

Candida auris (*C. auris*)

Disease Category: Healthcare-Associated Infection

Timeframe to follow-up: within one working day

Signs and Symptoms	Most cases of <i>C. auris</i> are asymptomatic and detected via screening. For those with active infection caused by <i>C. auris</i>, symptoms are nonspecific and depend upon the severity and location of the infection. - Localized infection symptoms: pain, redness, and swelling at the infection site (increased drainage for infected wounds). - Systemic infection symptoms: fever and chills. Severe systemic infections may lead to sepsis causing symptoms such as clammy or sweaty skin, confusion, disorientation, high heart rate, weak pulse, shortness of breath, and organ failure.
Incubation	The incubation period for <i>C. auris</i> is currently not well defined. Individuals may be colonized with <i>C. auris</i> and never develop symptoms.
Case Classification	Clinical criteria: none. Confirmed Clinical Case: Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care.* *This includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of <i>C. auris</i> may simply represent colonization and not true infection. This does not include swabs collected for screening purposes. Confirmed Screening Case: Person with confirmatory laboratory evidence from a swab collected for the purpose of screening for <i>C. auris</i> colonization regardless of site swabbed.** **Typical screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. Swabs collected from a wound or draining ear as part of clinical care are considered clinical specimens.
Differential Diagnosis	Other candidiasis causing fungal pathogens (e.g. <i>Candida albicans</i> and <i>Candida glabrata</i>) and other multidrug resistant organisms, or MDROs, (e.g. carbapenem resistant organisms) that lead to localized or systemic infection.
Treatment	Consult with an infectious disease specialist. CDC does not recommend treatment in colonized patients or <i>C. auris</i> identified from non-invasive sites (such as respiratory tract, urine, and skin). Echinocandins are typically used in adults and children over 2 months in age. Treatment should be carefully monitored and

	susceptibility testing done. Additional supportive treatment as necessary (e.g. IV fluids).
Duration	No defined duration period, colonization may persist for long periods of time.
Exposure	Exposure occurs mostly in healthcare facilities. Transmission occurs via direct (i.e. physical touch) or indirect (i.e. touching shared surfaces or equipment) contact with infected or colonized individuals.
Laboratory Testing	Nevada State Public Health Laboratory (NSPHL) can test <i>C. auris</i> DNA through quantitative polymerase chain reaction (qPCR). See NSPHL website (https://www.unr.edu/nevada-state-public-health-laboratory/directory-services/candidozyma-auris) for preferred specimen and shipping requirements. All specimens will be sent to Washington Antimicrobial Resistance Laboratory Network (ARLN) for susceptibility testing. Local Health Authority can arrange testing if an outbreak is suspected or for contacts.
Control of Contacts	Nevada considers <i>C. auris</i> in all counties, excluding Clark, to be a tier III organism. Please see CDC's Multidrug-resistant Organism (MDRO) Containment Strategy for recommendations of screening contacts in a healthcare facility. - Household contact (HHC) screening is generally not recommended for tier III organisms. Consider screening HHC's who have frequent inpatient healthcare exposure or had extensive contact with case. - If case is in a healthcare facility, consider broad screening for healthcare contacts. - Prioritize roommates and residents who share a bathroom with case and residents with frequent inpatient exposure.
Key areas of focus during investigation	Focus on the specific criteria outlined in the <i>C. auris</i> case report form (CRF). Be sure to gather data on the patient's facility transfer history, presence of indwelling medical devices, dialysis treatment, and history of antifungal medication use. A fillable and printable version of the CRF can be accessed here: Healthcare Associated Infection Prevention and Control (HAI) - Training & Education
Public Health Actions	Reports of <i>C. auris</i> cases must be made to the Local Health Authority during the regular business hours of the health authority on the first working day following the identification of the case. Local Health Authority to notify the Office of State Epidemiology Healthcare Associated Infections (HAI team) (outbreak@health.nv.gov) or call 775-684-5911/775-400-0333 (after

	hours) if outbreak suspected. For individual confirmed or probable cases: • Confirm diagnosis, if possible • Identify potential exposures • Prepare a case report and submit to the Chief Medical Officer (through OSE) within 7 days after completing the case investigation • Identify any contacts for screening. • Identify potential outbreaks from common sources. • Provide education about how to prevent transmission. To the best of the local health authority's ability, each step of the investigation should be completed within one working day or in alignment with NAC 441A.
Key Partner Agencies	• Nevada State Public Health Lab (NSPHL) • Local health authorities • Medical facilities • Nevada HAI team

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CANDIDA AURIS (C. AURIS)

I. DISEASE REPORTING

A. Legal Reporting Requirements

A report to the health authority may be made by telephone; telecopy (in the form prescribed by the health authority); or any form of electronic communication identified by the health authority, following the specified format and procedure.¹

1. *Health Care Providers and Health Care Facilities*

Health providers and facilities must notify the health authority where provider is located within the first working day after identifying the case.¹⁻³

2. *Laboratories*

Laboratories must notify the health authority within the first working day after identifying the case.¹ If the lab is located outside of Nevada, notify the Nevada Chief Medical Officer through the Office of State Epidemiology (OSE) within the same timeframe.^{1,4}

3. *Local Health Authority (LHA)*

LHA's must notify the Office of State Epidemiology (OSE) within 7 days after completing the case investigation.⁵

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background

Candida auris (*C. auris*) is a type of yeast that spreads among patients in healthcare facilities.⁶ The first known report of *C. auris* occurred in Japan, in 2009; it has now been reported in over 30 states and over 30 countries.⁷ Those at greatest risk for infection related to *C. auris* include patients with extensive exposure to healthcare facilities, patients with severe underlying medical conditions, patients with invasive medical devices, and patients with a history of long-term antimicrobial use.^{7,8} About 34% of patients with fungal infection attributed to *C. auris* die.⁹ The crude mortality rate increases to 47% when *C. auris* is detected in the bloodstream.⁹

B. Etiologic Agent

C. auris is a fungal organism that can cause candidiasis, an invasive fungal infection, in patients in healthcare facilities. Many *C. auris* strains are resistant to at least one antifungal medication, making treatment difficult.⁶

C. Description of Illness

Approximately 90-95% of patients who are colonized with *C. auris* are asymptomatic.¹⁰ The remaining 5-10% of patients develop fungal infection (candidiasis).¹⁰ Symptoms for candidiasis are nonspecific and depend upon the severity and location of the infection.¹¹ Localized infections may present with pain, itching, redness, and swelling at the infection site; infected wounds may additionally present with increased drainage.⁶ Those with systemic candidiasis (or candidemia) may experience fever or chills.⁶ In severe cases of candidemia, additional symptoms of sepsis may be present which include clammy or sweaty skin, confusion or disorientation, extreme pain or discomfort high heart rate or weak pulse, shortness of breath, organ failure, and death.¹² Though treatment with antifungal medication can resolve symptoms, patients can remain colonized with *C. auris* on their skin and other body parts indefinitely.⁶

D. Disease Burden in Nevada

C. auris was first reported in Nevada in 2021.^{13,14} There has been a general increase in reports of colonized, or screening, cases throughout the state since March 2024 likely due to increased spread of disease, improvements in screening efforts, or both.¹⁴ *C. auris* is endemic to Clark County and is commonly detected throughout the rest of the state.¹⁵ Pan-Resistant or Echinocandin-resistant strains of *C. auris* are not commonly detected throughout Nevada.¹⁵ *C. auris* can be separated into the following tiers which influences how the organism is contained:

Tier	Applicable types of <i>C. auris</i>
Tier 1: Never Detected in Nevada	<i>C. auris</i> does not meet this criterion
Tier 2: Not commonly detected in Nevada	Pan-resistant and Echinocandin-resistant <i>C. auris</i>
Tier 3: Commonly detected, but not endemic in Nevada	<i>C. auris</i> – All counties except Clark County
Tier 4: Endemic in Nevada	<i>C. auris</i> – Clark County

E. Reservoirs

Colonized and infected patients can both harbor *C. auris* and spread it to susceptible individuals.¹⁶ In colonized patients, *C. auris* is often detected on the skin in warm, moist environments such as the axilla or groin.¹⁶ *C. auris* also remains on surfaces found in medical facilities such as bedrails, doorknobs, and mobile or shared patient equipment for extended time periods.^{16,17}

F. Modes of Transmission

Candida auris is a contact transmitted pathogen and is spread via touching infected or colonized patients and contaminated surfaces.¹⁶ Direct contact with bodily fluids or skin of infected or colonized individuals are methods of transmission. Contaminated surfaces include medical equipment such as ventilators, stethoscopes, blood pressure machines, mobile computers, and other high-touch surfaces such as bedrails, doorknobs, and bedside tables.^{16,17}

G. Incubation Period

The incubation period of *C. auris* is not well defined, due to its ability to colonize patients without causing infections. A study published in 2022 showed an incubation period lasting 41 days.¹⁸ Colonization can last for years or longer, and symptoms may never appear.¹⁷

H. Period of Communicability

While a definite period of communicability has not been determined, both infected and colonized individuals can spread *C. auris*, if the organism is present in bodily fluids or on the skin.¹⁶ Therefore, even if an individual has recovered from an infection and they are no longer symptomatic, they can continue to spread the pathogen as long as they remain colonized.¹⁹ Colonization is possible even after obtaining appropriate treatment.¹⁹ Individuals at greatest risk for contracting and transmitting *C. auris* are medically complex individuals who are receiving intensive care, those who require extensive contact to help complete activities of daily living, those with draining wounds, those with indwelling medical devices, and those who have been previously treated with antifungals.¹⁷

I. Testing

Screening Overview

Screening for *C. auris* colonization is a key strategy to prevent spread in healthcare facilities. Patients who are at high risk of infection or colonization, including those with invasive medical devices, those with frequent or prolonged healthcare facility encounters, those with a history of multidrug resistant organism (MDRO) infection or colonization, and those with known or suspected exposure to *C. auris* should be prioritized for screening.²⁰

For detailed screening criteria visit the following site: [Screening Recommendations for Healthcare Facilities | Candida auris \(C. auris\) | CDC](#)

Specimen Collection

A non-invasive composite sterile skin swab of the patient's axilla and groin is recommended for detection of *C. auris* colonization.²¹ Real-time PCR is the preferred method for detecting *C. auris*, as it is accurate and provides the fastest results.²²

In the case of suspected infection, specimens should be collected as clinically indicated depending on the infection site (i.e. collect wound and blood specimen in accordance with facility protocol).

Ensure specimens are collected aseptically, labeled accurately, and transported promptly to the laboratory under recommended conditions. Personal protective equipment (i.e. gloves and a lab coat) are recommended during specimen collection.²¹

For more information on specimen collection and appropriate sample types, see NSPHL website (<https://www.unr.edu/nevada-state-public-health-laboratory/directory-services/candidozyma-auris>).

Susceptibility Testing

All *C. auris* isolates should undergo antifungal susceptibility testing following Clinical and Laboratory Standards Institute (CLSI) guidelines.²³ Tests with a *C. auris* isolate should be sent to NSPHL for sequencing. *C. auris* isolates will then be sent along to the region Antibiotic Resistance Lab Network (ARLN) in Washington State for susceptibility testing.

J. Treatment

Echinocandins are the initial recommended treatment for *C. auris* in adults and children over 2 months. However, providers should refer to susceptibility test results and tailor treatment accordingly. Treatment is not recommended in patients without signs or symptoms of clinical infection.¹⁹

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of *C. auris*, within one working day of notification or in alignment with [NAC 441A](#).

A. Step 1: Review relevant information about the disease.

1. *Review scientific information in [Control of Communicable Diseases Manual](#), most current edition.*
2. *Review [Candida auris](#) case definition (2023 CDC).*

B. Step 2: Begin investigating the case.

1. *Contact Reporting Source and/or Reported Case*

Upon receiving an initial case report, review lab test results and available clinical details and epidemiologic factors. Please use the specific *C. auris* case report form (CRF) to gather accurate information about the case. While the fillable version of the *C. auris* CRF is preferred, both a fillable and printable version can be found on the Healthcare Associated Infections Prevention and Control Training and Education [Candida auris](#) page on the DBPH website. When filling out the CRF, focus on the key data elements listed above. The completed PDF version, patient's face sheet, culture results, H&P, and antifungal medication list should be attached to a secure email and sent to outbreak@health.nv.gov. The CRF should be completed within 7 days of completing the investigation of the case.⁵

C. Step 3: Identify potential source of infection

Investigating the potential source of infection depends upon how a facility classifies *C. auris*. The following exposure periods should be investigated based upon which tier *C. auris* is classified under:

Tier	Period of Exposure Requiring Investigation
Tier 1: Never Detected in Nevada	<i>C. auris</i> has been detected in various regions within Nevada and therefore does not meet this criterion.
Tier 2: Pan-Resistant and Echinocandin Resistant <i>C. auris</i>	Review the patient's healthcare exposures from approximately 90 days prior to the initial positive culture up to the present.
Tier 3: Susceptible <i>C. auris</i> cases, not endemic to Nevada (excluding Clark County)	Review all exposures during the patient's current healthcare facility admission. Exception: if patient was at a different healthcare facility immediately prior to the current admission, the admission was within 90 days of specimen collection, and the organism has never or rarely been identified at this facility, then the investigation should be expanded to include this facility, especially if the patient was admitted to a unit with high-acuity and/or long lengths of stay.
Tier 4: Susceptible <i>C. auris</i> cases endemic to Nevada (Clark County)	Prioritize prevention; containment principles generally do not apply.

For more information on how to identify potential sources of infection, visit [MDRO Containment Strategy | HAIs | CDC](#).²⁵

D. Step 4: Initiate control measures for case and/or for contacts (see Section IV – Section VI below).

E. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see Section IX below).

IV. CONTROL OF CASE²⁵

Most cases occur within a healthcare setting (e.g., acute and long-term care hospitals or nursing homes (e.g., Skilled nursing facilities). Work with HAI team to notify the Infection Preventionist immediately to ensure that all precautions (e.g., contact precautions, enhanced barrier precautions) are enforced. Review [infection control guidance](#) from the CDC. Cases in hospitals should be placed on Contact Precautions and in nursing homes, at minimum, Enhanced Barrier Precautions.

Review [MDRO strategy](#) for tier 3 organisms to assess risk for transmission. case's healthcare exposures prior to positive culture, including overnight stays in healthcare settings.

Candida auris is considered a tier 3 organism in all Nevada counties (excluding Clark), so investigations should be limited to current admission. However, if hospitalized prior to current admission occurred within 30 days of specimen collection or occurred at a facility where the organism has not been identified previously, may expand investigation to include previous facility, especially if the case was admitted to a unit with high-acuity or was admitted for a long-period of time.

Conduct contact investigation (see [Control of Contacts](#) section).

Environmental screening is not generally recommended for tier 3 organisms, unless transmission is identified or suspected and there is epidemiologic evidence implicating an environmental reservoir in ongoing transmission. All cases should practice proper hand hygiene which consists of washing hands with an alcohol-based hand sanitizer.¹⁷ Visibly soiled hands should be washed with soap and water.¹⁷ Additionally, proper disinfectants should be used in healthcare facilities to clean shared medical equipment (e.g. blood pressure cuffs, glucometers, temperature probes, ventilators, ultrasound machines, nursing carts, and physical therapy equipment) and high touch surfaces (e.g. bedside tables, bedrails, and windowsills).¹⁷ The CDC recommends using an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant effective against *C. auris*. This can be found on the EPA's [list P](#).¹⁷ Patient charts for positive cases should be flagged and education is to be provided to healthcare providers, patient visitors, and all other personnel who are involved in the patient's stay.¹⁷ Educate patient on disease communicability to prevent further transmission of *C. auris*. Above listed measures should be taken depending upon the specific case.

If transferring facilities, ensure that case's *C. auris* status and required infection control precautions are communicated at time of transfer.

1. *Exclusion Notifications*

Not applicable for *C. auris* cases.

V. CONTROL OF CONTACTS

Screening of contacts is recommended if the contact is a patient within a medical facility or is otherwise at high risk.²⁰ Investigate symptomatic contacts in the same manner as a case.

If the case likely acquired the infection in a healthcare facility, if there is evidence or suspicion for transmission on the unit, or if the case was on a unit or in a facility with long average length of stay consider prioritizing a broader screening, such as a unit or facility-wide point prevalence survey. It is not recommended to screen healthcare personnel if there is no known or suspected transmission from someone working at the facility.

Screening household contacts is not recommended for tier 3 organisms unless the contacts have had frequent inpatient healthcare exposure and had extensive contact with the case.

If case is in a residential care setting, consider prioritizing the screening of roommates and residents who share bathrooms with case and residents who have frequent inpatient exposure.

Screening in other non-healthcare settings is not recommended unless an outbreak is suspected.²⁵

1. *Exclusion Notifications*

Not applicable for *C. auris* cases.

VI. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify DPBH HAI team, local health authorities, or infection control, as appropriate.

Upon identification of a *C. auris* outbreak in a medical facility, the member of the Healthcare Associated Infections (HAI) team assigned to that specific facility will initiate an outbreak investigation. Facility outbreaks will follow the same protocol regardless of facility type (i.e. acute care facility vs. skilled nursing facility). The following steps should be taken by the assigned HAI lead when investigating an outbreak:

1. Gather necessary information and verbally coordinate the start of the outbreak response.
2. Complete an Interjurisdictional Notification Form (INF).
3. Log the outbreak, create an outbreak folder and open an incident corresponding to the outbreak in REDCap.
4. Write and send a start of outbreak letter, REDCap instructions and educational materials to the facility.
5. Distribute the INF to internal stakeholders.
6. Call the facility to discuss the outbreak response and provide support.
7. Continue to monitor the outbreak and update the rest of the HAI team during the official Outbreak Meeting and as needed.
8. Write/update CIR as needed.
9. When the outbreak is ready to be closed, a close of outbreak letter and outbreak summary should be sent to the facility. All internal stakeholders should be notified of this closure as well.

VII. PREVENTION

The investigator should reference the most recent disease specific public educational materials from the CDC. The [Nevada OSE website](#) also provides information about *C. auris*, as does the [Nevada DBPH website](#). Some prevention techniques for stopping the spread of *C. auris* include the following:

- Frequent hand washing with alcohol-based hand sanitizer
 - Soap and water if hands are soiled or if alcohol-based hand sanitizer not available.
- Place patients with *C. auris* in a room separated from those at risk.
- Clean the patient's room with EPA approved disinfectants often.

- When providing care to an infected individual, wear appropriate PPE (e.g. gloves and gown)
- Ensure patient's visitors clean hands with alcohol-based hand sanitizer (or soap and water if not available).
- When transferring the patient, inform receiving healthcare facilities of the patient's infective status.
- When visiting a doctor's office or any other medical facility, always inform healthcare providers about previous positive test results for *C. auris*.⁸

VIII. REFERENCES

1. *REPORTING OF COMMUNICABLE DISEASES - 441A.225*. Vol 441A.225.; 2021:Section 225. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec225>
2. *REPORTING OF COMMUNICABLE DISEASES - 441A.230*. Vol 441A.230.; 2021:Section 230. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec230>
3. *REPORTING OF COMMUNICABLE DISEASES - 441A.240*. Vol 441A.240.; 2021:Section 240. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec240>
4. *REPORTING OF COMMUNICABLE DISEASES - 441A.235*. Vol 441A.235.; 2021:Section 235. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec235>
5. *DUTIES AND POWERS RELATING TO THE PRESENCE OF COMMUNICABLE DISEASES - 441A.290*. Vol 441A.290.; 2021:Section 290. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec290>
6. About C. Auris. CDC Candida auris (C. auris). April 24, 2024. Accessed July 23, 2025. <https://www.cdc.gov/candida-auris/about/index.html>
7. Vazquez JA. Candidemia in adults: Epidemiology, microbiology, and pathogenesis. In: *UpToDate*. ; 2024.
8. Preventing the Spread of C. auris. CDC Candida auris (C. auris). April 24, 2024. Accessed July 23, 2025. https://www.cdc.gov/candida-auris/prevention/index.html#cdc_prevention_risk-risk-factors
9. Benedict K, Forsberg K, Gold J, Baggs J, Lyman M. Candida auris-Associated Hospitalizations, United States, 2017-2022. Published online July 2023. Accessed July 28, 2025. https://wwwnc.cdc.gov/eid/article/29/7/23-0540_article
10. Hayes JF. Candida auris: Epidemiology Update and a Review of Strategies to Prevent Spread. *J Clin Med*. 2024;13(22):6675. doi:10.3390/jcm13226675

11. Vazquez JA. Overview of Candida infections. In: *UpToDate*. ; 2024.
12. About Sepsis. CDC Sepsis. March 8, 2024. Accessed July 28, 2025. https://www.cdc.gov/sepsis/about/index.html#cdc_disease_basics_testing_screening-diagnosis
13. Tracking C. auris. CDC Candida auris (C. auris). December 9, 2024. Accessed July 28, 2025. <https://www.cdc.gov/candida-auris/tracking-c-auris/index.html>
14. Candida auris cases and facilities update. Published online July 21, 2025.
15. Nevada Targeted Multidrug Resistant Organism Guidance.
16. Clinical Overview of Candida auris. CDC Candida auris (C. auris). April 24, 2024. Accessed July 28, 2025. <https://www.cdc.gov/candida-auris/hcp/clinical-overview/index.html>
17. Infection Control Guidance: Candida auris. CDC Candida auris (C. auris). April 24, 2024. Accessed July 23, 2025. <https://www.cdc.gov/candida-auris/hcp/infection-control/index.html>
18. Alanio A, Snell HM, Cordier C, et al. First Patient-to-Patient Intrahospital Transmission of Clade I Candida auris in France Revealed after a Two-Month Incubation Period. Krysan DJ, ed. *Microbiol Spectr*. 2022;10(5):e01833-22. doi:10.1128/spectrum.01833-22
19. Clinical Treatment of C. auris infections. CDC Candida auris (C. auris). April 24, 2024. Accessed July 28, 2025. <https://www.cdc.gov/candida-auris/hcp/clinical-care/index.html>
20. Screening Recommendations for Healthcare Facilities. CDC Candida auris (C. auris). April 24, 2024. Accessed July 23, 2025. <https://www.cdc.gov/candida-auris/hcp/screening-hcp/index.html>
21. C. auris Screening: Patient Swab Collection. CDC Candida auris (C. auris). April 24, 2024. Accessed July 28, 2025. <https://www.cdc.gov/candida-auris/hcp/screening-hcp/c-auris-screening-patient-swab-collection-1.html>
22. Guidance for Detection of C. auris Colonization. CDC Candida auris (C. auris). April 24, 2024. Accessed July 29, 2025. <https://www.cdc.gov/candida-auris/hcp/laboratories/detection-colonization.html>
23. Antifungal Susceptibility Testing for C. auris. CDC Candida auris (C. auris). April 23, 2024. Accessed July 28, 2025. <https://www.cdc.gov/candida-auris/hcp/laboratories/antifungal-susceptibility-testing.html>
24. Candida auris 2023 Case Definition. CDC National Notifiable Diseases Surveillance System (NNDSS). February 28, 2023. Accessed July 23, 2025. <https://ndc.services.cdc.gov/case-definitions/candida-auris-2023/>
25. MDRO Containment Strategy. CDC Healthcare-Associated Infections. March 19, 2024. Accessed July 29, 2025. <https://www.cdc.gov/healthcare-associated->

[infections/php/preventing-mdros/mdro-containment-strategy.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/guidelines.html#cdc-generic_section_8-response-recommendations-tier-2-organisms](https://www.cdc.gov/hai/containment/guidelines.html#cdc-generic_section_8-response-recommendations-tier-2-organisms)

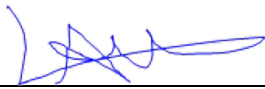
IX. ACKNOWLEDGEMENTS

This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- Washington State Department of Health Reporting and Surveillance Guidelines
- Washoe County Health District Epidemiology and Communicable Disease Program Investigation of Communicable Disease Manual

The Nevada Office of State Epidemiology would like to acknowledge the work of these great partners.

X. UPDATE LOG



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Chief Medical Officer

6/25/26

Chief Medical Officer Approval Date