were university employees. Descriptive characteristics for the COVID-19 infections and adjudications are outlined in Table 2. Severe disease among employees was significantly less frequent compared to patients in the health system (15.3% vs 2.2%, p < 0.01). The frequency of travel within 14 days, masked gatherings and unmasked gatherings/activities was not significantly different between the community and unknown, likely community groups or the community and unknown groups (Table 3).

Conclusion. The majority of COVID-19 infections were linked to acquisition in the community, and few were attributed to workplace exposures. Employees with unknown sources of COVID-19 participated in higher-risk activities at approximately the same frequency as employees with community sources of COVID-19. The most frequently reported initial symptoms were mild and non-specific and rarely included fever. Despite a comprehensive testing and benefit program, a large proportion of COVID-positive employees worked with symptoms, highlighting ongoing challenges with presenteeism in healthcare.

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379. Abstract For Comparison of Mandatory vs Non-Mandatory Compliance Rates For SARS-CoV-2 Testing in Grades K-12
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Session: P-16. COVID-19 Epidemiology and Screening

Background. Rapid testing to identify asymptomatically infected students with SARS-CoV-2 in elementary schools has been suggested as a possible method to reduce risk for in person instruction. As of August 3, 2020 (updated on January 25, 2021), California schools who obtained a waiver to conduct in-person instruction are not required to have mandatory testing for asymptomatic students, except for high contact sports which are required to undergo weekly testing. We explored the uptake of voluntary mandatory testing in a private waivered school.

Methods. Between the dates January 25, 2021 to April 16, 2021, the K-12 school superintendent sent an email to all parents outlining the voluntary testing program with a link to the on-line sign up and consent form. All students were offered weekly self-collected anterior nares BinaxNOW Rapid Antigen Test. Signed parental consent was required and tests were performed at the school. Students participating in contact sports were required to undergo testing the week a varsity game was played as a condition of participation. Data was gathered from the school administration and de-identified.

Results. K-5 Lower school had a school population of 448 students. Testing was offered on 8 weeks during the period of 2/15-2/19 to 4/5-4/9. 2 students (0.45%) received screening on the week of 3/22-3/26. The other seven weeks when screening was offered 0 students received screening. 6-12 Upper school had a school population of 360 enrolled students. Testing was offered 3/8-3/12 and 3/15-3/19. The upper school had 22 students (6.11%) receive testing on the week of 3/8-3/12 and 21 students (5.83%) on the week of 3/15-3/19. Contact sports teams had 67 students on their roster. Weekly testing was offered from 3/22-3/26 to 4/12-4/16. Contact sports teams had 10 students (14.93%) receive testing on the week of 3/22-3/26, 33 students (52.24%) on the week of 4/5-4/9, and 32 students (49.25%) on the week of 4/12-4/16.

Figure 1. Percent of students from each campus and sports team screened per week offered.

Percent of Students Tested

Conclusion. Voluntary SARS-CoV-2 screening was not a feasible approach for detection of asymptomatically infected individuals due to low uptake, however in the same school, mandatory testing had high uptake and would be a feasible strategy.

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Background. The COVID-19 pandemic has disproportionately affected nursing home (NH) patients, accounting for 5% of all cases and 32% of all COVID-19 deaths nationwide. Little is known about the frequency and persistence of SARS-CoV-2 environmental contamination in NHs. We characterize SARS-CoV-2 contamination in the rooms of COVID-19 patient rooms and common areas in and around COVID-19 units.

Methods. A prospective cohort study was conducted at four NHs in Michigan between October 2020 and January 2021. Clinical research personnel obtained swab specimens from high-touch room surfaces of COVID-19 infected patients, up to three times per patient. Weekly swab specimens from six high-touch surfaces in common areas were also obtained. Demographic and clinical data were collected from patient clinical records. Our primary outcome of interest was the probability of SARS-CoV-2 detection from specific environmental surfaces in COVID-19 patient rooms.

Results. One hundred four patients with COVID-19 were enrolled and followed for 241 visits. Patient characteristics included: 61.5% over the age of 80; 67.3% female; 89.4% non-Hispanic white; 50.1% short-stay. The study population had significant disabilities in activities of daily living (ADL; 81.7% dependent in four or more ADLs) and comorbidities including dementia (55.8%), diabetes (40.4%) and heart failure (32.7) (Table 1). Over the 3-month study period, 2087 swab specimens were collected (1896 COVID-19 patient room surfaces, 191 common area swabs). Figure 1 shows contamination rates at sites proximate and distant to the patient bed. SARS-CoV-2 positivity was 28.4% (538/1896 swabs) on patient room surfaces and 3.7% (7/191 swabs) on common area surfaces. Over the course of follow-up, 89.4% (93/104) of patients had SARS-CoV-2 contamination in their room at least once (Figure 2). Environmental contamination detected on enrollment correlated with contamination of the same site during follow-up. Functional independence increased the odds of proximate contamination.

Conclusion. We conclude that environmental contamination of surfaces in the rooms of COVID-19 patients is nearly universal and persistent. Patients with greater independence are more likely than fully dependent patients to contaminate their immediate environment.

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Table 1. Clinical and Demographic Characteristics of the Study Population Including Short- and Long-stay Patients

| Characteristic | Total Population (N=104) | Short-stay patients (N=55) | Long-stay patients (N=50) | p-value |
|----------------|--------------------------|---------------------------|--------------------------|---------|
| Age 45-69     | 21 (20.6)                | 9 (16.4)                  | 12 (24.0)                | 0.218   |
| Age 70-79     | 22 (21.1)                | 11 (20.4)                 | 11 (22.0)                |         |
| Age 80-89     | 36 (34.6)                | 16 (29.6)                 | 20 (40.0)                |         |
| Age 90+       | 28 (26.9)                | 13 (23.6)                 | 15 (30.0)                |         |
| Male sex      | 34 (32.7)                | 21 (38.6)                 | 13 (26.5)                | 0.147   |
| Race           |                          |                           |                          |         |
| Non-Hispanic white | 93 (89.4)            | 50 (90.9)                 | 43 (86.0)                | 0.125   |
| Non-white or Unknown | 11 (10.6)         | 5 (9.1)                   | 6 (12.0)                 |         |
| BMI score, mean (SD) | 26.4 (5.9)       | 26.3 (5.9)                | 26.5 (6.0)               | 0.286   |
| Activities of Daily Living (ADL) | 2 (3.8)          | 1 (3.8)                   | 1 (3.8)                  |         |
| 0-2 disabilities | 34 (32.7)           | 19 (34.5)                 | 15 (30.0)                |         |
| 3-4 disabilities | 14 (13.5)            | 9 (16.4)                  | 5 (10.0)                 |         |
| Charlson Comorbidity index score, median (IQR) | 2 (1-3)            | 2 (1-4)                   | 2 (2-3)                  | 0.250   |
| Charlson Comorbidity index score, median (IQR) | 2 (1-3)            | 2 (1-4)                   | 2 (2-3)                  | 0.250   |

Figure 1. Contamination of Environmental Surfaces Relative to Distance from Patient Bed

Figure 2. SARS-CoV-2 on Swab Specimens Collected – Patient-level, Visit-level, and Swab-level

Conclusion. We conclude that environmental contamination of surfaces in the rooms of COVID-19 patients is nearly universal and persistent. Patients with greater independence are more likely than fully dependent patients to contaminate their immediate environment.

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381. The Importance of Data Accuracy and Transparency for Policymaking During a Public Health Crisis: A Case Study in the State of Iowa

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Session: P-16. COVID-19 Epidemiology and Screening

Background. High-quality data are necessary for decision-making during the SARS-CoV-2 pandemic. Lack of transparency and accuracy in data reporting can erode public confidence, mislead policymakers, and endanger safety. Two major data errors in Iowa impacted critical state- and county-level decision-making.

Methods. The Iowa Department of Public Health (IDPH) publishes daily COVID-19 data. Authors independently tracked daily data from IDPH and other publicly available sources (i.e., county health departments, news media, and social