Hepatitis A Outbreak in Skilled Nursing Facility, Los Angeles County, California, USA, 2025

Mona T. Yazdi, Alicia H. Chang, Angela Wong, Christopher Asuncion, Bonnie Dao, Prabhu P. Gounder

Author affiliation: Los Angeles County Department of Public Health, Los Angeles, California, USA

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We investigated an outbreak of 5 hepatitis A cases among skilled nursing facility residents in Los Angeles County, California, USA, including 3 who were vaccinated after exposure. Our results suggest that persons in congregate living facilities should receive both the vaccine and immune globulin after hepatitis A exposure to mitigate further transmission.

Hepatitis A (HepA) is a communicable disease of the liver caused by hepatitis A virus (HAV), which can easily spread between persons in congregate living facilities. A person with acute hepatitis A is considered infectious 14 days before and up to 7 days after jaundice onset, or 14 days after symptom onset if there is no jaundice. The HepA vaccine is recommended for postexposure prophylaxis (PEP) within 14 days of exposure, during the infectious period, if no prior immunity is documented. Immune globulin (IG) can be considered for PEP in persons with special risk factors for either HAV infection or severe disease from HAV infection (*1*).

Since January 2024, Los Angeles County (LAC), California, USA, experienced an increase in community transmission of HepA. Initially, HepA cases were predominantly among persons experiencing homelessness, who use drugs, or both. By 2025, however, most cases in LAC were in persons without risk factors for HAV infection. We describe an outbreak of HepA among skilled nursing facility (SNF) residents and the public health effort to mitigate spread.

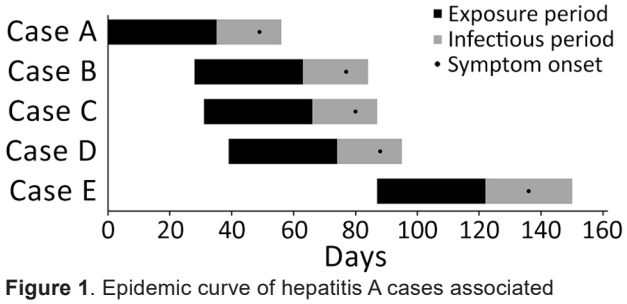

Figure 1. Epidemic curve of hepatitis A cases associated with a skilled nursing facility outbreak in Los Angeles County, California, USA, 2025 (N = 5). We defined the exposure period as 50 days before symptom onset and until onset of infectious period; we defined the infectious period as 14 days before symptom onset to 7 days after jaundice onset (or 14 days after symptom onset if no jaundice).

In January 2025, the LAC Department of Public Health (DPH) was notified of a HepA case in an LAC SNF with 5 separate units and 285 residents, all >40 years of age. Medical providers and laboratories are mandated to report HepA cases to LAC DPH. LAC DPH investigators reviewed medical records to determine if reports met the Council of State and Territorial Epidemiologists' surveillance definition of a confirmed HepA case (*2*). When possible, LAC DPH also obtained blood samples from reported cases for HepA PCR confirmatory testing.

We identified the first HepA case (case A) in a closed 38-bed unit intended for patients with cognitive or behavioral health needs (unit 1) (Figure 1). After the first case was identified, LAC DPH staff administered the HepA vaccine to all 34 residents without documented immunity in unit 1 (Figure 2). However, 2 additional cases of HepA (cases B and C) were identified in unit 1 after HepA vaccination and were reported to DPH (Figure 1). We measured total HAV antibodies in the serum of 31 residents (1 resident did not provide a sample) who had not contracted HAV but received the HepA vaccine. Of those residents, 68% (n = 21) had protective HAV antibody levels ($\geq$10 mIU/mL). We administered IG to 10 residents who did not develop protective antibody levels and to the 1 resident not tested.

We initially missed the next HepA case (case D) because the resident was in unit 1 and was transferred to unit 2 before the LAC DPH investigation (Figure 1). After case D was reported, LAC DPH staff administered the HepA vaccine and IG for PEP to the remaining 5 residents in unit 2. Subsequently, LAC DPH staff offered the HepA vaccine to residents in the 3 unaffected units and to all facility staff. Overall, 235 (82%) SNF residents and 10 (4%) facility staff members received the HepA vaccine. In addition, 16 residents from units 1 and 2 received IG.

An additional case (case E) was reported to the LAC DPH 78 days after the initial case (Figure 1). Case E was a resident of unit 1, had received the HepA vaccine for PEP, and was seropositive after 1 dose. The exact infection onset was unknown because the resident did not have symptoms or clinical findings associated with acute hepatitis but had detectable HAV

IgM and a positive HAV PCR result. All patients with HepA recovered, and no HAV infections were identified among SNF staff.

We investigated a HepA outbreak among residents of a SNF, an uncommon setting for HAV infection (*3*). Cases B, C, and E received 1 dose of the HepA vaccine for PEP, and case E had detectable serum HAV antibodies. Those cases might have already had established infections before receiving PEP and might not represent prophylaxis failure. However, our finding of incomplete early (<14 days) immunity after a single dose of the HepA vaccine for PEP is consistent with prior reports (*4*). Those results support offering concurrent IG to all exposed persons in congregate settings who have an indicated condition associated with reduced early immune response to the HepA vaccine alone (*1*). In addition, anyone exposed to HepA who did not develop the disease should get a second dose of the HepA vaccine >6 months after the first, to ensure lasting immunity against HAV.

Our findings should also prompt increased surveillance for HepA in congregate living facility residents during periods of elevated community transmission.

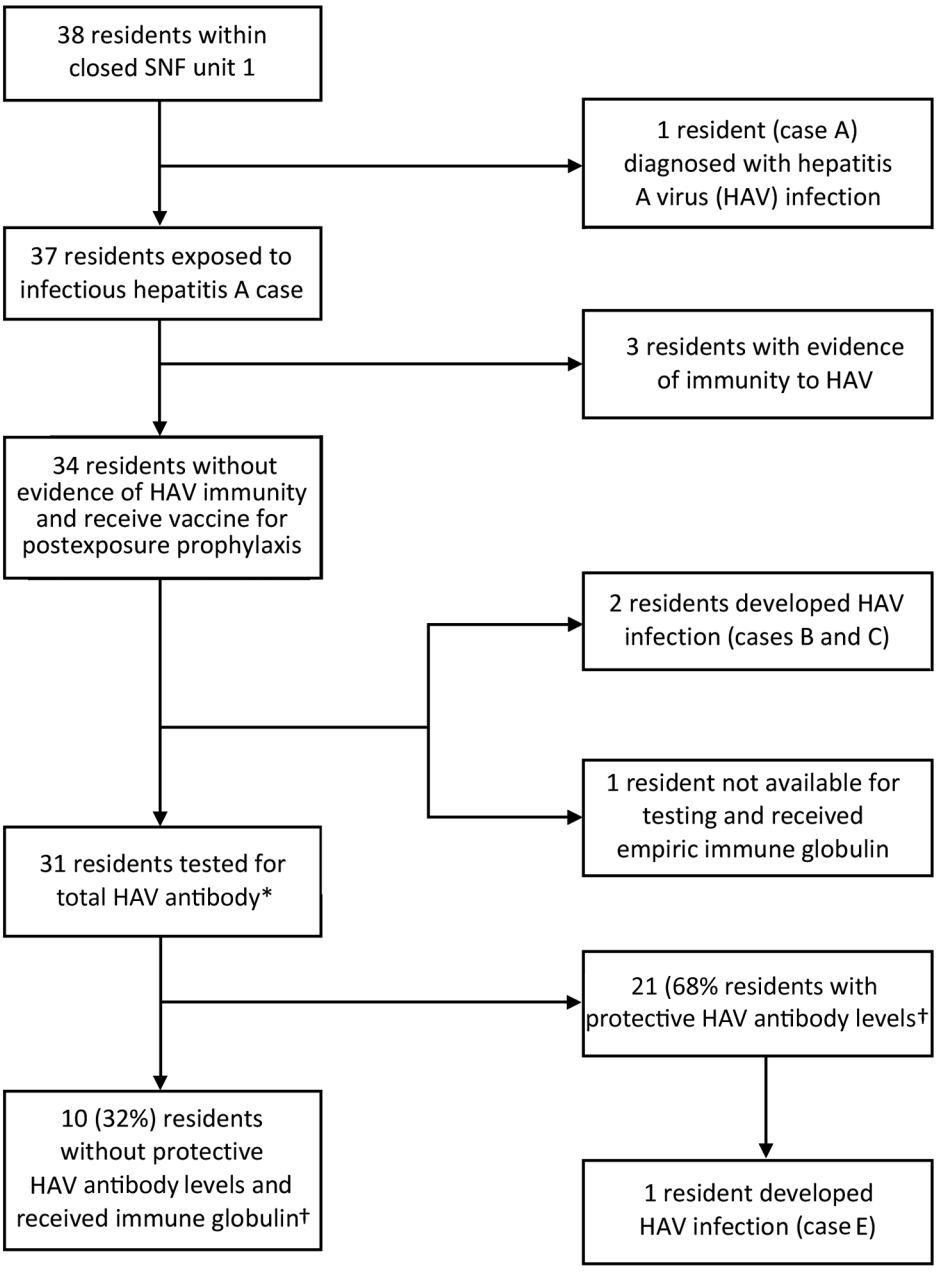

Figure 2. Outcomes of residents in skilled nursing facility closed unit 1 who were exposed to a resident with infectious HAV during an outbreak in a SNF, Los Angeles County, California, USA, 2025. Asterisk (*) indicates testing occurred 18 days after HAV vaccine postexposure prophylaxis. Dagger (†) indicates protective HAV total antibody levels that we defined as titer ≥10 mIU/mL. HAV, hepatitis A virus; SNF, skilled nursing facility.

Under those circumstances, providers could consider routinely offering the HepA vaccine to all residents and staff in congregate living facilities to reduce the risk infection and transmission, particularly because HAV seropositivity among adults has declined since 1996 (*5*,*6*).

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About the Author

At the time of this investigation, Dr. Yazdi was serving as a physician specialist in the Community and Field Services branch of the Los Angeles County Department of Public Health. Her interests include infectious diseases outbreak mitigation and investigation, community health, and refugee care.

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Address for correspondence: Mona Yazdi, Los Angeles County Department of Public Health 313 N Figueroa St, Rm 212, Los Angeles, CA 90012, USA; email: myazdi@ph.lacounty.gov

Antibodies Cross-Reactive with Bundibugyo Virus in Ferrets Vaccinated with Ebola Virus Vaccine

Jordan Wight, Helene Schulz, Logan Banadyga

Author affiliations: Public Health Agency of Canada, Winnipeg, Manitoba, Canada (J. Wight, H. Schulz, L. Banadyga); University of Manitoba, Winnipeg (L. Banadyga)'

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Banked serum samples from ferrets previously immunized with the Ebola virus vaccine revealed a prominent but limited humoral immune response that cross-reacted with Bundibugyo virus. The supporting immunogenicity data we report may help guide the ongoing response to the current outbreak of Bundibugyo virus in the Democratic Republic of the Congo.

On May 15, 2026, the Democratic Republic of the Congo (DRC) declared an outbreak of Ebola disease after laboratory confirmation of persons infected with Bundibugyo virus (BDBV) in the country's Ituri Province (*1*). At the time, DRC reported 246 suspected cases and 65 deaths associated with an outbreak that probably began weeks earlier. Since the declaration, the outbreak has expanded substantially; 695 confirmed cases and 138 deaths have been reported as of June 13, including 19 cases and 2 deaths in neighboring Uganda (*2*). On May 16, the World Health Organization classified the outbreak as a Public Health Emergency of International Concern. This outbreak marks only the third known emergence of BDBV, which previously caused outbreaks in Uganda in 2007 and in DRC in 2012.

Currently, no therapeutics or vaccines are available to treat or prevent BDBV disease. Although countermeasures are available for the closely related Ebola virus (EBOV), their efficacy against BDBV is unclear. Of particular interest is the recombinant vesicular stomatitis virus (rVSV)–based vaccine encoding the EBOV glycoprotein (rVSV-EBOV) (tradename ERVEBO; Merck, https://www.merck.com), which has been approved by the US Food and Drug Administration and the European Medicines Agency for prevention of EBOV disease (EVD). A previous study by Falzarano et al. (*3*) showed that 3 of 4 cynomolgus macaques vaccinated with rVSV-EBOV were protected against subsequent challenge with BDBV. Conversely, a separate study by Mire et al. (*4*) demonstrated that cynomolgus macaques vaccinated with a