Ministry of Children, Community and Social Services

COVID-19 Guidance for MCCSS-funded and Licensed Congregate Living Settings

June 2022

Highlights of changes: This symbol  indicates updated direction for congregate living settings. **Appendix 1** also provides an overview of what has changed.

This document replaces previously issued MCCSS COVID-19 Guidance for MCCSS-funded and Licensed Congregate Living Settings (April 2022)

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Introduction

The Ministry of Health (MOH) has issued **COVID-19 Guidance: Congregate Living for Vulnerable Populations** to support local public health units (PHUs) with their COVID-19 response in congregate living settings (CLSs).

In response, the Ministry of Children, Community and Social Services has updated this **COVID-19 Guidance for MCCSS-funded and Licensed Congregate Living Settings** to reflect the principles in MOH's guidance for PHUs. While the guidance aligns closely, this document also includes some modified and/or additional requirements for MCCSS-funded and licensed CLSs that the Ministry has deemed appropriate for our settings.

Please note that PHUs may continue to provide direction that may be different and/or in addition to those in this guidance to prevent and mitigate the spread of COVID-19 and/or other infectious diseases to ensure a tailored response to each local outbreak scenario.

This guidance is intended to be followed in ***addition to other applicable legislation and/or health guidance*** including, but not limited to:

- Local Public Health Unit direction to address local circumstances (e.g.community spread).
- Public Health Ontario COVID-19 Preparedness and Prevention in CongregateLiving Settings
- Public Health Ontario Managing COVID-19 Outbreaks in Congregate LivingSettings
- Resources to prevent COVID-19 in the Workplace
- Occupational Health and Safety Act (OHSA)

This document is not legal advice. Therefore, service providers may wish to seek an independent legal opinion regarding the application of legislative and other requirements in the context of the services they provide.

As always, the health and safety of individuals served, including their mental and

emotional well-being, remains our top priority.

Scope

This guidance document applies to the following MCCSS-funded and licensed congregate living settings:

- Adult developmental services residential services;
- Intervenor residential services;
- Violence against women shelters;
- Anti-human trafficking (AHT) residences;
- Children's residential facilities;
- Indigenous Healing and Wellness services (IHWS) facilities.

Note for Youth Justice operators: the guidance in this document does not apply to youth justice open and secure custody/detention facilities. Please continue to follow the existing direction which can be found here.

MCCSS recognizes that **CLSs in First Nations communities** may need to collaborate with Chief and Council, and if applicable the federal government and/or local public health unit, in applying this guidance to their settings in a way that is culturally appropriate and in relation to applicable federal and First Nation laws and public health measures. Urban Indigenous service providers may also need to work with their leadership and their local public health unit, to apply the guidance in a way that is culturally appropriate.

Terms Used in this Document

Please refer to the Ministry of Health's website for the definition of "**fully vaccinated**" where applicable in this document.

"Staff" refers to anyone conducting activities in the CLS regardless of their employer. This includes, but is not limited to:

- Staff employed by the CLS;
- Temporary and/or staffing agency staff;
- Third-party staff who are performing job duties (e.g., support services staff, Elders, contracted cleaning staff, tradespeople);
- Students on placement (e.g., nursing students); and
- Volunteers.

"Residents" refers to individuals who reside in and receive ministry-funded or licensed services in a CLS.

"Household" refers to a group of individuals (i.e., residents) who live together AND are part of each other's daily routine and therefore spend most of their time in close physical contact with one another.

- In general, household members do NOT include those living in separate residential units within a single CLS facility.
- However, this term may be applied in select CLSs where a small number of residents live and spend most of their day-to-day activities together, often owing to shared medical, physical, mental, cognitive, and/or behavioural needs.
- PHUs will use their discretion to determine whether a CLS is equivalent to a household, as this has implications for case and contact management due to the potential for high-risk exposure if COVID-19 were to be introduced in this setting.

"Visitors" are defined broadly in two categories:

- **Essential visitors"** provide essential support to the ongoing operation of a CLS and/or are considered necessary to maintain the health, wellness, and safety, or any applicable legal rights, of a congregate living resident. **MCCSS recognizes a parent/guardian, or other family members as essential visitors.** An essential visitor may also include social service workers and health care providers or other person(s) recognized as meeting the criteria above. Essential visitors are permitted to enter the CLS even when residents are in self-isolation and/or the CLS is in an outbreak.

- **"General visitors"** comprise all other types of visitors who are not considered essential visitors as per above. They are not permitted to visit resident(s) who are self-isolating and/or when the CLS is in an outbreak.

"Point of care risk assessment (PCRA)" (also known as **personal risk assessment**) is a dynamic risk assessment completed by a staff person before every resident care/interaction in order to determine whether there is a risk of being exposed to an infection. A PCRA will help determine the appropriate personal protective equipment (PPE) required to protect the staff in their interaction with the resident and their environment.

"**Absences**" are defined broadly in two categories:

- **"Short-stay absences"** occur the same day. This includes "essential absences" (e.g. resident leaves the CLS for work, school, medical appointment, physical exercise) and "recreational outings" (e.g. activities for pleasure, visit a friend's home).
- **"Overnight absences"** may be short-term or extended absences. This includes residents' "essential overnight absences" (necessary to maintain the health, wellness, and safety, or any applicable legal rights, of a resident), and "general overnight absences" (non-essential) from the CLS.

Prevention of Disease Transmission

The use of multiple layers of public health measures will help protect residents, staff, and visitors against COVID-19 and other respiratory infections. Many of these recommended measures should already be part of existing organizational plans developed for infectious disease outbreaks or other emergencies (e.g., pandemic and/or business continuity plans). Factors such as the physical/infrastructure characteristics of the CLS, staffing availability, and the availability of personal protective equipment (PPE) should all be considered when developing CLS-specific policies.

Vaccination

COVID-19 vaccination is one of the most effective public health measures to prevent infection and severe outcomes including hospitalizations and death due to COVID-19. As such, all residents, staff, and visitors should be encouraged to get vaccinated against COVID-19 (including booster doses, when eligible) as soon as possible if they have not already done so.

- New resident admissions to the CLS who have not yet received a COVID-19 vaccine or are not up-to-date with booster dose(s) should be offered access to a complete series of COVID-19 vaccinations as soon as possible, and booster dose(s), when eligible.
- More information on COVID-19 Vaccination can be found on the MOH's COVID-19 Vaccine-Relevant Information and Planning Resources webpage.

Influenza vaccination: All eligible staff, visitors, and residents are also strongly encouraged to receive the annual influenza vaccine.

- More information on influenza vaccination can be found on the MOH's 2021/2022 Universal Influenza Immunization Program (UIIP) webpage.

Screening

Active Screening for Anyone Entering the CLS

All persons seeking entry to the CLS should be actively screened for COVID-19 symptoms and exposure history, regardless of their vaccination status. This includes all staff, visitors, and residents returning from an overnight/extended absence.

Emergency first responders should be permitted entry without screening.

- A formal process should be used to ensure a rigorous active screening process at all times, including after hours. CLSs may use mobile apps or other tools to assist in the screening process. However, the individual being screened should interact with the screener prior to being permitted entry.
- As part of active screening, all residents, staff, and visitors should be advised that if they start to feel unwell while on-site, they should immediately notify a designated individual (either staff or a supervisor).
- A CLS can choose to use or adapt the screening tools that have been developed by the Ministry of Health, such as:
    - COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes (gov.on.ca)
    - General COVID-19 Self-Assessment; and
    - For staff and essential visitors specifically, COVID-19 worker and employee screening.

During active screening, CLSs should continue to consider:

- Limiting points of entry into the setting to help facilitate screening;
- Rearranging the layout at the entrance so that physical distancing can be maintained while staff conduct screening;
- Placing a physical barrier (e.g., plexiglass) that staff can stand or sit behind while conducting screening at entrances;
- Providing access to alcohol-based hand rub (ABHR, 60-90% alcohol), tissue, and lined no-touch wastebasket or bin; and
- Encouraging all residents, staff, and visitors to use ABHR before entering.

- If a **staff** or **visitor** has not passed active screening (e.g., has symptoms of COVID-19), they should not be allowed to enter the CLS. They should be instructed to self-isolate immediately and be encouraged to get tested for COVID-19. Staff should also report their result to their immediate supervisor/ manager or occupational health and safety representative in the CLS.
    - Visitor policies should incorporate allowances for visitors that fail screening that consider the type of visitor and the resident's circumstances (i.e., there may be instances where CLSs may need to consider permitting the entry of an individual who has failed active screening for compassionate and/or palliative reasons). This should include consideration for additional precautions that may need to be put in place to facilitate a safe visit (e.g. PPE, other barriers).
- CLSs should instruct all staff and visitors to self monitor for COVID-19 symptoms at home and not come to work if feeling ill. Those who are experiencing symptoms should report this to their employer.
- Staff with post-vaccination related symptoms may be exempt from exclusion from work as per the Guidance for Employers Managing Workers with Symptoms within 48 Hours of COVID-19 Immunization.
- Staff responsible for occupational health and safety in the setting should follow up with all staff who have screened positive to provide advice on any work restrictions.
- Staff who are close contacts or cases of COVID-19 must follow the protocols and the return to work requirements as per the MOH's guidance for early return to work .

- **Residents** being **admitted, transferred** or returning from an **overnight absence** are to undergo active screening. The General COVID-19 Self Assessment can be used as a tool to guide screening activities and can be adapted as needed.
- Residents who do not pass screening should be given a medical (surgical/procedure) mask to wear, unless they are subject to a masking

exemption (see masking section), and directed to a designated space away from other residents where they can self-isolate and wait for arrangements to be made for a clinical assessment, including getting tested for COVID-19 as appropriate.

- See Caring for Individuals Who Need to Self-Isolate, below for more information.
- See **Appendix 2** for additional detail on active screening requirements for staff, visitors and residents.

Daily Symptom Assessment of Residents

Residents should be assessed at least once daily to identify any new or worsening symptoms of COVID-19. Where deemed appropriate, this could include temperature checks.

- CLSs are strongly encouraged to conduct symptom assessment more frequently (e.g., at every shift change), especially during an outbreak, to facilitate early identification and management of ill residents.
- CLSs should be aware that some residents (e.g., elderly, young children, non-verbal individuals) may present with subtle or atypical signs and symptoms of COVID-19. As much as possible, it is important for the CLS to understand a resident's baseline health and functioning and ensure routine monitoring of their status to facilitate early identification and management of ill residents.
    - In large CLSs that primarily serve transient and/or large numbers of residents, it may be challenging to ascertain the resident's health status. As much as possible, staff should be encouraged to check in with the residents, inquire about how they are doing opportunistically while providing services, remind residents to self–identify if they are feeling unwell through verbal reminders and passive signage, and ensure good IPAC practices on site.

Asymptomatic Testing

Rapid antigen screening can quickly identify asymptomatic cases of COVID-19 that would have otherwise gone undetected and can help stop the spread of the virus. Service providers can use rapid antigen screening as a tool to enhance their existing Infection Prevention and Control (IPAC) measures for individuals living, visiting, participating, and working in congregate settings or receiving in-person services.

- Antigen Point of Care Testing (POCT) does not replace public health measures such as vaccination, symptom screening, physical distancing, masking, and hand hygiene.

Service providers that are interested in participating in the Provincial Antigen Screening Program (PASP) may apply through the Ontario Together Portal.

Passive Screening

CLSs should post signage prompting anyone on site to self-identify if they feel unwell or screen positive for symptoms of COVID-19.

- Where signage is deemed, by the service provider, to be inappropriate for resident living spaces (e.g. small settings that operate like a household), signage should be posted at the entrance(s) to the setting and in staff-only spaces, such as an office or break room.

Hand Hygiene

- Access to handwashing stations and/or alcohol-based hand rub (ABHR) should be available at multiple, prominent locations throughout the CLS, such as at entrances and in common areas, to promote frequent hand hygiene.
- All staff, visitors, and residents should be reminded through training and signage to:
    - Clean hands frequently throughout the day by washing with soap and water or using ABHR (60-90% alcohol) when hands are not visibly soiled;

Perform hand hygiene before and after using any shared equipment or items; and
    - If gloves are being used, perform hand hygiene prior to putting on gloves and immediately after removing them. After use, gloves should be placed in the garbage (i.e. non-touch, lined waste receptables, which should be placed throughout the CLS) . Gloves are not recommended for hand hygiene.
    - Safe placement of alcohol-based hand sanitizer to avoid consumption is important, especially for young children.
- Assistance should be provided to residents who may not be able to perform hand hygiene on their own.

Physical Distancing

Physical distancing remains one of the key public health measures to reduce the transmission of COVID-19. In general, all individuals should be encouraged to practice physical distancing (maintaining a minimum of 2 metres from others) to reduce the risk of transmission of COVID-19.

Physical distancing may be practiced in a number of different ways depending on the nature of the CLS. See the table below on when physical distancing should be practiced and when it may not be possible and/or necessary.

When physical distancing may be necessary	When physical distancing may not be possible or necessary
• In CLS facilities that serve transient and/or large number of residents*; • Individual(s) are immunocompromised and/or at a higher risk of severe disease from COVID-19.	• During the provision of direct care (appropriate PPE should be worn based on the nature, duration, and type of interaction); • Among residents who reside in a small CLS that is equivalent to a household.

* In emergency shelter settings, physical distancing may not always be possible due to demand. In such situations, rigorous compliance with all other measures – including active screening,

masking and wearing appropriate PPE – will be all the more important as part of the layered approach to COVID-19 prevention.

As much as possible, CLSs should continue to adjust activities in the setting to optimize and support physical distancing. This will also enable CLSs to adapt to enhanced precautions (e.g., in outbreak situations) as appropriate.
Depending on the nature of the CLS, this may include:

- Limiting capacity in common areas;
- Posting signage in common areas regarding capacity limits;
- Moving furniture/equipment around and/or removing unnecessary furniture/equipment;
- Placing markers on the floor or walls to guide physical distancing and unidirectional flow of movement;
- Planning enhanced in-house/on the property recreation and structured activities that support physical distancing; and
- Supporting and/or encouraging activities outdoors.

In shared bedrooms, beds should be spaced at least 2 metres apart. If this is not possible, consider different strategies to keep residents apart (e.g., place beds head to foot or foot to foot).

- Avoid using bunk beds.
- Consider additional measures, such as private rooms or rooms with the fewest number of occupants.

Masking

The Chief Medical Officer of Health and MCCSS continue to recommend masking in congregate living settings. The Ministry of Health's (MOH's) current recommendations related to masking in congregate living settings can be found here.

Where service providers choose to maintain masking requirements in their settings, they should take steps to ensure this does not become a barrier to entry for permitted visitors (a supply of masks should be available to individuals who may

have been unaware of the provider's requirement and would otherwise be refused entry without a mask).

- For more information about how to order masks, see **Appendix 3**.

Personal Protective Equipment (PPE) for Staff and Essential Visitors

PPE is intended to protect the wearer by minimizing their risk of exposure to COVID-19. The effectiveness of PPE depends on the appropriate selection and fit, and the person wearing it correctly and consistently. Recommendations for the use of PPE are based on risk assessments of specific environments and risk of exposure.

> **The employer must train workers on the care, use, and limitations of any PPE that they use.**

A person should wear appropriate PPE that provides protection of the person's eyes, nose, and mouth if, in the course of providing services, the person is required to come within two metres of another person who is who is isolating on Droplet and Contact Precautions (e.g. such as when providing care to a resident who is isolating) or during a COVID-19 outbreak (see Caring for Individuals who Need to Self-Isolate, below). The choice of PPE, including the use of fit-tested N95 respirators, should be based on a point of care risk assessment guided by the nature, type, and duration of the intended interaction.

  - For more information, see PHO's Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 for more information on PPE use.
- Eye protection includes face shields, goggles, or certain safety glasses. Properly fitting eye protection should be close-fitting around the head and/or provide a barrier from the front, the sides, and the top.
  - Non-medical masks are not considered PPE.

Use of N95 Respirators

In CLSs the need for the use of N95 respirators will most often be indicated based

on the medical needs (i.e., aerosol-generating medical procedures) of an individual who is known or suspected to have COVID-19.

Based on the organization's PCRA MCCSS-funded or licensed service providers may identify situations not described in the guidance linked above where PPE including N95 respirators may be used as part of an individual's care plan. Service providers should ensure documentation of any such requirements within the individual's care plan.

- N95 respirators will be available to staff in CLSs based on an organization's risk assessment of the needs of individuals receiving service and the nature of the supports being provided by staff and documented in an individual's care plan.
- Service providers should ensure the appropriate and necessary policies and procedures are in place to support the access to and usage of N95 respirators as part of a respiratory protection program. For example, the process for staff to access respirators outside of regular business hours. This may require the engagement of an organization's Joint Health and Safety Committee (JHSC) in the development and review of measures and procedures.
- A service provider's respiratory protection program should incorporate the necessary training for staff to ensure that the PPE will be used safely and appropriately by staff and in accordance with any industry-based standards that may exist.

Fit Testing for N95 Respirators

Before N95s can be accessed and used, service providers must have identified staff fit tested to ensure a proper seal and trained on appropriate usage of the respirator.

- Please contact your MCCSS IPAC Hub Champion for support in accessing fit testing.
- The 3M 1870+ N95 is the most common model available through MCCSS. In the case that the 3M 1870+ N95 does not seal for an individual, staff may be fit tested to an alternative N95 provided by the

ministry.

For more information about ordering N95 respirators, see **Appendix 3.**

Environmental Cleaning and Disinfection

CLSs should ensure that the premises are cleaned regularly. Commonly used cleaners and disinfectants are effective against COVID-19.

- All common areas (including bathrooms) and high-touch surfaces that are touched and used frequently should be cleaned and disinfected at regular intervals (e.g., once daily) and when visibly dirty. These include door handles, kitchen surfaces, and small appliances, light switches, elevator buttons, television, remotes, phones, computers, tablets, medicine cabinets, sinks, and toilets.
- Cleaning and disinfection should be more frequent during an outbreak. See Managing COVID-19 Outbreaks in Congregate Living Settings (publichealthontario.ca).
- Hand hygiene should be performed before and after use of shared items.
- Clean linen should be provided to all residents for individual use, with instructions not to share, and should be cleaned on a regular schedule.
- Lined no-touch garbage bins (such as garbage cans with a foot pedal) are preferred for disposal.
- For more information and guidance on environmental cleaning, please refer to PHO's Fact Sheet on Cleaning and Disinfection for Public Settings.

Ventilation and Air Filtration

In general, ventilation with fresh air and filtration can improve indoor air quality and are layers of protection in a comprehensive COVID-19 strategy.

- To reduce the risk of COVID-19 transmission, outdoor activities are encouraged over indoor activities where possible.
- Indoor spaces should be as well ventilated as possible, through a combination of strategies: natural ventilation (e.g., by opening windows),

local exhaust fans, or centrally by a heating, ventilation, and air conditioning (HVAC) system.

- Where ventilation is inadequate or mechanical ventilation does not exist, the use of portable air cleaners can help remove particles from the air. Expert consultation may be needed to assess and identify priority areas for improvement and improve ventilation and filtration to the extent possible given HVAC system characteristics.
    - Ensure that HVAC systems are functioning properly through regular inspection and maintenance (e.g., filter changes).
    - Service providers should consider, as part of regular HVAC maintenance, the type of filter used to support ongoing air quality improvements and should use the highest efficiency ventilation filters possible, without it having detrimental effects on overall HVAC system capacity performance.
    - Minimum Efficiency Reporting Values, or MERV, report a filter's ability to capture particles. Filters with MERV-13 or higher ratings can trap smaller particles. Upgrading to a MERV-13 rated filter, or the highest-rated filter that your HVAC system fan and filter slot can accommodate could improve the system's efficacy in removing particles from circulated air. Service providers should consult with an HVAC expert if they are considering making changes to the type of filter they are using to ensure it is compatible with the system that they have on-site.
    - For more information, see PHO's Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings and COVID-19.
- Ventilation and filtration are important for overall indoor air quality as they help to dilute or reduce respiratory particles in a given space. However, they do not prevent transmission in close contact situations and need to be implemented as part of a comprehensive and layered strategy against COVID-19.

HEPA Filters in Congregate Living Settings

In September 2021 MCCSS began distributing HEPA filters to congregate living settings to support increased air quality and reduce the chance of potential exposure to COVID-19.

HEPA filters are air purification systems that capture a minimum of 99.97% of contaminants at 0.3 microns in size and will kill germs and viruses, remove airborne

chemicals and odours, and filter dust and pollen. The HEPA filters are portable, meet Canadian standards, and can be used in areas where residents and staff congregate. See additional detail here.

Ontario's Science Table ** has advised about use and placement including:

- The position of portable air cleaners in an indoor space should take into consideration the likelihood that aerosols/droplets are being captured by the intake and that the exhaust is not directed to occupants. Placement near the center of the room or near potential sources of SARS-CoV-2 droplets/aerosols (i.e., common rooms, dining rooms) is helpful.
- It is also important that HVAC and supplemental ventilation/filtration systems are regularly maintained according to manufacturers' instructions and that measures are checked with the goal of optimization (e.g., air exchange rates, outdoor air intake, temperature, humidity).

** School Operation for the 2021-2022 Academic Year in the Context of the COVID-19 Pandemic - Ontario COVID-19 Science Advisory Table (covid19-sciencetable.ca).
See section: Achieving and Maintaining Adequate Air Quality through Ventilation and Filtration.

Use of CO2 Monitors in Congregate Living Settings

Carbon dioxide (CO_2) sensors may be used to help identify areas with poor ventilation (**they cannot identify the presence or absence of COVID-19 in the air**). During pandemic conditions, it is beneficial to keep indoor air as close to "fresh" outdoor conditions as possible, where outdoor air generally has a CO_2 concentration < 450 parts per million (ppm). When CO_2 levels are consistently increasing over time, this is a strong signal that ventilation is inadequate for the number of occupants and/or their activities. However, because of the need to heat or cool air to keep the indoors comfortable,100% fresh air is not always possible and some amount of CO_2 buildup is unavoidable. Notably, the United States Centers for Disease Control and Prevention (CDC) and the Federation of European Heating, Ventilation and Air

Conditioning Associations (REHVA) have reduced their recommended indoor CO_2 levels to 800 ppm during pandemic conditions.

COVID-19 Specific Policies and Procedures

All CLSs should continue to have COVID-19 operational policies for their setting that take into consideration the physical, mental, emotional, and psychological well-being of the residents, while ensuring that their policies are culturally appropriate and responsive to their residents' needs.

These policies should consider different levels of COVID-19 risk in the setting and in the community. CLSs should plan for contingencies when activities may need to be curtailed to ensure the health and safety of the residents, staff, and visitors in the setting. Activities should be modified, limited, postponed, or paused under the following circumstances:

- If a resident is self-isolating for any reason;
- If a resident resides in a COVID-19 outbreak area of the CLS;
- To align with any provincial or regional restrictions; and/or
- As directed by the local PHU.

Admissions and Transfers

Pre-screening of new admissions/transfers: As much as possible, new residents should be screened over the phone for signs and symptoms of COVID-19 before admission (intake).

- Regardless of whether pre-admission screening has taken place, the CLS should also conduct **active screening** in-person upon the arrival of the resident to the setting (see above).
- In general, admissions and transfers to a CLS in a COIVD-19 outbreak should be avoided. However, if the risks of not admitting a resident are determined to outweigh the risks of admitting the resident into a CLS in an outbreak,

consultation with the local PHU should be considered. The following risk-based considerations may be taken into account:

- Residents without active COVID-19 infection may be admitted or transferred to an area of the CLS not in outbreak, with their informed consent.
- Residents with active COVID-19 infection, or who fail active screening, may be admitted/transferred to an outbreak area of the CLS, with their informed consent. Ideally, residents admitted into this situation should be admitted into a private room.

- For **individuals who are partially vaccinated, unvaccinated, or for whom their COVID-19 vaccination status is unknown**, they should:
  - Follow additional precautions until they receive a negative result on a COVID-19 PCR test **OR** 10 days have passed:
  - Monitor for symptoms.
  - Avoid using common areas; however, if a common area cannot be avoided, the resident must use a medical (surgical/procedural) mask if tolerated.
  - Limit contact with other residents.
  - Only participate in group activities if physical distancing is maintained (i.e. 2 metres) and a medical (surgical/procedural) mask is used for the duration of the activity.
  - Practice proper hand hygiene by washing hands often (using soap and water or using ABHR).
  - Adhere to respiratory etiquette.

- CLSs should consider whether it is necessary, safe, and operationally appropriate to proceed with or postpone the admission of those who fail their active screening and/or test positive. This decision should be made in consultation with the local PHU. If admission is postponed, individuals should be referred to other organizations or services in the community where they can be safely housed for their self-isolation period.
- Any resident being admitted or transferred, regardless of their COVID-19 vaccination status, who is identified as having symptoms, exposure, and/or

diagnosis of COVID-19 must be placed on Droplet and Contact Precautions and managed as per the Management of Cases and Contacts of COVID-19 in Ontario.

- Individuals who have previously tested positive for COVID-19 in the last 90 days (based on positive rapid antigen test or molecular test results) and have since been cleared are exempt from isolation and testing should they have a subsequent exposure, as long as they are currently asymptomatic.

Absences (short-stay and overnight)

When a resident leaves the CLS on an absence for any reason, they should be provided with a medical (surgical/procedural) mask, unless they are subject to a masking exemption (see masking section above for more information) and should also be reminded to follow general public health guidance in the community In community spaces where masking is not mandated, residents may choose to wear a mask or not to.

- Depending on the nature of the CLS and the residents, when operationally feasible and appropriate (e.g. when there is an overnight or extended absence of a resident in a setting serving immunocompromised individuals or those at higher risk of severe disease due to COVID-19), residents should be actively screened upon their return to the CLS.

CLSs should have policies in place that enable the setting to flexibly adjust their absence policies where necessary. This includes limiting or restricting **short-stay recreational outings** and **general overnight absences** if the CLS is in an outbreak.

- There may be circumstances in which absences must be permitted. CLSs should seek the advice of the local PHU on how to facilitate an absence safely in these circumstances, which may include absences:

- To seek medical care or for palliative/compassionate reasons, which must not be denied at any time.
- To mitigate any undue hardship for the resident, recognizing the specific needs and challenges that many residents of CLSs may face (e.g., to access support persons or services which may include but are not limited to social workers, case supervisors, group sessions, and/or other paramedical care for mental health and/or substance use).

Visitors

The following pre-requisites must be met before accepting visitors in a setting:

- Proactive and ongoing communication with residents, families/friends, and staff about on-site visit procedures, which should include, but not be limited to:
  - Visit scheduling protocols and any site-specific policies (e.g., outbreak);
  - PPE requirements for indoor/outdoor visitors (see sections on masking and PPE above).
  - Operational procedures such as limiting movement inside the CLS, if applicable, and ensuring visitors' agreement to comply with the procedures prior to each visit.
  - Identification of dedicated indoor and outdoor visitation areas.
  - A list/log of visitors and their contact information, which is to be made available to relevant staff and for PHU case and contact management, as needed. Logs are to be kept for a minimum of one month.
  - An approach to dealing with non-adherence to these policies and procedures, including the discontinuation of visits where appropriate.
- Protocols are in place to maintain IPAC standards prior to, during and after visits, which include:
  - Active screening of all visitors upon arrival, with policies and

protocols in place to admit entry to only those who pass the screening.
    - Proper respiratory etiquette and frequent hand hygiene.
    - Education on all required protocols will be provided by the site.
    - Adequate staffing to implement visitation protocols and continue ongoing operations within the setting.
    - Environmental cleaning and disinfection of the visitation space(s) (including washrooms), following recommended IPAC standards.
    - Where appropriate, the CLS is able to facilitate visits in a manner that permits physical distancing, including identifying a space(s) where visiting takes place and the areas that are off-limits to visitors (e.g., common areas, etc.), and the maximum capacity limit based on ability to physically distance within a designated space.
    - Scheduling of indoor non-essential visits to ensure physical distancing within a designated space can be maintained.

- For each visit, all essential and non-essential visitors must:
    - Pass an active screening questionnaire that screens for COVID-19 signs andsymptoms.
    - Read and agree to the parameters of the visit set out by the service providerin compliance with this document and public health direction.
    - Share their contact information, which will be made available to relevant staff and for PHU contact tracing activity, as needed.
    - Remain within designated spaces as identified by the service provider.

- CLSs may choose to request a visitor attestation to the acceptance of the visitor protocols and the consequences of failure to adhere to them.

Communal Activities for Residents

There are many cognitive, social, and psychological benefits for residents to participate in communal dining and other forms of activities. CLSs are strongly encouraged to continue with programs and activities for their residents while ensuring that they align with public health recommendations and in consideration of the measures outlined in this document in order to reduce the risk of COVID-19 transmission for residents while outside of the CLS.

This includes community-based programs and activities that are also open to residents (i.e., day programs).

Some considerations for reducing the risk of COVID-19 in group settings include:

- Keeping the groups (cohorts) as consistent as possible to reduce the number of potential high-risk contacts in the event of COVID-19 exposure;
- Keeping the size of the groups small – recognizing that group sizes may need to be balanced to address the psychosocial needs of the residents, the CLS's staffing capacity, and/or take into consideration any capacity limits for indoor areas;
- Ensuring same staffing assignment to each group where operationally feasible; and
- Ensuring that residents wear medical (surgical/procedural) masks, unless they are subject to a masking exemption, and practicing physical distancing, particularly in settings that serve transient and/or a large number of residents (see sections on physical distancing and masking above).
- Using larger spaces and improving ventilation (e.g. opening windows and doors), and moving communal activities to outdoor areas, where feasible.
    - This section does not apply to CLSs that already function like a household.

Caring for Residents Who Need to Self-Isolate

Note: Some residents of CLS may live with certain conditions and/or experience undue hardships when it comes to self-isolation and/or frequent COVID-19 testing (e.g., mental health, behavioural or cognitive conditions, substance use,

trauma/violence, and/or other precarious factors). This should not result in refusal of services and CLSs should work with the resident and the PHU to identify resident-centered solutions that can reduce the potential risk of COVID-19 transmission and mitigate potential harms. Examples include permitting some degree of socialization or outdoor breaks during a self-isolation period. Layering as many public health measures possible, such as masking and physical distancing, will be extremely important.

Residents who need to **self-isolate on Droplet and Contact Precautions** include:

- Residents who have not passed active screening following return from an overnight/extended absence (see above);
- Residents who are unwell with symptoms of COVID-19 and/or other common respiratory infections, such as influenza;
- Residents awaiting test results for COVID-19 and/or other common respiratory infections;
- Residents who have tested positive for COVID-19 and/or other common respiratory infections;
- Residents who have been identified as close contacts of a known case of COVID-19 and/or instructed to self-isolate by the local PHU.

Any resident who is self-isolating should be placed in a single room with a door that closes and, if feasible, have access to a private bathroom.

- If this is not possible, at the direction of the local PHU, the resident may be grouped (cohorted) with others who have tested positive for COVID-19 and are in self-isolation. In this case, each resident should wear a medical (surgical/procedural) mask, unless they are subject to a masking exemption (see masking section for more information), and maintain as much distance as possible from others. See PHO's Cohorting in Outbreaks in Congregate Living Settings document for further guidance on developing cohorts of residents in CLSs during an outbreak.

If a resident needs to leave self-isolation:

- They should maintain physical distance from others and wear a medical (surgical/procedural) mask, unless they are subject to a masking exemption,

for the entire time they are outside of their room. This includes when accessing a shared bathroom or leaving the CLS to seek external care.

- Staff providing direct care should take appropriate precautions depending on the nature of the planned interaction and what is known about the health status of the resident. This includes ensuring that staff are wearing appropriate PPE (i.e., minimum of medical (surgical/procedural) mask and eye protection) when providing care to a resident (within 2 metres). Gloves and gowns should also be worn if providing direct care where skin or clothing could become contaminated. See PHO's Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 for more information on PPE use.
- CLSs should have plans to address:
  - How and where the resident can be clinically assessed and/or tested for COVID-19 (e.g., assessment centre, health care provider on site);
  - How and where to self-isolate the resident for the duration of their required self-isolation period. Wherever possible, private rooms are preferred;
  - How to support the resident remaining in their room, including the ability to receive meals in their room, to have hygiene and essential care services provided for, and, if possible, not sharing a bathroom with others;
  - How to safely support the use of shared facilities by the resident in self-isolation where required. This may include maintaining physical distancing, staggering access, and undertaking thorough cleaning and disinfection of shared spaces;
  - Who will monitor the resident's symptoms and how often this will be done, what PPE is required, and how to determine when additional medical care and intervention is required; and
  - What to do if a resident develops severe symptoms; and
  - How to access private transportation if there is a need to transfer the resident, including if they need to be transferred to an external location.
  - Public transportation should be avoided.

- CLSs should proactively alert their local PHU if self-isolation is not possible on site and to identify alternate isolation location(s) with municipal and/or health system partners.

Responding to a Symptomatic Individual

When a resident(s) is symptomatic: Regardless of their COVID-19 vaccination status, any resident who is exhibiting signs or symptoms consistent with an acute respiratory illness including COVID-19 should be self-isolated (see Caring for Individuals Who Need to Self-Isolate, above) and tested.

When a staff or a visitor is symptomatic: All symptomatic staff or visitors should not be permitted to enter the CLS. If they become symptomatic during their shift or visit, they should be asked to leave immediately and/or isolated until they can safely leave the CLS. They should be instructed to continue to self-isolate, seek medical assessment as required, and be encouraged to get molecular testing for COVID-19. Note that staff, volunteers and visitors in highest risk settings are eligible and prioritized for PCR testing.

Note: per page 12, visitor policies are to incorporate allowances for visitors that fail screening in certain circumstances (i.e.. compassionate and/or palliative reasons).

Mandatory Positive Case Reporting:

CLS must contact PHU when:

- There is a probable case of COVID-19 in the CLS, OR
- There is a confirmed case of COVID-19 in the CLS; OR
- An outbreak is suspected based on ill residents, staff, and/or frequent visitors.

CLS must also:

- Continue to report COVID- 19 cases through the ministry's Serious Occurrence Reporting, and

- Provide regular status updates to their primary ministry contact.

Case and Contact Management

PHUs are responsible for COVID-19 case and high-risk contact (HRC) management. CLSs should follow all advice and direction received from the PHU with respect to self-isolation (case management) and contact management when a resident, staff, or visitor of the setting is confirmed positive for COVID-19.

For further information, including case and contact management recommendations for staff and visitors, refer to the following provincial guidance document:

- Management of Cases and Contacts of COVID-19 in Ontario.

Outbreak Management

Declaring an outbreak: The following definitions are for surveillance purposes only. PHUs have the discretion to declare a suspected or a confirmed outbreak based on the results of their investigation, including when the definitions below are not completely met.

- **A suspect outbreak** in a CLS is defined as one lab-confirmed COVID-19 case in a resident.
- **A confirmed outbreak** in a CLS is defined as two residents and/or staff (or other visitors) in a CLS each with a positive PCR test or rapid molecular test OR rapid antigen test AND with an epidemiological link, within a 10-day period.
    - *Epidemiological link defined as: reasonable evidence of transmission between clients/staff/other visitors AND there is a risk of transmission of COVID-19 to other clients within the CLS.

Outbreak management: the local PHU is responsible for investigating (e.g., determining when cases are epidemiologically linked), declaring and managing outbreaks under the ***Health Protection and Promotion Act***. As such, the local PHU directs and coordinates the outbreak response. CLSs should adhere to any guidance provided by the local PHU with respect to implementation of outbreak response measures.

- Additional information can be found in the following:
  - Management of Cases and Contacts of COVID-19 in Ontario.
  - Also see PHO's Checklist: Managing COVID-19 Outbreaks in Congregate Living Settings document to provide further guidance on managing COVID-19 outbreaks in congregate settings.

Outbreak testing in a CLS is directed by the local PHU. This should be guided by the Management of Cases and Contacts of COVID-19 in Ontario.

- PHUs will advise the CLS on the need and the frequency for repeat testing as part of an ongoing outbreak investigation to identify additional cases.
- If large numbers of individuals in a CLS require testing, the local PHU and the CLS provider should consider making arrangements to either bring testing services to the setting or make arrangements with the local COVID-19 Assessment Centre.
  - At this time, RATs are not intended for diagnostic purposes in highest risk settings given the limited sensitivity of RATs compared with PCR testing; however, they may be used to facilitate case, contact, and outbreak management. The results of a RAT may be used to declare a suspect or confirmed outbreak while awaiting PCR or rapid molecular diagnostic test results. If a RAT is used for a staff or client with symptoms or high-risk exposure, PCR or rapid molecular testing should be performed in parallel.
  - Negative RAT results should not be used independently to rule out

COVID-19 in an outbreak situation or for a symptomatic individual or a close contact who works or resides in a CLS due to the limited sensitivity of RATs.

Outbreak measures are any action or activity that can be used to help prevent, eliminate, or reduce the ongoing transmission of COVID-19. The CLS should consult with the PHU on the following outbreak measures:

- **Defining the outbreak area** (i.e., affected unit(s) versus the whole CLS) to which outbreak measures will be implemented.
- **Limiting or restricting all communal activities and/or spaces** within the CLS where residents, staff, and visitors can congregate.
- **Establishing resident cohorts based on their COVID-19 exposure status (i.e., exposed vs non-exposed):** this is an important IPAC strategy to limit potential transmission throughout the facility.
- Where operationally feasible, **establishing staff cohorts** alongside the residents based on their COVID-19 exposure status and/or designating staff to work with only one group of cohorts on each shift.
- **Limiting work locations for staff** to prevent spread to other settings.
- **Limiting or restricting new admissions and transfers:** Best practice is that no new residents are allowed into an outbreak area until the outbreak is declared over. Where new admissions or transfers cannot be avoided, the CLS provider should consult the local PHU for guidance.
- **Limiting or restricting resident absences**: Residents who have left the CLS on an overnight absence prior to an outbreak being declared should, if possible, avoid returning to the setting until the outbreak is declared over.
- **Limiting or restricting visitors into the CLS**: Only essential visitors are permitted in an outbreak. General visits must be restricted in an outbreak.
    - CLSs should ensure that visitations are not unnecessarily discontinued and continue to safely facilitate essential visitors on-site during an outbreak. However, CLSs may wish to consider limiting the number of visitors at any one time to reduce crowding and ensure all outbreak measures can be followed.

Outbreak communication: As part of the outbreak management process, the CLS should notify all relevant individuals and/or agencies about the outbreak as listed in the setting's procedures and policies.

- Residents, staff, family members, and visitors should be made aware of the outbreak measures being implemented at the CLS. As much as possible, efforts should be made to facilitate interactions between residents and their loved ones through technology (telephone and video).

Declaring the outbreak over: The outbreak may be declared over by the PHU when there are no new cases in residents or staff linked to exposure in the CLS after 10 days (maximum incubation period) from the latest of:

- Date of isolation of the last resident case; OR
- Date of illness onset of the last resident case; OR
- Date of last shift at work for last staff case.

- For greater clarity, if staff continue to test positive for COVID-19 (i.e., a staff presumed or linked to an external exposure), the outbreak may be declared over at the discretion of the PHU, provided there is no evidence of transmission to clients. The CLS should continue to conduct enhanced symptom surveillance for clients.

Following the end of an outbreak, the CLS should follow directions from the PHU with respect to de-escalation of COVID-19 outbreak control measures as the cases are resolved.

Occupational Health and Safety

The *Occupational Health and Safety Act* (OHSA) requires employers to take every precaution reasonable in the circumstances for the protection of workers.[1] This includes protecting workers from the transmission of infectious diseases in the workplace.

More information on occupational health and safety requirements and workplace guidance for COVID-19 are available on the Ontario COVID-19 and workplace health and safety website and the Ministry of Labour, Training and Skills Development (MLTSD) website.

Reporting occupational illness

- Under OHSA, if an employer is advised that a worker has tested positive for COVID-19 due to exposure at the workplace, or that a claim has been filed with the Workplace Safety and Insurance Board (WSIB), the employer must provide written notice within four days to:
  - MLTSD;
  - The workplace's joint health and safety committee or a health and safety representative; and
  - The worker's trade union (if applicable).
- Additionally, under the *Workplace Safety and Insurance Act, 1997* (WSIA), an employer must report any occupationally acquired illnesses to the WSIB within 72 hours of receiving notification of said illness.

[1] This section will refer to workers as defined under the *Occupational Health and Safety Act.*

Appendix 1: Outline of updates to Guidance for Congregate Living Settings

Page #	Description of update
Throughout	Removed references to O. Reg. 364/20
13-14	Recommendation for wearing a mask

Appendix 2: Summary of Active Screening

The following table provides a summary of the suggested screening practices. Please refer to Active Screening for Anyone Entering the CLS, above, for more details as well as for considerations for implementation.

	Staff, Visitors, and Anyone Entering the CLS	**Current Residents of the CLS**
Who does this include?	• Staff working at the CLS and all visitors, including essential visitors and anyone else entering the setting. • Exception: First responders in emergency.	• Residents currently residing in the CLS.
What are the screening practices?	• Conduct active screening (at the beginning of the day or shift). • At a minimum, the CLS should ask questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. • Temperature checks are not required. • All visitors coming into the CLS must adhere to the setting's visitor policies.	• Conduct symptom assessment of all residents at least once daily to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms. • All residents returning from an overnight or extended absence should be actively screened at entry upon their return.
What if someone does not pass active screening?	Staff, visitors, and those attempting to enter the CLS who are experiencing symptoms of COVID-19 or had potential exposure to COVID-19, and have not passed active screening should: • Not enter the CLS; • Instructed to immediately to self-isolate; and • Be encouraged to be tested for COVID-19.	• Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) should be isolated under Droplet and Contact Precautions and tested. • For a list of typical and atypical symptoms, refer to

		the COVID-19 Reference Document for Symptoms.

Appendix 3: Personal Protective Equipment (PPE) Supply

Core PPE

Medical (surgical/procedure) masks, face shields, hand sanitizer, gloves, disinfectant wipes, and isolation gowns are considered 'core' PPE types. By reporting your current inventory, daily consumption, and forecasted usage via the Critical Supplies and Equipment (CSE) survey portal, MCCSS can see when your survey results indicate less than a 2 week supply of core PPE, which will trigger anautomatic 2-week top-up shipment to be sent within one week of the survey close.

Niche PPE

Items such as eye goggles, larger-sized gowns, and thermometers are considered a "niche" PPE type and can be obtained through the Ontario Association of Children's Aid Societies (OACAS) SharedServices PPE Order Page.

Service providers are asked to use discretion when ordering niche PPE and should default to using core PPE (i.e., face shields as opposed to eye goggles) when operationally feasible as access and supply to these products is more stable.

Service providers should forecast their requirements in the CSE survey portal. In case of an emergency (i.e., COVID-19 outbreak, having less than a 5-day supply of PPE) organizations requiring additional medical (surgical/procedure) masks, eye protection and isolation gowns can request additional supplies from the OACAS Shared Services PPE Order Page.

N95 Respirators

CLSs who determine a need for N95s should begin reporting inventory and consumption data through the existing COVID-19 Critical Supplies and Equipment(CSE) Survey link https://ontario-ppecse-survey.mgcs.gov.on.ca/.

Please note that N95s are not currently shipped through automatic shipments.Orders for N95s must be placed through the MCCSS web portal link: https://request.cwconnects.org/tpr/.

Appendix 4: Public Health Ontario Resources

- ***General:***
    - Public Resources
    - COVID-19 Resources for Congregate Living Settings
    - Congregate Living Setting Resources Toolkit
- ***Infection Prevention and Control:***
    - COVID-19 IPAC Fundamentals Training (course)
    - COVID-19 Checklist: Preparedness and Prevention in Congregate Living Settings
    - COVID-19 Vaccine Communication Strategies for Community Congregate Living Settings
    - COVID-19: Personal Protective Equipment and Non-Medical Masks in Congregate Living Settings
    - Cleaning and Disinfection for Public Settings
- ***COVID-19 Outbreaks:***
    - Cohorting in Outbreaks in Congregate Living Settings
    - COVID-19 Checklist: Managing COVID-19 Outbreaks in Congregate Living Settings

Respiratory Virus Outbreaks:

- Planning for Respiratory Virus Outbreaks in Congregate Living Settings
- Key features of influenza, SARS-CoV-2 and Other Common Respiratory Viruses
- Antiviral use in congregate settings

- ***Indoor air quality:***
    - COVID-19: Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings
    - Use of Portable Air Cleaners and Transmission of COVID-19