

Ministry of Health

COVID-19 Guidance: Congregate Living for Vulnerable Populations

Version 4 – June 10, 2022

Highlights of Changes:

- Removal of references to expired legislation and Orders.
- Inclusion of the IPAC Hubs under Roles and Responsibilities
- Updated language to screening and physical distancing
- Updated setting-specific considerations for infection prevention and control principles.
- General housekeeping (e.g., updated links and terminology)

This guidance document provides basic information to support local public health units (PHU) with their COVID-19 response in congregate living settings (CLSs). PHUs may provide directions that may be different and/or in addition to those in this guidance in order to prevent and mitigate the spread of COVID-19 and/or other infectious disease to ensure a tailored response to each outbreak scenario.

The goal of this document is to provide guidance on how to minimize COVID-19 transmission among individuals working, residing in, or visiting a CLS by preventing, detecting, and managing individual cases and outbreaks of COVID-19 within these settings. The updates in this document are based on the scientific evidence and public health expertise available at the time of writing.

This document is not intended to take the place of medical advice, diagnosis or treatment, legal advice, or any other requirements which apply to CLS. In the event of any conflict between this guidance document and any applicable legislation or orders or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the legislation, orders and/or directives prevail.

Please check the Ministry of Health's (MOH) [COVID-19 Guidance for the Health Care Sector](#) regularly for updates to this document as well as other COVID-19 relevant information. [Appendix A](#) contains additional resources developed by Public Health Ontario (PHO).

Note for CLS service providers: Service providers should refer to sector-specific guidance documents developed by relevant government ministries, organizations, agencies, service managers and/or municipalities that have oversight for their sector on how to operationalize and implement the principles found in this document in a culturally appropriate manner specific to their setting.

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Scope of Document

The term “**congregate living setting**” (CLS) encompasses a number of different sectors that vary in the nature of the clientele they serve, the services they provide, and the environment in which congregate living activities take place. However, CLSs all serve vulnerable populations that may face unique physical, mental, cognitive, and behavioural factors that increase their clients' risk of COVID-19 transmission and associated severe outcomes, as well as pose complexities when managing COVID-19 in these settings.

As such, this document is intended to highlight the key infection prevention and control (IPAC) principles that are integral to COVID-19 response efforts and are common to all settings. It also attempts to provide additional considerations and alternate approaches to routine public health COVID-19 management to mitigate potential unintended adverse consequences. The guidance in this document, where applicable, should also be applied to programs and activities that operate within CLSs but are open to members of the community (i.e., day programs).

This guidance document is intended for PHUs to apply to the majority of high risk CLSs identified in Ontario's [COVID-19 Action Plan: Vulnerable People](#), which include:

- Supportive housing¹;
- Supported developmental services/intervenor residences;
- Emergency homeless shelters;
- Mental health and addictions congregate settings;
- Homes for special care and community homes for opportunity;
- Violence against women (VAW) shelters;
- Anti-human trafficking (AHT) residences;
- Children's residential facilities; and
- Indigenous Healing and Wellness Residential sites.

¹ Where appropriate, this guidance can also be considered for application in unregulated and/or unlicensed CLS that function as a type of supportive housing (e.g., group homes).

CLSs in First Nations communities are encouraged to collaborate with the community's leadership, including Chief and Council, and if applicable the federal government and/or local PHU, should they wish to apply this guidance to their settings. Collaboration may be helpful in determining the most appropriate ways to implement the recommendations, including any processes to report and support COVID-19 outbreaks, and ensure that these actions are culturally responsive.

The following settings are **not** intended to be included in the scope of this guidance document and should follow their own relevant sector-specific guidance:

- Adult correctional institutions should refer to guidance that has been developed by the Ministry of the Solicitor General (SOLGEN) in alignment with advice from the MOH and PHO.
- Youth justice open and secure custody/detention facilities should continue to follow existing [guidance](#) from the Ministry of Children, Community and Social Services (MCCSS).
- For Seasonal International Agricultural Workers, see MOH's [COVID-19 Guidance: Workplace and Living Settings for Seasonal International Agriculture Workers \(IAWs\)](#).
- Educational institutions with dormitories, including [Provincial and Demonstration Schools](#), should also refer to their relevant ministries for additional guidance.

Terms Used in this Document

- Please refer to the Ministry of Health's [guidance](#) on staying "up to date" with COVID-19 vaccinations.
- The term **"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;
 - Health care workers and other support persons employed by the client and/or their family;
 - Health care workers seeing a single client for a single episode,
 - Temporary and/or agency staff;
 - Third party staff who are performing job duties (e.g., support services staff, contracted cleaning staff, tradespeople);
 - Students on placement (e.g., nursing students); and

- Volunteers.
- The term **“client”** refers to individuals who reside in or receive services from a CLS facility.
- The term **“household”** refers to a group of individuals (i.e., clients) who live together AND are part of each other's daily regular routine, and therefore spend most of their time in close physical contact with one another.
 - As per the [Management of Cases and Contacts of COVID-19 in Ontario](#), 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 clients live and spend most of their day-to-day activities together, often owing to shared medical, physical, mental, cognitive, and/or behavioural needs. Discretion is strongly advised when PHUs are determining a CLS to be 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 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 client. Essential visitors are permitted to enter the CLS even when clients 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 client(s) who are self-isolating and/or when the CLS is in an outbreak.
- A **“point of care risk assessment (PCRA)”** / **“[personal risk assessment](#)”**) is a dynamic risk assessment completed by health care workers and other staff before every patient/client care/interaction in order to determine whether there is risk of being exposed to an infection. A risk assessment will help determine the appropriate personal protective equipment (PPE) required to protect the staff in their interaction with the patient/client and their environment.

Roles and Responsibilities

Note: Roles and responsibilities of MOH, PHO, Ministry of Labour, Training, and Skills Development (MLTSD), Ontario Health, IPAC Hubs, and other external partners have previously been summarized in MOH's [COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units](#).

Role of the Public Health Unit (PHU)

Prevention and Preparedness

- Advise on prevention of COVID-19 transmission and preparedness for the management of COVID-19 cases, contacts and outbreaks, in conjunction with advice provided through the MOH, the MCCSS, MMAH, and any other relevant ministry.

Case and Contact Management/Outbreak Management

- Receive and investigate reports of suspected or confirmed cases and contacts of COVID-19 in accordance with the [Health Protection and Promotion Act, 1990](#) (HPPA).
- Manage cases and contacts in accordance with relevant [provincial guidance](#) and tools, including [Management of Cases and Contacts of COVID-19 in Ontario](#) or as current.
- Enter cases, contacts, and outbreaks in the provincial surveillance system, in accordance with data entry guidance provided by PHO.
- Determine if an outbreak exists and declare an outbreak, as per the outbreak definition.
- Provide guidance and recommendations to the CLS on outbreak control measures in conjunction with advice provided by MOH, as well as MCCSS and/or other ministries as relevant.
- Make recommendations on who to test, in alignment with the guidance provided within this document and the [Management of Cases and Contacts of COVID-19 in Ontario](#), as applicable. Facilitate a coordinated approach to testing, in collaboration with Ontario Health, including provision of an investigation or outbreak number.
- Facilitate outbreak meetings with the CLS, PHO, Ontario Health, IPAC Hubs, etc, as needed.

- Issue orders by the medical officer of health or their designate under the HPPA, if necessary.
- Declare the outbreak over.

Coordination and Communication

- In the event that a case or contact resides in a PHU that is different than that of the CLS, discussions between the respective PHUs should take place to coordinate contact follow-up and delineate roles and responsibilities.
 - The PHU of the CLS is typically the lead PHU for setting follow-up.
 - Request support from the Ministry of Health's Emergency Operations Centre (MEOC) if coordination between multiple PHUs is required for outbreak management.
- Notify the MEOC (EOCOperations.moh@ontario.ca) of:
 - Potential for significant media coverage or if media releases are planned by the PHU.
- Notify the Office of the Chief Medical Officer of Health of any orders issued by the PHU's medical officer of health or their designate to the CLS and share a copy.
- Engage and/or communicate with relevant partners, stakeholders and ministries, as necessary.

Role of Respective Ministries (including MOH, where relevant)

- Provide legislative and policy oversight of CLSs.
- Communicate expectations and provincial-level guidance on COVID-19 related policies, measures, and practices to CLSs.
- Provide ongoing support and communications to CLSs with partner agencies, other ministries, and the public as necessary.

Role of the Congregate Living Setting (CLS)

- Review and consider any guidance provided by the province (e.g., MOH, MLTSD, relevant ministries) and/or their local PHU.

- Be aware of their legal obligations and duties under relevant legislation, including the *Occupational Health and Safety Act*, (OHSA), and ensure compliance. **Note:** All employers under OHSA have a duty to take every precaution reasonable in the circumstances for the protection of a worker. This includes protecting workers from infectious disease. For more information, see [Occupational Health and Safety section below](#).
- Ensure adequate supplies, including appropriate PPE, are maintained.
- Accurate records of staff attendance, all visitors, and client information should be maintained. This information should be available to be accessed and shared with the local PHU in a timely manner (within 24 hours) for investigations and communication upon request. Visitor logs should include, at minimum, the name of the visitor, reason for entering the CLS, location(s) and/or client(s) visited, up to date contact information, and dates/times of the visit to facilitate contact follow-up if needed.
 - Records of staff attendance and visitor logs, as well as their up to date contact information, should be kept for the last 30 days.
 - Facilitate access to staff lists of those not directly employed by the CLS (e.g., third party/temporary agency workers) and provide to the PHU.
 - **Note:** Some CLSs may face challenges when maintaining records for some of their more transient clients (e.g., emergency homeless shelters). CLSs should proactively identify any potential issues so that a mutually feasible solution can be put into place before an outbreak occurs.
- Name(s) and contact information of a designated point of contact for use during and/or after business hours, to ensure timely investigation and follow up of cases, contacts, and outbreaks should be provided to the PHU.
- As much as operationally feasible, collect data on client vaccination status for COVID-19 and influenza consistently through a process (that includes [written consent](#)), and make this available to PHUs to inform their investigation. Any data should be collected, retained and disposed of in a manner that respects privacy, including complying with the [Personal Health Information and Protection Act, 2004](#) (PHIPA) where applicable.

- **Note:** where sector-specific policy is issued by a relevant ministry, CLSs should follow those directions for collecting and reporting data on COVID-19 vaccination rates. Follow the directions of the local PHU if any staff or clients have COVID-19, are exposed to someone with COVID-19, or if there is a suspect or confirmed outbreak in the CLS.
- Coordinate with the local PHU and other stakeholders as appropriate on the implementation of outbreak measures in the setting.
- Communicate proactively with the CLS staff, visitors, clients, and clients' families/support networks about COVID-19 outbreak measures and about how ill individuals, cases, contacts, and outbreaks will be handled.

Role of the IPAC Hubs

- Support building IPAC capacity within CLSs, including:
 - Providing recommendations to strengthen IPAC programs and practices
 - Assisting CLSs with the implementation of IPAC recommendations and outbreak control measures provided by the PHU.

Prevention of Disease Transmission

PHUs should remind all CLSs on the use of the [multiple layers of public health measures](#) described in this document in order to protect their clients, 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 PPE should all be considered when developing CLS-specific policies.

Immunizations

- PHUs are encouraged to support COVID-19 and influenza vaccinations in CLSs in collaboration with relevant health system partners as feasible.
- COVID-19 vaccination is one of the most effective public health measures to prevent severe illness and death due to COVID-19. As such, all clients, staff,

and visitors should be encouraged to get vaccinated against COVID-19 and to remain [up-to-date](#) with their vaccinations .

- New 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 a complete series of COVID-19 vaccinations as soon as possible, and booster dose(s), when eligible.
- More information can be found on the MOH's [COVID-19 Vaccine-Relevant Information and Planning Resources](#) webpage.

Screening

Active Screening and Passive Screening

- The purpose of active and passive screening is to prevent those who may be infectious from spreading the infection within the CLS.
- Passive screening means those entering the CLS monitor their own health and may review screening questions themselves; there is no verification or attestation of screening (e.g., signage at entrances as a visual reminder to not enter if symptomatic).
- Active screening means there is some form of attestation/confirmation of screening. This can be achieved through pre-arrival submission of online screening or in-person.
 - For staff and volunteers, active screening may be done through completing and submitting an online screening tool prior to the start of a shift without the need for interaction with an in-person screener for confirmation, unless asked/requested by the CLS or advised by the PHU. The provincial [COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes](#) may be used or adapted by the CLS.
 - CLSs should instruct all staff, volunteers, (essential and general) and visitors to self-monitor for COVID-19 symptoms at home and not come to the CLS if they are feeling ill.
 - CLSs should have an established process for conducting active screening for COVID-19 symptoms and exposures for visitors entering the home. CLSs may incorporate options for how active screening will be conducted (e.g., prearrival submission of online screening or in person on arrival) and it should be clearly communicated to those entering the CLS. CLSs may use mobile apps or other tools to facilitate the active screening process.

- For example, a visitor may complete an online screening tool and have their results be sent electronically to the screener or demonstrate their results to the screener prior to entry.
- A summary chart of active screening practices can be found in Appendix B.
- Clients being admitted, transferred or returning to a CLS from an extended absence should 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.
- CLSs should post signage that list the signs and symptoms of COVID-19 for self-monitoring and provide steps that should be taken if COVID-19 is suspected or confirmed in a staff member, visitor, or a client. A list of COVID-19 symptoms, including atypical symptoms, can be found in the [Management of Cases and Contacts of COVID-19 in Ontario](#).
- CLSs should also post signage throughout the CLS to encourage all persons in the CLS to wear their masks, perform hand hygiene, and follow respiratory etiquette as per routine measures for respiratory season.
- **Note:** As much as possible, signage should be in the format and/or language that is most accessible to the clients of that setting. For examples, see [PHO's multilingual resources](#) or the [US Centers for Disease Control and Prevention's pictograph-based signage](#). CLSs may refer to PHO's Technical Brief on [Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings](#), for guidance on the use of active or passive screening for staff, visitors, and clients and depending on the risk of transmission in their community.
- CLSs may consult their local public health unit for guidance on when to use of active versus passive screening for visitors and staff.
- Emergency first responders must be permitted entry without screening.

Screening Outcomes

- If a staff or a visitor is showing symptoms of COVID-19 during screening or has not passed the screening for other reasons, they should not be allowed to enter the CLS. They should be instructed to self-isolate immediately and be encouraged to get a COVID-19 PCR test (as applicable).
 - CLSs should have policies in place options for allowances for individuals that fail screening that consider the type of visitor and the

client'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). CLSs should ensure that individuals wear a well-fitted medical mask, maintain physical distance from other individuals, and perform hand hygiene.

- Any staff who does not pass their screening should contact their supervisor(s)/manager(s) or the relevant occupational health and safety staff or representative in the CLS.
 - Staff responsible for occupational health and safety in the CLS should follow up with all staff who have screened positive to provide advice on work restrictions.
 - 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 or Influenza Immunization](#).
- Staff who are on early return to work should follow the protocols and requirements as per the MOH's guidance for [early return to work](#) and any sector-specific requirements or policy on Test to Work/early return to work.
- Clients with symptoms or those who do not pass screening should be given a medical mask to wear, unless they are subject to a masking exemption (see masking section), and directed to a designated space away from other clients 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.

Daily Symptom Assessment of Clients

- Clients should be assessed at least once daily to identify any new or worsening [symptoms of COVID-19](#). Where applicable, this can take place at the same time as routine vital signs check and may 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 clients.
- CLSs should be aware that some clients (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 client's baseline health and functioning and ensure routine monitoring of their status to facilitate early identification and management of ill clients.

- In large CLSs that primarily serve transient and/or large numbers of clients, it may be challenging to ascertain the client's health status. As much as possible, staff should be encouraged to check in with the clients, inquire about how they are doing opportunistically while providing services, remind clients to self-identify if they are feeling unwell through verbal reminders and passive signage, and ensure good IPAC practices on site.

Hand Hygiene

- Access to handwashing stations and/or alcohol-based hand rubs (ABHRs) should be available at multiple, prominent locations throughout the CLS, including entrances and in common areas, to promote frequent hand hygiene.
- All staff, visitors, and clients should be reminded through training and [signage](#) to:
 - Clean hands frequently throughout the day by washing with soap and water or using ABHR (70%-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 receptacles, which should be placed throughout the CLS). Gloves are not a replacement for hand hygiene.
 - Safe placement of ABHR to avoid consumption is important, especially for young children.
- Assistance should be provided to clients who may not be able to perform hand hygiene on their own.

Physical Distancing

- In general, all individuals should be encouraged to avoid the 3 C's where COVID-19 can spread more easily:
 - Avoid **c**rowded places with many people nearby;

- Avoid **c**lose-contact settings; and
- Avoid **c**onfined and enclosed spaces with poor ventilation.
- Physical distancing may be practiced in a number of different ways depending on the nature of the CLS. See table below on when physical distancing should be encouraged and when it may not be possible.

When physical distancing should be encouraged	When physical distancing may not be possible
<ul style="list-style-type: none"> • In CLS facilities that serve transient and/or large number of clients*; • Individual(s) are immunocompromised and/or at a higher risk of severe disease from COVID-19. 	<ul style="list-style-type: none"> • During the provision of direct care (appropriate PPE should be worn based on the nature, duration, and type of interaction); • Among clients 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, all other measures – including active screening, masking, and wearing of 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 at least 2 metres apart. If this is not possible, consider different strategies to keep clients apart (e.g., place beds head to foot or foot to foot).

Masking

- Universal masking is recommended for the purpose of source control to help prevent the spread of potentially infectious respiratory droplets and aerosols from the nose and mouth of the person wearing the mask to others.
 - Universal masking means wearing a mask at all times, whether or not the CLS is in outbreak and regardless of one's COVID-19 vaccination status. Physical distancing measures, where applicable, should be maintained even when wearing a mask.
- **Staff**
 - Well-fitted medical (surgical/procedural) masks are strongly recommended.
 - Masks should not be removed when staff are interacting with clients and/or in designated client areas.
- **Visitors** should wear a well-fitted mask at all times while indoors at the CLS (subject to very limited exceptions).
 - Given the frequency, duration, and/or the intimate nature of interaction between essential visitors and clients, essential visitors are strongly encouraged to practice universal masking in the CLS, while indoors, at all times regardless of their COVID-19 vaccination status.
- **Clients** in a CLS should wear a well-fitted mask in any indoor common areas, subject to limited exceptions as noted below.
 - This masking requirement does not apply to individuals who are unable to wear a mask due to a medical condition, unable to put on or remove their mask or face covering without the assistance of another person, and/or are being reasonably accommodated in accordance with [Accessibility for Ontarians with Disabilities Act, 2005](#) or the [Human Rights Code](#).
 - Medical masks are preferred and should be provided free of charge for clients in large congregate settings and/or in settings that serve transient populations.

- Clients who are on [Droplet and Contact Precautions](#) due to COVID-19 or other respiratory infections should avoid common areas and wear a medical mask during the provision of direct care, unless they are subject to a masking exemption. See [Caring for Individuals who Need to Self-Isolate](#), below.
- Additional considerations should be given to:
 - Providing resources and training for staff, clients, and visitors on proper mask use (e.g., how to wear and remove a mask), as well as on safe use and limitations of masks. For additional information, see [Ontario's COVID-19](#), and [MLTSD](#) webpages;
 - Mitigating any possible physical and psychological injuries that may inadvertently be caused by wearing a mask (e.g., interfering with the ability to see or communicate); and
 - Following any additional sector-specific direction or guidance provided by relevant ministry, organizations, and agencies with oversight of the sector and/or local PHU.
 - For further information, please see PHO's [COVID-19: Personal Protective Equipment and Non-Medical Masks in Congregate Living Settings](#).

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 using it correctly and consistently. Recommendations for the use of PPE are based on risk assessments of specific environments and risk of exposure. If manipulated or altered, PPE may not function to manufacturer's specifications.
 - The employer should train workers on how to perform a personal risk assessment and 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 isolating on Droplet and Contact Precautions (e.g., such as when providing care to a client who is isolating) or during a COVID-19 outbreak (see [Caring for Individuals who Need to Self-Isolate](#), below).

- Additional PPE may be necessary in specific situations. Choosing PPE, including the use of fit-tested N95 respirators, should be based on a personal risk assessment guided by the nature, type, and duration of the intended interaction.
 - See [COVID-19 Guidance: Personal Protective Equipment \(PPE\) for Health Care Workers and Health Care Entities](#) and [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 and PHO's COVID-19: Personal Protective Equipment and Non-Medical Masks in Congregate Living Settings](#) for more information on PPE use
 - Eye protection for PPE purposes 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.
 - The use of eye protection is in addition to and does not replace the need for a medical mask or equal or greater protection (e.g., fit-tested N95 respirator)
 - Non-medical masks are not considered PPE.
 - CLSs should be aware of any sector-specific requirements, including directives or orders, or guidance on PPE provided by relevant ministry, organizations, and agencies with oversight of sector, and/or local PHU.

Environmental Cleaning and Disinfection

- CLSs should ensure that the premises are cleaned on a regular schedule. Commonly used cleaners and disinfectants are effective against COVID-19. It is recommended that disinfectants have a Drug Identification Number (DIN) given by Health Canada to confirm it is approved for use in Canada.
- All common areas (including bathrooms) and high-touch surfaces that are touched and used frequently should be cleaned and disinfected at regularly scheduled intervals (e.g., at least 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.
 - Common areas and high-touch surfaces should be cleaned more frequently during an outbreak (e.g., at least twice daily).

- All shared items should be cleaned and disinfected between each client/use.
- Clean linen should be provided to all clients 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 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.
- [Careful consideration should be given to the use and placement of portable fans](#) and air conditioning units (e.g., place the fan at bed level or higher; never place the portable fan on the floor). Portable fans can disperse dust particles and microorganisms, change the airflow pattern, and potentially increase the dispersion of aerosols.
- 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).
 - For more information, see PHO's [Heating, Ventilation and Air Conditioning \(HVAC\) Systems in Buildings and COVID-19](#).
 - Where ventilation is inadequate or mechanical ventilation does not exist, the use of [portable air cleaners](#) can help remove particles from the air.
- Ventilation and filtration are important for overall indoor air quality as they help to dilute or reduce respiratory particles in a given space. They do not prevent transmission in close contact situations and as with other measures need to be implemented as part of a comprehensive and layered strategy against COVID-19.

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 client, while ensuring that their policies are culturally appropriate and responsive to their clients' needs. The policies should also adhere to any direction provided by the relevant ministry, organizations, and agencies that have oversight for the sector.

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 clients, staff, and visitors in the setting. Activities should be modified, limited, postponed, or paused under the following circumstances:

- If a client is self-isolating for any reason;
- If a client 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.

For more information on considering different levels of COVID-19 risk, refer to PHO's [Technical Brief Interim Infection Prevention and Control Measures based on COVID-19 Transmission Risks in Health Care Settings](#).

Admissions and Transfers

- As much as possible, new clients should be screened for [signs and symptoms of COVID-19](#) before admission (intake).
- Regardless of whether pre-admission screening has taken place, CLSs should also conduct active screening in-person upon the arrival of the client to the facility (see [above](#)).
- In general, admissions and transfers to a CLS in COVID-19 outbreak should be avoided. However, if the risks of not admitting a client are determined to outweigh the risks of admitting the client into a CLS in outbreak, consultation with the local PHU should be considered. The following risk-based considerations may be taken into account:
 - Clients without active COVID-19 infection may be admitted or transferred to an area of the CLS not in outbreak, with informed consent.

- Clients with active COVID-19 infection, or who fail active screening, may be admitted/transferred to an outbreak area of the CLS, with informed consent. Ideally, clients admitted in this situation would be admitted into a private room.
- For individuals, regardless of their vaccination status, being admitted or transferred to a setting where there are longer stays (e.g., group homes): Screen and isolate on arrival on Droplet and Contact Precautions until a negative result is obtained from a laboratory-based molecular test or rapid molecular test result taken on admission.
 - 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, as long as they are currently asymptomatic.
- For settings where stays are shorter and of a more transient nature, testing and isolating upon arrival may not be necessary, unless directed by the local public health unit. Where self-isolation and testing is not feasible, ensure rigorous active screening, masking, physical distancing, and hand hygiene.
- Where a client requires multiple transfers across several institutions, it may not be necessary to test and/or restart the self-isolation period upon each admission to a new CLS, provided that none of the institutions are experiencing a COVID-19 outbreak. The decision to not self-isolate or test should be made on a case by case basis in consultation with the local PHU.
- 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 client being admitted or transferred, regardless of their COVID-19 vaccination status, who is identified as having symptoms, an exposure, and/or diagnosis of COVID-19 should be placed on Droplet and Contact Precautions and managed as per the Ministry of Health's [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

- When a client is leaving on an absence for any reason, the CLS should provide a medical mask to the client, unless they are subject to a masking exemption (see masking section for more information), and remind them to follow public health guidance in the community.
- Depending on the nature of the CLS and the clients it serves, when operationally feasible and appropriate (e.g., when there is a prolonged or overnight absence of a client in a setting serving immunocompromised individuals or those at higher risk for severe disease due to COVID-19), clients should be actively screened upon their return to the CLS. In general, CLSs should have policies in place that enables the setting to flexibly adjust their absence policies where necessary. This includes limiting or restricting 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 client, recognizing the specific needs and challenges that many clients 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).

Communal Activities for Clients

- There are many cognitive, social, and psychological benefits for clients to participate in communal dining and other forms of activities. CLSs are strongly encouraged to continue with programs and activities for their clients while ensuring that they align with public health guidance and in consideration of the measures outlined in this document in order to reduce the risk of COVID-19 transmission in the setting.
 - This includes programs and activities that are also open to members of the community (i.e., day programs).
- Some considerations for reducing the risk of COVID-19 in group settings include:

- Keeping a record of participants (staff, clients and visitors), and providing this record to the PHU within 24 hours of request;
- 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 clients, the CLS's staffing capacity, and/or take into consideration capacity limits for indoor areas;
- Ensuring same staffing assignment to each group where operationally feasible; and
- Encourage clients to wear a masks, unless they are subject to a masking exemption, and practicing physical distancing, particularly in settings that serve transient and/or large number of clients (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.

Caring for Individuals Who Need to Self-Isolate

- Some clients of CLSs 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. CLSs should work with the client and the PHU to identify client-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 their self-isolation period. Layering as many public health measures as possible, such as vaccination, masking and physical distancing, will be extremely important.
- Clients who should self-isolate on Droplet and Contact Precautions include:
 - Clients who have not passed their active screening on arrival (see [above](#));
 - New admissions and transfers (see [above](#));
 - Clients who are unwell with symptoms of COVID-19 and/or other respiratory infections, such as influenza;

- Clients awaiting test results for COVID-19 and/or other respiratory infections;
 - Clients who have tested positive for COVID-19 and/or other respiratory infections;
 - Clients who have been identified as a close contact of a known case of COVID-19 and/or instructed to self-isolate by the local PHU.
- Any client 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 client may be grouped (cohorted) with others who have tested positive for COVID-19 and are in self-isolation. In this case, each client should wear a medical 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 cohorting of clients in CLSs during an outbreak.
- If a client needs to leave self-isolation, they should wear a medical 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 client. This includes ensuring that staff are wearing appropriate PPE (i.e., minimum of medical mask and eye protection) when providing care to a client (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](#), or as current, for more information on PPE use.
- CLSs should have plans to address:
 - How and where the client 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 client for the duration of their self-isolation period. Wherever possible, private rooms are preferred;

- How to support the client 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 client 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 client'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 client develops severe symptoms; and
 - How to access private transportation if there is a need to transfer the client, 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.

Caring for a Symptomatic Individual

- **When a client(s) is symptomatic:** Any client who is exhibiting [signs or symptoms](#) consistent with an acute respiratory illness including COVID-19 should be immediately self-isolated (see [Caring for Individuals Who Need to Self-Isolate](#), above) and should be encouraged to get tested for COVID-19 using a laboratory-based molecular test or rapid molecular test (e.g., ID NOW, GeneXpert). This is regardless of the individual's COVID-19 vaccination status.
 - **Testing:** All symptomatic clients should be tested for COVID-19 using a laboratory-based molecular test (e.g., PCR) or a rapid molecular test (e.g., ID NOW, or GeneXpert). Rapid antigen tests (RATs) should not be used for clients of higher risk settings who are symptomatic.
 - In exceptional circumstances, when access to timely molecular testing is not available RATs may be performed concurrently to ensure timely implementation of case, contact, and potential outbreak management
 - Two upper respiratory tract swabs should be taken from the first four symptomatic individuals in a CLS; one for COVID-19 and one for multiplex

- respiratory virus PCR panel (MRVP) testing. See PHO Laboratory's website on testing for [Respiratory Viruses](#) for more information.
- One swab may be appropriate depending on the testing laboratory. Consult with the local PHU and testing laboratory for further direction.
- After the first four symptomatic individuals, all other subsequent symptomatic individuals should be tested for COVID-19 but should not undergo MRVP testing, unless directed to by the PHU, as the viral cause of the outbreak is likely to be confirmed after four test results.
 - [Molecular testing \(PCR or rapid molecular\) for COVID-19](#) is highly recommended for symptomatic individuals in highest risk settings, as outlined in the [Management of Cases and Contacts of COVID-19 in Ontario](#). If using rapid antigen testing to expedite outbreak management, concurrent molecular testing is highly recommended in highest risk settings with the molecular test result superseding the rapid antigen test result once available.
- Also see [Case and Contact Management](#).
- **When a staff or a visitor is symptomatic:** Symptomatic staff or visitors should not be permitted entry into the CLS. If they become symptomatic during their shift or visit, they should be isolated until they can safely leave the CLS and/or be asked to leave immediately. They should be instructed to 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 for molecular testing](#).

Case and Contact Management

- Case and contact management decisions are made by the local PHU guided by relevant [provincial guidance](#).
- All individuals who are identified as a [confirmed or probable COVID-19 case](#) should self-isolate as per [Management of Cases and Contacts of COVID-19 in Ontario](#). This is regardless of the individuals' COVID-19 vaccination or previously positive status.
- A client must self-isolate, ideally in a single room on [Droplet and Contact Precautions](#). Where this is not possible, individuals may be placed in a room with other clients who have active COVID-19 infections who should also be placed on Droplet and Contract Precautions.

- Asymptomatic clients living in the same room as the case should be tested and placed on Additional Precautions immediately (as close contacts), under the direction of the local PHU (see Contact Management below).
- When a staff or a visitor tests positive for COVID-19: they will be directed to self-isolate at their own home or another location (e.g., if they have young children or other vulnerable individuals at home), and may not be permitted to return to the CLS until after symptoms resolve and the appropriate self-isolation period has elapsed, as per [Management of Cases and Contacts of COVID-19 in Ontario](#).
- All clients residing in a [highest risk CLS](#) should isolate for 10 days from the onset of symptoms or positive test date, whichever is earlier, regardless of vaccination status. Isolation may be discontinued after 10 days, provided that the client has no fever and symptoms are resolving for at least 24 hours or 48 hours if gastrointestinal symptoms.
- When there are clients who reside in a small CLS where the nature of their interaction with a case would be equivalent to a household exposure, those clients would be considered close contacts.
- For [close contacts](#) of individuals who are a suspect or confirmed case:
 - Close contacts who live in a CLS should isolate for 5 days from last exposure to the case, followed by masking and physical distancing when outside the setting and in shared areas inside the setting (except when required to remove, e.g., sleeping and eating) for a full 10 days from last exposure to the case (i.e., for the duration of the 5-day isolation and a further 5 days post-isolation).
 - Asymptomatic close contacts who live in a CLS are recommended to be tested by PCR on/after Day 3 from last exposure to a positive case to assess for transmission amongst contacts before ending their 5-day self-isolation.
 - If timely molecular test results are not available, two negative rapid antigen tests (RATs) on Day 4 and Day 5 from last exposure are strongly recommended prior to discontinuing self-isolation. It is at the discretion of the PHU to assess the risk of discontinuing isolation on Day 5 should the client decline testing, depending on the nature of the CLS and risk profile of its clientele. Active symptom screening should occur from Day 6 to 10 following exposure.

- Close contacts, including staff, clients and visitors, who have tested positive for COVID-19 in the last 90 days are not required to isolate upon subsequent high-risk exposures, provided they remain asymptomatic.
- **Exception for staff on early return to work:** Staff who are close contacts may return to work on early return to work as per [Appendix A in the Management of Cases and Contacts of COVID-19 in Ontario](#) and any sector-specific guidance.
- For further information, including case and contact management recommendations for staff and visitors, refer to the [Management of Cases and Contacts of COVID-19 in Ontario](#).

Table 1: Case and Contact Management for Individuals Residing in Higher-Risk CLSs COVID-19 versus Other Respiratory Viruses

Symptomatic Individual is POSITIVE for COVID-19	
Case management for individual with COVID-19	<ul style="list-style-type: none"> Isolate in Droplet and Contact Precautions for 10 days from symptom onset or positive test result (if asymptomatic)*
Contact management for close contacts who live in the CLS, regardless of vaccination status	<ul style="list-style-type: none"> Isolate in Droplet and Contact Precautions for a minimum of 5 days from last contact with case Monitor for symptoms for 10 days from last contact Molecular testing (lab-based or rapid) on Day 3 (or any time symptoms develop) highly recommended.
Symptomatic Individual is POSITIVE for Other Respiratory Virus (i.e., COVID-19 Negative)	
Case management for individual with symptoms	Duration of self-isolation depends on the incubation and communicability periods of the virus detected.
Contact management	Monitor for symptoms

* Self-isolate as per the [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 suspect 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 positive molecular test OR rapid molecular OR rapid antigen test in a client.
 - **A confirmed outbreak** in a CLS is defined as two or more clients and/or staff (or other visitors) in a CLS each with a positive molecular 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.
 - **Note:** the definitions above are for surveillance purposes only. PHUs have the discretion to declare a suspect or confirmed outbreak based on the results of their investigation, including when the above definitions are not completely met.
 - For greater clarity, staff cases are those whose COVID-19 infection was deemed due to a workplace exposure by the PHU.
 - For the purposes of outbreak management, if an assessment is not possible to determine the source of acquisition and there is no evidence to support an epidemiological link to the CLS, the PHU has the discretion to presume staff COVID-19 infections were not acquired in the CLS during periods of high community transmission.
 - The CLS's workplace health and safety and/or IPAC team has a duty to report an employee case as per OHSA and WSIB requirements.
 - Declaring an outbreak may not be necessary in certain scenarios such as:
 - When the source of COVID-19 acquisition for staff cases are deemed to have reasonably occurred outside the workplace, and there is no evidence of transmission or an epidemiological link to client cases.

- **Outbreak management:** the local PHU is responsible for investigating (e.g., determining when cases are epidemiologically linked), declaring and managing outbreaks under the HPPA. 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 resources:
 - [Management of Cases and Contacts of COVID-19 in Ontario](#);
 - PHO's [COVID-19: Cohorting in Outbreaks in Congregate Living Settings](#);
 - PHO's [Checklist: Managing COVID-19 Outbreaks in Congregate Living Settings](#).
- **Outbreak testing** in a CLS is directed by the local PHU. This should be guided by the [COVID-19 Provincial Testing Guidance](#) and the above section on [Caring for a Symptomatic Individual for recommendations on PCR \(MRVP\) testing](#).
 - PHUs are responsible for determining the need and the frequency for repeat testing as part of ongoing outbreak investigation to identify additional cases.
 - PHUs should follow usual outbreak notification steps to the PHO laboratory to coordinate/facilitate outbreak testing according to the [Respiratory Outbreak Testing Prioritization](#) protocol.
 - 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.
 - RATs are not intended for diagnostic purposes in highest risk settings given the limited sensitivity of RATs compared with molecular testing; they should not be used on symptomatic individuals living or working in highest risk congregate living settings unless there are significant issues with accessing timely laboratory-based molecular testing or rapid molecular testing (e.g., ID NOW or GeneXpert) If a RAT is used for a staff or client with symptoms or high-risk exposure, molecular testing should be performed in parallel with the molecular test result superseding the RAT result once available.
 - 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. Outbreak measures include:
 - 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 clients, staff, and visitors can congregate.
 - For example, where appropriate for the setting, this may mean providing in-room tray service meals within the outbreak area to avoid communal dining, staggering meal times for each cohort, or ensuring physical distancing.
 - At the discretion of the PHU, Day programs for community members may continue, provided that all other [public health measures](#) continue to be followed for staff and attendees.
 - Cohorting clients 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. See PHO's [Cohorting in Outbreaks in Congregate Living Settings](#) on how to cohort.
 - Where operationally feasible, cohorting staff alongside the clients based on their COVID-19 exposure status and/or designating staff to work with only one group of cohorts on each shift.
 - Consideration should be strongly given to limiting work locations for staff to prevent spread to other settings.
 - **Limiting or restricting new admissions and transfers:** in general, admissions and transfers to a CLS in outbreak should be avoided. However, depending on the nature of the CLS, CLSs should consider when other harms, such as not admitting a client to the setting, would be significant. Where new admissions or transfers cannot be avoided, the CLS provider should consult the local PHU for guidance. See the section on [Admissions and Transfers](#), above, for further details.

- **Limiting or restricting client absences:**
 - For CLS's that function like a household: Clients who have left the CLS on an overnight absence prior to an outbreak being declared should generally not be allowed to return to the setting until the outbreak is declared over.
 - For CLS's that provide shorter-stay accommodations to clients, PHUs should be consulted to help identify ways to safely accommodate client absences during an outbreak.
 - PHUs should help CLSs to identify, with other health system partners as necessary, to find safe self-isolation locations for these individuals. Also see [Absences](#), above.
- **Limiting or restricting visitors into the CLS:** Only essential visitors are permitted in an outbreak. General visitors should be restricted in an outbreak.
 - CLSs should ensure that visitations are not unnecessarily discontinued and to 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, including municipal Service Managers and District Social Services Administration Boards for MMAH-funded settings.
 - Clients, 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 clients 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 clients or staff linked to exposures in the CLS after 10 days (maximum incubation period) from the latest of:
 - Date of isolation of the last client case; OR
 - Date of illness onset of the last client 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, please see PHO's guidance document on [De-escalation of COVID-19 Outbreak Control Measures in Long-Term Care Homes and Retirement Homes](#).

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.² This includes protecting workers from the transmission of infectious disease 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 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.

² This section will refer to workers as defined under the *Occupational Health and Safety Act*.

Appendix A: Public Health Ontario Resources

- **General:**
 - [Public Resources](#)
 - [COVID-19 Resources for Congregate Living Settings](#)
- **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](#)

Appendix B: 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 Clients of the CLS
Who does this include?	<ul style="list-style-type: none"> Staff working at the CLS and all visitors, including essential visitors and anyone else entering the setting. Exception: First responders in emergency situations 	<ul style="list-style-type: none"> Clients currently residing in the CLS.
What are the screening practices?	<ul style="list-style-type: none"> 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 home's visitor policies. 	<ul style="list-style-type: none"> Conduct symptom assessment of all clients at least once daily to identify if any client has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms. All clients returning from any type of absence should be actively screened at entry upon their return.
What if someone does not pass active screening?	<p>Staff, visitors, and those attempting to enter the CLS who are experiencing symptoms of COVID-19 or had a potential exposure to COVID-19, and have not passed active screening should:</p> <ul style="list-style-type: none"> Not enter the CLS; Instructed to immediately to self-isolate; and Be encouraged to be tested for COVID-19 with a molecular test. 	<ul style="list-style-type: none"> Clients 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.