

procedure codes to verify identified cases and to search for other PECs. All PECs were notified by telephone and mail, and serologic testing for human immunodeficiency virus (HIV-1), hepatitis C virus (HCV), and hepatitis B virus (HBV) was offered. Results were compared to prior bloodborne pathogen (BBP) testing results extracted from the CDW. Facility microbiology laboratory records of positive cultures/microscopy for enteric pathogens also were compared to the list of PECs; no active testing was performed. **Results:** Of the 565 PECs, 552 (98%) were successfully contacted. 8 declined testing or preferred non-VA testing, and 22 died before testing could be initiated. Repeat testing at 6 months was requested for PECs who had initial testing performed <6 months after exposure; 32 refused additional tests or did not respond to additional requests. In total, 522 PECs (92%) had testing performed for 1 or more BBPs: (1) 521 were anti-HIV negative with 1 previously known positive; (2) 481 were anti-HCV negative—43 were previously known positive and 1 PEC with an undetectable HCV viral load was newly identified; (3) 461 were negative for both HBV core or surface antibodies and surface antigen—32 were previously known positive and 17 were newly positive for one or both antibody tests with negative HBV surface antigen. Of 17 newly identified positive PECs, 16 had undetectable HBV DNA; 1 died prior to HBV DNA testing. **Conclusions:** There was no evidence of transmission of BBPs in this cohort of PECs who had procedures with potentially improperly cleaned fiberoptic endoscopes. Although not all patients completed all retrospective BBP testing, <10% were missing all or some tests. Local passive surveillance did not indicate enteric pathogen transmission. Additional education regarding and monitoring of reprocessing procedures have been instituted.

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Leptospirosis Outbreak in a Hill Due to Water From an Unprotected Well, Keerakadu Village, Kollihills, Namakkal, Tamilnadu, India

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Background: Annually, an estimated 1.03 million leptospirosis cases lead to 2.9 million disability adjusted life years. A cluster of fever cases was reported in Keerakadu village, Kollihills block in Namakkal district of Tamilnadu state, India, on April 28, 2017. We investigated to control the outbreak. **Methods:** We did a cross-sectional survey between April 29 and May 1. We defined a case of fever as any resident of Keerakadu village with fever for >2 days, with or without headache or myalgia, between April 15 and May 1, 2017. We conducted active surveillance. We reviewed medical records. We collected the line list from nearby health centers. We computed proportions to calculate the attack rate. We collected 11 serum samples and tested for dengue, scrub typhus, hepatitis A and leptospirosis by IgM ELISA method. We did a Widal slide agglutination test. We conducted an environmental survey to identify water sources. We performed a dengue larval survey. We collected 5 water samples: 1 from unprotected well, 1 from overhead tank and 3 from the houses of residents. We tested for fecal coliforms in the district

public health laboratory. **Results:** The population of Keeradu village was 540. We identified 11 cases, for an attack rate of 2% (11 of 540). The hospitalization rate of cases was 81% (9 of 11). Median age was 45 years (range, 23–65). Of 11 samples, 3 were positive for leptospirosis; all were negative for dengue, scrub typhus, hepatitis A, and typhoid. The single water source for the whole village was an open, unprotected well. This well supplied water every day to the community, both for drinking purpose and domestic use. No breeding of dengue larva was observed. All the 5 water samples tested positive for fecal coliforms. Water was not chlorinated regularly. All patients were isolated and treated in the primary health center. Prophylactic antibiotics were given to the whole community. **Conclusions:** There was a leptospirosis outbreak in Keerakadu village, probably due to contaminated water from unprotected well. There were no cases after May 1, 2017. We recommended that the community chlorinate the water regularly and protect the well. We also recommend continued surveillance and a rodent survey.

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Lessons Learned From a Decade of Dental Lookback Investigations in the Department of Veterans' Affairs (VA): 2009–2019

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Background: The Department of Veterans' Affairs (VA) operates 146 hospitals providing healthcare to >6 million veterans annually, including dental care to qualified veterans. Although bloodborne pathogen transmission after dental procedures is rare, little is known of risk when there are breaches. A standardized approach to performing lookback investigations after dental infection control breaches could better quantify these risks. We reviewed dental lookback investigations from the past decade conducted by our VA office for lessons learned to improve processes. **Methods:** Three VA hospitals had dental infection control breaches during 1992–2016. Facility A had dental instruments that were not cleaned according to the manufacturer's recommendations, and dentists at facilities B and C failed to adhere to proper infection control standards. Exposed veterans who underwent dental procedures were notified of possible exposure and were offered testing for human immunodeficiency (HIV-1), hepatitis B virus (HBV), and hepatitis C virus (HCV). Prior clinical testing was also reviewed. Newly identified positive results were compared to known positives prior to exposure to determine strain relatedness when sufficient plasma viral load was present for viral sequence comparison. **Results:** There were 2,939 patients with potential exposures in these dental investigations: 2,667 were tested for HBV, 2,642 were tested for HCV and 2,599 were tested for HIV-1. No evidence of viral transmission was found based on genetic sequence comparison of positive cases, but relatively few samples were available for this testing. **Lessons Learned:** Each facility faced different challenges with their investigation; however, several key processes were identified. (1) Early engagement by our office with local facility leadership and lookback teams resulted in more efficient investigation and testing processes. (2) To improve