]
[1]Northeast Ohio VA Healthcare System; [2]VA Northeast Ohio Healthcare System; [3]Department of Veteran Affairs and [4]VA Pittsburgh Healthcare System

Background: Nursing homes residents are at high risk of severe COVID-19 infections. Age-related immunosenescence blunts the response to routine vaccinations, such that the estimated vaccine effectiveness for COVID-19 is <33% in nursing home residents. We assessed risk factors associated with breakthrough COVID-19 infections (BT) among previously vaccinated residents of Veterans Affairs (VA) nursing homes, termed Community Living Centers (CLCs). Methods We characterized residents who had received the primary COVID vaccine series and were present in VA CLCs at four census dates: 1/1/21, 7/1/21, 1/1/22, and 7/1/22 which included the Delta (mid-2021), Omicron BA.1 (early 2022) and BA.4/BA.5 (mid-2022) peaks. In each of these census cohorts, we assessed COVID-19 booster vaccines and identified laboratory confirmed COVID cases. We identified time-at-risk for BT starting at 14 days post-primary series vaccination or the beginning of the 6-month interval; and extending until death, BT, 7 days after discharge, or the end of the 6-month interval. For each census date, we characterized risk factors for BT and death following BT using survival and logistic regression models, respectively. Results We identified Table 1). Cases of BT infection increased from 41 pre-Delta to <800 during the Omicron BA.1 and BA.4/BA.5 waves. Survival models indicated an increased risk of BT among residents aged ≥Figure 1). We did not detect significant effects of sex, race and ethnicity, or Charlson Comorbidity Index (CCI). Compared to the primary series alone, a single booster dose had a protective effect against BT infection during the July 2021 and January 2022 eras; we did not detect effects of additional boosters. Mortality models from all census dates included 2011 residents with BT. Age ≥Figure 2). Discussion Among vaccinated nursing home residents, age ≥

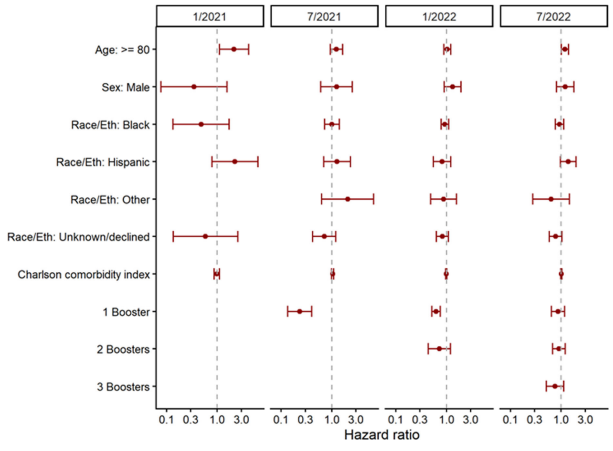
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Table 1. Characteristics of Community Living Center Residents Who Received the Primary COVID-19 Vaccine Series

Resident Characteristics	1/1/2021 (N=5982)	7/1/2021 (N=5868)	1/1/2022 (N=5544)	7/1/2022 (N=5296)
Age, mean ± standard deviation (SD)	75.1 ± 10.2	75.2 ± 10.1	75.3 ± 9.9	75.4 ± 9.7
Male	5817 (95.9%)	5654 (96.4%)	5322 (96%)	5075 (95.8%)
Race				
White	2740 (68.8%)	4029 (68.7%)	3760 (67.8%)	3529 (66.6%)
Black	925 (23.2%)	1391 (23.7%)	1346 (24.3%)	1315 (24.8%)
Other[a]	316 (7.9%)	446 (7.6%)	436 (7.9%)	450 (8.5%)
Ethnicity				
Non-Hispanic	3655 (91.8%)	5383 (91.7%)	5073 (91.5%)	4842 (91.4%)
Hispanic	166 (4.2%)	246 (4.2%)	237 (4.3%)	230 (4.3%)
Other[b]	161 (4%)	238 (4.1%)	233 (4.2%)	224 (4.2%)
Charlson Comorbidity Index, mean ± SD	4.3 ± 2.6	4.5 ± 2.7	4.5 ± 2.7	4.5 ± 2.7
Comorbid Health Conditions				
Diabetes Mellitus	2003 (50.3%)	3009 (51.3%)	2891 (52.1%)	2769 (52.3%)
Dementia	2283 (57.3%)	3039 (51.8%)	2919 (52.7%)	2865 (54.1%)
Chronic Pulmonary Disease	1043 (26.2%)	1670 (28.5%)	1539 (27.8%)	1506 (28.4%)
Stroke	1401 (35.2%)	2058 (35.1%)	1921 (34.7%)	1913 (36.1%)
Chronic Heart Disease	1145 (28.8%)	1908 (32.5%)	1735 (31.3%)	1680 (31.7%)
Chronic Renal Disease	1046 (26.3%)	1701 (29.0%)	1611 (29.1%)	1595 (30.1%)
Peripheral Vascular Disease	1043 (26.2%)	1670 (28.5%)	1539 (27.8%)	1506 (28.4%)
Cancer[c]	826 (20.7%)	1382 (23.6%)	1288 (23.2%)	1195 (22.6%)
Chronic Liver Disease	487 (12.2%)	759 (12.9%)	721 (13.0%)	705 (13.3%)
HIV	25 (0.6%)	39 (0.7%)	54 (1.0%)	44 (0.8%)
Breakthrough Infections	41 (1.0%)	263 (4.5%)	894 (16.1%)	813 (15.4%)

[a]Includes American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Asian, Multiracial, Unknown, Other, and Prefer Not to Answer; [b]Includes Other and Prefer Not to Answer; [c]excludes skin cancers

Figure 1: Forest plot predicting breakthrough infection by era



‡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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