

Vancomycin-intermediate *Staphylococcus aureus* and Vancomycin-resistant *Staphylococcus aureus* (VISA/VRSA)

Disease Category: Healthcare-Associated Infection

Timeframe to follow-up: Within one working day

See the link to the [Disease Investigation Process document](#)

Signs and Symptoms	- Pimples, boils, wound infections, skin and soft tissue abscesses, and deep organ infections - Serious <i>S. aureus</i> infections in the healthcare facility can also present as bloodstream infections, sepsis, osteomyelitis, endocarditis, or pneumonia
Incubation	Usually variable and indefinite
Case Classification	Clinical criteria: <i>S. aureus</i> can manifest as a variety of syndromes (i.e., skin and soft tissue infection, empyema, bloodstream infections, osteomyelitis, etc.). Asymptomatic individuals may be colonized. Most frequent site of colonization is the nares. Confirmed: A case of vancomycin-intermediate or vancomycin-resistant <i>S. aureus</i> that is laboratory-confirmed Minimum Inhibitory Concentration (MIC=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA). Probable: Not applicable.
Differential Diagnosis	Infectious or Inflammatory skin-soft disorders; Sepsis syndrome and Septic shock; Abscess; Endocarditis; Acute gastroenteritis; Wound infection; Necrotizing fasciitis caused by beta-hemolytic streptococci; Acute arthritis; Acute bursitis; Spondylitis; Implanted medical device and prosthesis infection; Pneumonia; and Meningitis. ^{1,2}
Treatment	Treatment should be determined in consultation with an infectious disease specialist. Antimicrobial susceptibility testing should be performed to determine appropriate antimicrobial treatment.
Duration	A definitive period of VISA/VRSA communicability is currently unknown.
Exposure	Documented transmission of VRSA has not occurred in the United States. VRSA can potentially be transmitted like methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) (e.g., contact with infected people, wounds, contact with contaminated bandages).
Laboratory Testing	Local Health Authority can arrange testing if an outbreak is suspected OR for contacts: - NSPHL offers a list of services, including MRSA cultures. NSPHL Service Request Form can be completed to acquire VISA/VRSA testing. - Testing Recommendations can also be found in CDC's Investigation and Control of Vancomycin-Resistant <i>Staphylococcus aureus</i> guide.
Control of Contacts	Identify contacts based on their level of interaction. Contacts who had extensive interaction with the VRSA patient during a defined period before the VRSA culture date should be prioritized. Length of time is determined by culture results, settings where patient was treated, and clinical assessment.

Key areas of focus during investigation	Confirm the diagnosis. Identification and categorization of contacts. Evaluation of the efficacy of infection control precautions. If in a healthcare facility, additional measures must be implemented to prevent potential transmission, as mentioned in NAC 441A.693 subsection 2 .
Public Health Actions	Reports of VISA/VRSA 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 Office of State Epidemiology (dpbhepi@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 it to the Chief Medical Officer (through OSE) within 7 days after completing the case investigation • Identify potential outbreaks from common sources • Evaluate the efficacy of any infection control precautions in effect • 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 Laboratory (NSPHL) • Nevada Division of Public and Behavioral Health (DPBH) Health Care Infections (HAI) team • Centers for Disease Control and Prevention (CDC)

TABLE OF CONTENTS

TABLE OF CONTENTS	3
I. DISEASE REPORTING.....	5
A. Legal Reporting Requirements.....	5
1. Health Care Providers and Health Care Facilities.....	5
2. Laboratories.....	5
3. Local Health Authority (LHA).....	5
II. THE DISEASE AND ITS EPIDEMIOLOGY	5
A. Background	5
B. Etiologic Agent.....	6
C. Description of Illness.....	6
D. Disease Burden in Nevada	6
E. Reservoirs	6
F. Modes of Transmission.....	6
G. Incubation Period	7
H. Period of Communicability	7
I. Testing.....	7
J. Treatment.....	7
III. EPIDEMIOLOGIC CASE INVESTIGATION	7
A. Step 1: Review relevant information about the disease.....	8
1. Review scientific information in Control of Communicable Diseases Manual, most recent edition.....	8
2. Review VISA/VRSA most recent CDC case definition (2007) and CSTE position statements 09-ID-58 and 09-ID-59.	8
B. Step 2: Begin investigating the case.....	8
1. Contact Reporting Source and/or Reported Case.....	8
C. Step 3: Identify potential sources of infection	8
D. Step 4: Initiate control measures for case and/or for contacts (see Section IV – Section VI below).....	8
E. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see Section IX below).....	8
IV. CONTROL OF CASE.....	8
1. Confirm the diagnosis;.....	8
2. Identify, categorize, and evaluate contacts; and.....	8
3. If the case having VISA/VRSA is in a medical facility, the facility must:	8
4. Exclusion Notifications.....	9
V. CONTROL OF CONTACTS (if applicable)	9
1. Management/Exclusions for Specific Groups or Settings.....	9
2. Exclusion Notifications ¹⁵	10
VI. CONTROL OF CARRIERS (if applicable)	10
1. Carrier Management/Exclusions	11
2. Carrier Notifications.....	11
VII. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL	11
VIII. PREVENTION	11
IX. REFERENCES.....	12
VISA/VRSA	3

X. Appendix.....	14
A. CONTROL OF CASE.....	14
1. Confirm the diagnosis;.....	14
2. Identify, categorize, and evaluate contacts; and.....	14
3. If the case having vancomycin-resistant or vancomycin-intermediate <i>Staphylococcus aureus</i> is in a medical facility, the medical facility must:	14
B. VRSA CONTACT DEFINITIONS FOR SPECIFIC GROUPS/SETTINGS ²²	14
1. Moderate Interactions.....	15
2. Minimal Interactions	15
C. CONTROL OF CONTACTS.....	15
1. Management for Specific Groups – Specimen Collection	15
2. Exclusion Notifications.....	15
D. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL.....	16
1. Acute-Care Settings ^{15,16}	16
2. Dialysis Settings	16
3. Other Outpatient Settings (Primary Care, Wound Care)	17
4. Home Healthcare Settings	18
XI. ACKNOWLEDGEMENTS.....	18
XII. UPDATE LOG	19

VANCOMYCIN INTERMEDIATE AND VANCOMYCIN RESISTANT *STAPHYLOCOCCUS AUREUS* (VISA/VRSA)

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.³

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. Reports must be made in accordance with [NAC 441A.225](#), by either the healthcare provider or the facility's director or person in charge, or the infection preventionist following administrative procedures of the facility ([NAC 441A.230](#), [NAC 441A.240](#)).³⁻⁵

2. *Laboratories*

Laboratories must notify the health authority within the first working day after identifying the case.³ 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.^{3,6}

3. *Local Health Authority (LHA)*

LHA's must notify OSE within 7 days after completing the case investigation.⁷

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background

Staphylococcus aureus (*S. aureus*) is a gram-positive bacterium that is commonly found on the skin and nose, often not causing harm to healthy individuals.⁸ *S. aureus* can become resistant to vancomycin and lead to rare infections such as vancomycin-intermediate (VISA) or vancomycin-resistant (VRSA). In the healthcare setting, risks of serious infection increase for ICU patients, those with surgical history, inserted devices, and weakened immunity. Bloodstream infections, pneumonia, endocarditis (infection of the heart valves), or osteomyelitis (bone infection) can also develop.⁸ Factors likely to make patients vulnerable to VRSA infection include prior Methicillin-resistant *Staphylococcus aureus* (MRSA) and

VISA/VRSA

February 2026

5



enterococcal infections or colonization, underlying conditions (e.g., chronic skin ulcers, diabetes), or previous vancomycin treatment.⁹

Geographic clustering had been observed with 8 of 10 VRSA cases (2002 to 2009) occurring in Michigan and all 4 VRSA cases (2010 to 2015) from Delaware. In 2021 the 15th confirmed VRSA case was identified in Michigan and in December 2021, the 16th confirmed VRSA case was identified in North Carolina.^{9,10} These two most recent cases were not epidemiologically linked and reflected VRSA emergence in two distinct patients and locations.

B. Etiologic Agent

The etiologic agents for VISA and VRSA are highly specific and rare strains of *S. aureus* bacteria.¹¹ These bacterial strains often arise from MRSA and can then develop decreased susceptibility or full resistance to the antibiotic vancomycin.

C. Description of Illness

S. aureus can produce a variety of clinical syndromes, with manifestations ranging from a single pustule (small, pus containing pimple), localized or invasive suppurative infections, deep organ infections, and death. Infections can also occur with or without bacteremia associated with a foreign body (i.e., intravascular catheters or grafts).¹² Similarly, VISA/VRSA infections can affect all body sites and appear as pimples, boils, or other skin conditions.¹¹ A pus-containing lesion(s) can be the primary clinical finding for a skin infection, while abscess formation can reflect deeper tissue infections. If lesions extend or become widespread, fever, malaise, headache, and anorexia may develop.¹³

Features common to many U.S. cases of VISA included ongoing or recent dialysis, MRSA bacteremia with central venous catheters or prosthetic graft material, and prolonged vancomycin exposure (6 to 18 weeks) in the 3-6 months prior to the infection.¹⁴

D. Disease Burden in Nevada

As of February 2026, no VRSA infections have been reported in Nevada. VRSA/VISA is not currently endemic to Nevada; however, *S. aureus* infections resistant to one or more antibiotics have occurred.

See the [Nevada Office of State Epidemiology Communicable Disease Dashboard](#) for Nevada specific data on other communicable diseases and relative zoonotic (bacterial, viral, and parasite) diseases in the [Communicable Disease Dashboard](#) and [Monitoring Zoonotic Diseases](#) sections.

E. Reservoirs

S. aureus reservoirs are commonly found in humans and rarely animals.¹³

Livestock-associated MRSA (LA-MRSA) is found primarily in farm and companion animals and has had increasing incidence in recent years.¹³

F. Modes of Transmission

VRSA can potentially be transmitted in the same ways as MRSA, either through person-to-person contact or contact with contaminated surfaces, medical devices, or equipment (e.g., close contact with patients or passed from contaminated materials like bandages).¹¹

VISA/VRSA

February 2026

6



G. Incubation Period

The incubation period for community-associated and hospital acquired *S. aureus* is variable and indefinite.¹³

H. Period of Communicability

A definitive period of communicability for VISA/VRSA is currently unknown.

I. Testing

CDC definitions for classifying isolates of *S. aureus* with reduced susceptibility to vancomycin are based on the laboratory breakpoints established by the Clinical and Laboratory Standards Institute (CLSI) (last modified in 2009). CDC defines *S. aureus* strains as VISA or VRSA based on the MIC for vancomycin obtained by reference broth microdilution.

- Vancomycin-susceptible *S. aureus* (VSSA): MIC ≤ 2 $\mu\text{g/mL}$ ¹⁵
- Vancomycin-intermediate *S. aureus* (VISA): MIC = 4-8 $\mu\text{g/mL}$ ¹⁵
- Vancomycin-resistant *S. aureus* (VRSA): MIC = ≥ 16 $\mu\text{g/mL}$ ¹⁵

Additional susceptibility testing may be warranted in patients with repeated *S. aureus* isolates from normally sterile sites despite appropriate therapy for longer than three days.¹⁴

CDC tests all presumptive VISA and VRSA isolates by gradient diffusion. Isolates confirmed as VRSA at CDC are then further examined by rapid polymerase-chain reaction (PCR). For more information on how to send CDC isolates for testing, email haioutbreak@cdc.gov.

J. Treatment

All VISA and VRSA isolates in the United States have been found to be susceptible to several FDA-approved drugs.¹¹ Antimicrobial susceptibility testing should be performed to determine appropriate antimicrobial treatment. Depending on the presentation or source of infection (i.e., wound infection vs. osteomyelitis), management of the patient and treatment can vary case-by-case. Treatment should be switched to narrow-spectrum drugs as soon as possible and should be done in consultation with an infectious disease specialist.¹³

Based on guidance from the 2021 Red Book (*Staphylococcus aureus* chapter) for pediatric bacteremia and other serious *S. aureus* infections, linezolid, ceftaroline, daptomycin, quinupristin-dalfopristin, or tigecycline may be considered based on in-vitro susceptibility results. Alternatively, combination therapy with vancomycin plus linezolid (with or without gentamicin) or vancomycin plus trimethoprim-sulfamethoxazole could be considered. Experience with these agents in children is limited, thus consultation with an infectious disease specialist is recommended.

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of VISA/VRSA, step by step, within one working day of notification or in alignment with [NAC 441A.693 \(NAC Chapter 441A\)](#).¹⁶

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

1. ***Review scientific information in Control of Communicable Diseases Manual, most recent edition.***
2. ***Review VISA/VRSA most recent CDC case definition (2007) and CSTE position statements 09-ID-58 and 09-ID-59.***

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 make three attempts to contact the case (text and phone calls) on separate days, at different times of the day (morning, afternoon, late afternoon). Document all attempts to contact a reporting source and/or reported case, preferably in the “Encounters” tab of EpiTrax. Please use case report forms (CRF) to gather accurate information about the case. Focus on the key data elements listed above. Filling out an electronic version of the CRF in EpiTrax (called a Confidential Morbidity Report (CMR) in EpiTrax) is preferred. If used, the completed PDF version should be attached to the CMR in EpiTrax. The CRF should be completed within 7 days of completing the investigation of the case.⁷

C. Step 3: Identify potential sources of infection

The investigation focuses on exposures in the defined period before the first vancomycin-resistant or intermediate culture. The reporting facility should provide information such as the organism species, genus, and mechanism with laboratory reports, bed trace, and medical records.¹⁷ Identifying patient transfer history, procedure and treatment history (e.g., antibiotics, dialysis, surgery), community exposures, travel history, and suspected additional cases can also be beneficial.

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 CASE

1. ***Confirm the diagnosis;***
2. ***Identify, categorize, and evaluate contacts; and***
 - a. Evaluate the efficacy of any contact precautions, disease specific precautions, or other infection control precautions that in effect.
3. ***If the case having VISA/VRSA is in a medical facility, the facility must:***
 - a. Isolate the case in a private room;

- b. Minimize the number of persons providing care to the case; and
- c. Require any person who provides care to the case to use contact precautions,
- d. Dedicate for use only on the case any non-disposable item that cannot be cleaned and disinfected between uses;
- e. Inform and educate
- f. Determine whether transmission has already occurred
- g. Assess the efficacy of any contact precautions, disease specific precautions, or other infection control precautions through testing.
- h. Work with the health authorities before transferring or discharging the case.¹⁵

For further *Control of Case* details, see Appendix A.

4. **Exclusion Notifications**

If the case is not in a medical facility, the health authority should determine any necessary (case specific) exclusions following diagnosis confirmation. The decision should be made in consideration of the identification, categorization, and evaluation of potential contacts.

V. CONTROL OF CONTACTS (IF APPLICABLE)

Contacts are categorized based on their level of interaction with the VISA/VRSA (colonized or infected) patient, including *extensive*, *moderate*, or *minimal* interactions. VRSA contacts should be investigated regardless if transmission is suspected and symptomatic contacts to be investigated similarly to a case.¹⁶

Extensive interactions with the VRSA patient during the defined period before the VRSA culture date should be prioritized during the investigation. In the healthcare facility, extensive contacts can be patients who share the VRSA patient's room. Physicians who care for wounds dressings, perform debridement outside the operating room or extensive patient exams. Direct patient care or ancillary staff who frequently visit the patient (>3 per shift), have prolonged contact during ambulation or bathing, handle secretions or bodily fluids, change dressings, or have contact during physical therapy/rehabilitation (i.e., dialysis/respiratory technicians/home health aides). For family members or household contacts, this includes providing primary care or having prolonged close physical contact with the patient or their immediate environment.

For moderate and minimal interaction definitions see Appendices B.1-B.2. Additional details for the management of specific groups are discussed in Appendix C.1.

1. **Management/Exclusions for Specific Groups or Settings**

	Symptomatic	Asymptomatic
Sensitive Occupation	N/A (See 'General Population')	N/A (See 'General Population')
Childcare/School Attendee	(MRSA) – Exclude if draining sores are present and cannot be completely covered and contained with a clean, dry bandage, or unable to maintain good personal hygiene. ¹⁸ Children with draining sores should not participate in activities with skin-	(MRSA) – Attendees who are only colonized do not need to be excluded.

	to-skin contact (including contact sports), until sores have healed.	
Case in a Medical Facility	Appropriate personnel should be informed and educated of VISA/VRSA presence in the facility.¹⁹ Efficacy of infection control precautions should be assessed by testing staff for the acquisition of an isolate. Perform baseline cultures from hands and nares to determine transmission.	N/A (See 'Symptomatic' column)
General Population	Identify, categorize, and evaluate VRSA contacts (investigate VISA contacts if transmission suspected)¹⁶ For extensive contacts, perform cultures of frequently colonized sites.¹⁵ (See Appendix C.1 for culturing recommendations) Risk of transmission to household members is extremely low – if providing care follow the same precautions as home health care personnel (See Appendix D.4 for home health management)	N/A (See 'Symptomatic' column)

2. **Exclusion Notifications**

Unusual or abrupt prevalence increases in community staphylococcal infections may necessitate investigation of a potential common source.¹⁵

Prior to culturing any VISA/VRSA patient contacts, a plan should be developed to outline the management of VRSA colonized or infected individuals for control measures and potential exclusions. See Appendix C.2 for situations to consider.

VI. CONTROL OF CARRIERS (IF APPLICABLE)

From a contact investigation, patients, healthcare workers, or family members may be identified as colonized with VRSA. A patient can be simultaneously infected and colonized (i.e., patient with a VRSA wound infection and VRSA colonization in the nares). Investigate carriers in the same manner as a case.

1. **Carrier Management/Exclusions**

Decolonization, reducing the organism burden on the colonized person with the goal of organism eradication, may be decided. Decolonization decisions should be coordinated with the patient's physician and health authorities and in consideration of the carrier's

underlying disease and/or immune status, ability to tolerate therapy, and risk of transmission.

2. **Carrier Notifications**

If a carrier is identified and attempt for decolonization are recommended, carriers should be notified and educated about the risks of transmission and the goal of eradicating the organism.

VII. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify DPBH HAI team at OSE, local health authorities, or infection control, as appropriate. It is important to coordinate with the facility infection preventionist and facility leadership along with the HAI experts at OSE to examine line list of cases and contacts to prioritize testing and assessment.

Information regarding the management of special situations for VISA/VRSA infections for acute-care, dialysis, outpatient, and home healthcare settings are further detailed in Appendices D.1-D.4.

VIII. PREVENTION

The investigator should reference the most recent disease specific public educational materials from CDC.

The [Nevada OSE website](#) also provides information about [vancomycin-intermediate *Staphylococcus aureus* \(VISA\)](#) and [vancomycin-resistant *Staphylococcus aureus* \(VRSA\)](#).

- Caregivers, visitors and others who have close physical contact with hospital patients infected with VISA/VRSA should:
 - Practice and maintain good hygiene through appropriate hand hygiene with soap and water or alcohol-based hand sanitizer and restrict sharing personal items.
 - Keep wounds clean and covered with bandages or dressings and avoid direct contact with wounds and contaminated wound materials.
 - Frequently used items and surfaces contacting bare skin or open wounds should be cleaned regularly and disinfected with [EPA registered products](#) adhering to product labels and guidelines for use.²⁰
 - Follow the healthcare facility's recommended transmission precautions when visiting a patient.

IX. REFERENCES

1. Taylor TA, Tobin EH, Unakal CG. *Staphylococcus aureus* Infection. In: *StatPearls*. StatPearls Publishing; 2026. Accessed March 16, 2026. <http://www.ncbi.nlm.nih.gov/books/NBK441868/>

2. Tobin EH, Jogu P, Koirala J. Methicillin-Resistant Staphylococcus aureus. In: *StatPearls*. StatPearls Publishing; 2026. Accessed March 16, 2026. <http://www.ncbi.nlm.nih.gov/books/NBK482221/>
3. *REPORTING OF COMMUNICABLE DISEASES - 441A.225*. 441A.225. 2021:Section 225. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec225>
4. *REPORTING OF COMMUNICABLE DISEASES - 441A.230*. 441A.230. 2021:Section 230. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec230>
5. *REPORTING OF COMMUNICABLE DISEASES - 441A.240*. 441A.240. 2021:Section 240. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec240>
6. *REPORTING OF COMMUNICABLE DISEASES - 441A.235*. 441A.235. 2021:Section 235. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec235>
7. *DUTIES AND POWERS RELATING TO THE PRESENCE OF COMMUNICABLE DISEASES - 441A.290*. 441A.290. 2021:Section 290. Accessed January 19, 2024. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec290>
8. CDC. Staphylococcus aureus Basics. Staphylococcus aureus. April 15, 2024. Accessed February 9, 2026. <https://www.cdc.gov/staphylococcus-aureus/about/index.html>
9. CDC. Clinician Brief: Clinical Laboratories' and Infection Preventionists' Roles in the Search for and Containment of Vancomycin-Resistant Staphylococcus aureus. *Staphylococcus aureus*. July 18, 2025. Accessed February 19, 2026. <https://www.cdc.gov/staphylococcus-aureus/hcp/clinical-overview/index.html>
10. MacFarquhar JK, Bajpai A, Fisher T, et al. Identification and Characterization of Vancomycin-Resistant Staphylococcus aureus CC45/USA600, North Carolina, USA, 2021 - Volume 31, Number 1—January 2025 - Emerging Infectious Diseases journal - CDC. Published online January 2025. doi:10.3201/eid3101.241573
11. CDC. About Vancomycin-resistant Staphylococcus aureus. *Staphylococcus aureus*. July 9, 2024. Accessed February 13, 2026. <https://www.cdc.gov/staphylococcus-aureus/about/vancomycin-resistant-staph.html>
12. Kimberlin DW, Barnett ED, Lynfield R, Sawyer MH, eds. *Red Book (2021): Report of the Committee on Infectious Diseases*. American Academy of Pediatrics; 2021. doi:10.1542/9781610025225
13. Kaasch A. Staphylococcal Diseases. In: *Control of Communicable Diseases Manual*. Control of Communicable Diseases Manual. American Public Health Association; 2015. doi:10.2105/CCDM.2745.134

14. Lowy F. Staphylococcus aureus bacteremia with reduced susceptibility to vancomycin. UpToDate. November 11, 2025. Accessed February 23, 2026. https://www.uptodate.com/contents/staphylococcus-aureus-bacteremia-with-reduced-susceptibility-to-vancomycin?search=vancomycin%20resistant%20staph&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H1593593876
15. Walters M, Lonsway D, Rasheed K, et al. Investigation and Control of Vancomycin-Resistant Staphylococcus aureus. Published online 2015.
16. *INVESTIGATING, REPORTING, PREVENTING, SUPPRESSING AND CONTROLLING PARTICULAR COMMUNICABLE DISEASES - 441A.693*. 441A.693. 2021:Section 693. Accessed February 9, 2026. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec693>
17. Osman F. Nevada Targeted Multidrug Resistant Organism Guidance.
18. *Specific Disease Exclusion Guidelines for Childcare*. Accessed April 13, 2026. <https://nvose.org/programs/facility-inspection-prevention-special-population/section-i/>
19. *INVESTIGATING, REPORTING, PREVENTING, SUPPRESSING AND CONTROLLING PARTICULAR COMMUNICABLE DISEASES - 441A.325*. 441A.325. 2021:Section 325. Accessed February 9, 2026. <https://www.leg.state.nv.us/nac/nac-441a.html#NAC441ASec325>
20. CDC. Preventing Methicillin-resistant Staphylococcus aureus (MRSA). Methicillin-resistant *Staphylococcus aureus* (MRSA). June 27, 2025. Accessed March 16, 2026. <https://www.cdc.gov/mrsa/prevention/index.html>
21. CDC. Staphylococcus aureus Basics. Staphylococcus aureus. April 15, 2024. Accessed February 9, 2026. <https://www.cdc.gov/staphylococcus-aureus/about/index.html>
22. Walters M, Lonsway D, Rasheed K, et al. Investigation and Control of Vancomycin-Resistant Staphylococcus aureus. Published online 2015:14-15.
23. Walters M, Lonsway D, Rasheed K, et al. Investigation and Control of Vancomycin-Resistant Staphylococcus aureus. Published online 2015:15.

X. APPENDIX

A. CONTROL OF CASE

In accordance with NAC 441A.693, the health authority shall investigate each report of a case having VISA or VRSA to:

1. **Confirm the diagnosis;**
2. **Identify, categorize, and evaluate contacts; and**
 - a. Evaluate the efficacy of any contact precautions, disease specific precautions, or other infection control precautions that are in effect.
3. **If the case having vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is in a medical facility, the medical facility must:**
 - a. Isolate the case in a private room;
 - b. Minimize the number of persons providing care to the case; and
 - c. Require any person who provides care to the case to use contact precautions, including without limitation to:
 1. Wearing a sanitary mask and eye protection if performing a procedure that is likely to cause the provider of care to come into contact with contaminated material; and
 2. Use a cleansing agent for hand washing that is appropriate for the disease;
 - d. Dedicate for use only on the case any non-disposable item that cannot be cleaned and disinfected between uses;
 - e. Inform and educate the appropriate persons about:
 1. The presence in the medical facility of a case with vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*; and
 2. The need to observe contact precautions, disease specific precautions, and other infection control precautions;
 - f. Determine whether transmission has already occurred by performing baseline cultures of specimens from the hands and nares of:
 1. Any person who has had physical contact with the case;
 2. Each health care provider of the case; and
 3. Any roommate of the case.
 - g. Assess the efficacy of any contact precautions, disease specific precautions, or other infection control precautions by testing the appropriate personnel for the acquisition of an isolate of *S. aureus*.
 - h. Work with the health authorities before transferring or discharging the case from a medical facility.¹⁵

B. CONTACT, INTERACTION DEFINITIONS²¹

A “contact” is defined as a person that has been exposed to a case, carrier or an environment known to be contaminated with VISA or VRSA, in a manner likely to cause transmission of the infectious agent ([NAC 441A.045](#), [NAC 441A.693](#)).^{16,18}

Interaction categories for other patients, direct patient care or ancillary staff, physicians, and family members/household contacts can reflect extensive, moderate, or minimal contact.

1. **Moderate Interactions**

Moderate interaction contact definitions are available for the following groups: patients, direct patient care/ancillary staff, physicians, and family members/household contacts.

Patients who share patient care areas and healthcare providers with the VRSA patient for extended periods (e.g., receiving dialysis on the same shift or hospitalized in different rooms but with same providers for several days while patients not on Contact Precautions)

VISA/VRSA

February 2026

14



Direct patient care or ancillary staff who deliver medication; only cross-cover the patient; or have limited interactions (e.g., radiology technicians)

Physicians who see the patient on daily rounds (without conducting extensive exams), perform surgical or invasive procedures where sterile barriers or aseptic techniques are used.

Family members or household contacts who live with or have physical contact with the VRSA patient, but do not meet the criteria for extensive interaction.

2. *Minimal Interactions*

Minimal interaction contact definitions are available for the following groups: patients, direct patient care/ancillary staff, and physicians.

Patients who are in the same ward for a short period of time or while the patient is on contact precautions, or patients who are seen in the same outpatient clinic on the same day as the VRSA patient.

Direct patient care or ancillary staff who monitor patient-care equipment and do not have known contact with secretions, and/or provide dietary or maintenance services and no direct patient interaction.

Physicians who consult infrequently without performing extensive examinations and/or visit during teaching rounds only.

C. CONTROL OF CONTACTS

1. *Management for Specific Groups – Specimen Collection*

For contacts identified with having extensive interactions with the colonized/infected patient multiple cultures should be collected from frequently colonized sites, such as the anterior nares, throat, groin, axilla, or peri-rectal area. Skin lesions should also be cultured, including abscesses, dermatitis, or open wounds.¹⁵

For contacts identified as having moderate or minimal interactions, decisions should be made in consultation with public health authorities. Screening for contacts with minimal interactions is typically not required unless substantial transmission is suspected amongst the extensive or moderate interaction groups.¹⁵

2. *Exclusion Notifications*

Prior to culturing contacts of VRSA patients, a plan should be developed. When developing a plan of action, the following situations should be considered for the management of control measures and potential exclusions:

- Will identified colonized or infected individuals be offered decolonization?
 - If yes, what regimen will be used?
- Will follow-up cultures be obtained?
- When will the individual be considered free of colonization?
 - (i.e., A requirement for the VRSA contact to complete decolonization only or decolonization with additional screening? If post-decolonization screening is needed, what kind of screening is required and within what time interval?)

- Will colonized or infected healthcare personnel be permitted to work?
- If a healthcare staff member is positive for VRSA or VISA, will they be removed from direct patient-care activities?
 - If yes, under what circumstances and how long until they can return to work?

D. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

1. *Acute-Care Settings*^{15,16}

- Isolate the patient in a private room.
- Minimize the number of people caring for the patient; assign dedicated staff to care for the VRSA patient.
- Implementation of appropriate infection control precautions during patient care.
- Use Standard and Contact Precautions (gowns and gloves for room entry).
- Per Standard Precautions guidelines, wear a facemask with eye protection or face shield when performing procedures likely to splash or splatter (wound manipulation or suctioning) of contaminated VRSA material, including blood, bodily fluids, secretions, and excretions.
- Perform proper hand-hygiene using an appropriate agent (alcohol-based hand sanitizer or hand washing with soap and water).
- Dedicate non-disposable items that cannot be cleaned and disinfected between patients for use only on the patient with VRSA (e.g., adhesive tape, cloth-covered blood pressure cuffs).
- Monitoring and strict enforcement of compliance with Contact Precautions.
- Educate and inform the appropriate healthcare personnel about the presence of a patient with VRSA and need for Contact Precautions.
- Facilities should 'flag' the patient's chart or utilize internal notification systems to alert infection/colonization with VRSA.
- Ensure that the patient's VRSA status and required infection control precautions are communicated at transfer (if approved by the LHA) and an [inter-facility transfer form](#) is completed.

Infection control precautions should remain in place until a pre-defined endpoint that has been determined in consultation with local health authorities (e.g., the patient has been culture-negative three times over 3 weeks or the patient's infection has healed).¹⁹

2. *Dialysis Settings*

Four of the 14 United States VRSA patients have been hemodialysis patients.⁹ Hemodialysis clinics are expected to follow standard precautions and additional infection control recommendations specifically for hemodialysis settings.

Providers should pay close attention and adhere to the following precautions when caring for a patient with VRSA.¹⁵

- Wear disposable gowns and gloves when caring for the patient or coming in direct contact with the patient's equipment at the dialysis station.
- Carefully remove and dispose of gown and gloves, followed by hand hygiene when leaving the patient's station.
- If available, use a separate room (ensure that it is not in use for Hepatitis B isolation for patient treatment).
- If a separate room is not available, dialyze the patient at a station that has the least adjacent stations as possible (e.g., at the end or corner of the unit).
- Items brought into the dialysis station should be disinfected following use. Items unable to be disinfected should be disposed of.
- Dialysis stations should be thoroughly disinfected between patients, including chairs, beds, tables, and machines. Information specific to dialysis facilities disinfection:
- [Environmental Surface Disinfection in Dialysis Facilities](#)
- [Dialysis Wall Boxes and Drains](#)
- [Dialysis Station Routine Disinfection \(Checklist\)](#) and [Dialysis Station Routine Disinfection Observations \(Audit Tool\)](#)
- Educate and inform the appropriate personnel about the presence of a patient with VRSA and need for Contact Precautions.
- In the event the patient needs to be admitted or transferred to another facility, the receiving facility must be notified of the patient's VRSA status.²² ([Inter-facility Transfer Form](#))

3. Other Outpatient Settings (Primary Care, Wound Care)

- Healthcare providers in outpatient settings should follow the same VRSA precautions as hospital-based healthcare providers.^{15,16}
- Use Standard Precautions with strict adherence to hand hygiene.
- Use Contact Precautions (gown and gloves) to enter the patient's room or care area if extensive contact is anticipated or contact with infected areas on the body (e.g., debridement or dressing of colonized or infected wounds).
- Per Standard Precautions guidelines, wear a facemask with eye protection or face shield when performing procedures likely to splash or splatter (wound manipulation or suctioning) of contaminated VRSA material, including blood, bodily fluids, secretions, and excretions.
- Perform proper hand-hygiene using an appropriate agent (alcohol-based hand sanitizer or hand washing with soap and water).
- Dedicate non-disposable items that cannot be cleaned and disinfected between patients for use only on the patient with VRSA (e.g., adhesive tape, cloth-covered blood pressure cuffs).
- Minimize the number of staff who care for the VRSA colonized/infected patient (dedicate one staff member).

- Ensure meticulous cleaning of the patient room and care area at the end of each visit.
- Educate and inform the appropriate healthcare personnel about the presence of a patient with VRSA and need for Contact Precautions.
- In the event the patient needs to be admitted or transferred to another facility, the receiving facility must be notified of the patient's VRSA status.²¹ ([Inter-facility Transfer Form](#))

4. Home Healthcare Settings

- Transmission risk to household members (even those with extensive contact) is extremely low.
- Home healthcare providers should generally follow the same VRSA precautions as hospital-based healthcare providers.²³
- Wear gown and gloves upon entering the area of the home where patient care will be provided.
- Per Standard Precautions guidelines, wear a facemask with eye protection or face shield when performing procedures likely to splash or splatter (wound manipulation or suctioning) of contaminated VRSA material, including blood, bodily fluids, secretions, and excretions.
- Perform proper hand-hygiene using an appropriate agent (alcohol-based hand sanitizer or hand washing with soap and water).
- Minimize the number of staff with access to the VRSA colonized/infected patient (dedicate one staff member to provide home healthcare for this patient).
- Dedicate non-disposable items that cannot be cleaned and disinfected between patients for use only on the patient with VRSA (e.g., adhesive tape, cloth-covered blood pressure cuffs).
- Household members should practice hand hygiene (frequent hand washing with soap and water or use of alcohol-based hand sanitizers).
- If household members are providing care to the VRSA patient, such as dressing changes on infected wounds, these individuals should follow the same precautions as listed for home health care.

XI. ACKNOWLEDGEMENTS

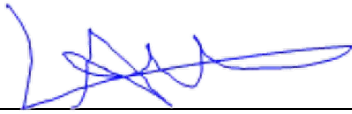
This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- Arizona Department of Health Services Investigative Guidelines
- Oregon Health Authority Investigative Guidelines
- Texas Department of State Health Services Investigation Guidelines
- Washington State Department of Health Reporting and Surveillance Guidelines

- Northern Nevada Public 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.

XII. UPDATE LOG



Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

8/21/2026

Chief Medical Officer Approval Date