employees. After instituting universal masking, the number of concerning exposures to patients were 3 compared to 35 prior to universal masking.

Conclusion: We describe the experience of a novel Contact Tracing Center, leveraging alternate staffing pools to track EPE resulting in no secondary transmission to patients either before or after universal masking. We credit sick policy adherence, high hand hygiene compliance, use of standard precautions, universal masking, robust contact tracing operations and a strong data collection system to identify process gaps.

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488. SARS-CoV-2 Preparedness among Community Hospitals in Southeastern United States

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Session: P-17. COVID-19 Infection Prevention

Background: The SARS-CoV-2 pandemic has placed a tremendous strain on the U.S. healthcare system leading to personal protective equipment (PPE) and resource shortages. Hospitals have developed contingency and crisis capacity strategies to optimize the use of resources, but, to date, community hospital preparedness has not been described.

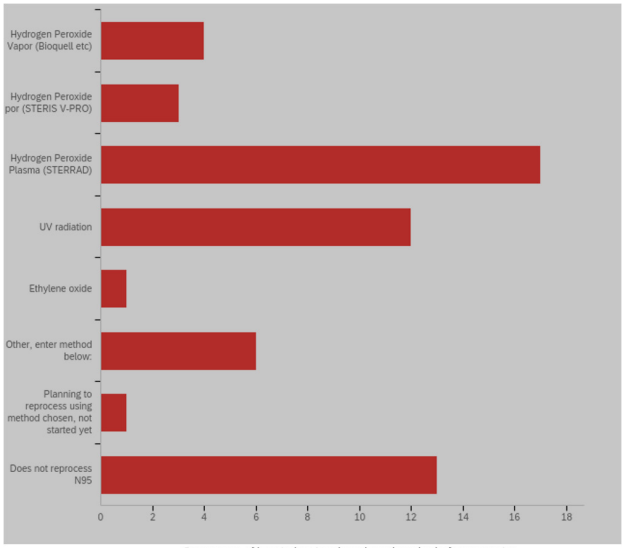
Methods: We performed a cross-sectional survey of infection preventionists in 60 community hospitals within the Duke Infection Control Outreach Network between April 22 and May 7, 2020 using Qualtrics. The survey included 13 questions related to resource availability, crisis capacity strategies and approaches to testing.

Results: We received 50 responses during the study period with a response rate of 83%. Community hospitals reported varying degrees of PPE shortages (Table 1); 80% of community hospitals were implementing strategies to extend and reuse N95 respirators, Powered Air-Purifying Respirators, face shields and face masks. Over 70% of facilities reported reprocessing N95 respirators (Figure 1). Almost all facilities reported universal masking at time of this survey with 90% performing daily employee screening at point of entry. Additionally, 8% of facilities restarted elective procedures at the time of this survey, but only 54% of facilities reported that they were performing preoperative testing for SARS-CoV-2. Thirty-seven percent of facilities performed one SARS-CoV-2 test before discharging an asymptomatic patient to skilled nursing facility, while 43% of facilities performed 2 tests.

Table 1- Supply of Personal Protective Equipment and other resources in 50 community hospitals in southeastern United States

#	PPE/Resources	Plenty (No shortage)	Many days supply	Few days supply	Almost out or none	Unknown
1	N95 respirators	12%	58%	30%	0%	0 %
2	Face shields	34%	50%	16%	0%	0%
3	Surgical facemasks	24%	50%	24%	2%	0%
4	PAPRs	20%	24%	34%	14%	8%
5	Gowns	24%	34%	32%	8%	2%
6	Goggles	26%	44%	16%	4%	10%
7	Gloves	54%	40%	6%	0%	0%
8	Hand Sanitizer	34%	44%	22%	0%	0 %
9	Hand Soap	50%	36%	10%	0%	4%
10	Env disinfectant	20%	40%	22%	18%	0%

Figure 1: Different methods of reprocessing N95 respirators by 50 community hospitals in southeastern United States



Conclusion: Our findings reveal differences in resource availability, crisis capacity strategies and testing approaches used by community hospitals in preparation for the SARS-COV-2 pandemic. Lack of harmonization in approaches may be in part due to differences in state guidelines and decentralized federal approach to SARS-CoV-2 preparedness.

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489. A Case-Control Approach to an Outbreak of SARS-CoV-2 on an Acute Stroke Unit in the U.S.

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Background: Detailed descriptions of hospital-acquired SARS-CoV-2 infections and transmission chains in healthcare settings are crucial to controlling outbreaks and improving patient safety. However, such reports are scarce. We sought to determine origins and factors associated with nosocomial transmission of SARS-CoV-2 in a 528-bed teaching hospital in Western New York.

Methods: The index patient, who had mental illness, wandered throughout the ward, would not wear a facemask, and was often kept seated at the nursing station, developed COVID-19 on day- 22 of hospitalization. A case-control approach was used, wherein all patients, staff, and 128 randomly selected environmental surfaces on the outbreak unit (case), and randomly selected patients, staff, and environmental surfaces on designated COVID-19 and non-COVID-19 units (control), were tested for SARS-COV-2 by RT-PCR and IgG SARS-COV-2 antibodies (SAR-Ab). Compliance with hand hygiene (HH) and COVID-specific personal protective equipment (PPE) was assessed.

Results: 145 staff and 26 patients were potentially exposed resulting in 25 secondary cases (14 staff and 11 patients). 4/14 (29%) of the staff and 7/11 (64%) of the patients who tested positive, and later became ill, were asymptomatic at the time of testing (Figures 1–2). There was no difference in mean cycle threshold for SARS-COV-2 gene targets between asymptomatic and symptomatic individuals. 0/32 randomly selected staff from the positive and negative control wards tested positive. PPE compliance based on 354 observations was not significantly different between wards. Environmental surface contamination with SARS-COV-2 RNA was not different between outbreak and control wards. Mean monthly HH compliance, based on 20,146 observations, was lower on the outbreak ward ($p < 0.006$) (Figure 3). 142 staff volunteered for serologic testing. The proportion staff with detectable SAR-Ab was higher on the outbreak ward (OR 3.78: CI 1.01–14.25).