Ontario

Ministry of Health

COVID-19 Guidance: Congregate Living for Vulnerable Populations

Version 2 – November 29, 2021

Highlights of Changes:

- **Scope of Document** section provides guidance on the settings to which this guidance is and is not intended to apply
- **Roles and Responsibilities** of different partners are outlined
- **Definitions** provided for some commonly used terms
- Emphasizes the importance of both **COVID-19 and influenza vaccinations** as part of an overall public health approach to reduce the risk of respiratory infection outbreaks
- **Active screening, masking, and PPE** are explicitly linked to the requirements and exceptions under the *Reopening Ontario Act* and associated regulations
- **Physical distancing** is framed as when it should be considered vs when it may not be necessary based on the individuals' vaccination status and/or their risk of severe COVID-19 outcomes
- **Admissions and Transfers** COVID-19 testing and self-isolation recommended for those who are not fully vaccinated and/or whose status is unknown
- **Case and contact management** includes considerations for both COVID-19 and non-COVID-19 respiratory infections
- **Outbreak definition** updated
- **Setting specific considerations** on how to implement infection prevention and control principles are provided throughout
- **Appendix A:** Public Health Ontario Resources for congregate living settings
- **Appendix B:** A summary table of active screening practices

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 the 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 across Canada and abroad, and they are subject to change as the knowledge about COVID-19 evolves over time.

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 emergency orders or directives issued by the Minister of Health (MOH) or the Chief Medical Officer of Health (CMOH), the orders and/or directives prevail.

Please check the MOH's COVID-19 Guidance for the Health Care Sector and the Orders, Directives, Memorandums and Other Resources 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- and setting-appropriate manner.

Some CLSs may also be subject to emergency orders and regulations made under *the Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* (ROA), including restrictions on staff mobility under O. Reg 177/20 and general public health COVID-19 restrictions under O. Reg. 364/20. All settings subject to emergency orders must follow the requirements of these orders. Failing to comply with the requirements of ROA regulations/emergency orders can result in charges under the ROA and *Provincial Offences Act.* More information regarding emergency orders can be found here.

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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 takes 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 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.

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 and the COVID-19 Vaccination Plan (see Phase 2), which include:

- Supportive housing[1];
- 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 Facilities.

[1] Where appropriate, this guidance can also be considered for application in unregulated and/or unlicensed CLS that function as 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 public health unit, 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 Temporary Foreign Workers, see MOH's On-Farm Outbreak Management.
- 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 COVID-19 Fully Vaccinated Status in Ontario document for the definition of **"fully vaccinated"** where applicable in this document.
- 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 and 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)"** (also known as personal risk assessment) is a dynamic risk assessment completed by a health care worker before every patient care/interaction in order to determine whether there is risk of being exposed to an infection. A PCRA will help determine the correct personal protective equipment (PPE) required to protect the health care worker in their interaction with the patient and patient environment.[2]

[2] Definition adapted from: Ontario Agency for Health Protection and Promotion (Public Health Ontario). IPAC recommendations for use of personal protective equipment for care of individuals with suspect or confirmed COVID-19. 6th revision. Toronto, ON: Queen's Printer for Ontario; 2021.

Roles and Responsibilities

Note: Roles and responsibilities of MOH, PHO, Ministry of Labour, Training, and Skills Development (MLTSD), Ontario Health, Infection Prevention and Control (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 homes on COVID-19 prevention (including hierarchy of controls) and preparedness for managing COVID-19 cases, contacts and outbreaks, in conjunction with advice provided through the Ministry of Health (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), Public Health Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance.
- 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.
- Provide guidance and recommendations to the home 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 COVID-19 Provincial Testing Guidance update, facilitate a coordinated approach to testing, in collaboration with Ontario Health, including provision of an investigation or outbreak number.
- Host and coordinate outbreak meetings with the home, PHO, Ontario Health, Infection Prevention and Control (IPAC) Hubs, etc.
- 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 home, discussions between the respective PHUs should take place to coordinate contact follow-up and delineate roles and responsibilities.
    - The PHU of the home is typically the lead PHU for home 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 and/or CLS.
    - 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 to 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 (i.e. MOH, MLTSD, among others 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), the ROA, and their regulations, as applicable, 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.

- As best practice, 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, 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). PHUs should communicate their data needs to CLSs and encourage CLSs to 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 staff and client vaccination rates 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 immunization rates.
- In addition to any duty to report a suspected or confirmed case of COVID-19 under the HPPA and any other legal reporting requirements, as applicable, administrators of all CLSs are encouraged to contact their local PHU if a resident, staff or essential visitor has or may have COVID-19 to facilitate timely contact tracing and outbreak management within the setting. It is important to indicate the type of care setting to the local PHU as they are tracking cases within CLSs.

  - CLSs should also notify other ministries and/or organizations that provide oversight, as appropriate (e.g., MMAH funded settings should notify their municipal Service Manager or District Social Services Administration Board).
- 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.

Prevention of Disease Transmission

PHUs should remind all CLSs on the use 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.

The measures described below are also effective for many common respiratory viruses (e.g., common cold, influenza), in addition to COVID-19, and should be carried out at all times regardless of the COVID-19 situation within the CLS. No single intervention on its own is perfect at preventing COVID-19 spread, and vaccinations are not available for all common respiratory viruses.

Immunizations

Note: Some settings (i.e., programs funded by MCCSS are required to have a COVID-19 vaccination policy in accordance with the Letters of Instruction issued by the Office of the CMOH under the authority of subsection 2(2.1) of Schedule 1 of O. Reg. 364/20: Rules for Areas at Step 3 and at the Roadmap Exit Step under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* (ROA).

- 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 important public health measures to prevent infection and transmission, and it is the most effective way to prevent severe outcomes including hospitalizations and death due to COVID-19. As such, all clients, staff, and visitors should be encouraged to get vaccinated against COVID-19 as soon as possible if they have not already done so.
    - New admissions to the CLS who have not yet received a COVID-19 vaccine should be offered a complete series of COVID-19 vaccinations as soon as possible. This is especially crucial in settings that primarily serve including First Nations and Urban Indigenous populations, and transient and/or vulnerable populations.
    - More information can be found on the MOH's COVID-19 Vaccine-Relevant Information and Planning Resources webpage.
- **Influenza vaccination:** All eligible staff, visitors, and clients CLSs are also strongly encouraged to receive the annual influenza vaccine.
    - COVID-19 vaccines may be given at the same time as, or any time before or after, other vaccines, including live, non-live, adjuvanted, or unadjuvanted vaccines.
    - More information can be found on the MOH's 2021/2022 Universal Influenza Immunization Program (UIIP) webpage.

Screening

- Screening should consist of the following measures:
  - **Active screening** of all individuals[3] entering the CLS for symptoms and exposure history of COVID-19 (see below);
  - **Daily symptom assessment of clients** (see below);
  - **Passive screening** through signage posted prompting anyone on site at a CLS to self-identify if they feel unwell or screen positive for symptoms of COVID-19[4]; and
  - Where applicable, **asymptomatic testing** of individuals using rapid antigen tests as part of the active screening process. This topic is beyond the scope of this document and any CLS participating in the Provincial Antigen Screening Program should refer to the program requirements for guidance.
  - A summary chart of screening practices can be found in Appendix B.

> **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 Center for Disease Control's pictograph-based signage.

Active Screening for Anyone Entering the CLS

- **All persons** seeking entry to the CLS should be actively screened regardless of their COVID-19 vaccination status. This includes all staff, visitors, and clients returning from an absence.
  - **Emergency first responders should be permitted entry without screening.**

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[3] Note that per clause 2(3)(b) in Schedule 1 of O. Reg. 364/20, the person responsible for a business or organization that is open **must** actively screen every person who works at the business or organization before they enter the premises of the business or organization.

[4] Note that per clause 2(3)(a) in Schedule 1 of O. Reg. 364/20, the person responsible for a business or organization that is open **must** post signs at all entrances to the premises of the business or organization, in a conspicuous location visible to the public, that inform individuals on how to screen themselves for COVID-19 prior to entering the premises.

- 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 clients, 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).
  - CLS can choose to use or adapt the screening tools that have been developed by the Ministry of Health, such as:
    - 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 waste basket or bin; and
  - Encouraging all clients, staff, and visitors to use ABHR before entering.
- Only **staff and visitors** who pass active screening should be permitted to enter the CLS.
  - If a staff or a 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.

Note: 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 (e.g., to visit a dying client). PHUs should work with the CLS, the client(s), and the visitor(s) to facilitate a safe visit.

   - 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 home should follow up with all staff who have screened positive to provide advice on any work restrictions.
- **Clients** who do not pass this 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.

Note: In large CLSs that primarily serve transient and/or large number clients, it is 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 infection prevention and control practices on site.

Hand Hygiene

- Access to handwashing stations and/or 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 clients 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);
    - Wash hands with soap and water if hands are visibly dirty;
    - Perform hand hygiene before and after using any shared equipment or items; and
    - Perform hand hygiene prior to putting on gloves and immediately after removing them. After use, gloves should be placed in the garbage. Gloves are not a replacement for hand hygiene.

Note: Safe usage and placement of the ABHR to avoid consumption are important (e.g., for young children).

- Assistance should be provided to clients 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 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 clients*; • The vaccination status of others are unknown; • Others are known to be unvaccinated or partially vaccinated; • The person is immunocompromised and/or at a high risk of severe disease from COVID-19; and • Interacting with others who are immunocompromised and/or at a high 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 clients who reside in a small group home setting that is equivalent to a household; • Outdoors when interacting with a small group of individuals who are all known to be fully vaccinated.

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

- As much as possible, CLSs should continue to alter 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. This may include:
  - Limiting capacity in common areas, including staff break rooms;
  - Posting signage in common areas re: maximum capacity;
  - Moving furniture 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;
  - Supporting and/or encouraging activities outdoors; and
  - Staggering staff meals and/or break times.

- In shared bedrooms, space should be increased between beds to 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).
    - Avoid using bunk beds.
    - Consider additional measures, such as private rooms or rooms with the fewest number of occupants.

Masking

- Per subsection 2(3.1), Schedule 1 of O. Reg. 364/20, the person responsible for a business or organization that is open **must** ensure that ***any*** person in an indoor area of the premises wears a mask or face covering in a manner that covers their mouth, nose and chin during any period they are in an indoor area, subject to limited exceptions. Additional information is provided below for specific groups of individuals in a congregate setting.
    - 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*.[5]
- **Staff should practice universal masking in the CLS.** Universal masking means wearing a mask at all times, **both indoors and outdoors**, whether or not a CLS is in an outbreak and regardless of one's COVID-19 vaccination status. This means that in addition to the indoor masking requirement, staff should also wear a mask at all times while they are outdoors.
    - Medical (surgical/procedural) masks are strongly recommended.
    - During their breaks, to prevent staff-to-staff transmission of COVID-19, staff should be physically distanced before removing their medical mask for eating and drinking. Masks should not be removed when staff are interacting with residents and/or in designated resident areas.
- **Visitors** must wear a mask or a face covering at all times while indoors at the CLS (subject to very limited exceptions – see above).

[5] For the full list of exemptions to the masking requirements, see subsection 2(4) and subsection 3.1(1), Schedule 1 of O. Reg. 364/20.

  - 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, both indoors and outdoors, and at all times regardless of their COVID-19 vaccination status.
  - In addition, visitors should wear a mask outdoors when:
    - There are individuals present who are immunocompromised and/or at a high risk of severe disease from COVID-19; and
    - The COVID-19 vaccination status of the individuals present are unknown, or known to be unvaccinated or partially vaccinated.
- **Clients** in a CLS must wear a mask or face covering in any common areas if physical distancing cannot be maintained as per subsection 2(5), Schedule 1 of O. reg. 364/20[6], subject to limited exceptions as noted above.
  - 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 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.

Note: Clients in CLSs that are considered to be equivalent to a household are not required to mask when sharing common spaces.

- Additional considerations should be given to:
  - Providing resources and training for 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, MLTSD, and PHO webpages;

[6] Note that per clause 2(5)(e) in Schedule 1 of O. Reg. 364/20, the masking requirement does not apply to any person who is receiving residential services and supports in a residence listed in the definition of "residential services and supports" in subsection 4 (2) of the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*.

- 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.

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 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.**
- Per subsection 2(7), Schedule 1 of O. Reg. 364/20, a person must 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 not wearing a mask when indoors and is not separated by plexiglass or some other impermeable barrier.
  - In the context of CLS, this includes the scenario in which staff and essential visitors are providing direct care to an unmasked client within 2 metres.
  - 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.
  - Eye protection is not required when the individual is separated by plexiglass or other impermeable barrier from unmasked persons.
- Additional PPE is required in specific situations such as when providing care to a client who is placed on Droplet and Contact Precautions or during a COVID-19 outbreak (see Caring for Individuals who Need to Self-Isolate, below). The choice of PPE should be based on a risk assessment guided by the nature, type, and duration of the intended interaction. For more information, see PHO's COVID-19: Personal Protective Equipment and Non-Medical Masks in Congregate Living Settings.
  - Non-medical masks are not considered PPE.

- CLSs should be aware of any sector-specific requirements 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 regularly (e.g., at least once daily). 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., 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).
- Hand hygiene should be performed before and after use of shared items.
- 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 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.
- Where ventilation is inadequate or mechanical ventilation does not exist, the use of portable air cleaners can help filter out 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.

- Ventilation and filtration are important for overall indoor air quality as they help to dilute or reduce respiratory droplets and aerosols 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.

COVID-19 Specific Policies and Procedures

PHUs should encourage all CLSs to 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.[7] 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.

Admissions and Transfers

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

[7] Note that all businesses are required to have a written safety plan as per s. 3, Schedule 1 of O. Reg 364/20. For more information, see MLTSD's webpage.

- Regardless of whether pre-admission screening has taken place, CLS should also conduct **active screening** in-person upon the arrival of the client to the facility (see above).
- In general, **fully vaccinated individuals** are considered to be at low risk for a COVID-19 infection and **do not** require self-isolation or COVID-19 testing on arrival, provided that they are not symptomatic and/or have not had a recent high risk exposure to a known COVID-19 case.
    - **Exception:** testing (see below) of all individuals (regardless of vaccination status) should be strongly considered in some settings that serve primarily transient and/or large number clients given the high risk nature of these settings (e.g., emergency homeless shelters). This may also help to reduce potential stigma associated with vaccine status within the setting.
- For all other individuals (i.e., **individuals who are partially vaccinated, unvaccinated, or for whom their COVID-19 vaccination status is unknown**), they should be:
    - **Self-isolated** on Droplet and Contact Precautions for 10 days.
        - Some CLSs may find it challenging to implement self-isolation of clients on arrival due to the nature and purposes of these settings (e.g., where an average length of stay may be less than or equal to 10 days).
        - Where self-isolation is not feasible, ensure rigorous active screening, masking, physical distancing, and hand hygiene.
        - See Caring for Individuals who Need to Self-Isolate, below.
    - **Tested using a molecular (e.g., PCR) COVID-19 test** on arrival (day 0). **A repeat PCR test** should be conducted between days 7 and 10 following arrival (if applicable, based on the duration of the client's stay).
        - Note: The preferred molecular testing method is laboratory-based molecular testing (e.g. PCR). Molecular point of care testing (POCT) may also be used for screening individuals, following the test interpretation and case classification guidelines outlined in Table 1 of Appendix 9: Management of Individuals with Point-of-Care Testing Results.

- 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, exposure, and/or diagnosis of COVID-19 must be placed on Droplet and Contact Precautions and managed as per the Public Health Management of Cases and Contacts of COVID-19 in Ontario.

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 measures, such as physical distancing and hand hygiene.
- At minimum, all clients, regardless of type or duration of the absence or their COVID-19 vaccination status, should be actively screened upon their return to the CLS.
    - For **recommendations** on self-isolation and COVID-19 testing following an absence, see "Admissions and Transfers", above. These measures are to be implemented where operationally feasible and appropriate (e.g., when there is a prolonged absence of a client in a home serving immunocompromised individual or those at high risk for severe complications due to COVID-19).
- 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, if the region in which the setting is based is experiencing high levels of COVID-19 transmission in the community, and/or to align with any provincial restrictions.

- Despite this, 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).

Visitors

- See Roles and Responsibilities, under Role of the Congregate Living Setting (CLS).

Communal Activities for Clients

> **Note:** This section does not apply to CLSs that already function like a household.

- 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 requirements in O. Reg. 364/20 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 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

- Ensuring that clients are wearing masks, unless they are subject to a masking, and practicing physical distancing, particularly in settings that serve transient and/or large number of clients (see sections on physical distancing and masking above).

Caring for Individuals Who Need to Self-Isolate

Note: Some clients 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 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 possible, such as masking and physical distancing, will be extremely important.

- Clients who need to **self-isolate[8] 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 common respiratory infections, such as influenza;
  - Clients awaiting test results for COVID-19 and/or other common respiratory infections;
  - Clients who have tested positive for COVID-19 and/or other common 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 needs to self-isolate should be placed in a single room with a door that closes and, if feasible, have access to a private bathroom.

[8] While the isolation of asymptomatic contacts is technically termed "quarantine," the common use of **"self-isolation"** is used to refer to both symptomatic/infected and exposed individuals. As such, for ease of understanding, in this document, the term "self-isolation" refers to both asymptomatic close contacts who are COVID-19 negative or not tested for ease, in addition to those who are symptomatic and/or infected for ease of understanding.

  - If this is not possible, at the direction of the local PHU, the client may be grouped (cohorted) with others who are in the same situation as the client (e.g., group those who are unwell/symptomatic). 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., 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.
- 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 required 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, 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;

Note: 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.

- 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.

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 self-isolated (see Caring for Individuals Who Need to Self-Isolate, above) and tested. This is regardless of the individual's COVID-19 vaccination status.
- **Testing: Two upper respiratory tract swabs** should be taken from the first four symptomatic individuals in a congregate setting for **COVID-19** and **multiplex respiratory virus PCR (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 this, all other subsequent symptomatic individuals should be tested for COVID-19.
  - 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 tested for COVID-19.

Case and Contact Management

- A summary of case and high risk contact (HRC) management is provided below. PHUs should be aware that this is only intended to serve as a quick summary for their initial response. For more detailed information, refer to the following provincial guidance documents:
  - Public Health Management of Cases and Contacts of COVID-19 in Ontario;

- COVID-19 Fully Vaccinated Individuals: Case, Contact, and Outbreak Management Interim Guidance;
- COVID-19 Provincial Testing Guidance Update; and
- Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018.

Table 1: Case and Contact Management for COVID-19 versus Other Respiratory Viruses

Symptomatic Individual is POSITIVE for COVID-19		
Case management		• Self-isolate*
Contact management	Client is HRC	• Test for COVID-19 • Self-isolate*
	Staff or visitor is HRC	• Test for COVID-19 • Self-isolate* (only if not fully vaccinated for COVID-19)
Symptomatic Individual is POSITIVE for Other Respiratory Virus (i.e., COVID-19 Negative)		
Case management		Duration of self-isolation depends on the incubation period of the virus detected.
Contact management	Client is HRC	• Monitor • Consider antivirals if influenza
	Staff or visitor is HRC	• Monitor • Consider exclusion/antivirals if influenza and not vaccinated for flu

* Self-isolate as per Public Health Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Vaccinated Individuals: Case, Contact, and Outbreak Management Interim Guidance.

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 lab-confirmed COVID-19 case in a client.
    - **A confirmed outbreak** in a CLS is defined as two or more lab-confirmed COVID-19 cases in clients and/or staff (or other visitors) in a CLS with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the CLS. Examples of reasonably having acquired infection in a CLS include:
        - No obvious source of infection outside of the CLS setting; OR
        - Known exposure in the CLS setting.
- **Outbreak management** is at the direction of the local PHU and should be guided by the Public Health Management of Cases and Contacts of COVID-19 in Ontario and the COVID-19 Fully Vaccinated Individuals: Case, Contact, and Outbreak Management Interim Guidance.
    - 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 most recent COVID-19 Provincial Testing Guidance Update and the COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance.
    - 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.
    - 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.

- **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, 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.
        - 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.
        - Some CLSs may be subject to restrictions on staff mobility under O. Reg 177/20.
    - **Limiting or restricting new admissions and transfers:** Best practice is that no new clients 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 client absences**: 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.

        - 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 after 14 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.**
- 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.[9] 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.

[9] 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
  - 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 Checklist: Managing COVID-19 Outbreaks 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
- **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 for 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?	• Staff working at the CLS and all visitors, including essential visitors and anyone else entering the setting. • Exception: First responders in emergency situations	• Clients 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 home's visitor policies.	• 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?	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: • Not enter the CLS; • Instructed to immediately to self-isolate; and • Be encouraged to be tested for COVID-19 PCR test.	• 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.