Ontario

Ministry of Health

COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units

Version 4 – February 3, 2022

Highlight of Changes:

- Updated confirmed outbreak definition
- Updates to the Management of Contacts section:
    - Definitions for high-risk contacts and lower-risk contacts
    - Details for how to identify and manage contacts
- Additional guidance provided on cohorting during outbreaks
- Clarity on admissions and transfers, particularly for admitting/transferring residents TO a home with an outbreak
- Appendix E: Algorithm for Admissions and Transfers for LTCHs and RHs
- Appendix F: Algorithm for Managing Contacts in LTCHs and RHs

This guidance document provides information for local public health units (PHU) to support their COVID-19 response in long-term care homes (LTCHs) and retirement homes (RHs). It is not intended to take the place of medical advice, diagnosis or treatment, or legal advice or requirements.

- **Note:** In addition to COVID-19, common viral pathogens that are traditionally responsible for respiratory infection outbreaks in LTCHs and RHs are also currently circulating in Ontario. These viruses include, but are not limited to, entero/rhinovirus, respiratory syncytial virus (RSV), and influenza virus. Where appropriate, this version of the guidance has incorporated strategies to prevent and manage these non-COVID-19 viral pathogens. However, for more detailed information on this topic, please refer to the MOH's Control of Respiratory Infection Outbreaks in Long-Term Care Homes, which is the foundational document for respiratory outbreak-related guidance in LTCHs.

This guidance is intended to complement and provide interpretation of the requirements set forth in Directive #3 for Long-Term Care Homes. To this end, this document provides guidance to PHUs on:

1. The implementation of the required infection prevention and control measures under Directive #3;
2. COVID-19 testing and self-isolation requirements for admissions and transfers; and
3. COVID-19 case, contact, and outbreak management in these settings.

Specific guidance and operationalization of these requirements vary between LTCHs and RHs due to the inherent differences between these two sectors. 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.

In accordance with subsection 27(5) of O. Reg 166/11 made under the *Retirement Homes Act, 2010*, all RHs are required to take all reasonable steps to follow the requirements of Directive #3.

For LTCH, where directives, policies or guidance that apply to a LTCH are issued by the Office of the Chief Medical Officer of Health, the Minister of Long-Term Care or Ministry of Long-Term Care (MLTC), such directives, policies or guidance apply despite anything in O. Reg 263/20 and O. Reg 364/20 under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* (ROA). In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health, Minister of Long-Term Care, or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

The updates in this guidance document are based on the scientific evidence and public health expertise available so far across Canada and abroad and are subject to change as the knowledge of COVID-19 vaccines and immunity evolve over time.

Other resources:

- Please consult the Ministry of Health's (MOH) COVID-19 website regularly for updates to this document, case definition, FAQs, and other COVID-19 related information.
- Please check the Directives, Memorandums, and Other Resources page regularly for the most up to date Directives.
- Public Health Ontario (PHO) has developed a number of LTCH and health care sector-specific resources on COVID-19, including:
    - Infection Prevention and Control for Long-Term Care Homes: Summary of Key Principles and Best Practices.
    - 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.

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 **"home"** is used to include a long-term care home (LTCH) and retirement home (RH).
- For this document, the term **"staff"** is used to include anyone conducting work activities in LTCHs or RHs, regardless of their employer. This includes, but is not limited to:
    - Staff employed by the home (e.g., health care workers, support staff),
    - Health care workers seeing a single resident for a single episode,
    - Temporary and/or agency staff,
    - Students on placement (e.g., nursing students), and
    - Volunteers.
- The term "**self-isolation**" has been commonly used in the public discourse during the pandemic and, for ease of understanding, is used in this document refer to both **quarantine** (separating individuals who have been exposed from

others) and **isolation** (separating individuals who are infected from others who are not sick).

- **Additional Precautions** refer to those precautions that are necessary in addition to routine practices for certain pathogens or clinical presentations and are based on the method of transmission. Additional precautions include Contact Precautions, Droplet Precautions and Airborne Precautions. In comparison, routine precautions are a system of Infection Prevention and Control (IPAC) practices that is to be used with all clients/patients/residents during all care to prevent and control transmission of microorganisms in all health care settings.*

* Definition adapted from: Ontario Agency for Health Protection and Promotion, Provincial Infectious Diseases Advisory Committee. Routine Practices and Additional Precautions in All Health Care Settings. 3rd edition. Toronto, ON: Queen's Printer for Ontario; November 2012.

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Roles and Responsibilities

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 MLTC, and the Ministry for Seniors and Accessibility (MSAA).

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, the COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance, and the COVID-19Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge.
- 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 MLTC and/or MSAA 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 home, MLTC/ Retirement Homes Regulatory Authority (RHRA), 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 LTCH/RH.
    - Any orders issued by the PHU's medical officer of health or their designate to the LTCH/RH 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 to PHUs and their Boards of Health.
- Issue guidance to PHUs on the management of COVID-19 cases, contacts, and outbreaks, and provide clear expectations of PHUs' roles and responsibilities.
- Provide ongoing support to PHUs with partner agencies, ministries, health care professionals, and the public, as necessary.
- Support PHUs during investigations, through the MEOC and/or the Office of the Chief Medical Officer of Health (OCMOH), with respect to coordination, policy interpretation, communications, etc. as requested.
- Support and coordinate teleconferences, if needed, via the MEOC.
- Receive notification through the MEOC:
    - 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 home.

Role of MLTC and MSAA/RHRA

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

- Support the procurement of supplies of personal protective equipment (PPE).

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, programs, and approaches to inform the supports provided by IPAC Hubs.
- Provide advice and support to IPAC Hubs to expand pre-existing IPAC networks.
- 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 long-term care home (LTCH) and the retirement home (RH)

- All homes are required to report that a person is or may be infected with an agent of a communicable disease to their local PHU, as per subsection 27(2) of the HPPA.
    - COVID-19 is a designated disease of public health significance and a communicable disease (O. Reg. 135/18). As such, all suspected and confirmed cases of COVID-19 are reportable to the local PHU under the HPPA.
    - LTCHs are required to immediately report any COVID-19 case or outbreak (suspected or confirmed) to the 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 107 of O. Reg 79/10 under the *Long-Term Care Homes Act, 2007.*
    - RHs are required to report any outbreak to the Retirement Homes Regulatory Authority, at the same time that the outbreak is reported to the local PHU.
- All homes, as employers under *Occupational Health and Safety Act, 1990* (OHSA) and its regulations, have a duty to take every precaution reasonable in the

circumstances for the protection of a worker. This includes protecting workers from the hazards of infectious diseases.

- Under OHSA, an employer must provide written notice to the Ministry of Labour, Training and Skills Development (MLTSD) within four days of being advised that a worker has an occupational illness and under the *Workplace Safety and Insurance Act, 1997* (WSIA), must report to Workplace Safety Insurance Board (WSIB) and to relevant trade union, if any, within 72 hours of receiving notification of said illness.
- Implement prevention measures found in guidance or as directed by the MOH, MLTSD, and their local PHU, as well as MLTC (including Directives issued by Minister of Long-Term Care) and/or MSAA as applicable.
- Coordinate with the local PHU and other stakeholders as appropriate, as part of the investigation of cases, contacts, and outbreaks.
- Maintain accurate records of staff attendance, all visitors, and resident information.
    - Records of staff attendance and visitor logs must be kept for the last 30 days, as well as up to date contact information for staff and visitors.
    - This information should be available to be accessed and shared with the local PHU in a timely manner (within 24 hours) for investigations and communications.
    - Facilitate access for PHUs to staff lists for staff not directly employed by the home (e.g. third party/temporary agency workers).
    - Keep a log of all visitors (i.e., essential visitors including caregivers, general visitors) who enter the home, location(s) visited and dates/times of visit to facilitate contact follow-up if needed.
    - Provide PHU with the 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 cases, contacts and outbreaks.
    - In collaboration with the PHU, communicate proactively with the home's staff, visitors, residents, and the resident families about COVID-19 prevention measures and about how ill individuals, cases, contacts and outbreaks will be handled.
- Provide training to home staff, including temporary/agency staff and staff/volunteers from external partners, with respect to outbreak prevention and

control measures, including IPAC measures and the use of personal protective equipment (PPE).

- Follow the directions of the local PHU if any staff or residents have COVID-19, are exposed to someone with COVID-19, or if there is a suspect or confirmed outbreak in the home.
- Encourage/support COVID-19 vaccination by providing education to workers.

Role of Ontario Health

- Coordinate local planning among health system partners for testing to ensure the availability of testing resources.
- Deploy testing resources and modalities to meet the testing needs identified by the PHU and the home.
- Collaborate with the PHU and the homes to monitor testing demands and access.
- Work with testing centres to optimize sample collection and distribution to reduce turnaround times.

Role of the IPAC Hubs

- Facilitate access to IPAC training and practice needs for LTCHs and RHs within their catchment area.
- Strengthen current partnerships with Homes in their catchment and broker new ones.
- Support a network of IPAC service providers and experts and work to align local resources to IPAC needs within LTCHs and RHs for both prevention and response.
- Bring forward and escalate issues of concern that are outside of the scope of IPAC through established mechanisms with ministry partners.
- Collaborate with PHO and other government and health system partners to strengthen IPAC programs reflecting field observations.
- Help to support homes with the implementation of outbreak control measures provided by the PHU or Outbreak Management Team.

Role of MLTSD

- Receive notice of an occupational illness from employers under subsection 52(2) of the OHSA. An occupational illness includes any condition that results from

exposure in a workplace to a physical, chemical or biological agent to the extent that normal physiological mechanisms are affected, and the health of the worker is impaired; and includes an illness caused by an infection from an exposure at the workplace.

- Investigate occupational illness notifications to determine if the employer is in compliance with the OHSA and its regulations and that appropriate measures have been taken to prevent further illnesses.
- Inspect workplaces to monitor compliance with the OHSA and its regulations.
- Investigate unsafe work practices, critical injuries, fatalities, work refusals and occupational illness, all as related to worker health and safety. This includes investigation of reports of COVID-19 by employers to MLTSD.
- Issue orders under the OHSA and its regulations.
- The MLTSD Health and Safety Contact Centre (1-877-202-0008) is available for anyone to report health and safety concerns or complaints.
- While this document focuses in part on the role of the MLTSD's health and safety program, the ministry also administers the *Employment Standards Act, 2000*. If workplace parties request information regarding employment standards, they can be referred to the Employment Standards Information Centre: 1-800-531-5551.

Role of external partners

- This includes external organizations who are engaged or brought on to assist with a home's outbreak response including, but not limited to, the Canadian Red Cross.
- Inform the PHU and the home of their engagement to assist with the home's outbreak response.
- Follow the direction of the PHU and assist in the outbreak response as advised by the PHU.
- Follow the direction of the IPAC hubs and assist IPAC hubs as part of the overall outbreak response (e.g., auditing, training, reinforcing of IPAC practices).

Prevention of Disease Transmission

Homes can help prevent and limit the spread of COVID-19 and other common respiratory viruses by ensuring that general IPAC practices (e.g., hand hygiene and respiratory etiquette) are in place while also respecting the physical, mental,

emotional, and psychosocial well-being of residents. Factors such as the physical/infrastructure characteristics of the home, staffing availability, and the availability of and training on personal protective equipment (PPE) should all be considered when developing home-specific policies.

The measures outlined below should be carried out at all times regardless of the COVID-19 situation in the home and may also help to protect against non-COVID-19 common respiratory virus infections and outbreaks.

IPAC Audits

- Per Directive #3, homes must follow this document for detailed requirements and information regarding IPAC audits.
- Pursuant to section 86 of the *Long-Term Care Homes Act, 2007* (LTCHA) and section 60 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.
- Each home must have individual(s) who are responsible for an IPAC program in the home.
    - For LTCHs, also refer to O. Reg. 79/10, s 229 and Ministry of Long-Term Care Infection Prevention and Control (IPAC) Program Guidance for additional requirements for the IPAC program.
- IPAC audits are an integral component of a home's IPAC program that enable homes to:
    - Meet their minimum requirements under applicable legislation, regulations, and Directive #3;
    - Increase the home's awareness and consistency in application of best practices in IPAC measures;
    - Assess their staff's knowledge and ability to implement IPAC measures; and,
    - Identify any gaps for further improvement through a continuous quality improvement process.
- The individual(s) responsible for the home's IPAC program is also responsible for conducting IPAC self-audits at regular intervals in a supportive learning environment in order to normalize and promote IPAC best practices into the home's day-to-day operations and culture.
    - As per Directive #3, homes must conduct self-audits every two weeks when the home is not in an outbreak and every week during an outbreak.

  - At minimum, homes must include in their self-audit PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes
  - Results of the IPAC self-audit should be kept for at least 30 days and shared with inspectors from the PHU, MLTSD, and MLTC for LTCHs and the RHRA for RHs upon request.
- Homes must take action based on the results of the IPAC self-audit to ensure ongoing quality improvement and proper IPAC practices in the home. They should connect with external partners (e.g., PHUs, IPAC Hubs, PHO Regional teams) for further resources and assistance as appropriate.
- PHUs should ensure that homes are regularly conducting audits and ensuring that they are connected with appropriate supports to set homes up for success, including but not limited to IPAC hubs and other health system partners.

Vaccination

- **PHUs are asked to continue to support COVID-19 vaccination in the LTCH/RH sectors in collaboration with the home and relevant health system partners.** This includes assisting LTCHs with implementing the Minister's Directive: Long-Term Care Home COVID-19 Immunization Policy and RHs with implementing the Letter of Instructions issued by the Office of the Chief Medical Officer of Health.
  - Where possible, this includes assisting homes with on-site vaccination and supporting hospitals to vaccinate individuals if they are being admitted to a LTCH/RH from hospital.
- **COVID-19 vaccination** is one of the most important public health measures to help prevent infection and transmission, and it is the most effective way to help prevent severe illness and death due to COVID-19.
  - New admissions to LTCHs and RHs who have not yet received a COVID-19 vaccine in the community or hospital should be offered a complete series of a COVID-19 vaccination, or their remaining eligible doses, as soon as possible.
- **Influenza vaccination:** All staff, visitors, and residents of LTCHs and RHs 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.

- Residents may also be eligible for the pneumococcal, tetanus and diphtheria vaccines in accordance with Ontario's publicly funded immunization schedule.

Active Screening for Anyone Entering the Home

- Directive #3 requires homes to ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home, including for outside visits.
- Active screening is required regardless of one's COVID-19 vaccination status and prior to permitting the entry (including for outside visits) of:
    - All staff, including students, and volunteers;
    - Essential and general visitors;
    - Residents returning from an absence; and
    - All other persons.
- As per Directive #3, first responders in emergency situations are exempt from this requirement and must be permitted entry.
- Homes should have a screener at the entrance who is able to conduct active screening during business hours and change of shift. Outside of these times, the home's charge nurse/administrator should develop processes and procedures to ensure that all persons entering the home are screened and visits are logged. In either case, homes must ensure that screening occurs in accordance with all applicable legal requirements, including Directive #3 for Long-Term Care Homes and the Minister's Directive: COVID-19 – Long-Term Care Home Surveillance Testing and Access to Homes.
- Homes may use mobile apps or other tools to facilitate the active screening process. However, the active part of the screening process requires the individual being screened to interact with the screener prior to being permitted entry.
    - For example, a staff may complete an online screening tool and have their results be sent electronically to the screener or demonstrate their results to the screener prior to entry to fulfill the interactive component.
- At a minimum, homes must ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes.
    - Temperature checks as part of active screening at entry are no longer required by Directive #3.

- A summary chart of screening practices can be found in Appendix A.
    - For symptoms, refer to the COVID-19 Reference Document for Symptoms.

Daily Symptom Assessment of Residents

- Per Directive #3, homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks. The purpose of this practice is to identify ***any* new or worsening symptoms** that may be indicative of an acute respiratory infection including COVID-19.
    - Homes are strongly encouraged to conduct symptom assessment more frequently (e.g., at every shift change), especially during an outbreak to facilitate early identification and management of ill residents.
    - This can take place at the same time as routine vital signs check, where applicable.
    - All residents being admitted or transferred to a home must undergo twice daily symptom screening for 10 days following arrival.
- Homes should be aware that elderly individuals may present with subtle or atypical signs and symptoms of COVID-19. As much as possible, it is important for homes to understand a resident's baseline health and functioning and ensure routine monitoring of their status to facilitate early identification and management of ill residents.
- See Appendix B for a list of acute respiratory symptoms for different respiratory outbreak-associated viruses including COVID-19.

Passive Screening and Signage

- Homes should post signage that list the signs and symptoms of COVID-19 for self-monitoring and provide steps that must be taken if COVID-19 is suspected or confirmed in a staff member, visitor, or a resident. A list of COVID-19 symptoms, including atypical symptoms, can be found in the COVID-19 Reference Document for Symptoms.
- Homes should also post signage throughout the home to remind all persons in the home to physically distance, wear their masks, perform hand hygiene, and follow respiratory etiquette as per routine measures for respiratory season.

Asymptomatic Testing

- This refers to the practice of routinely testing asymptomatic individuals who are neither experiencing COVID-19 symptoms nor have been exposed to a known

COVID-19 case. The rationale for this type of testing is to create an additional layer of protection, in addition to active screening, through the early identification and management of asymptomatic cases. **This does not replace, and should not supersede, routine IPAC practices nor is it equivalent to diagnostic testing** (see Management of Symptomatic Individuals, below)**.**

- Per Directive #3:
    - LTCHs must follow the requirements in the Minister of Long-Term Care's Directive: COVID-19 – Long-Term Care Home Surveillance Testing and Access to Homes effective January 27, 2022 or as amended; and,
    - RHs must follow the requirements in the Instructions issued by the Office of the Chief Medical Officer of Health effective December 24, 2021 or as current.
- For more information on rapid antigen testing, please refer to COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge.
- PHUs should advise homes of the benefits and the limitations associated with the COVID-19 testing platforms available. For example, individuals who have previously been diagnosed with and cleared of COVID-19 infection recently may continue to test positive for COVID-19 for several weeks even though they are no longer infectious, particularly on PCR testing.

Screening Outcomes: What to do

- If a staff or a visitor is showing symptoms of COVID-19 at screening or has not passed the screening for other reasons, they must not be allowed to enter the home. They should be instructed to self-isolate immediately and be encouraged to get a COVID-19 PCR test (as applicable).
    - Refer to Directive #3 for the exceptions for individuals who fail screening and may be permitted to enter the home under certain conditions.
- Any staff who does not pass their screening should contact their immediate supervisor(s)/manager(s) or the relevant Occupational Health staff in the home.
    - Staff responsible for occupational health in the home should follow up with all staff who have been screened positive to provide advice on work restrictions.

    - Staff with post-vaccination related symptoms may be exempt from exclusion from work as per the Managing Health Care Workers with Symptoms within 48 Hours of Receiving COVID-19 Vaccine guidance.

- Staff who are on early return to work as part of management of critical staffing shortages must follow the protocols and requirements for early return to work as outlined in Directive #3, Interim Guidance Omicron Surge Management of Critical Staffing Shortages in Highest Risk Settings, and their sector-specific requirements or policy on Test to Work/early return to work, including:
    - MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario effective January 14, 2022 or as current.
    - The RHRA's Retirement Homes Policy to Implement Directive #3, effective January 26, 2022 or as current.
- Residents with symptoms compatible with an acute respiratory infection including COVID-19 (see Appendix B) or those who have not passed active screening on return to the home following an absence must be placed in self-isolation on additional precautions and tested. See Management of Symptomatic Individuals, below.

Hand Hygiene

- Access to handwashing stations and/or alcohol-based hand sanitizers should be available at multiple, prominent locations in the home, including entrances and common areas to promote frequent hand hygiene.
- All staff, visitors, and residents should be reminded through training and signage to:
    - Clean hands by washing with soap and water or using an alcohol-based (70%-90% alcohol) hand sanitizer.
    - Wash hands with soap and water if hands are visibly dirty.
    - If gloves are being used, perform hand hygiene prior to putting on gloves.
    - After use, gloves should be placed in the garbage. After removing them, clean hands again.
- Homes should ensure adequate supplies are maintained.

Physical Distancing

- As per Directive #3, homes must ensure that physical distancing (a minimum of 2 metres or 6 feet) is practiced by all individuals at all times, except for the

purposes of providing direct care to a resident(s). Additionally, please refer to following documents for sector-specific exceptions for physical distancing.

  - **LTCHs** must follow MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective January 14, 2022 or as current.
  - **RHs** must follow RHRA's Retirement Homes Policy to Implement Directive #3, effective January 26, 2022 or as current.

- In instances where physical distancing is not possible (e.g., in the provision of direct care), staff, caregivers, and/or visitors must wear appropriate PPE based on the nature, duration, and type of interaction and in accordance with all applicable legal requirements (e.g., Directive #3, Directive #5).
- In instances where physical contact is permitted (e.g., between a resident and a fully vaccinated caregiver), staff, caregivers, and/or visitors must continue to practice hand hygiene and masking. Physical distancing from other staff, residents and visitors must be maintained.
- Homes must continue to reconfigure physical space and modify activities to optimize and support physical distancing. This includes:
  - Posting signage in common areas re: maximum capacity;
  - Moving furniture around or removing unnecessary furniture/equipment;
  - Placing visual markers on the floor to guide physical distancing;
  - Reviewing opportunities to reduce the number of staff present together at the same time within break facilities and common areas; and
  - Reviewing opportunities to consolidate and streamline residents' medication administration schedules as much as possible to minimize the number of times staff need to enter a resident's room.

Masking

For staff and essential visitors:

- Per Directive # 3, homes must ensure that all staff and essential visitors wear a well-fitted mask for the entire duration of their shift/visit, both indoors and outdoors, regardless of their COVID-19 vaccination status. General visitors must wear a medical mask if indoors or a medical or non-medical mask if outdoors. This applies regardless of whether the home is in an outbreak or not. See Directive # 3 for the full set of masking requirements, as well as masking exceptions.

- Universal masking is required for the purpose of *source control* to help prevent the spread of potentially infectious respiratory droplets and aerosols of the person wearing the mask to others
- Universal masking means wearing a mask at all times, whether or not a home is in an outbreak and regardless of one's COVID-19 vaccination status. Physical distancing measures must be maintained even when wearing a mask.
- Homes should provide resources and training for staff, residents, and visitors on proper mask use (e.g., how to wear and remove a mask).
- For guidance on universal mask use, refer to Public Health Ontario (PHO)'s COVID-19: Universal Mask Use in Health Care and COVID-19: Universal Mask Use in Health Care Settings and Retirement Homes documents.

For residents:

- Residents are strongly recommended to wear medical masks in common areas or in communal spaces with others (e.g., when within 2 metres of others). Exceptions must be made when the resident is unable to wear a mask because they are being accommodated in accordance with the *Accessibility for Ontarians with Disabilities Act* and/or being reasonably accommodated in accordance with the *Human Rights Code.*
- As much as possible, residents who are on additional precautions due to COVID-19 (e.g., those who are a case or a close contact of a case) should wear a medical (surgical/procedural) mask during the provision of direct care, where masking is tolerated.
- Please refer to the following documents for sector-specific policies and exceptions for masking.
    - **LTCHs** must follow MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective January 14, 2022 or as current.
    - **RHs** must follow RHRA's Retirement Home's Policy to Implement Directive #3, effective January 26, 2022 or as current.

Personal Protective Equipment (PPE)

- PPE is intended to protect the wearer to minimize their risk of exposure to COVID-19.
- **The effectiveness of PPE depends on the worker wearing it correctly and consistently. The employer must train workers on the care, use and limitations**

of any PPE that they use. If manipulated or changed, PPE may not function to manufacturer's specification.

- In addition to source control, medical masks also serve as PPE for staff and essential visitors. Medical masks protect the person who is wearing the mask from becoming exposed to other people's potentially infectious respiratory droplets.
    - ASTM certified medical masks of any level are appropriate for this purpose.
    - Non-medical masks (e.g., cloth masks) cannot be used as PPE.
- Additional PPE may be required in specific situations. Choosing PPE, including the use of N95 respirators, should be guided by the nature, type, and duration of the intended interaction and by a point-of-care risk assessment.
    - See PHO's Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 for more information on PPE use.
- Eye protection is used to protect the wearer (specifically, their eyes/conjunctival mucosal membranes) from potentially infectious respiratory droplets and aerosols. Eye protection for PPE purposes includes face shields, some safety glasses, and goggles. When choosing eye protection, ensure that it is close fitting around the head and/or with integrated side shields to provide a barrier from the front, the sides, and the top. Use of eye protection is in addition to and does not replace the need for a medical mask or equal or greater protection (e.g., fit-tested N95 respirators).
    - Where eye protection is used, homes should establish appropriate procedures for cleaning and disinfecting of re-useable eye protection.
- Appendix C contains information on how to initiate PPE inquiries to the Ministry.
- Per Directive # 3, with respect to PPE, homes must follow COVID-19 Directive # 5 for Hospitals within the meaning of the *Public Hospitals Act* and Long Term Care Homes within the meaning of the *Long-Term Care Homes Act, 2007.* . Homes must also provide all health care workers, other staff and any essential visitors who are required to wear PPE with information and training on the care, safe use and limitations of that PPE, including training on proper donning and doffing.

Environmental Cleaning and Disinfection

- Per Directive # 3, homes are required to maintain regular environmental cleaning of their facility, among other requirements.
- Homes should be cleaned regularly (e.g., at least once a day). Cleaning should 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) should 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 home.
- Homes should establish appropriate procedures for cleaning and disinfecting Controlled Areas under the *Smoke-Free Ontario Act, 2017*. This includes implementing capacity limits (i.e., one user at a time), a waiting period of 15 minutes following use to allow aerosols from smoking or vaping to settle or ventilate out of the room, as well as cleaning and disinfecting the area between uses.
- Contact surfaces (i.e., areas within 2 metres) of the 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.

Ventilation and Filtration

- In general, ventilation with fresh air and filtration can improve indoor air quality and provide 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 appropriate and possible.
- 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.

- Portable fans should be avoided as these can increase dispersion of aerosols.
- Expert consultation may be needed to assess and identify priority areas for improvement and improve ventilation and filtration to the extent possible given HVAC system characteristics.
    - Ensure that HVAC systems are functioning properly through regular inspection and maintenance (e.g., filter changes).
    - For more information, see PHO's Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings and COVID-19.
    - Where ventilation is inadequate or mechanical ventilation does not exist, the use of portable air cleaners can help filter out aerosols.
- Ventilation and filtration are important for overall indoor air quality as they help to dilute or reduce potentially infectious respiratory droplets and aerosols in a given space over time while they operate. 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.

Resident Activities

Grouping of Staff and Residents in Non-Outbreak Settings

- In general (i.e., non-outbreak situations), assigning residents and staff into small groups for daily activities will help to minimize the potential number of high-risk contacts and to reduce the risk of transmission throughout the home in the event that the virus is introduced into the home.
    - These groups should be kept as consistent as possible and should not differentiate based on the COVID-19 vaccination status of the residents.
    - To the extent possible, residents should be grouped within a single floor/unit.
    - Group sizes should balance the psychosocial needs of the resident, the home's staffing needs, and take into consideration capacity limits for common areas and inclusion of essential caregivers as required. Homes should consult with their IPAC team and as needed, the local PHU.
- In general, staffing assignments should ideally be organized for consistent cohorting of staff to specific resident areas to limit interactions of staff to different areas of the home.
    - To the extent possible, staff should be cohorted to work on consistent floors/units even when the home is not in an outbreak.

  - Where possible, change rooms and break rooms should be on the floor to limit mixing of staff between floors/units.
  - Where full cohorting is not possible, partner specific floors/units to share change rooms and break rooms and cross-cover consistently when necessary, rather than staff mixing across the entire facility.

- Where staff are fully vaccinated and are working in multiple homes and/or health care facilities as per O. Reg 146/20 and O. Reg 158/20 made under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* (ROA) for LTCHs and RHs respectively,
  - Homes should maintain a list of all staff who are:
    - Fully vaccinated; and
    - Working at multiple sites.
  - Each home should work with the staff member to minimize the number of cohorts to which the staff member is assigned; and
  - Homes must continue to ensure strong adherence to IPAC practices in the home.

Cohorting in an Outbreak Setting

- Cohorting is an important part of an overall IPAC approach within a home to limit the potential transmission throughout the home in the event of an introduction of an infection even when a home is not in an outbreak. Please see section on Outbreak Management on cohorting principles for outbreak situations.
- Best practice is for staff who have worked in an outbreak setting in another facility (e.g., acute care, another LTCH or a RH) should not work in other facilities for the duration of the outbreak, regardless of their COVID-19 vaccination status. This is to limit the risk of COVID-19 transmission across homes/facilities.
  - Where this is not possible, staff should be assigned to also work in an outbreak area at the second location, be actively screened every day, and be rapid antigen tested every day.

COVID-19 Specific Policies and Procedures

As per Directive #3, all homes are required to have policies and procedures in place to ensure the implementation of strong IPAC controls and precautions that are balanced against residents' individual and collective self-determination, desires, and their need for social interaction, emotional, and physical support. In addition, homes need to have policies and procedures that are flexible and account for various scenarios, from where there is minimal risk of COVID-19 in the home and in the community to where there is a higher risk of COVID-19 in the home and the strictest measures are required to prevent and mitigate uncontrolled spread in the home. PHUs continue to have the discretion to modify or discontinue any activity in the home as part of their outbreak investigation and management.

Admissions and Transfers

- Per Directive #3, homes must follow this document for detailed requirements and information on testing and isolation of new admissions and transfers into the home.
- In general, admissions and transfers are permitted when the home is not in an outbreak and the resident is not on additional precautions due to symptoms, exposure, or diagnosis of COVID-19 to minimize the risk of infection transmission.
    - Admissions and transfers to a home in an outbreak and/or involving a resident who is on additional precautions may be considered in partnership with the local PHU and with respect to patient/resident safety, quality of care, and system capacity. There should be concurrence between the home, local PHU, and hospital. Refer to table 1 and Appendix E for more information.
- Admissions and transfers to an outbreak floor/unit should be avoided in the following circumstances, recognizing this may not always be possible:
    - 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 due to health or other reasons.

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

- If necessary, residents that were NOT exposed to COVID-19 at their home in outbreak prior to admission or transfer to the acute care facility or during their stay may be admitted or transferred to a floor/unit with an uncontrolled/uncontained outbreak, provided the following conditions are met:
    - Resident is fully vaccinated and boosted (3rd or 4th dose):
    - 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 resident should not face any unintended consequences in terms of home placement should the resident (or substitute decision-maker) choose not to consent;
    - Resident is admitted or transferred to a private room;
    - Resident is asymptomatic on discharge from the acute care facility; AND,
    - The resident can remain isolated until the outbreak is contained and the PHU has determined that the resident's isolation Precautions may be safely discontinued.
- Any resident being admitted or transferred, regardless of their COVID-19 vaccination status, who is identified as having symptoms, exposure, and/or diagnosis of COVID-19 must be self-isolated and placed on additional precautions at the home and managed as per the COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge in addition to the requirements below.
- **Enhanced admissions and transfers protocols due to the Omicron variant:** In light of emerging evidence suggesting a greater risk of COVID-19 re-infections with the Omicron variant, all residents who are being admitted or transferred to a home must undergo COVID-19 testing and be self-isolated on additional precautions, where applicable, **regardless of their COVID-19 vaccination status.**
    - **If the resident is coming from another LTCH, RH, or a health care facility that is NOT experiencing a COVID-19 outbreak at the time of transfer:** A laboratory-based COVID-19 PCR or rapid molecular test is required either prior to admission (i.e., within 24 hours of planned transfer) or on arrival (i.e., day 0). On arrival, the resident must be placed in self-isolation on additional precautions until a negative result is received. Refer to Table 1 below and Appendix E which includes a rapid antigen testing option for when timely PCR test results or rapid molecular tests are unavailable.
        - If the test is positive, see Case Management below.

- If the resident is being transferred from a health care facility that is in a COVID-19 outbreak, treat as a contact (see Contact Management, below).

- **If the resident is coming from the community:** A laboratory-based COVID-19 PCR or rapid molecular test is required on or after day 5, and the resident must be placed in self-isolation on additional precautions for a minimum of 5 days. A negative laboratory-based COVID-19 PCR test or rapid molecular result collected on or after day 5 is required to discontinue self-isolation on additional precautions. Refer to Table 1 below and Appendix E for rapid antigen testing options for when timely PCR test results or rapid molecular tests are unavailable.
- **If it is necessary for residents to be admitted or transferred to a home with a COVID-19 outbreak** in order to provide optimal care for residents or due to capacity issues, etc., Refer to Table 1 below and Appendix E for setting specific requirements for admissions and transfers.
    - 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 vaccinated and boosted (3rd or 4th dose):
        - 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.
    - The resident (and resident's family, where appropriate) should be advised of and consent to admission or transfer to a home (e.g., floor/unit) with a COVID-19 outbreak. They should receive information on the measures that are in place to reduce the risk of exposure in the home.
    - For admissions or transfers from an acute care facility, the discharging physician should agree to the admission or transfer to a home in outbreak.

- All residents being admitted or transferred to a home must undergo twice daily symptom screening for 10 days following arrival.

Table 1: Testing and Self-Isolation Requirements for Admissions and Transfers

Setting	Requirements
From a LTCH, RH, or a health care facility NOT in an outbreak	• Screen and isolate on arrival until a negative PCR or rapid molecular test result taken within 24 hours of admission/transfer • If timely PCR or rapid molecular results are unavailable: perform 2 RATs separated by 24 hours (i.e., day 0 and day 1) • In the event that molecular testing was also performed upon arrival and is positive, re-isolation is required based on the molecular result as the most accurate testing modality.

Setting	Requirements	
From a health care facility in an outbreak Admission or transfer should be considered in partnership with the local PHU, and there is concurrence between the home, the local PHU, and the health care facility	**Consultation with PHU is not required if the resident has:** Recovered from COVID-19 in the last 90 days* • Isolation not required; monitor for symptoms **OR** Been exposed to COVID-19 in their home prior to admission to the hospital and are still within their isolation period following exposure • Treat resident as a high-risk contact **OR** NOT been exposed to COVID-19 in their home prior to hospital admission or during their hospital stay. • Admitted to home not in outbreak. • Isolate on arrival until negative PCR or rapid molecular test results taken within 24hrs of admission of arrival (day 0) • If positive: manage as a case	**Consultation with PHU required if returning:** • COVID-19 positive resident to home NOT in outbreak • Symptomatic resident to home NOT in outbreak (without negative PCR result) • A well or COVID-19 negative resident from hospital to a home with an active (uncontrolled/uncontained) outbreak • Resident is unable to access a private room • Resident is not vaccinated and boosted (3rd or 4th dose) PHU to advise on isolation and testing

Setting	Requirements

From the community	**If resident is vaccinated and boosted (3rd or 4th dose):**
	• Screen and isolate on arrival until negative PCR or rapid molecular test result obtain from day 5 testing
	• A PCR or rapid molecular test required on or after day 5
	  o If positive: manage as a case
	  o If negative: isolation may be discontinued. Continue to monitor for symptoms
	• If timely PCR results are unavailable: perform 2 RATs separated by 24 hours (i.e., day 5 and day 6)
	If resident is not vaccinated and boosted (3rd or 4th dose):
	• Screen and isolate on arrival for 10 days
	• A PCR or rapid molecular test required on or after day 5
	  o If positive: manage as a case
	• If timely PCR results are unavailable: perform 2 RATs separated by 24 hours (i.e., day 5 and day 6)

Absences

- Any resident who is self-isolating on additional precautions is not permitted to break their self-isolation other than for medical and/or palliative/compassionate reasons. Homes should seek the advice of local PHU if self-isolation must be broken for these reasons.
    - Where a resident who is self-isolating on additional precautions is required to leave the home for a medical absence, homes should notify the health care facility so that care can be provided to the resident with the appropriate additional precautions in place.
- Homes must provide a medical mask to the resident (unless the resident falls under a masking exception) and remind them to follow public health measures, such as physical distancing and hand hygiene, while they are away from the home in order to minimize potential exposure to COVID-19.
- All residents, regardless of type or duration of the absence, must be actively screened upon their return to the home. For absences permitted and additional

requirements on return to the home, including COVID-19 testing and self-isolation, please see:

- For LTCHs, the COVID-19 Guidance Document for Long-Term Care Homes in Ontario; and
- For RHs, the RHRA Policy to Implement Directive #3.

Visitors

- Per Directive #3, homes must maintain visitor logs of all visit to the home, which must include at a minimum the name and contact information of the visitor, time and date of the visit and the purpose of the visit. These records must be kept for a period of at least 30 days and be readily available to the local PHU for contact tracing purposes upon request.
- For information on sector-specific requirements on visitors, including definition of types of visitors, IPAC measures to follow, the number of visitors permitted, as well as any COVID-19 testing and/or vaccination requirements, see:
  - For LTCHs: COVID-19 Guidance Document for Long-Term Care Homes in Ontario, Minister's Directive: Long-Term Care Home Surveillance Testing and Access to Homes and Minister's Directive: Long-Term Care Home COVID-19 Immunization Policy, issued by the Minister of Long-Term Care;
  - For RHs: RHRA's Retirement Homes Policy to Implement Directive #3 for RHs; and the Letter of Instructions issued by the Office of the Chief Medical Officer of Health for RHs.

Management of Critical Staffing Shortages

- Staff who are on early return to work as part of management of critical staffing shortage must follow the protocols and requirements for Test to Work.

Case and Contact Management

Management of Symptomatic Individuals

- Per Directive #3, all individuals in a home who are exhibiting signs or symptoms consistent with acute respiratory illness including COVID-19 (see Appendix B) must be tested and self-isolated on additional precautions. This is regardless of the individual's COVID-19 vaccination status.
- **When a resident is symptomatic:** Residents must be self-isolated and placed on additional precautions, be clinically assessed, and tested, as per Directive #3.

- **Diagnostic testing:** The list of preferred specimen types for PCR testing is available on the Public Health Ontario website. Swabs should ideally be collected from the residents early in the course of their acute symptoms (onset within the preceding 48 hours). There should be a low threshold to test for COVID-19 in the event of new or worsening symptoms.
  - **Per Directive #3, all symptomatic residents must be tested for COVID-19**, even during non-COVID outbreaks, using a laboratory-based PCR test or a molecular point-of-care test (POCT) (e.g., ID NOW COVID-19)[‡]. RATs may also be performed concurrently when timely PCR results or POCT are not available to ensure timely case, contact, and potential outbreak management.
  - **All symptomatic residents with acute respiratory symptoms, will be eligible for testing of other respiratory viruses**, using a multiplex respiratory virus PCR (MRVP) test. During an outbreak, up to four (4) specimens will be accepted for concurrent MRVP testing by PHO Laboratories.
- **If the COVID-19 and/or MRVP test results are positive:** see Case Management below.
- **If both COVID-19 laboratory results and MRVP test results are negative:** may discontinue additional precautions if there has not been an exposure and symptoms are improving. Continue to monitor the symptomatic resident closely for worsening symptoms, and test again if a new symptomatic resident is identified.
- See Appendix D for a summary.

[‡] Please refer to MOH's COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge document for more information on interpreting molecular POCT results.. Rapid antigen tests may facilitate case, contact, and outbreak management while awaiting PCR or rapid molecular diagnostic test results.

Table 2: Testing of Symptomatic Residents

Home Status	COVID-19 Test	MRVP Test
Not in Outbreak	Test ALL symptomatic residents with PCR	Test ALL symptomatic residents
In Outbreak	Test ALL symptomatic residents with PCR	Test first FOUR residents only

*** See PHO Laboratory's Respiratory Viruses test information page for more information.**

- **When a staff or a visitor is symptomatic:** Symptomatic staff or visitors must not be permitted entry into the home, as per Directive #3. If they become symptomatic during their shift or visit, they should be self-isolated until they can safely leave the home's property and/or be asked to leave immediately. They must be instructed to self-isolate, seek medical assessment as required, and be encouraged to get tested for COVID-19, as per Directive #3.
    - See Directive #3 for exceptions where individuals who fail screening may be permitted entry into the home.

Case Management

- Per Directive #3, All individuals who are identified as a confirmed or a probable COVID-19 case must be self-isolated as per the COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge. This is regardless of the individuals' COVID-19 vaccination or previously positive status.
- **When a resident tests positive for COVID-19 (irrespective of MRVP results):** Residents must be self-isolated and placed on additional precautions to prevent the spread of infection to others in the home, as per Directive #3.
    - 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.
    - Asymptomatic residents living in the same room as the case should be tested and placed on additional precautions immediately along with the

infected resident under the direction of the local PHU (see Contact Management below).

- **When a staff or a visitor tests positive for COVID-19:** Staff and visitors who receive a positive COVID-19 test result while they are at the LTCH/RH must leave the facility immediately and be directed to self-isolate at their own home, as per Directive #3.
    - Staff and visitors who are ill or diagnosed with a confirmed COVID-19 infection (by RAT or laboratory-based test) may not be permitted to return to the home until after symptoms resolve and the appropriate self-isolation period has elapsed.
- **Exception for staff on early return to work in critical staffing shortages:** Staff who test positive for COVID-19 may be required to work on early return to work during critical staffing shortage following the policy and guidance issued by the MLTC and MSAA and the Interim Guidance on Management of Critical Staffing Shortages Omicron Surge.
- Detailed case management for non-COVID-19 respiratory infection outbreaks are outside the scope of this document. See Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018 for more information.
    - For case definition for influenza and other respiratory infection outbreak in institutions and hospitals, refer to the relevant disease specific chapters in Ministry of Health's Appendix A and B to the Infectious Diseases Protocol.

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.
    - A **high-risk contact (HRC)** is defined as a resident who was in contact with a positive case during their period of communicability (within 48 hours prior to symptom onset if symptomatic or 48 hours prior to the specimen collect date if asymptomatic, and until the positive person started self-isolating) AND meet one or more of the following:
        - Received direct care from a staff positive for COVID-19 (unless this interaction meets the definition of a lower-risk exposure below);
        - Close prolonged contact (within 2 metres) with a symptomatic person (e.g., roommates, essential caregivers, visitors) or body fluids

of a positive case (e.g., cough, sneeze), without the consistent and appropriate use of PPE.

- A **lower-risk contact** is defined as a resident who is fully vaccinated and boosted (3rd or 4th dose) and who was in contact with a positive case during their period of communicability, but the exposure may be lower risk. Examples of lower risk exposures include:
  - Receiving direct care from staff who was positive for COVID-19 when the staff had consistent and appropriate use of masking (a well-fitting medical mask or N95 respirator used for source control).
  - Sharing an indoor space with a person with a positive case or in settings where close interactions occur (e.g., dining room) where public health measures (e.g., masking, physical distancing) are in in place and the person does not fit the definition of minimal/no risk and/or high-risk.

- When a PHU is conducting a risk assessment, the PHU may deem an exposure high-risk if there were other factors involved that may increase the risk of transmission (e.g., accumulated contact time with the positive case).
- For details on how to identify and manage contacts, refer to Appendix F.
  - All HRCs should be monitored for COVID-19 symptoms and be isolated and tested as per Appendix F.
  - HRCs who are fully vaccinated and boosted (3rd or 4th dose) may discontinue isolation on or after day 5 from last exposure, provided they remain asymptomatic and receive a negative PCR or rapid molecular test result taken on or after day 5 from last contact with a positive case.
    - In the absence of access to timely PCR or rapid molecular testing, 2 consecutive negative RATs, taken at least 24 hours apart (i.e., day 5 and day 6 from date of last exposure), may be used to discontinue isolation, provided they remain asymptomatic . For clarity, the resident must still complete a minimum 5-day isolation following contact with a positive case and may discontinue isolation on or after day 6 with 2 negative RATs.
    - Isolate for 10 days from last contact with positive case if testing is declined. If the individual develops symptoms, then the isolation period would be 10 days from symptom-onset.
  - HRCs who aren't fully vaccinated and boosted (3rd or 4th dose) are to:

- Continue isolating for 10 days from date of last contact with positive case.
- Continue isolating, if they become symptomatic and/or test positive, for 10 days after the specimen collection date or symptom onset, whichever is earlier.

- If a resident does not meet the definition of a HRC, testing and isolation may not be required, unless symptoms develop.
- Asymptomatic residents who have been previously infected with COVID-19 (based on a molecular or rapid antigen test) on or after December 20th, 2021 and cleared within the last 90 days are not required to isolate if they have been in contact with a positive case.

Table 3: Contact Management for LTCH and RH Residents based on Exposure Type and Vaccination Status

Lower-risk

Exposure	Residents who are fully vaccinated and boosted (3rd or 4th dose)	Residents who are NOT fully vaccinated and/or have NOT been boosted (3rd or 4th dose)*
Received direct care from a staff positive with COVID-19 who had consistent and appropriate masking**	• Monitor for symptoms for 10 days. • PCR and rapid molecular test taken on or after day 5 • Isolation not required unless symptoms develop or positive test result	• Isolate for 10 days • PCR or rapid molecular test on or after day 5
Was in a shared indoor space with a case or in a setting where close interactions occur but with public health measures in place		

High-risk

Exposure	Residents who are fully vaccinated and boosted (3rd or 4th dose)	Residents who are NOT fully vaccinated and/or have NOT been boosted (3rd or 4th dose)*
Received direct care from case who did not have appropriate masking	• Isolated until PCR or rapid molecular test results taken on or after day 5 are received OR for a minimum of 10 days from last contact with case (without testing) • Monitor for symptoms for 10 days • PCR or rapid molecular test on day 5 • If negative: isolation may be discontinued • If positive: treat as a case	• Isolate for 10 days • PCR or rapid molecular test on or after day 5
Close prolonged contact (<2m) with a symptomatic person (e.g., roommates,) or body fluid of a positive case without the consistent and appropriate use of PPE***		

* Includes residents who are not vaccinated, partially vaccinated (1 dose), and fully vaccinated (2 doses)

**masking for source control is defined as the case wearing well-fitted medical mask or fit-tested N95 respirator appropriately and consistently

***PPE in this situation is defined consistent and appropriate use of a fit-tested N95 respirator and eye protection

NOTE: In the absence of access to timely PCR or rapid molecular testing, 2 consecutive negative RATs, taken at least 24 hours apart (i.e., day 5 and day 6 from date of last exposure), may be used.

- **COVID-19 contact management** should be done as per:
    - Public Health Management of Cases and Contacts of COVID-19 in Ontario;
    - COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance; and
    - COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge.
- For contact management for other (non-COVID-19) respiratory viruses, see Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018.
    - Contacts of non-COVID-19 respiratory illness cases are not routinely self-isolated.
    - For influenza antiviral prophylaxis, see PHO's At a Glance: Influenza Antiviral Treatment.

Table 4: Contact Management for COVID-19 and Other Respiratory Viruses

Case tests positive for	If the high-risk contact is a Resident	If the high-risk contact is a Staff/Visitor
COVID-19	Refer to Table 3 and Appendix F	Test for COVID-19* Self-isolate as applicable
Other respiratory virus **(i.e., COVID-19 negative)**	Monitor Consider antivirals if influenza	Monitor Consider exclusion/antivirals if influenza and unvaccinated for flu

* Test for COVID-19 using laboratory-based PCR test or molecular POCT. Testing with RAT may be considered when timely PCR test results or POCT are not available.

Outbreak Management

The local PHU is responsible for investigating (e.g., determining when cases are epidemiologically linked), declaring, and managing outbreaks under the HPPA. As such, the local PHU directs and coordinates the outbreak response. 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.

Additional information can be found in the following resources:

- Public Health Management of Cases and Contacts of COVID-19 in Ontario;
- COVID-19 Fully Immunized and Previously Positive Individuals: Case, Contact and Outbreak Management Interim Guidance; and
- COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge.

Detailed outbreak management for non-COVID-19 respiratory infection outbreaks are outside the scope of this document. See Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018 for more information. For surveillance outbreak definitions and for influenza and other respiratory infection outbreaks in institutions and hospitals, refer to the relevant disease specific chapters in Ministry of Health's Appendix A and B to the Infectious Diseases Protocol.

Declaring an Outbreak

- Surveillance definitions of **COVID-19 outbreaks** in LTCH/RH are as follows:
    - **A suspect outbreak** in a home is defined as:
        - one positive PCR test OR rapid molecular test OR rapid antigen test in a resident
    - **A confirmed outbreak** in a home is defined as:
        - two or more residents and/or staff/other visitors in a home (e.g., floor/unit) each with a positive PCR test OR rapid molecular test OR rapid antigen test result AND with an epidemiological link*, within a 10-day period.

*Epidemiological link defined as: reasonable evidence of transmission between residents/staff/other visitors AND there is a risk of transmission of COVID-19 to residents within the home.

- **Note:** the definitions above 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 above definitions are not completely met.
- For greater clarity, staff cases are those whose COVID-19 infection was deemed due to workplace exposure (i.e., acquisition in the home) by workplace health and safety, the PHU, or the IPAC team.
    - For the purposes of outbreak management, if a staff assessment is not possible to determine the source of acquisition and there is no evidence to support an epidemiological link to the home, the PHU has the discretion to presume staff COVID-19 infections were not acquired in the home during periods of high community transmission.
    - The home's workplace health and safety and/or IPAC team has a duty to report an employee case as per OHSA requirements.
- All positive PCR, rapid molecular, 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.
- During a suspect or confirmed outbreak, homes should continue to conduct enhanced symptom assessment (minimum twice daily) of all residents to facilitate early identification and management of ill residents.

- Declaring a COVID-19 outbreak may not be necessary in certain scenarios such as:
    - When a resident has tested positive during their self-isolation period following their admission or transfer and has been under Droplet and Contact Precautions for the entirety of this period.
    - When the source of COVID-19 acquisition for staff cases are deemed to have reasonable occurred outside the workplace and there is no evidence of transmission or an epidemiological link to resident cases in the home.
- For greater clarity,

- Declaration of an outbreak (suspected or confirmed) is not required to implement enhanced measures at the discretion of the Outbreak Management Team or as directed by the local public health unit (e.g., enhanced disease surveillance, infection prevention and control measures).
- At this time RATs are not primarily intended for diagnostic purposes; however, they may be used to facilitate case, contact, and outbreak management. The results of a RAT may be used to declare a suspect or confirmed outbreak while awaiting PCR or rapid molecular diagnostic test results.
- Negative RAT results should not be used independently to rule out COVID-19 in an outbreak situation due to its 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., to expedite outbreak management) PCR or rapid molecular diagnostic (e.g., ID NOW) testing should also be performed in parallel.
    - Staff and/or residents are to be managed as a case if a positive RAT or an epidemiological link until PCR (i.e., negative PCR) or rapid molecular diagnostic test results are received.

Suspect Outbreak Management

- Suspect outbreak management should include the following steps at minimum:
    - Case and their high-risk of exposure contacts (e.g., roommates, dining/ activity cohort, staff who cared for the case without appropriate and consistent PPE) should be tested (PCR or rapid molecular diagnostic, and concurrent RAT if necessary) and managed appropriately as per the section on Contact Management;
    - Staff and residents must be cohorted to limit the potential spread of COVID-19;
    - Increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces);
    - Additional testing at discretion of PHU; and
    - Additional control measures at discretion of PHU.

Confirmed Outbreak Management

- Once an outbreak is declared, 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 COVID-19 risk to residents and the potential harm of resident isolation and testing when implementing public health measures (e.g., facility-wide versus limiting to floors/units where appropriate).
- Confirmed outbreak management should include the following steps at minimum:
    - Defining the outbreak area of the home (e.g., floor or unit or whole facility) 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, and in consideration of factors such as exposed resident/staff COVID-19 vaccination status and whether cases are infected with a variant of concern with known immune/vaccine escape potential;
    - Enhanced monitoring for new symptoms in all residents and staff in the outbreak area;
    - Conducting weekly IPAC self-audits as per Directive #3;
    - Facilitate assessment of IPAC and outbreak control measures by health system partners as applicable;
    - Increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces);
    - The need for staff to follow additional precautions for all resident interactions in the outbreak area;
    - Modification of dining and indoor social activities (as applicable);
    - Limiting or restricting new admissions and transfers; and
    - Limiting or restricting visitors, depending on the nature of the outbreak.
- At the discretion of the PHU and where operationally feasible for the home:
    - group activities, dining, and other social gathering may continue/resume in areas of the home (e.g., floors/units) not affected by the outbreak if residents are able to adhere to public health measures (e.g., masking, physical distancing).

- Group activities/gatherings within an outbreak area of the home (e.g., floors/units) may continue/resume for specific cohorts (e.g., previously infected with COVID-19). Considerations may include:
    - Appropriate staff cohorting can be maintained;
    - There have been no concerns raised on the IPAC audits of the homes that are unaddressed; or,
    - Residents within the cohort are able to adhere to public health measures (e.g., masking);
- Activities for residents in isolation may continue/resume. For example:
    - 1:1 walks in an empty hallway with HRC or case and staff or essential caregiver, both with appropriate use of PPE.
    - Staff or essential caregiver supported visits to a designated room other than the residents' room where others are not occupying or travelling through.

Diagnostic Testing for Outbreak Management

- Local PHUs are responsible for making recommendations on and facilitating outbreak testing using a risk-based approach based on exposures (e.g., affected outbreak floor/unit).
    - When timely PCR results may not be available, RAT may be collected to facilitate timely outbreak management.
- Asymptomatic individuals who initially test negative should be re-tested if they develop symptoms.
- Local PHUs have the discretion to exclude residents and staff who are vaccinated and boosted (3rd or 4th dose) and/or previously infected with COVID-19 (in the last 90 days and since December 20, 2021) from point prevalence testing, unless a high-risk exposure is determined or cannot be ruled out or there is ongoing transmission in the home occurring.
    - In the event of ongoing transmission during an outbreak, testing of all residents and staff should be considered.
- In the event of **ongoing transmission** in an outbreak, following the initial testing of the home at the time of outbreak declaration, repeat testing of all residents and staff who initially tested negative should be conducted within 3-7 days from when the initial testing was conducted. If additional cases or symptomatic individuals are identified, continue repeat testing of residents and staff who

tested negative every 3-7 days until no new cases are identified. Testing with PCR is recommended, and when timely access to PCR results is not available, consider collecting RAT.

- PHUs are responsible for following usual outbreak notification steps to the PHO Laboratory to coordinate/facilitate outbreak testing and ensuring an outbreak number is assigned.

Declaring the Outbreak Over

- The outbreak may be declared over by the PHU when there are no new cases in residents or staff linked to exposures in the home after 10 days (maximum incubation period) from the latest of:
    - Date of self-isolation of the last resident case; OR
    - Date of illness onset of the last resident case; OR
    - Date of last shift at work for last staff case.
- For greater clarity, if staff continue to test positive for COVID-19 (i.e., a staff presumed or linked to a community exposure), the outbreak may be declared over at the discretion of the PHU, provided there is no evidence of transmission to residents. The home should continue to conduct enhanced symptom surveillance for residents.
- In homes with ongoing transmission and/or evidence of increased severity of illness, the PHU may require 14 days to elapse before the outbreak is declared over.
- 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 & Safety

Staff Exposure/Staff Illness

- Any staff or visitor who fails active screening (i.e., having symptoms of COVID-19 and/or having had contact with someone who has COVID-19) must not be allowed to enter the home. In addition, they must report their failed active screening result to their supervisor/manager or to Occupational Health designate and discuss any work restrictions.

    - Refer to Directive #3 for exceptions where individuals who fail screening may be permitted to enter the home and the associated section on Test to Work.

- Staff who test positive for COVID-19 should report their illness to their manager/supervisor or to Occupational Health designate as per usual practice. Homes must report all suspect and confirmed cases of COVID-19 to their local PHU.
    - 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 support workers with symptoms and/or illness to self-isolate.
- Staff who have been diagnosed with COVID-19, have COVID-19 symptoms, or are a high-risk contact with some who is COVID-19 positive should notify their manager/supervisor or Occupational Health in consultation with their health care provider.
    - Staff must report to Occupational Health prior to return to work. Detailed general occupational health and safety guidelines for COVID-19 are available on the MOH COVID-19 website.
- Symptomatic staff who decline testing should follow directions provided by their employer, manager/supervisor, and/or Occupational Health.
    - Further guidance can be found in COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge.
- Staff who are on early return to work as part of management of critical staffing shortages must follow the protocols and requirements for early return to work as outlined in Directive #3, Interim Guidance Omicron Surge Management of Critical Staffing Shortages in Highest Risk Settings, and their sector-specific requirements or policy on Test to Work/early return to work, including:
    - MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario effective January 14, 2022 or as current.
    - The RHRA's Retirement Homes Policy to Implement Directive #3, effective January 26, 2022 or as current.

Reporting staff illness

- Workers who are unwell should report their illness-related absence to their supervisor or employer.
- In accordance with the *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 MLTSD.
    - 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.
- In accordance with the 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 MLTSD:
    - Employment Standards Information Centre: Toll-free: 1-800-531-5551
    - Health and Safety Contact Centre: Toll-free: 1-877-202-0008
- For more information from the WSIB, please refer to the following:
    - Telephone: 416-344-1000 or Toll-free: 1-800-387-0750.

Appendix A: Summary for Active Screening Practices for Homes

	Staff and Visitors	Current Residents
Who does this include?	Staff and all visitors, including caregivers, students, and volunteers. Exception is provided to first responders, who should, in emergency situations, be permitted entry to the home without screening.	Residents currently living in the home.
What are the screening practices?	• Conduct active screening (including rapid antigen testing as appropriate) before they are allowed to enter the home, including for outdoor visits. At a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. • Temperature checks are not required. • All visitors entering the home must adhere to the home's visitor policies.	• Conduct symptom assessment of all residents at least once daily to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms. • Conduct symptom screening of all residents at least twice daily for 10 days following admission/transfer. • All residents returning from any type of absence must be actively screened at entry upon their return.

	Staff and Visitors	Current Residents
What if someone does not pass screening (i.e., screens positive)?	Staff and visitors who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive must: • Not enter the home, • Be instructed to immediately self-isolate, and • Seek testing if eligible See Directive # 3 for possible exceptions.	Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) must be self-isolated on additional precautions and tested. For a list of typical and atypical symptoms, refer to the COVID-19 Reference Document for Symptoms.

Appendix B: Clinical Presentation for Respiratory Tract Infections

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

Respiratory Illness	Signs and Symptoms
COVID-19* and other upper respiratory illness (including common cold, pharyngitis) * For more information on COVID-19 symptoms, refer to MOH's COVID-19 Reference Document for Symptoms. ** Not related to receiving a COVID-19 vaccine in the last 48 hours.	• Fever/abnormal temperature for the resident (typically ≥ 37.8 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

Respiratory Illness	Signs and Symptoms

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.

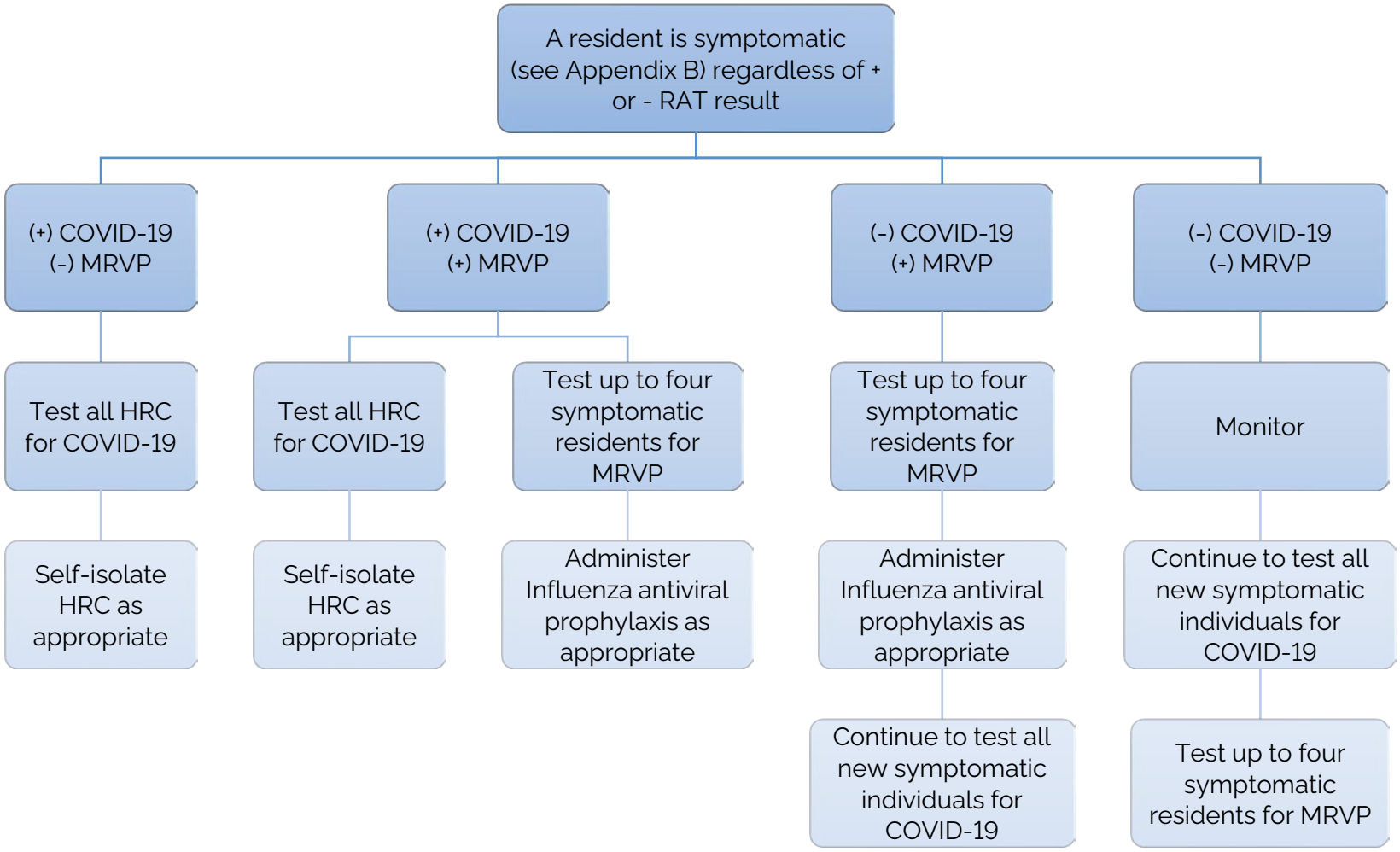
Appendix C: PPE Escalations to the Region and Ministry

The escalation process for acquiring PPE for your organization is as follows:

1. Implement conservation and stewardship strategies: Ontario Health Recommendations to Optimize PPE Supply.
2. Use existing supply chain processes and collaboration with local partners to obtain supplies.
3. Expand alternate inventories to obtain supplies: Ontario Workplace PPE Supplier Directory.
4. Continue with the Critical PPE Requests-Intake Form to escalate to your Regional Lead.

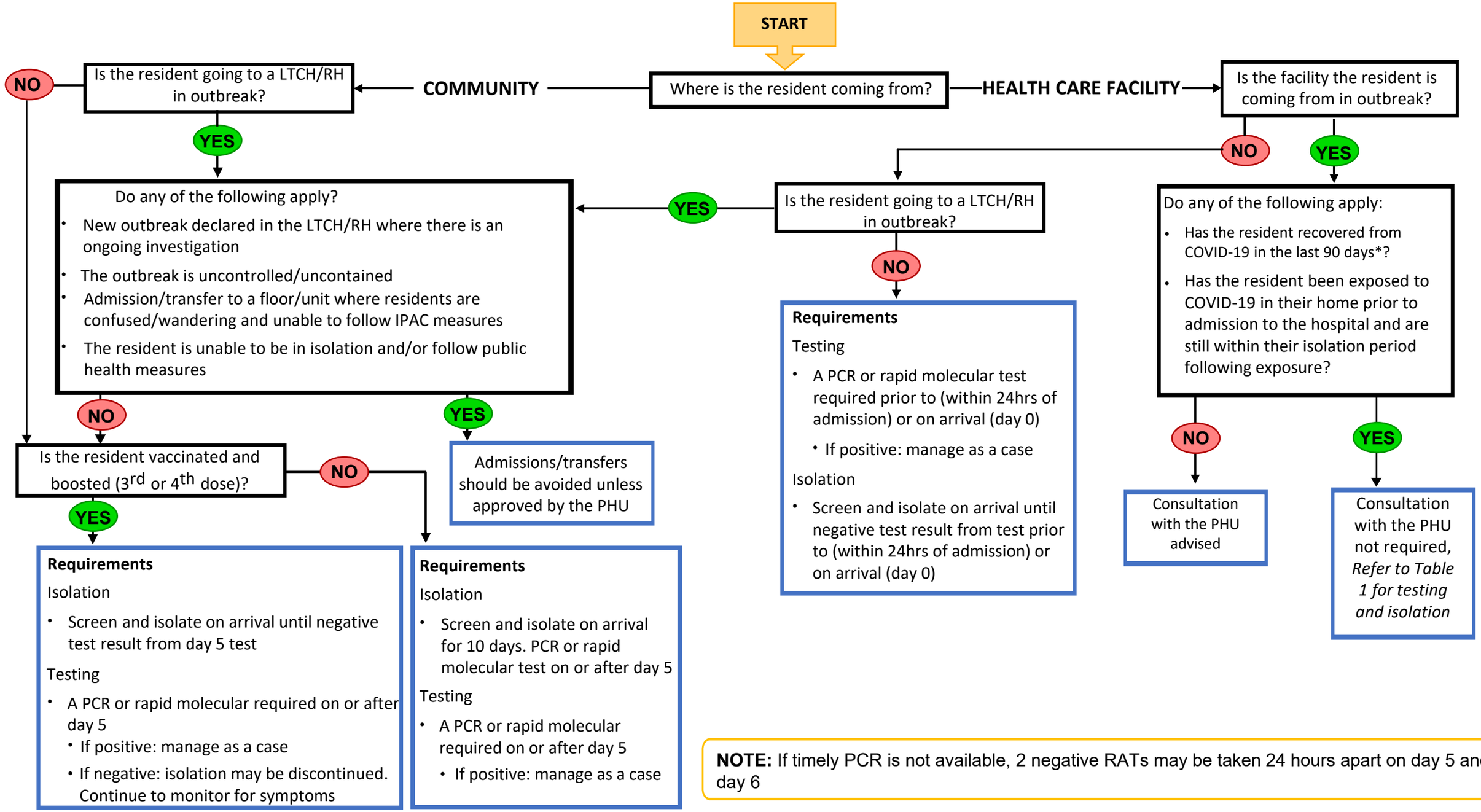
Health service providers are reminded to follow the hierarchy of controls to eliminate or reduce the risks of transmission, and to minimize their need for PPE. Health service providers and employers should be sourcing PPE through their regular supply chain, and they remain responsible for sourcing and providing PPE to their frontline workers. PPE allocation from the provincial pandemic stockpile will continue and PPE can be accessed, within available supply, on an emergency basis for those who have exhausted all efforts to procure their own stock through the established escalation process.

Appendix D: Algorithm for Testing and Management of Acute Respiratory Illness in LTCHs and RHs



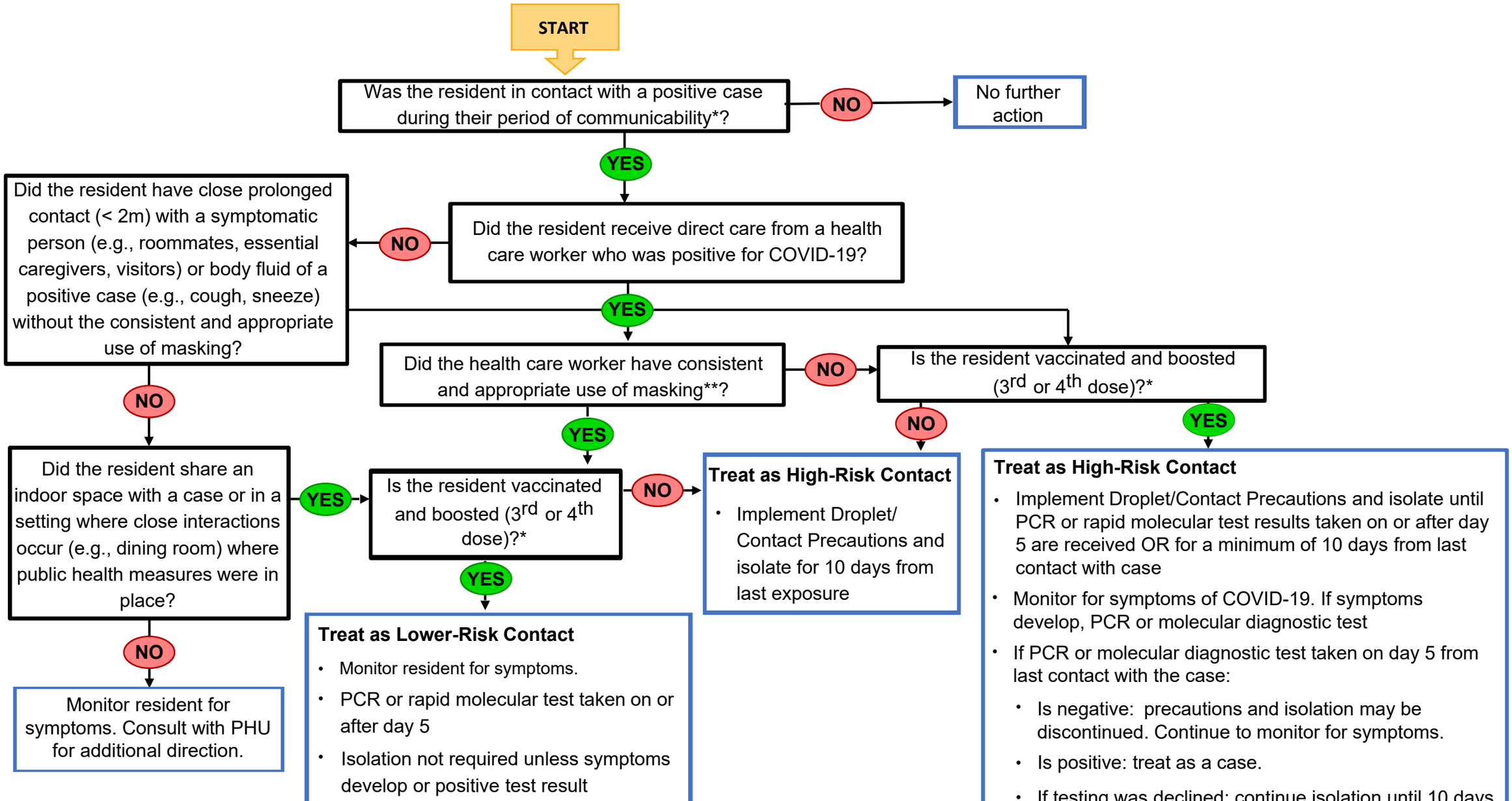
Abbreviations: MRVP – Multiplex Respiratory Virus PCR; HRC – high risk contact

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



NOTE: If timely PCR is not available, 2 negative RATs may be taken 24 hours apart on day 5 and day 6

Appendix F: Algorithm for Managing Contacts in LTCHs and RHs



NOTE: If timely PCR is not available, 2 negative RATs may be taken 24 hours apart on day 5 and day 6