

drains and 6 of 75 resident room sink drains. WGS and SNP analysis suggest relatedness among resident and environmental KPC-CRE isolates. Gaps in IPC measures including hand hygiene, use of personal protective equipment (PPE), environmental cleaning and disinfection, and sink hygiene practices were observed during onsite assessments. Use of an EPA-registered biofilm disinfectant in facility drains and repeated environmental sampling has demonstrated a decrease in KPC-harboring bacteria within the premise plumbing, but not complete elimination. **Conclusion:** Containing the spread of KPC-CRE within LTCF-A has been challenging due to environmental reservoirs of KPC-CRE along with insufficient implementation of IPC practices. Continued colonization screening has been necessary to detect newly colonized residents and reinforce efforts to increase IPC compliance. Strict implementation and adherence to IPC measures, including those that minimize the spread of KPC-CRE from facility premise plumbing, are needed to fully halt KPC-CRE transmission within LTCF-A.

Antimicrobial Stewardship & Healthcare Epidemiology 2024;4(Suppl. S1):s127-s128

doi:10.1017/ash.2024.289

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Outbreaks

Candida auris cluster in a center with no previous infections associated with a single organ donor

Evan Rivere, Medical University of South Carolina; Eric Meissner, Medical University of South Carolina; Alexandra Mills, Medical University of South Carolina; Courtney Harris, Medical University of South Carolina; Adrienne Lorek, Medical University of South Carolina and Scott Curry, Medical University of South Carolina

Background: *Candida auris* is an opportunistic pathogen reported in the US since 2016. *C. auris* infections (CAI) are frequently healthcare-associated, but only one case of donor-derived CAI in a lung transplant recipient has been reported (PMID 28520901). We describe a cluster of two CAIs at a single center in South Carolina occurring in 2 different recipients from the same solid organ transplant donor. **Methods:** We describe two cases of invasive CAIs occurring in an academic medical center without prior CAI in Charleston, SC in October 2023. *C. auris* was identified using Bruker MALDI-TOF and confirmed by the state health department. **Results:** Patient 1: 40-49 year-old male underwent heart transplantation on day 19 from admission complicated by growth of *C. auris* on post-op day #15 from a drain. He was readmitted post-op days 22-63 with positive blood cultures for *C. auris* and underwent re-operation with debridement and hardware removal. *C. auris* pericarditis required multiple returns to the OR (Figure). He was discharged on micafungin/posaconazole with plans for long-term antifungal therapy. Patient 2: 50-59 year-old male underwent liver and kidney transplantation on day 25 from admission from the same donor as Patient 1 in a separate hospital complex. His course was complicated by possible infected biloma not amenable to drainage and *C. auris*/*C. glabrata* fungemia, which was further complicated by abdominal wall collection cultures growing *C. auris* on post-operative day 35 on washout. He was managed with dual micafungin/posaconazole however, he died of unrelated causes at 93 days after transplant (Figure). Investigation: The donor for both recipients was a 10-19 year-old male who suffered brain death after trauma and was hospitalized for 56 days prior to procurement in Atlanta, GA without known CAI. Airway cultures at the time of organ procurement were positive for rare *Pseudomonas* and light unidentified yeast of multiple morphologies; urine cultures also grew 40,000 cfu/ml un-identified yeast. Screening of 35 and 4 inpatients in units exposed to patients 1 & 2, respectively, with axilla/groin PCR was negative (Figure). A third organ recipient for this donor (kidney) at our center was identified and had negative urine fungus cultures. **Conclusions:** Despite no definitive link to a known donor infection, this cluster of CAI occurring simultaneously in 2 patients in separate hospitals/units at a single center with no known prior cases represents likely donor-derived CAI. Our

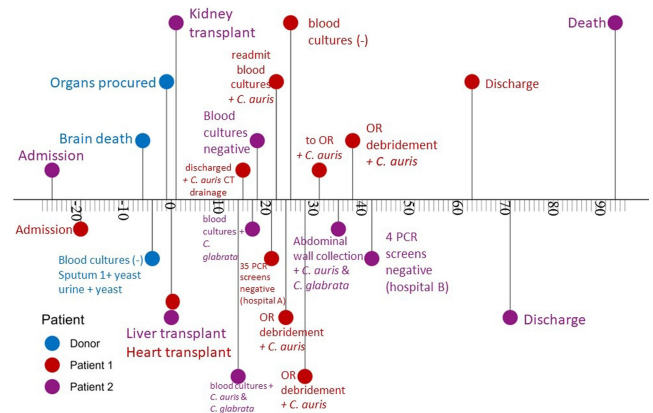


Figure: Timeline of *C. auris* cluster at the Medical University of South Carolina hospitals A & B in September - December 2023. Axis depicts days relative to the heart and liver transplant date (day 0). PCR screens refer to axilla-groin screening PCR tests for patients co-located in inpatient units with patients 1 & 2.

experience suggests that organ procurement organizations should consider improved screening techniques for *C. auris* in donor cultures.

Disclosure: Scott Curry: Consultant- Ferring; Abbott Diagnostics- Speaker honorarium

Antimicrobial Stewardship & Healthcare Epidemiology 2024;4(Suppl. S1):s128

doi:10.1017/ash.2024.290

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Outbreaks

Multi-year Epidemiology of Nontuberculous Mycobacteria Across a Diverse Healthcare System

Spencer Schrank, UPMC, University of Pittsburgh; Lee Harrison, University of Pittsburgh; Elise Martin, VA Pittsburgh Healthcare System and Graham Snyder, UPMC, University of Pittsburgh

Background: Nontuberculous mycobacteria (NTM) are ubiquitous potential pathogens implicated in healthcare-associated outbreaks. There is a paucity of studies describing transmission risk in the healthcare setting. To estimate the potential healthcare-associated transmission of NTM, we characterized the frequency of NTM clinical isolates across our multi-facility healthcare system. **Method:** We performed a retrospective review of all clinical NTM isolates at 21 healthcare facilities in a large health system between January 2019 through June 2023 (inclusion criteria: all first unique species). We analyzed the quarterly frequency of isolates for each species, by facility. We identified higher-than-expected species frequencies, which was defined as a quarterly frequency $\geq 50\%$ higher than the average quarterly frequency for that facility, for the entire study period (analysis omitted for any hospital with an average quarterly frequency 10 unique patient isolates in any 12-month period or >2 in a single month except for *M. abscessus* at Hospital A. The quarterly frequency of the three most common species among hospitals with ≥ 2 unique isolates per 12-month period are displayed in figure 2. An increase of 50% from the average

Figure 1 The Count and Percentage of all Nontuberculous Mycobacteria, January 2019 - June 2023

