Ontario

Ministry of Health

COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings

Version 11 – June 26, 2023

Highlight of Changes:

- Added that the requirements in the guidance should be followed during periods of non-high-risk COVID-19 transmission.
- Added a recommendation for staff to consider masking for source control during prolonged direct (<2metres for >15 minutes) care indoors and outdoors.
- Visitors and caregivers are recommended, but no longer required, to wear a mask indoors when visiting settings that are not in outbreak.
- Added clarity on visitor restrictions after visitor tests positive or is symptomatic.
- Added information on staff return to work staff tests positive or is symptomatic.
- Revised LTCH/RH resident isolation requirements (i.e., residents able to mask vs. residents unable to mask).
- Additional recommendations for proactively assessing residents for COVID-19 therapeutics prior to potential infection.

Introduction

Ontario's COVID-19 response continues to evolve to reflect the current context of the pandemic. Access to vaccinations and therapeutics has substantially reduced the risk of severe outcomes from COVID-19 for many individuals, especially those living in higher-risk congregate settings; however, the Omicron sub-variants of COVID-19 remain easily transmissible, and some individuals living in congregate living settings (CLSs) may have an increased risk for severe disease (e.g., older adults, immunocompromised individuals, individuals with multiple chronic medical conditions, or individuals who are pregnant). The goal of Ontario's COVID-19 response in higher-risk CLSs (outlined below) is a balanced approach which aims to protect clients/residents from severe outcomes of COVID-19 while minimizing the impact on residents' overall health and well-being through prevention, detection, and management of COVID-19 within these settings. Infection prevention and control (IPAC) recommendations in this document consider the overall respiratory virus transmission risk in the community and in the province.

The measures outlined below should be carried out during **non-high-risk periods** of COVID-19 transmission. Please refer to PHO's Interim Infection Prevention and Control Measures Based on Respiratory Virus Transmission Risk in Health Care Settings for more information on classification of periods of high-risk transmission and non-high-risk transmission. Additional measures to prevent transmission during high-risk transmission periods should be implemented based on local/regional context, and province-wide during periods of high risk as identified by Office of the Chief Medical Officer of Health, Public Health.

This document provides local public health units (PHUs) guidance to support case, contact and outbreak management in long-term care homes (LTCHs), retirement homes (RHs), and other higher-risk CLSs that fall under the definition of "institution" in subsection s.21(1) of the *Health Protection and Promotion Act (HPPA)* **AND** serve populations who are at increased risk of severe outcomes from COVID-19, such as:

- "Supported group living residences" within the meaning of the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008;*

- "Intensive support residences" within the meaning of the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008;*
- "Homes for special care" within the meaning of the *Homes for Special Care Act;*
- "Children's residence" within the meaning of Part IX (Residential Licensing) of the *Child, Youth and Family Services Act, 2017*;
- "Psychiatric facilities" within the meaning of the *Mental Health Act,* including mental health and addictions congregate settings.

PHUs may apply case, contact, and outbreak management principles outlined in this guidance document to correctional institutions, but note that adult correctional institutions may be subject to additional sector-specific guidance and preventative measures that will be facilitated by the Ministry of the Solicitor General (SolGen).

This document is also intended to provide guidance on prevention strategies to reduce transmission of COVID-19 in other CLSs, which may provide residence to individuals who are at increased risk of severe outcomes from COVID-19, including:

- Supportive housing, including unregulated and/or unlicensed CLS that function as a type of supportive housing (e.g., group homes);
- 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;
- Indigenous Healing and Wellness Residential sites; and
- Youth justice open and secure custody/detention facilities.

PHUs may provide outbreak management support using principles outlined in this document to other CLSs that are not designated as an "institution" under the HPPA but provide residential services to individuals who are medically and/or socially vulnerable to COVID-19 (e.g., hospices, unlicensed private group homes, emergency shelters for people experiencing homelessness, shelters supporting victims of domestic violence) when within their capacity to do so.

NOTE: Throughout the document LTCHs, RHs, and CLSs as defined above are referred to collectively as "settings" unless expressly written otherwise.

In addition to COVID-19, common viral pathogens that are traditionally responsible for respiratory infection outbreaks in congregate settings may also be circulating in Ontario. These viruses include, but are not limited to, rhinovirus, respiratory syncytial virus (RSV), and influenza virus. For further guidance on the control of these pathogens and other respiratory-outbreak related measures, please refer to the Ministry of Health (MOH)'s Control of Respiratory Infection Outbreaks in Long-Term Care Homes (2018). Where there are discrepancies between this guidance document and the Control of Respiratory Infection Outbreaks in Long-Term Care Homes document, please note that this guidance document has been developed for the 2022-23 respiratory season and so may be considered to supersede the 2018 Respiratory Guidance.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes issued under the *Fixing Long-Term Care Act, 2021*, effective April 27, 2022 ("the Minister's Directive"), licensees must ensure that certain aspects of this guidance document are followed in their LTCH. Please see the Minister's Directive and the COVID-19 guidance document for long-term care homes in Ontario for more information about what is required.

In accordance with clause 27(5) (0.a) of O. Reg. 166/11 under the *Retirement Homes Act, 2010,* the licensee of a retirement home shall ensure that any guidance, advice, or recommendations given to the retirement homes by the Chief Medical Officer of Health of Ontario ("CMOH") are followed in the retirement home. Per the CMOH memorandum dated June 11, 2022, the CMOH recommends that RHs implement the policies, procedures, and preventative measures in this guidance document. Please refer to the Ministry for Seniors and Accessibility's (MSAA) COVID-19 Guidance Document for Retirement Homes in Ontario ("MSAA's COVID-19 Guidance") for more information on what is required.

Specific guidance and operationalization of the policies, procedures and preventative measures in this guidance document may vary between settings due to the inherent differences. For additional clarity, in co-located LTCHs and RHs that are not operationally independent, the policies for the LTCH and RH should align where possible and follow the more restrictive requirements. For additional details on co-located RHs, please see MSAA's COVID-19 Guidance.

In the event of any conflict between this guidance document and any applicable orders, or directives issued by the Minister of Health, Minister of Long-Term Care, or the CMOH, the order or directive prevails.

The updates in this guidance document are based on the scientific evidence and public health expertise available at the time of writing and are subject to change as the knowledge of COVID-19 evolves over time.

This document replaces the "COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units" and the "COVID-19 Guidance: Congregate Living for Vulnerable Populations".

This document is not intended to take the place of medical advice, diagnosis or treatment, or legal advice.

Terms Used in this Document

- Please refer to the MOH's COVID-19 Vaccine Guidance document for the definition of **"up to date"** for COVID-19 vaccines where applicable in this document.
- "**LTCH**" is a long-term care home within the meaning of subsection 2(1) of the *Fixing Long-Term Care Act, 2021*.
- "**RH**" is a retirement home within the meaning of subsection 2(1) of the *Retirement Homes Act, 2010*.
- "**Setting**" is used throughout this document to collectively refer to LTCHs, RHs, and CLSs.
- **"CLS"** is used to refer to congregate living settings other than LTCHs and RHs. This includes higher-risk congregate living settings that fall under the definition of "institution" in subsection 21(1) of the HPPA. This also includes other congregate living settings in which individuals who may be at higher risk of severe outcomes from COVID-19 may reside. See the "Introduction" for more details.
- **"Staff"** refers to anyone conducting work activities in the setting, regardless of their employer. This includes, but is not limited to:
    - Staff employed by the setting (e.g., health care workers, support staff),
    - Health care workers seeing client(s)/resident(s) for one or more encounters,
    - Temporary and/or agency staff,

  - Students on placement (e.g., nursing students), and
  - Volunteers.
- **"Client/resident"** refers to an individual who resides in or receives services from the setting (whether on a temporary or permanent basis).
- "**Self-isolation**" has been commonly used in the public discourse during the pandemic and, for ease of understanding, is used in this document to refer to both **quarantine** (separating individuals who have been exposed from others) and **isolation** (separating individuals who are infected from others who are not known to be infected).
- "Outbreak Management Team" (**OMT**) typically includes representation from the PHU and individuals from the LTCH/RH, such as the Director of Care, Medical Director, Administrator, IPAC Lead, Staff members, resident representatives
- Additional Precautions refer to specific actions that should be taken in addition to Routine Practices for certain pathogens or clinical presentations and are based on the mode of transmission. For COVID-19, appropriate Additional Precautions includes the use of Droplet and Contact Precautions . For additional information, please see Public Health Ontario (PHO)'s Technical Brief: IPAC Recommendations for the Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19.

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Roles and Responsibilities

The following is an abridged description of roles and responsibilities specific to COVID-19 prevention, preparedness, and response. For details about roles and responsibilities for outbreaks of respiratory viruses in institutions/facilities, please refer to the Ministry of Health's Control of Respiratory Infection Outbreaks in Long Term Care Homes.

Role of the Public Health Unit (PHU)

Prevention and Preparedness

- Advise settings 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) and other relevant ministries.

Case and Contact Management/Outbreak Management

- Receive and investigate reports of suspected or confirmed outbreaks of COVID-19.
- Enter cases 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 setting on outbreak control measures in conjunction with advice provided by MOH, and other ministries, as relevant.
- Make recommendations on who to test, 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 setting, MLTC/ Retirement Homes Regulatory Authority (RHRA), Ontario Health, IPAC Hubs, etc.
- Issue orders by the medical officer of health or their designate under the *Health Protection and Promotion Act* (HPPA), if necessary.
- Declare the outbreak over.

Coordination and Communication

- Notify the MOH (IDPP@ontario.ca) of:
    - Potential for significant media coverage or if media releases are planned by the PHU and/or the setting.
    - Any orders issued by the PHU's medical officer of health or their designate to the setting and share a copy.
- Engage and/or communicate with relevant partners, stakeholders, and ministries, as necessary.

Role of the Ministry of Health (MOH)

- Provide legislative and policy oversight and ongoing support to PHUs with partner agencies, ministries, health care professionals, and the public, as necessary.
- Support PHUs during investigations with respect to coordination, policy interpretation, communications, etc. as requested.
- Receive notifications:
- If the PHU believes there is potential for significant media coverage.
- If orders are issued by the local medical officer of health or their designate to the setting.

Role of Other Ministries

- Provide legislative and policy oversight to their respective settings, where applicable.
- Provide ongoing support and communications to their sectors with partner agencies and the public, as necessary.

Role of Public Health Ontario (PHO)

- Provide scientific and technical advice to PHUs to support case and contact management, outbreak investigations, and data entry.
- Develop evidence-informed resources and programs.
- Advise on and support laboratory testing as needed.
- Work with MOH and other government and health system partners on a coordinated approach to strengthening IPAC programs and individual capacity.

- Provide scientific and technical advice to MOH and PHUs, including multi-jurisdictional teleconferences.

Role of the Setting

- Settings that are institutions within the meaning of subsection 21(1) of the HPPA, are required to report suspect or confirmed cases of COVID-19 in respect of a person lodged in the institution to their local PHU. This must be done as soon as possible after entry is made in the records of the institution. See section 27 of the HPPA for more details.
- Other settings may notify their local PHU if they have a suspect or confirmed outbreak in a timely manner (i.e., same day, if possible).
    - LTCHs are required to immediately report any COVID-19 case or outbreak (suspected or confirmed) to the Ministry of Long-Term Care (MLTC) using the Critical Incident System during regular working hours or calling the after-hours line at 1-888-999-6973 after hours and on weekends.
    - LTCHs must also follow the critical incident reporting requirements in section 115 of O. Reg. 246/22 under the *Fixing Long-Term Care Act, 2021* (FLTCA).
    - CLSs licenced, funded, and directly operated by the Ministry of Children, Community and Social Services (MCCSS) are to report a communicable disease which requires unscheduled medical attention from a regulated health professional and/or unplanned hospitalization to the MCCSS through Serious Occurrence Reporting no later than 24 hours after becoming aware of the serious incident. Confirmation of preventative measures taken by the service provider to stop the spread of the disease, and any follow-ups recommended by and/or conducted with public health officials must be included in the report
- Implement measures found in guidance or as directed by the MOH and the CMOH, MLITSD, and their local PHU, and their relevant ministry, as applicable.
- Coordinate with the local PHU and other stakeholders as appropriate, as part of the investigation and management of COVID-19 outbreaks.
- Follow the directions of the local PHU if there is a suspect or confirmed outbreak in the setting.

Role of the IPAC Hubs

- Deliver services to staff working in LTCHs, RHs, and other CLSs (i.e., IPAC Leads or most responsible persons). Services are offered both remotely (virtually) or onsite and are tailored to the unique types of settings:
    - Deliver education and training;
    - Host community/ies of practice) to support information sharing, learning, and networking to congregate living settings;
    - Support the development of IPAC programs, policy and procedures within sites/organizations;
    - Support assessments and audits of IPAC programs and practice;
    - Provide recommendations to strengthen IPAC programs and practices;
    - Mentor those with responsibilities for IPAC within CLSs;
    - Supporting the development and implementation of outbreak management plans (in conjunction with public health partners and CLSs); and,
    - Support CLSs to implement IPAC recommendations.

Prevention of Disease Transmission

Settings can help prevent and limit the spread of COVID-19 and other common respiratory viruses by ensuring that foundational IPAC best practices (e.g., hand hygiene and respiratory etiquette) are in place while also respecting the physical, mental, emotional, and psychosocial well-being of clients/residents. Many of these measures should be part of existing organization plans developed for infectious disease outbreaks or other emergencies. Factors such as the physical/infrastructure characteristics of the setting, staffing availability, and the availability of and training on the appropriate use of PPE should all be considered when developing setting-specific policies.

The measures outlined below should be carried out during **non-high-risk periods** of COVID-19 transmission. Please refer to PHO's Interim Infection Prevention and Control Measures Based on Respiratory Virus Transmission Risk in Health Care Settings for more information on classification of periods of high-risk transmission

and non-high-risk transmission. Additional measures to prevent transmission during high-risk transmission periods should be implemented based on local/regional context, and province-wide during periods of high risk as identified by Office of the Chief Medical Officer of Health, Public Health.

Please note that PHUs have the discretion to modify or discontinue any activity in the setting as part of their outbreak investigation and management.

Outbreak Preparedness Plan

- For LTCHs, refer to section 90 of the *Fixing Long-Term Care Act, 2021* and sections 268-271 of O. Reg. 246/22 for Emergency Plans requirements and section 1.1 of the Minister's Directive for COVID-19 Outbreak Preparedness Plan Requirements.
- It is recommended that RHs, in consultation with their joint health and safety committees or health and safety representatives, if any, ensure measures are taken to prepare for and respond to a COVID-19 outbreak, including developing and implementing a COVID-19 Outbreak Preparedness Plan. It is recommended that this plan include:
    - Identifying members of the Outbreak Management Team;
    - Identifying their local IPAC Hub and their contact information;
    - Enforcing an IPAC program, in accordance with the RHA and O. Reg. 166/11, both for non-outbreak and outbreak situations, in collaboration with IPAC Hubs, PHUs, local hospitals, Home and Community Care Support Services, and/or regional Ontario Health;
    - Ensuring non-expired testing kits are available and stored appropriately, and plans are in place for specimen collection (including training of staff on how to collect a specimen);
    - Ensuring sufficient PPE is available and that all staff and volunteers are trained on IPAC protocols, including how to perform a personal risk assessment and the appropriate use of PPE;
    - Developing policies to manage staff who may have been exposed to COVID-19;
    - Developing and implementing a communications plan to keep staff, residents, and families informed about the status of COVID-19 in the settings, including frequent and ongoing communication during outbreaks.

- CLSs are recommended to develop Outbreak Preparedness Plans to support the operationalization of the recommendations outlined in this guidance document, and to develop contingencies as appropriate to their setting and in accordance with any setting-specific guidance issued by their respective ministries. Plans should include policies and procedures for caring for a symptomatic or COVID positive client/resident, including supporting on-site isolation and developing plans for isolation off-site, if needed. Refer to Public Health Ontario's (PHO's) COVID-19 Preparedness and Prevention in Congregate Living Settings Checklist.

IPAC Programs and Audits

- Pursuant to section 23 of the *Fixing Long-Term Care Act, 2021* (FLTCA), and subsection 60(4) of the *Retirement Homes Act, 2010* (RHA), every LTCH and RH in Ontario is legally required to have an IPAC program as part of their operations.
- Per the legislation, each LTCH must have individual(s) who are responsible for an IPAC program in the home. It is recommended that each RH have individual(s) who are responsible for an IPAC program in the home.
    - For LTCHs, also refer to section 23 of that Act and section 229 of O. Reg. 246/22, as well as the IPAC Standard for Long-Term Care Homes.
- IPAC self-audits are an integral component of LTCHs' and RHs' IPAC program.
- For LTCHs, refer to section 1.1 of the Minister's Directive for IPAC audit requirements.
- It is recommended that RHs conduct IPAC self-audits every quarter when the home is not in outbreak and every week during an outbreak, and include in their audit the COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes. It is also recommended that RHs keep the IPAC audit results for at least 30 days and share with inspectors from the local PHU, MLITSD and the Retirement Homes Regulatory Agency (RHRA) upon request.
- CLSs may use PHO's COVID-19 Preparedness and Prevention in Congregate Living Settings Checklist to conduct self-audits on a regular basis.

Vaccination

- **COVID-19 vaccination** is one of the most effective ways to help prevent severe illness and death due to COVID-19. PHUs and settings are asked to continue to encourage clients/residents, staff, caregivers and visitors to remain up-to-date with their COVID-19 vaccinations.

  - New admissions to settings who are not up-to-date with their COVID-19 vaccinations should be offered a complete series of a COVID-19 vaccination, or their remaining eligible doses, as soon as possible.
  - For more information on the COVID-19 vaccine and resources available refer to Ontario's COVID-19 Communication Resources page.

- PHUs are asked to continue to support COVID-19 vaccination in settings in collaboration with the setting and relevant health system partners. Where possible, this includes assisting settings with on-site vaccination or at a location that is convenient and trusted by the client/residents.
- **Influenza vaccination**: All staff, visitors, and residents/clients should also be 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.
- Clients/residents may also be eligible for the pneumococcal, tetanus, zoster and diphtheria vaccines in accordance with Ontario's publicly funded immunization schedule.

COVID-19 Therapeutics

- Health care providers should discuss potential treatment options (i.e., Paxlovid, Remdesivir) with residents and caregivers in advance of potential COVID-19 infection.
- This should include obtaining a clinical assessment, up-to-date renal function tests and other relevant workup, medication reconciliation, and goals of care. A physician or nurse practitioner must determine if treatment is right for a resident based on multiple factors such as clinical judgement, goals of care, the potential for drug-drug interactions or other medication contraindications, as well as other general considerations.
- Plans should also include steps for accessing treatment so it can be made available as quickly as possible.
- LTC homes are encouraged to pre-emptively:

    - Determine if a resident meets eligibility, including reviewing medications for potential drug-drug interactions, and ordering a serum creatinine while the residents are well.
    - Connect with their contracted pharmacy about including Paxlovid in their emergency box, especially if a home is in a remote area. (All long-term care contracted pharmacies have access to Paxlovid and, in emergency situations, homes may rely on their secondary pharmacy to access Paxlovid.)

- If a patient is not eligible for Paxlovid, there exist other therapeutic treatment options (i.e., Remdesivir). Residents and their caregivers are encouraged to proactively speak with their primary healthcare provider.
    - Health care providers and LTCHs should work with their Nurse-Led Outreach Teams or OH regional contact to access Remdesivir through local pathways.
- RHs and other CLSs are encouraged to provide information on COVID-19 therapeutics and encourage residents and clients to speak with their primary care provider to come up with a treatment plan in case they get sick, as appropriate.

Active Screening and Passive Screening

- The purpose of active and passive screening is to identify those who may be infectious to prevent potential spread of infection within the setting.
- Passive screening means that those entering the setting review screening questions themselves, and there is no verification of screening (e.g., signage at entrances as a visual reminder not to 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 LTCHs, refer to section 9 of the Minister's Directive, which states that LTCHs are required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended ("MLTC COVID-19 Guidance"), are followed.

- It is recommended that RHs ensure that the COVID-19 screening measures set out in section 3.3 of MSAA's COVID-19 Guidance are followed.
- CLSs should post signage at entrances and throughout the setting advising individuals of signs and symptoms of COVID-19 and provide steps that should be taken if COVID-19 is suspected or confirmed in a staff member, visitor, or client. Staff and visitors who are experiencing new or worsening symptoms should not enter the setting.
- Clients/residents with symptoms compatible with an acute respiratory infection including COVID-19 (see Appendix B) should be placed in self-isolation on Additional Precautions and tested. See Management of Symptomatic Individuals, below.

Daily Symptom Assessment of Clients/Residents

- Per section 23(2) of the Fixing Long-Term Care Act, and section 102(9) of the associated Regulation 246, LTCHs are required to ensure the requirements pertaining to the daily symptom assessment of residents are followed.
- It is recommended that RHs ensure section 3.3.1 of MSAA's COVID-19 Guidance regarding symptom assessment of residents is followed.
- In other CLSs, clients/residents should be assessed at least once daily when the client is symptomatic, has tested positive for COVID-19, or is a close contact, to identify and monitor new or worsening symptoms of COVID-19.
- See Appendix B for a list of acute respiratory symptoms for different respiratory outbreak-associated viruses including COVID-19.

Hand Hygiene

- Hand hygiene is a critical component in preventing the transmission of infectious diseases. Please refer to PHO's hand hygiene webpage for more details.
- Access to alcohol-based hand rub (ABHR) and/or handwashing stations should be available at multiple, prominent locations in the setting, including entrances, common areas, and at point-of-care (e.g., client/resident rooms) to promote frequent hand hygiene, and signage should be posted to remind all staff, visitors and clients/residents of the importance of performing hand hygiene.

Masking and Personal Protective Equipment (PPE)

- PPE is intended to protect the wearer and to minimize their risk of exposure to COVID-19 and other potential hazards. The effectiveness of PPE depends on using it correctly and consistently.
- Masks worn for source control protect others from transmission of COVID-19 and other respiratory viruses from the wearer of the mask (e.g., protects residents from staff).

For LTCHs/RHs:

- For LTCHs, refer to:
    - Section 1.2 of the Minister's Directive, which states that LTCHs are required to ensure that masking requirements as set out in the MLTC COVID-19 Guidance are followed.
    - Section 2 of the Minister's Directive, which states that licensees of LTCHs are required to ensure that the PPE requirements as set out in this guidance document are followed.
- It is recommended that RHs ensure the PPE requirements as set out in this guidance document and COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities are followed. RHs should also ensure that the requirements for masking and PPE Training in MSAA's COVID-19 Guidance are followed.
- As per COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, all health care workers should complete a point of care risk assessment (PCRA) before every resident/client interaction. Health care workers are required to wear a mask (along with other appropriate PPE) based on the PCRA and in consideration of occupational health and safety for staff.
- Staff may consider wearing a mask for source control when providing prolonged direct (< 2 metres and > 15 minutes) care indoors and outdoors.
- Recommended PPE for providing direct care to a resident with **suspect or confirmed COVID-19**:
    - a fit-tested, seal-checked N95 respirator (or approved equivalent). Staff who are not yet fit-tested for an N95 respirator should wear a well-fitted surgical/procedure mask or a non-fit-tested N95 respirator (or approved equivalent).

  - appropriate eye protection (goggles, face shield, or safety glasses with side protection)
  - gown
  - gloves
- When interacting within 2 metres of residents in an **outbreak area**, recommended PPE includes:
  - a fit-tested, seal-checked N95 respirator (or approved equivalent). Staff who are not yet fit-tested for an N95 respirator should wear a well-fitted surgical/procedure mask or a non-fit-tested N95 respirator (or approved equivalent); and
  - appropriate eye protection (goggles, face shield, or safety glasses with side protection)
  - gloves and gown should be added if providing direct care to a resident within an outbreak area, based on a point-of-care risk assessment. Gloves are to be removed after use, and hand hygiene should be performed before and after wearing gloves. Gloves are to be changed between residents.

When providing care to a resident with symptoms of an acute respiratory infection (ARI) of unknown aetiology the recommended PPE is the same as for a suspect or confirmed COVID-19 case. Once a specific causative agent is confirmed, an individual may choose to wear PPE in accordance to current best practice recommendations for that specific organism. For example, for care of a resident with confirmed influenza infection, recommended PPE includes a well-fitted medical mask, eye protection (goggles or face shield), gown and gloves.

However, in the context of an outbreak, given that staff will be providing care to residents with symptoms or an acute respiratory infection of unknown etiology, the recommended PPE includes eye protection (goggles or face shield), fit-tested, seal-checked N95 respirator (or equivalent), gown and gloves. At this time, to avoid confusion, in a respiratory outbreak (regardless of etiology), it is recommended that all staff providing direct care to residents within the outbreak area employ the recommended PPE for suspect and/or confirmed COVID-19.

See COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities and PHO's IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 for more information on PPE use.

For CLSs:

- All staff and essential visitors should complete a personal risk assessment before every client interaction. Staff are required to wear a mask (along with other appropriate PPE) based on their personal risk assessment and in consideration of Occupational Health and Safety.
- Staff may consider wearing a mask for source control when providing prolonged direct (< 2 metres and > 15 minutes) care indoors and outdoors, for clients at high risk of severe outcomes (e.g., immunocompromised).
- All staff and essential visitors/caregivers providing direct care to or interacting within 2 metres of a client with **suspect or confirmed COVID-19** or in an **outbreak** area should wear eye protection (goggles, face shield, or safety glasses with side protection), and a well-fitted medical mask or an N95 respirator (or approved equivalent) as appropriate PPE.
    - When providing direct care to clients who are symptomatic or positive for COVID-19 or in the outbreak area (e.g., helping with feeding, bathing, changing clothing, toileting), gloves and gown may be added, based on a personal risk assessment. Gloves are to be removed after use, and hand hygiene should be performed before and after wearing gloves. Gloves are to be changed between clients.
- See COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities and PHO's COVID-19: Personal Protective Equipment and Non-Medical Masks in Congregate Living Settings for additional details.

Environmental Cleaning and Disinfection

- For LTCHs, refer to section 1.4 of the Minister's Directive for environmental cleaning requirements.
- It is recommended that RHs and CLSs ensure that regular environmental cleaning of their settings is maintained and enhanced environmental cleaning and disinfection for frequently touched surfaces is performed. It is also recommended that:
    - RHs and CLSs be cleaned regularly (e.g., at least once a day) and that cleaning be performed using a health care grade cleaner/disinfectant with a Drug Identification Number (DIN).

- All common areas (including bathrooms) and high-touch surfaces (i.e., that are frequently touched and used) be cleaned and disinfected at least once a day and when visibly dirty. These include door handles, light switches, elevator buttons, handrails, trolleys, and other common equipment in the setting.
- All shared equipment and items (e.g., shower chairs, vital machines, lifts) be cleaned and disinfected between each client/resident use.
- Contact surfaces (i.e., areas within 2 metres) of a person who has screened positive should be disinfected as soon as possible.

- For more information on environmental cleaning, refer to:
  - Key Elements of Environmental Cleaning in Healthcare Settings (Fact Sheet);
  - Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings; and,
  - PIDAC Routine Practices and Additional Precautions in All Health Care Settings.
  - For CLSs: COVID-19 Cleaning and Disinfection for Public Settings

Ventilation and Filtration

- In general, ventilation with fresh air and filtration can improve indoor air quality over time by diluting and reducing potentially infectious respiratory aerosols. Ventilation and air filtration 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.
- The risk of COVID-19 transmission is higher in indoor settings. Where appropriate and possible, encourage outdoor activities.
- Indoor spaces should be as well ventilated as possible, through a combination of strategies: natural ventilation (e.g., by regular opening of windows and doors), local exhaust fans, (e.g., bathroom exhaust fan), or centrally by a heating, ventilation, and air conditioning (HVAC) system.
- Directional currents can move air from one client/resident to another. Portable units (e.g., fans, air conditioners, portable air cleaners) should be placed in a manner that avoids person-to-person air currents. 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.

- For more information, see PHO's Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings and COVID-19 and Public Health Agency of Canada's guidance on Using Ventilation and filtration to reduce aerosol transmission of COVID-19 in long-term care homes.
- The use of portable air cleaners can help filter out aerosols, especially where ventilation is inadequate or mechanical ventilation does not exist.

Admissions and Transfers

- Per section 5.1 of the Minister's Directive, LTCHs shall ensure that the detailed requirements and information related to admission and transfer into the home, including requirements for testing and isolation, are followed as set out in this guidance document.
- It is recommended that RHs ensure that the admission and transfer measures set out in this guidance document are followed.
- COVID-19 testing is **not** recommended or required for a resident transfer to occur from a hospital to a LTCH/RH.
- Any resident being admitted or transferred to a LTCH/RH, regardless of their COVID-19 vaccination status, who is identified as having symptoms and/or diagnosis of COVID-19 should be tested, self-isolated and placed on Additional Precautions at the home and managed as per the requirements below.
- Admissions and transfers to a LTCH/RH outbreak floor/unit should be avoided in the following circumstances, recognizing it may not always be possible or safe to do so (in which case, consultation with the local PHU is advised):
    - Newly declared outbreak where there is an ongoing investigation;
    - Outbreaks where new cases are occurring beyond those known contacts who have already been isolating (i.e., uncontrolled/uncontained*); OR,
    - Admissions or transfer to floors/units where many residents are unable to follow public health measures.

* Uncontrolled/uncontained outbreaks are defined as outbreaks where new cases are occurring beyond those known contacts who have already been isolating.

- For LTCHs/RHs, if it is necessary for residents to be admitted or transferred to a setting with a COVID-19 outbreak in order to provide optimal care for client/residents or due to capacity issues, etc., the following should be taken into account:
    - Residents with conditions that present an increased risk to themselves or others if they become infected should **not** be admitted to the outbreak unit/floor without appropriate public health measures to prevent transmission. For example, residents:
        - Who are severely immunocompromised;
        - With a history of wandering/confused behaviour;
        - Who are not up-to-date with their COVID-19 vaccine;
        - With conditions requiring extensive care provisions unless there is adequate staffing to manage resident care needs; OR,
        - With other concerns which may result in decreased compliance with public health measures.
    - For admissions or transfers from an acute care facility, the discharging physician should agree to the admission or transfer to a home in outbreak.
    - If absolutely necessary, clients/residents who do not have an active COVID-19 infection may be admitted or transferred to a floor/unit with an outbreak, provided the following conditions are met:
        - For LTCH and RH, the resident is up-to-date on their COVID-19 vaccinations;
        - Client/resident (or substitute decision-maker) is made aware of the risks of the admission or transfer and consents to the admission or transfer. It is important to note the client/resident should not face any unintended consequences in terms of placement should the client/resident (or substitute decision-maker) choose not to consent;
        - Client/resident is admitted or transferred to a private room.
- For CLSs, any client being admitted or transferred who is identified as having symptoms and/or a diagnosis of COVID-19 should be tested, self-isolated, and managed as per the requirements below.

- In general, admissions and transfers to a CLS in 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, informed consent from the client should be obtained.

Absences

- For LTCHs, refer to section 6 of the Minister's Directive, which states LTCHs are required to ensure that the resident absence requirements as set out in the MLTC COVID-19 Guidance Document are followed.
- It is recommended that RHs ensure that the resident absence measures set out in section 4 of MSAA's COVID-19 Guidance are followed.
- For CLSs, there are no restrictions on absences; however, PHUs may provide considerations for absences during an outbreak to minimize risk of spread.

Visitors

- For LTCHs, refer to section 7 of the Minister's Directive, which states LTCHs are required to ensure that the visitor requirements as set out in the MLTC COVID-19 Guidance are followed.
- It is recommended that RHs ensure that section 3 of MSAA's COVID-19 Guidance regarding home visits is followed.
- For CLSs, visitors should be made aware of the screening and masking policies for the setting.
- It is recommended, but no longer required, that visitors and caregivers wear a mask in LTCHs, RHs, and other CLSs. Visitors are required to comply with any masking/PPE requirements as appropriate during outbreaks or if the resident or client is on Additional Precautions.
- General visitors who test positive for COVID-19 and/or have symptoms compatible with COVID-19 should avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., senior) as well as highest risk settings such as hospitals and long-term care homes for 10 days following symptom onset and/or positive test date (whichever is earlier/applicable).
- Where visits cannot be avoided (e.g., essential caregiver visits), visitors should wear a medical mask, maintain physical distancing, and should notify the setting of their recent illness/positive test. If the individual being visited can also wear a mask, it is recommended they do so.

- General visitors should postpone non-essential visits to client(s) who are symptomatic and/or self-isolating, or when the LTCH/RH/CLS is in outbreak.

Case, Contact, and Outbreak Management for LTCHs/RHs

- For LTCHs, refer to section 4 of the Minister's Directive, which states that LTCHs are required to ensure that the requirements for case, contact and outbreak management as set out in the MLTC COVID-19 Guidance are followed. Per the MLTC COVID-19 Guidance, homes are to abide by the guidance set out in this document.
- It is recommended that RHs ensure that the requirements for case, contact and outbreak management as set out in this guidance document are followed.

Management of Symptomatic Individuals

- **When a resident is symptomatic:** Residents who are exhibiting signs or symptoms consistent with acute respiratory illness (see Appendix B), should self-isolate and be placed on Additional Precautions, medically assessed, and tested for COVID-19 and other respiratory pathogens as soon a possible.
    - **Diagnostic testing:** The list of preferred specimen types for molecular testing is available on the Public Health Ontario website. Swabs should ideally be collected from residents as soon as possible after they develop symptoms (e.g., within 48 hours).
        - All symptomatic residents should be tested for COVID-19, even during non-COVID-19 outbreaks, using a laboratory-based molecular test or a rapid molecular test (e.g., ID NOW COVID-19 or GeneXpert)1F[‡].
        - RATs have a significantly lower sensitivity for COVID-19 than molecular tests and should **not** be used routinely for residents of LTCHs and RHs. Results of RATs (positive or negative) should not

[‡] Please refer to MOH's COVID-19 Provincial Testing Guidance for more information on interpreting rapid molecular results.

change the management plan for a symptomatic resident (i.e., they still have to isolate and be treated as a suspect case until their molecular test results are known).

- While a nasopharyngeal swab (NPS) is the preferred collection method, other specimen collection methods, including combined oral and nasal swabbing, may be used to support access to testing and maximize testing uptake.
- All symptomatic residents with acute respiratory symptoms are eligible for testing of other respiratory viruses for prospective surveillance, such as using a multiplex respiratory virus PCR panel (MRVP) test.

- **If the COVID-19 test results are positive:** see Case Management below.**If the COVID-19 molecular test and MRVP test are negative:** If there has not been a known exposure to COVID-19, the resident may discontinue Additional Precautions once they are afebrile (without the use of fever-reducing medications) and symptoms are improving for at least 24 hours (48 hours for gastrointestinal symptoms).

Table 2: Testing of Symptomatic Residents

Home Status	COVID-19 Molecular Test	MRVP Test
Not in Outbreak	Test ALL symptomatic residents	Test ALL symptomatic residents
In Outbreak	Test ALL symptomatic residents	Test only first FOUR symptomatic residents**; then test subsequent symptomatic residents with FLUVID panel

** FLUVID, detecting influenza A, influenza B, respiratory syncytial virus (RSV) A/B) and SARS-CoV-2 (COVID-19), will be performed on all symptomatic residents and healthcare workers/staff in institutional settings in an outbreak (beyond the first four that have been tested for SARS-CoV-2 and MRVP).

- **When a staff or a visitor is symptomatic:** Symptomatic staff or visitors should not be permitted entry into the home. Staff and visitors who become symptomatic while at the home should leave immediately and be directed to self-isolate at their own home and seek medical assessment as required.

COVID-19 Case Management

- For LTCHs, refer to section 4 of the Minister's Directive, which states that LTCHs are required to ensure that the requirements for case and outbreak management as set out in the MLTC COVID-19 Guidance are followed. Per the MLTC COVID-19 Guidance, homes are to abide by the requirements set out in this guidance document.
- It is recommended that RHs ensure the requirements for case and outbreak management as set out in this guidance document.
- Homes do not need to report individual staff or visitor cases to their local PHU unless those cases are linked to an outbreak or if they need further support/guidance.
- Residents who are identified as a confirmed or a probable COVID-19 case and are **unable to wear a mask**, should self-isolate on Additional Precautions for at least 10 days from symptom onset or date of specimen collection, if asymptomatic (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present. Residents are able to leave their room for walks in the immediate area with a staff person wearing appropriate PPE, to support overall physical and mental well-being.
- Residents who are identified as a confirmed or a probable COVID-19 case and are **able to independently and consistently wear a mask**, should self-isolate on Additional Precautions for at least 10 days from symptom onset or date of specimen collection, if asymptomatic (whichever is earlier/applicable). Residents may leave their room to participate in activities and join others in communal areas provided they meet the following criteria:
    - It has been a minimum of 5 days from symptom onset or positive test (whichever is earlier/applicable);
    - They are asymptomatic or their symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present; and
    - They wear a well-fitted mask at all times outside of their room, they do not join in communal activities where they would need to remove their mask within the setting (e.g., group dining), and they continue to follow additional precautions for 10 days after their symptom onset or positive test.

- Residents who test positive for COVID-19 should be assessed as soon as possible to determine if COVID-19 therapeutics are within their goals of care, and if so, to determine eligibility.
    - LTCHs should connect with their contracted pharmacy about including Paxlovid in their emergency box, especially if a home is in a remote area. All long-term care contracted pharmacies have access to Paxlovid and, in emergency situations, homes may rely on their secondary pharmacy to access Paxlovid.
    - If a patient is not eligible for Paxlovid, there exist other therapeutic treatment options (i.e., Remdesivir). Residents and their caregivers are encouraged to proactively speak with their primary healthcare provider.
        - Health care providers and LTCHs should work with their Nurse-Led Outreach Teams or OH regional contact to access Remdesivir through local pathways.
    - RHs and other CLSs are encouraged to provide information on COVID-19 therapeutics and encourage residents and clients to speak with their primary care provider to come up with a treatment plan in case they get sick, as appropriate.
    - Individuals requiring self-isolation should be placed in a single room on Additional Precautions. Where this is not possible, individuals may be placed in a room with no more than one (1) other resident who should also be placed in self-isolation on Additional Precautions. For the purposes of self-isolation, there should not be more than two (2) residents placed per room, including 3 or 4 bed ward rooms. If a resident is not in a private room, the use of partitions/barriers for separation between beds is recommended.
    - Asymptomatic residents living in the same room as the case should be placed on Additional Precautions immediately (along with the infected resident, when break of contact is not possible) under the direction of the local PHU (see Contact Management below).
    - Residents on Additional Precautions should:
        - Stay in their room during their self-isolation period but may be allowed outdoors or in the hallway (e.g., walking, with one-on-one supervision) while wearing a well-fitted medical mask, if tolerated, and minimizing any interaction with others.

        - Be encouraged to wear a well-fitted mask, if tolerated, when receiving direct care in their room.

- **When a staff or a visitor test positive for COVID-19:** Staff and visitors who receive a positive COVID-19 test result while they are at the LTCH or RH should leave the facility immediately and be directed to self-isolate at their own home until symptoms have been improving for 24 hours (48 hours if gastrointestinal symptoms) and no fever present.
    - Visitors: For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, visitors should avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., seniors) and avoid non-essential visits to highest-risk settings such as hospitals and long-term care homes. Where visits cannot be avoided (e.g., essential caregiver visits), visitors should wear a medical mask, maintain physical distancing, and notify the setting of their recent illness/positive test. If the individual being visited can also wear a mask, it is recommended they do so.
    - Staff: For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, staff should adhere to workplace measures for reducing risk of transmission (e.g., masking for source control, not removing their mask unless eating or drinking, distancing from others as much as possible) and avoid caring for patients/residents at highest risk of severe COVID-19 infection, where possible.

COVID-19 Contact Management

- Contact management decisions are made by the local PHU. Accordingly, all individuals who are identified as a close contact of a known case or an outbreak are required to follow the direction of the local PHU.
    - Identification and notification of close contacts of cases in LTCHs/RHs is the responsibility of the PHU in collaboration with the home. The PHU is responsible for conducting a risk assessment to identify close contacts who have had high-risk exposures to a confirmed positive COVID-19 case, an individual with COVID-19 symptoms, or an individual with a positive rapid antigen test result.
        - Close contacts would include roommate as well as other resident contacts who, following a risk assessment, are deemed to have had

significant exposures to the case (for example, contacts who have spent significant time together in close proximity without masking during the case's period of communicability. This may include dining table mates).

- All roommate close contacts should be placed on Additional Precautions. Individuals who remain asymptomatic may discontinue isolation after a minimum of 5 days of isolation (based on 5 days from when the case became symptomatic or tested positive if asymptomatic). Roommate close contacts should then wear a well-fitting mask, if tolerated, when receiving care and outside of their room, and physically distance from others when outside of their room until day 7 from last exposure to the case.
- Ideally, roommate close contacts are placed in a separate room to isolate away from the case. When this is not possible, the use of physical barriers (e.g., curtains or a cleanable barrier) to create separation between the case and the roommate is recommended.

- In general, other non-roommate resident close contacts within the unit and facility who remain asymptomatic should not be self-isolated/placed on Additional Precautions. However, the following risk reduction measures should be considered for non-roommate resident close contacts to reduce the risk of transmission to other residents, while balancing the resident's mental and social well-being:
  - Monitoring twice daily for symptoms,
  - Strongly encouraging the resident to wear a well-fitting mask, if tolerated, and physically distance from others when outside of their room for 7 days following their last exposure to the individual with COVID-19.
    - This may include avoiding attending group dining and group activities that involve unexposed residents where masking and physical distancing cannot be maintained by the close contact.
  - Encouraging the resident to wear a well-fitted mask, if tolerated, when receiving care.

- The local PHU has the discretion to recommend COVID-19 molecular testing of asymptomatic resident close contacts. This may be considered when:
    - there is a rapid increase in cases among residents; and/or
    - the outbreak is not responding to usual IPAC measures; and
    - the use of asymptomatic testing of close contacts is considered to have higher overall benefit (the identification of asymptomatic positive cases leading to reduced transmission, potentially reducing the duration and extent of the outbreak) than risk (harms associated with the isolation of asymptomatic residents).
    - Should this be recommended, testing is advised to occur no sooner than 24 hours following exposure, and, if negative, testing may be repeated 48 hours after the first negative test (i.e., on Day 3 following exposure). Isolation is not required while awaiting test results. Rather, the close contact should be strongly encouraged to follow the risk reduction measures outlined above.
    - Due to challenges in interpreting the result, testing is not recommended for asymptomatic residents who have recovered from COVID-19 in the last 90 days.
- If a close contact develops symptoms, promptly isolate under Additional Precautions and test for COVID-19 and other respiratory pathogens (i.e., MRVP or FLUVID).
- An asymptomatic contact who tests positive for COVID-19 should also be promptly isolated under Additional Precautions and managed as per Case Management.

COVID-19 Outbreak Management for LTCHs and RHs

- For LTCHs, refer to section 4 of the Minister's Directive, which states that LTCHs are required to ensure that the requirements for case and outbreak management as set out in the MLTC COVID-19 Guidance are followed. Per the MLTC COVID-19 Guidance, homes are to abide by the requirements set out in this guidance document.
- It is recommended that RHs ensure that the requirements for case and outbreak management as set out in this guidance document are followed.

- 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. LTCHs and RHs must adhere to any guidance provided by the local PHU with respect to implementation of any additional measures to reduce the risk of COVID-19 transmission in the setting.
- The PHU has the discretion to implement outbreak control measures that are protective to the resident population and that are appropriate and proportional to the risk profile of the outbreak.

COVID-19 Outbreak Definitions:

- Surveillance definitions of **COVID-19 outbreaks** in LTCH and RH can be found in Appendix 1 of the Infectious Diseases Protocol: Diseases caused by a novel coronavirus, including Coronavirus Disease (COVID-19), Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).
- All positive molecular test or RAT results in residents, staff, or visitors associated with a suspect or confirmed outbreak in the home must be reported to the PHU and Outbreak Management Team. Negative RAT results should not be used independently to rule out COVID-19 in an outbreak situation due to the test's limited sensitivity and the increased pre-test probability of COVID-19. If a RAT is used for a staff or resident with symptoms or high-risk exposure (e.g., in extraordinary circumstances when access to timely PCR testing is not available), molecular testing should also be performed in parallel.

COVID-19 Outbreak Management:

- The local PHU will direct testing and public health management of all those impacted (staff, residents, and visitors) using a risk-based approach. It is important to consider both the risk to residents and the potential harm of resident isolation and testing when implementing public health measures.
- Confirmed outbreak management should include the following steps at minimum:
    - Defining the outbreak area of the home (i.e., floor or unit) and cohorting based on COVID-19 status (i.e., infected or exposed and potentially incubating);
    - Assessing risk of exposure to residents/staff based on cases' interactions;

- Initiating Additional Precautions for all symptomatic residents and those with suspect or confirmed COVID-19. Post appropriate signage outside the resident's room;
- Facilitate assessment of IPAC and outbreak control measures, as needed;
- Resident close contacts who remain asymptomatic do not need to be placed on Additional Precautions, however, the following risk reduction measures should be recommended by the PHU for the duration of the outbreak:
    - Even if not under Additional Precautions, exposed residents within the outbreak area of the home should be cohorted separately from non-exposed residents.
    - Group activities and communal dining should be conducted such that the outbreak unit is cohorted separately from unexposed residents and units. At the discretion of the PHU/OMT, group activities and communal dining for cohorts (exposed separated from unexposed) may resume. Wherever possible, continuing group activities for exposed cohorts is recommended to support resident mental health and wellbeing.
    - Staff should remain in a single cohort per shift, wherever possible. If staff must work with more than one cohort during a single shift, it is recommended that staff work with unexposed residents first.
    - At the discretion of the PHU/OMT, communal dining and group activities may be paused completely in the case of a facility-wide outbreak where transmission is uncontrolled, the rate of increase in cases or severity of illness is significant or unexpected and the benefits of closure of communal activities are deemed to be greater than the harms caused to resident wellbeing. This decision should be revisited as the outbreak progresses.
    - At the discretion of the home, in consultation with the PHU, resumption of day programming may occur during an outbreak. However, all staff and residents who are part of the outbreak should be cohorted so as to be kept separate from participants and staff of day programs.

- Homes should conduct enhanced symptom assessment (minimum twice daily) of all residents in the outbreak area to facilitate early identification and management of ill residents.
- Homes should conduct weekly IPAC self-audits for the duration of the outbreak. The results of these audits should be reviewed by the OMT.
- Increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces);
- General visitors should postpone all non-essential visits to residents within the outbreak area for the duration of the outbreak.
- Caregivers, support workers, or individuals visiting a resident receiving end of life care, are allowed when a resident is isolating or resides in a home or area of the home in an outbreak, provided they are able to comply with the PPE recommendations above.

o Admissions and transfers are generally not permitted during an outbreak. See above section on Admissions/Transfers for further details.

Influenza and Other Acute Respiratory Infection (ARI) Case Management

The following constitutes interim case, contact and outbreak management of influenza and other respiratory pathogens in LTCHs and RHs for the 2022-2023 respiratory season. For further guidance on the control of these pathogens and other respiratory-outbreak related measures, please refer to the MOH's Control of Respiratory Infection Outbreaks in Long-Term Care Homes.

Symptomatic residents should be managed as above. Initiation of early empiric treatment with influenza antiviral medication should be considered, as antiviral treatment works best when initiated within 48 hours of symptom onset. Considerations for when to initiate influenza antiviral treatment empirically can be found in PHO's Antiviral Medications for Seasonal Influenza.

Symptomatic staff or staff who test positive for influenza or another respiratory virus should be excluded from the home until afebrile without the use of fever-reducing medication and symptoms have been resolving for at least 24 hours (48 hours if GI symptoms).

Influenza and Other Acute Respiratory Infection (ARI) Contact Management

All resident close contacts should be monitored twice daily for symptoms. Should symptoms develop, promptly isolate the resident on Additional Precautions and testing for COVID-19 and other respiratory viruses. Should the resident close contact be taking influenza antiviral prophylaxis as part of outbreak management, consideration should be given to switch empirically to treatment dosage of influenza antivirals if symptoms develop.

Influenza and Other Acute Respiratory Infection (ARI) Outbreak Management

In addition to the outbreak management recommendations outlined above, antiviral prophylaxis should be started as soon as an influenza outbreak is declared and continued until the outbreak is over. Consider a cautious approach to starting antiviral prophylaxis should be considered if suspect ARI definition is met (e.g., consider initiating when one lab-confirmed influenza case in a resident or in the context of co-circulation of influenza and COVID-19 in the same unit/area).

For further details on the use of antiviral medication for prophylaxis in an outbreak, please refer to:

- PHO's Antiviral Medications for Seasonal Influenza
- MOH's Control of Respiratory Infection Outbreaks in Long-Term Care Homes (2018)

Considerations for Management of Mixed Outbreaks in LTCHs and RHs

In the context of one or more residents testing positive for COVID-19 and one or more residents testing positive for influenza, a cautious approach is warranted. The following recommendations may be considered, at the discretion of the PHU:

- All additional symptomatic residents and staff may be considered for FLUVID testing (beyond the first 4 MRVP+). PHUs are to contact PHOL.

- Influenza antiviral prophylaxis should be initiated for all asymptomatic residents and residents who are COVID+/influenza negative until the influenza outbreak is declared over.
- For COVID-19 positive residents, both Tamiflu and Paxlovid can be given at the same time; however, given potential drug-drug interactions, the decision to initiate treatment is at the discretion of the treating physician.

Diagnostic Testing for ARI/Mixed Outbreaks in LTCHs and RHs

- All symptomatic residents and staff should be tested for COVID-19 and other respiratory pathogens as soon as symptoms present.
- PHO's laboratory has expanded the eligibility for outbreak-related respiratory virus FLUVID (influenza A, influenza B, RSV, and SARS-CoV-2) PCR testing to **all** specimens from symptomatic residents and staff.
- In general, it is recommended that outbreak testing be guided by clinical and epidemiological risk factors for the purposes of active case finding. Point prevalence testing may be done at the discretion of the PHU to guide assessment and management in the context of a new (sub)variant or an especially challenging/prolonged outbreak, however, if done, it is recommended that asymptomatic individuals not be required to remain in isolation pending test results.
- PHUs are responsible for following usual outbreak notification steps to PHO's laboratory to coordinate/facilitate outbreak testing and ensuring an outbreak number is assigned. See PHO's Respiratory Outbreak Testing Prioritization protocol for details.

Declaring the Outbreak Over

- Information on declaring the outbreak over can be found in Appendix 1 of the Infectious Diseases Protocol: Diseases caused by a novel coronavirus, including Coronavirus Disease (COVID-19), Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).

COVID-19 Case, Contact, and Outbreak Management for CLSs

This section applies to higher risk CLSs within the meaning of "institution" in subsection 21(1) of the HPPA.

PHUs may provide outbreak management using principles outlined in this document to other CLSs that are not designated as an "institution" under the HPPA but provides residential services to individuals who are medically and/or socially vulnerable to COVID-19 when within their capacity to do so.

Management of Symptomatic Individuals:

- Any client who is exhibiting signs or symptoms consistent with COVID-19 should be self-isolated and tested for COVID-19. Molecular testing remains the preferred test for symptomatic individuals associated with a highest risk setting. Ideally, rapid antigen tests (RATs) should not be used for symptomatic clients, however, if they are used, parallel molecular testing should be done to confirm results.
- Symptomatic clients should self-isolate away from others while awaiting test results, ideally in a single room with access to a private washroom. Where this is not possible, symptomatic individuals should be encouraged to physically distance least 2 metres away from others as much as possible and wear a well-fitting medical mask, if tolerated, around others while within the setting.
- When a staff or visitor is symptomatic, they should be directed to leave the setting immediately and self-isolate at their own home. If they test positive for COVID-19, they should self-isolate until symptoms have been improving for 24 hours (48 hours if gastrointestinal symptoms) and no fever present.
    - Visitors: For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, visitors should avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., seniors) and avoid non-essential visits to highest-risk settings such as hospitals and long-term care homes. Where visits cannot be avoided (e.g., essential caregiver visits), visitors should wear a medical mask, maintain physical distancing, and should notify the setting of their recent

illness/positive test. If the individual being visited can also wear a mask, it is recommended they do so.

- Staff: For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, staff should adhere to workplace measures for reducing risk of transmission (e.g., masking for source control, not removing their mask unless eating or drinking, distancing from others as much as possible) and avoid caring for patients/residents at highest risk of severe COVID-19 infection, where possible.

Case Management

- If the case **lives** in a CLS, they should:
  - isolate in the setting (i.e., in a separate room away from others, with access to a private washroom or disinfection of a shared bathroom between users) so as to limit the transmission of COVID-19 to others who work/reside in that same setting,
  - Remain isolated for **at least 5 days** after the onset of symptoms or date of specimen collection (whichever is applicable/earlier), and until the case has no fever and symptoms are improving for 24 hours (48 hours for gastrointestinal symptoms).
  - A client may also isolate away from the setting if alternative isolation facilities are available.
  - Until at least day 10 from symptom onset/positive specimen collection date (whichever is applicable/earlier), resident cases should continue to wear a well-fitted mask at all times. Exceptions include eating and sleeping, during which times the individual should maintain physical distancing where possible.
- Setting-specific guidance only applies to individuals when they are physically present in the CLS. For individuals who leave the setting (e.g., for work, school, other purposes), public health measures and any other setting-specific guidance applies when they are outside of the setting. This means that an individual may still be required to isolate away from others in their living situation (e.g., shelter, group home), but once they are afebrile and their symptoms have been

improving for 24 hours (or 48 hours if gastrointestinal symptoms), they can resume attending other settings in the community with precautions of masking and avoiding vulnerable individuals and other highest-risk settings for 10 days from their symptom onset or date of positive specimen collection. They should also avoid coming into contact with anyone who is at higher risk of severe complications from COVID-19 (e.g., immunocompromised and/or elderly) for 10 days from symptom onset or date of specimen collection (whichever is applicable/earlier).

- CLSs should ensure that clients who test positive for COVID-19 have access to the following, as applicable:
    - Medical care, including Paxlovid or other approved COVID-19 therapeutics, if eligible. For more information on eligibility, please see Ontario's COVID-19 antiviral treatment screener.
    - Routine medications, as applicable.
    - Mental health supports, as applicable.
    - Harm reduction supplies, as applicable.

Contact Management:

- While in the CLS, all close contacts should wear a mask at all times (except for eating/sleeping and maintain a distance of at least 2 metres from other individuals) for 7 days from last exposure to the case.
- When outside of the CLS, close contacts may follow community guidance.
- All close contacts should self-monitor for symptoms, and promptly isolate and get tested for COVID-19 if symptoms develop.

Outbreak Management:

- Per HPPA requirements, any suspect or confirmed cases of COVID-19 must be reported to the local PHU. If CLSs have 2 or more residents who are positive for COVID-19 within **a 7-day period**, the PHU should provide further guidance and support.

- **A confirmed outbreak** in a CLS is defined as: two or more clients with a common epidemiological link, each with a positive molecular or rapid antigen test, within a **7-day period**.
- Outbreak management in CLSs should follow the principles for outbreak management in LTCHs and RHs, while recognizing that there are important differences in settings and making modifications where necessary.
- For further information on how to modify outbreak measures to the unique circumstances of a CLS, please see PHO's Checklist: Managing COVID-19 Outbreaks in Congregate Living Settings.

Occupational Health & Safety

- The *Occupational Health and Safety Act* (OHSA) requires employers to take every precaution reasonable in the circumstances for the protection of workers. 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 MLITSD website.

Staff Exposure/Staff Illness

- Staff who test positive for COVID-19 should report their illness to their manager/supervisor or to Occupational Health designate as per usual practice.
    - The manager/supervisor or Occupational Health designate must promptly inform the Infection Control Practitioner or designate of any cases or clusters of staff including contract staff who are absent from work.
    - Employers should help workers with symptoms and/or illness to self-isolate and support them through the process.
- Staff who have COVID-19 symptoms or are a high-risk household contact of someone who is COVID-19 positive should notify their manager/supervisor or Occupational Health designate in consultation with their health care provider.
    - Staff should report to Occupational Health designate prior to return to work. Detailed general occupational health and safety guidelines for COVID-19 are available on the MOH COVID-19 website and the MLITSD website.

- Symptomatic staff who decline testing should follow directions provided by their employer, manager/supervisor, and/or Occupational Health.
- Staff who are returning to work after illness must follow their sector-specific requirements or policy on Test to Work/return to work.

Reporting worker illness

- Workers who are unwell should report their illness-related absence to their supervisor or employer.

  In accordance with the Occupational Health and Safety Act (OHSA) and its regulations, if an employer is advised that a worker has an occupational illness or that a claim has been filed with the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker with respect to an occupational illness, the employer must provide written notice within four days to:

  - A Director appointed under the OHSA of the MLITSD.
  - The workplace's joint health and safety committee (or a health and safety representative).
  - The worker's trade union, if any.
- This may include providing notice for an infection that is acquired in the workplace.
- The information to include in a notice of occupational illness is prescribed by the Ontario Regulation 420/21: "Notices and Reports, under sections 51 to 53.1 of the Act – Fatalities, Critical Injuries, Occupational Illnesses and Other Incidents".
- In accordance with the Workplace Safety and Insurance Act (WSIA), the employer must also report any instance of an occupationally acquired disease to the WSIB within 72 hours of receiving notification of said illness.
- For more information, please contact the MLITSD:
  - Employment Standards Information Centre: Toll-free: 1-800-531-5551
  - Health and Safety Contact Centre: Toll-free: 1-877-202-0008
  - Reporting workplace incidents and illnesses | ontario.ca
- For more information from the WSIB, please refer to the following:
  - Telephone: 416-344-1000 or Toll-free: 1-800-387-0750.

Other resources:

- Please consult the MOH's COVID-19 website regularly for updates to this document, case definition, FAQs, and other COVID-19 related information.
- PHO has developed a number of sector-specific COVID-19 resources for LTCHs and RHs, including:
    - COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes.
    - Prevention and Management of COVID-19 in Long-Term Care Homes and Retirement Homes.
    - Technical Brief: Interim Infection Prevention and Control Measures Based on Respiratory Virus Transmission Risk in Health Care Settings
- PHO has developed a number of setting-specific COVID-19 resources for other CLSs, including:
    - COVID-19 Preparedness and Prevention in Congregate Living Settings.
    - COVID-19: Personal Protective Equipment (PPE) and Non-Medical Masks in Congregate Living Settings.
    - Managing COVID-19 Outbreaks in Congregate Living Settings.

Appendix A: Summary for Screening Practices for Settings

	General Visitors	Staff, Students, Volunteers, and Essential Visitors	Current Residents
What are the recommended screening practices?	• Provide individuals with information to monitor themselves for COVID-19 symptoms and inform them they are not permitted to enter the home if they are feeling ill. • Signage at entrances and throughout the home listing signs and symptoms of COVID-19, information on self-monitoring, and steps that must be taken if COVID-19 is suspected or confirmed. • All visitors entering the home should adhere to the home's visitor policies, where applicable.		• For LTCHs and RHs: Conduct symptom assessments of residents as per sector-specific guidance or legislation to identify if any resident has symptoms of COVID-19. For a list of signs and symptoms, refer to Appendix B. • For other CLSs: Clients/residents should be assessed at least once daily when the client client/resident is symptomatic, has tested positive for COVID-19, or is a close contact, in order to monitor new or worsening symptoms of COVID-19. • Symptom assessments should include temperature checks only if the resident is symptomatic, has tested positive for COVID-19, or has been exposed to COVID-19. • Residents returning from absence can be screened at their next daily symptom assessment rather than upon arrival.

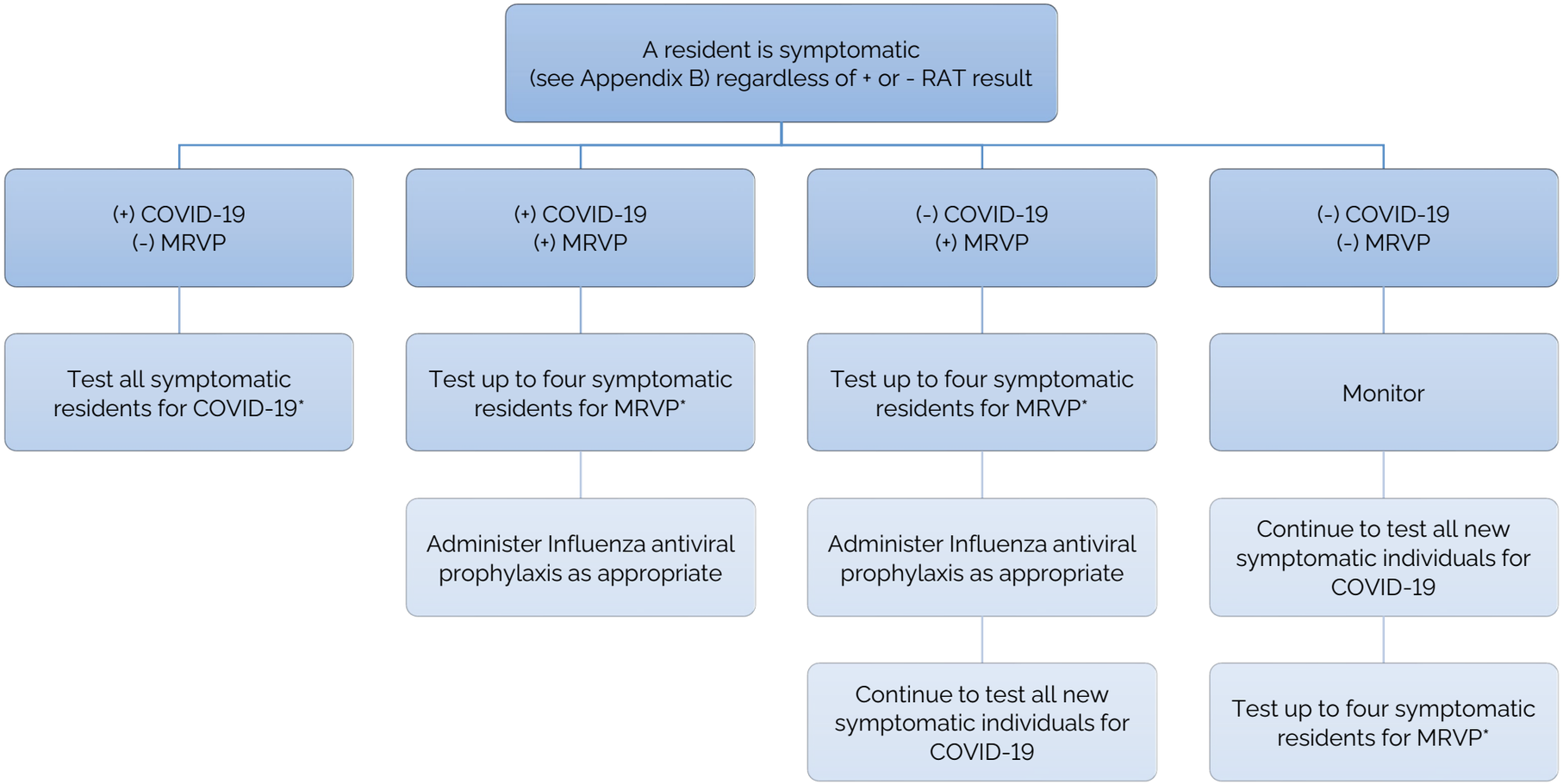
	General Visitors	Staff, Students, Volunteers, and Essential Visitors	Current Residents
What if someone does not pass screening (i.e., screens positive)?	Visitors who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive should: • Not enter the home • Be advised to follow public health guidance	Staff who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive should: • Not enter the home (unless on early return to work protocols), • Be advised to follow public health guidance	Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) should be self-isolated on Additional Precautions and tested. For a list of signs and symptoms, refer to Appendix B.

Appendix B: Clinical Presentation for Respiratory Tract Infections, including COVID-19

Adapted from the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018.

Respiratory Illness	Signs and Symptoms	
Upper respiratory illness (including common cold, pharyngitis) ** Not related to receiving a COVID-19 or influenza vaccine in the last 48 hours.	• Fever/abnormal temperature for the resident (typically ≥ 38°C) • Chills • Cough • Shortness of breath • Decreased or loss of taste and/or smell • Fatigue, tiredness, and/or malaise ** • Muscle aches and pain (myalgia) **	• Headache • Pink eye (conjunctivitis) • Runny nose (rhinorrhea) • Stuffy nose (nasal congestion) • Sore throat, hoarseness or difficulty swallowing • Abdominal pain, nausea, vomiting, and/or diarrhea • Decreased or loss of appetite
Lower respiratory illness (bronchitis, bronchiolitis)	• New or increased cough; • New or increased sputum production; • Abnormal temperature for the resident, or a temperature of ≤35.5˚C or ≥37.5˚C; • Pleuritic chest pain; • New physical findings on examination (rales, rhonchi, wheezes, bronchial breathing);	• One of the following to indicate change in status or breathing difficulty: o new/increased shortness of breath; o respiratory rate >25/minute; • Worsening functional or mental status (deterioration in resident's ability to perform activities of daily living or lowering of their level of consciousness).
Pneumonia	• Interpretation of a chest x-ray as pneumonia, probable pneumonia, or presence of infiltrate. • The resident must have at least two of the signs and symptoms described under lower respiratory tract infection. • Other non-infectious causes of symptoms, in particular congestive heart failure, must be ruled out.	

Appendix C: Algorithm for Testing and Management of Acute Respiratory Illness in Settings



* FLUVID, detecting influenza A, influenza B, respiratory syncytial virus (RSV) A/B) and SARS-CoV-2 (COVID-19), will be performed on symptomatic residents and healthcare workers/staff in institutional settings in an outbreak beyond the first four that have been tested for SARS-CoV-2 and MRVP.

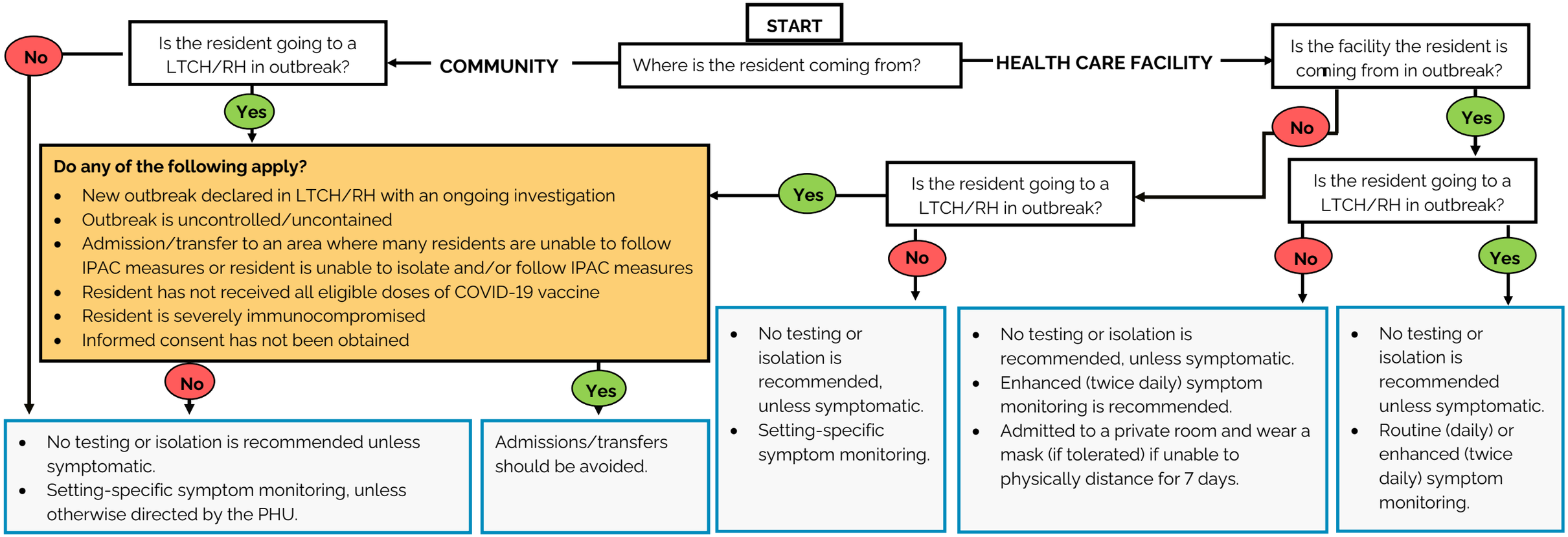
Appendix D: Instructions for COVID-19 Cases and Close Contacts Associated with LTCHs, RHs, and CLSs

Scenario	Self-Isolation Period	Additional Instructions
LTCH/RH resident case if able to independently and consistently wear a mask	At least 10 days after the date of specimen collection or symptom onset (whichever is applicable/earlier), and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	After day 5, if the resident is asymptomatic or their symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present, the resident: • May routinely participate in communal areas/activities but must wear a well-fitted mask at all times when outside of their room; and • May not participate in communal activities where they would need to remove their mask within the setting (e.g., group dining).
LTCH/RH resident case if unable to mask	At least 10 days after the date of specimen collection or symptom onset (whichever is applicable/earlier), and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	Residents are able to leave their room for walks in the immediate area with a staff person wearing appropriate PPE, to support overall physical and mental well-being.

Scenario	Self-Isolation Period	Additional Instructions
LTCH/RH resident asymptomatic close contact	Roommate close contacts: isolate and place on Additional Precautions. Individuals who remain asymptomatic may discontinue isolation after a minimum of 5 days of isolation (based on 5 days from when the case became symptomatic or tested positive if asymptomatic). All other close contacts do not need to self-isolate if asymptomatic, but should follow Additional Instructions for risk reduction measures.	For a total of **7 days** after last exposure to the COVID-19 case (or individual with symptoms): • Daily monitoring for symptoms; • Wear a well-fitted mask, if tolerated, and physically distance from others as much as possible when outside of their rooms; and • Not visit other (unaffected) areas of the home or interact with residents who have not been exposed.
CLS client case	While in the setting: Isolate at least 5 days after the date of specimen collection or symptom onset (whichever is applicable/earlier), and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present. When outside the setting: follow community guidance.	For a total of **10 days** after date of specimen collection or symptom onset (whichever is earlier/applicable): • Wear a well-fitted mask, if tolerated, and physically distance from others as much as possible while in the setting.
CLS client asymptomatic close contact	Does not need to self-isolate if asymptomatic.	For a total of **7 days** after last exposure to the COVID-19 case (or individual with symptoms): • Daily monitoring for symptoms; and • Wear a well-fitted mask, if tolerated, and physically distance from others as much as possible in common areas of the setting.

Scenario	Self-Isolation Period	Additional Instructions
LTCH/RH/CLS staff case	Follow community guidance when community settings outside of the LTCH/RH/CLS.	Staff may return to work if they are afebrile and their symptoms have been improving for 24 hours (48 hours if vomiting/diarrhea). For a total of **10 days** after date of specimen collection or symptom onset (whichever is earlier/applicable), staff should: • Strictly adhere to workplace measures for reducing risk of transmission (e.g., masking for source control, not removing their mask unless eating or drinking, distancing from others as much as possible); and • Avoid caring for patients/residents at highest risk of severe COVID-19 infection, where possible.
LTCH/RH/CLS visitor case	Follow community guidance when community settings outside of the LTCH/RH/CLS.	• For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, visitors should avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., seniors) and avoid non-essential visits to highest-risk settings such as hospitals and long-term care homes. • Where visits cannot be avoided, visitors should wear a medical mask, maintain physical distancing, and notify the setting of their recent illness/positive test. If the individual being visited can also wear a mask, it is recommended they do so.
LTCH/RH/CLS staff and essential visitor/caregiver asymptomatic close contact	Does not need to self-isolate if asymptomatic.	• Where feasible, additional workplace measures for individuals who are self-monitoring for 10 days from last exposure may include: o Active screening for symptoms ahead of each shift, where possible o Individuals should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e., not eating meals/drinking in a shared space such as conference room or lunch room.) o Working in only one facility, where possible; o Ensuring well-fitting source control masking for the staff to reduce the risk of transmission (e.g., a well-fitting medical mask or fit or non-fit tested N95 respirator or KN95).

Appendix E: Algorithm for New Admissions and Transfers for LTCHs and RHs



Important Reminders:

- COVID-19 testing is **not** required or recommended for the transfer of a resident from a hospital to a LTCH or RH.
- PHU approval is not required for admissions/transfers, but PHU consultation is recommended when IPAC advice or risk mitigation assistance is needed.
- Consultation with the PHU is recommended in the following situations:
    - The resident is from a health care facility in outbreak and is going to a LTCH/RH not in outbreak and there are concerns with compliance with IPAC measures.
    - The resident is from the community or a health care facility not in outbreak and going to a LTCH/RH in outbreak and any of the criteria in the yellow box above apply.