Ministry of Health

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

Version 1 – May 5, 2021

Highlights of Changes:

- Updated based on Directive #3
- Streamlined the audience for local public health units
- Inclusion of retirement homes in the application of the document
- Merged COVID-19 Guidance: Long-Term Care Homes and COVID-19 Guidance: Long-Term Care Home Outbreak Management
- New sections added:
    - Table of Contents
    - Roles and Responsibilities
    - COVID-19 Immunization
    - COVID-19 Specific Policies and Procedures
    - Case and Contact Management
    - Outbreak Management (previously part of COVID-19 Guidance: Long-Term Care Home Outbreak Management guidance document)
- A summary of modified measures in context of the high immunization coverage rates in long-term care homes and retirement homes

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

This guidance is intended to complement and provide interpretation of the requirements set forth in Directive #3 for Long-Term Care Homes. In accordance

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

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:**

- For sector-specific guidance, policies, and protocols, please see:
    - The Ministry of Long-Term Care's (MLTC) COVID-19 Guidance Document for Long-Term Care Homes in Ontario for LTCHs; and
    - The Ministry of Seniors and Accessibility's (MSAA) Retirement Home Guidance to Implement Directive #3 for RHs.
- 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:**

- The term **"staff"** is used to include anyone conducting activities in LTCH or RH, regardless of their employer. This includes, but is not limited to:
    - Staff employed by the home (e.g., health care workers, support staff),
    - Essential caregivers and health care workers (e.g., personal support workers) employed by the resident and/or their family,
    - 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 **"home"** is used to include a LTCH and RH.
- For this document, an individual is considered **"fully immunized"** if:
    - They have received the total required number of doses of a COVID-19 vaccine approved by Health Canada (e.g., both doses of a two-dose vaccine series, or one dose of a single-dose vaccine series); **and**
    - They received their final dose of the COVID-19 vaccine at least 14 days ago

# Table of Contents

Roles and Responsibilities . . . . . 4
COVID-19 Immunization . . . . . 10
Prevention of COVID-19 Disease Transmission . . . . . 10
COVID-19 Specific Policies and Procedures . . . . . 20
Case and Contact Management . . . . . 21
Outbreak Management . . . . . 24
Occupational Health and Safety . . . . . 27
Appendices . . . . . 29

# 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 MOH, the Ministry of Long-Term Care (MLTC), and the Ministry of Seniors and Accessibility (MSAA).

*Case and Contact Management/Outbreak Management*

- Receive and investigate reports of cases and contacts of COVID-19 in accordance with the Public Health Management of Cases and Contacts of COVID-19 in Ontario and the *Health Protection and Promotion Act, 1990* (HPPA).
- 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, in alignment with the province's broader testing strategy; where recommended, 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/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 Medical Officer of Health or their designate to the home.

**Role of MLTC and MSAA**

- Provide legislative and policy oversight to homes.
- Communicate expectations and provincial-level guidance on COVID-19 related policies, measures, and practices to homes.
- Ensure that homes are aware of their duties:
    - As employers under the *Occupational Health and Safety Act, 1990* (OHSA) and its regulations, including to report occupational illness to the Ministry of Labour, Training and Skills Development (MLTSD).
    - Under the HPPA and its regulations, including their duty to report to PHUs.
- Provide ongoing support and communications to homes with partner agencies, ministries, and the public, as necessary.
- For MLTC only: Support the procurement of supplies of personal protective equipment (PPE).

**Role of Public Health Ontario**

- Provide scientific and technical advice to PHUs to support case and contact management, outbreak investigations, and data entry.
- Develop resources and provide IPAC support as needed (e.g., participate in IPAC hubs).
- Advise on and support laboratory testing as needed.
- Provide scientific and technical advice to MOH and PHUs, including multi-jurisdictional teleconferences.

**Role of the long-term care home (LTCH)**

- All homes are required to report 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 (O. Reg. 135/18). 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.
- Employers have a general duty under OHSA to take every precaution reasonable in the circumstances for the protection of a worker, including in respect of infectious disease.
- Under OHSA, an employer must provide written notice to the 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) 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 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 should 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 (e.g., essential visitors, caregivers, social visitors, etc.) 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 workers 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 immunization 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 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.

- Provide recommendations to strengthen IPAC programs.
- Help to support an outbreak control plan by providing IPAC expertise and recommendations.

**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.
- MLTSD investigates occupational illness notifications to determine if the employer is in compliance with the OHSA and that appropriate measures have been taken to prevent further illnesses.
- Proactively inspect workplaces to monitor compliance with the OSHA 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 OSHA.
- The MLTSD Health and Safety Contact Centre (1-877-202-0008) is available for anyone to report health and safety concerns, complaints or to provide notices of occupational illnesses.
- 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. 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).

## COVID-19 Immunization

- Residents, staff, and essential caregivers of LTCHs and RHs were part of the phase 1 of Ontario's COVID-19 vaccine rollout.
- New admissions to LTCHs and RHs who have not yet received their COVID-19 immunization should be offered a COVID-19 vaccine as soon as possible.
- PHUs are asked to continue to support COVID-19 immunization in the LTCH/RH sectors in collaboration with the home and relevant health system partners.
- More information can be found on the MOH's COVID-19 Vaccine-Relevant Information and Planning Resources webpage.
- MLTC has developed a COVID-19 Vaccine Toolkit, which includes posters, fact sheets, and FAQs to promote COVID-19 immunization in this setting. It is available in multiple languages.

## Prevention of Disease Transmission

Homes can help prevent and limit the spread of COVID-19 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 personal protective equipment (PPE) should all be considered when developing home-specific policies. **The measures below should be carried out at all times regardless of the COVID-19 situation in the home.**

- **Note:** MOH's Control of Respiratory Infection Outbreaks in Long-Term Care Homes is the foundational document for respiratory outbreak-related guidance on the preparedness, prevention, and management of respiratory-related outbreaks in long-term care homes. The information in this document is intended to supplement these foundational principles with COVID-19 specific advice/recommendations.

## Screening

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

### Active Screening for Anyone Entering the Home

- See Appendix A for details on active screening.
- Active screening is required prior to permitting the entry of:
    - Staff, students, and volunteers;
    - Essential and general visitors; and
    - Residents returning from an absence.
- See Directive #3 for a list of exceptions to active screening.
- 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.
    - These procedures are to be applied seven days a week and 24 hours a day.
- Screeners should wear appropriate personal protective equipment (PPE) if they are unable to maintain physical distancing from the individual being screened and/or plexiglass barriers are not available.
    - Please refer to Appendix B for the required precautions and PPE when providing care.
- 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 no longer required by Directive #3.

### Daily Symptom Assessment of Residents

- See Appendix A for details on the daily symptom assessment of residents.
- All residents must be assessed at least twice daily, including temperature screening, to identify any new or worsening COVID-19-like symptoms.
- This can take place at the same time as routine vital signs check, where applicable.

- 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.

**Passive Screening and Signage**

- Signage should indicate 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 Surveillance Testing**

- Asymptomatic surveillance testing refers to the routine asymptomatic testing (using rapid antigen tests or laboratory-based PCR) of individuals who are neither experiencing COVID-19 symptoms nor have been exposed to a known COVID-19 case. The rationale for this surveillance testing is to create an additional level of protection, *in addition to* active screening, through the early identification of asymptomatic cases. **Asymptomatic surveillance testing does not replace, and should not supersede, routine IPAC practices nor is it equivalent to diagnostic molecular testing.**
- LTCHs and RHs should refer to their sector-specific policy on asymptomatic surveillance testing, including:
    - The Minister of Long-Term Care's Directive: *COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes* for LTCH;
    - The Testing in Retirement Homes memo for RH; and
    - Ministry of Health's COVID-19 Provincial Testing Guidance.
- For more information on rapid antigen testing, please see COVID-19 Guidance: Considerations for Rapid Antigen Screening and Appendix 9: Management of Individuals with Point-of-Care results.
- Individuals who have previously been diagnosed with and cleared of COVID-19 infection should:

- Resume asymptomatic surveillance testing after 90 days (from the specimen collection date) from their prior laboratory-confirmed COVID-19 infection.
- If there is uncertainty about the validity of the COVID-19 infection (e.g., asymptomatic infection with high cycle threshold value result), resume asymptomatic surveillance testing immediately.
- Homes should be aware that individuals who have previously been infected with COVID-19 may continue to test positive on laboratory-based PCR tests for several weeks after infection.

## 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, they must not be allowed to enter the home. They should be instructed to self-isolate immediately and be encouraged to get tested for COVID-19.
    - Information about assessment centres can be found here.
    - If they have questions related to COVID-19, they should contact their primary care provider or Telehealth Ontario (1-866-797-0000) or visit Ontario's COVID-19 website.
- Any staff who does not pass their screening should contact their immediate supervisor/manager or occupational health and safety representative in the home.
    - Staff responsible for occupational health and safety in the home should follow up with all staff who have been screened positive to provide advice on work restrictions.
    - Staff with post-immunization 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.
- Residents with symptoms compatible with COVID-19 or those who have not passed screening on return to the home following an absence must be placed in isolation under Droplet and Contact Precautions and tested for COVID-19.
- Please refer to Appendix B for the required precautions for PPE when providing care.

**Note:** Any staff providing care for and testing residents with suspected or confirmed COVID-19 should use precautions as per Directive #1 for Health Care Providers and Health Care Entities, Directive #5 for Hospitals and Long-Term Care Homes, as well as PHO's Technical Brief on IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19.

## 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, then clean hands again.
- Homes should ensure adequate supplies are maintained.

## Physical Distancing

- All staff, residents, and visitors in the home should practice physical distancing (maintaining a minimum of 2 metre or 6 feet distance apart from others) to reduce the transmission of COVID-19. Please see Directive #3 for a list of exceptions.
- In instances where physical distancing is not possible (e.g., in the provision of direct care), staff, caregivers, and/or visitors should wear appropriate PPE based on the nature, duration, and type of interaction. Residents are strongly recommended to wear masks, as tolerated, in common areas or in a shared space with others (e.g., when within 2 metres of others).
- In instances where physical contact is permitted (e.g., between a fully immunized resident and a fully immunized caregiver), caregivers, residents, and/or visitors should continue to practice hand hygiene, masking, and physical distancing from other residents and visitors.

- Homes should reconfigure the physical space and the layout throughout the home (i.e., common areas and resident/staff-specific areas) to facilitate physical distancing. This may include:
    - 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.
- All activities in the home must be modified to promote physical distancing (at least 2 metres) at all times for residents and staff.
    - Directive #3 provides exceptions for communal dining, organized indoor activities/gatherings, and for physical contact between a resident and their essential caregiver in context of COVID-19 immunizations. Please see COVID-19 Specific Policies and Procedures and Appendix D, below.
- Homes should review opportunities to reduce the number of staff present together at the same time within break facilities and common areas. This can be accomplished by reviewing staff break and cleaning schedules and posting maximum capacity.
- Homes, in consultation with the residents' physician and/or pharmacist, should review all residents' medication administration schedules to consolidate and streamline as much as possible to minimize the number of times staff need to enter a resident's room. Examples include:
    - Switching medications to less frequently dosed formulations or reducing dosing frequency, if safe to do so,
    - Re-assessing non-standard medication administration times
    - Aligning medication administration times to coincide with the timing of other resident care tasks,
    - Re-assessing the need for non-essential medications, and
    - Re-assessing the use of nebulizer therapy and replace with multi-dose inhaler (MDI) therapy when appropriate and safe.

## Universal Masking

- 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 immunization status.

- In LTCHs and RHs, universal masking is required for the purpose of *source control* to help prevent the spread of the potentially infectious respiratory droplets and aerosols of the person wearing the mask to others.
- Masks should be worn when in a shared space with others.
- Physical distancing measures should be maintained even when wearing a mask.
- Directive #3 provides requirements and exceptions for masking in a home. Homes should have written procedures, instructions, and training for staff and visitors on mask use (e.g., how to wear and remove a mask).
- Residents are encouraged, but are not required to wear a mask, recognizing that this may be challenging for some individuals depending on their physical, mental, and/or cognitive capabilities.
    - As much as possible, residents who are on Droplet and Contact 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.
- Masks used for source control can be used continuously for repeated close contact interactions with residents who are not on Droplet and Contact Precautions. Masks do not need to be removed/changed between providing care to different residents on routine practices, provided they do not need to be disposed of (i.e., masks should be disposed of when they become wet or soiled).
- 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.

## 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. PPE should not be manipulated or changed without consulting with local Occupational Health and Safety.**
- PPE for staff and visitors, including essential caregivers, includes medical masks and eye protection when providing routine care to a resident who is not on Droplet and Contact Precautions.

  - Non-medical masks (e.g., face coverings) should not be used as PPE.
  - Eye protection includes face shields, some safety glasses, goggles, and face shields. 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.
  - Homes should establish appropriate procedures for cleaning and disinfecting of re-useable eye protection.

- Additional PPE is required in specific situations, such as when providing care to a resident who is placed on Droplet and Contact Precautions (e.g., due to symptoms, COVID-19 exposure, or COVID-19 diagnosis). Choosing PPE should be guided by the nature, type, and duration of the intended interaction and by a point-of-care risk assessment.
- Masks used as PPE should be changed as part of routine doffing procedures.
  - When cohorting measures have been implemented, the same mask can be used across several resident interactions within the cohort provided the mask does not need to be disposed of between resident interactions (i.e. mask has become wet or soiled).
- Appendix B contains more information of PPE precautions based on resident status.
- Please refer to PHO's Technical Brief on IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 document for more information on PPE use.
- LTCHs are expected to follow the precautions outlined in Directive #1 for Health Care Providers and Health Care Entities, Directive #3 for Long-Term Care Homes, and Directive #5 for Hospitals and Long-Term Care Homes.
- Appendix C contains information on how to initiate PPE inquiries to the Ministry.

## Environmental Cleaning and Disinfection

- Homes should be cleaned regularly (e.g., minimum daily). Commonly used cleaners and disinfectants are effective against COVID-19.
- All common areas (including bathrooms) and high-touch surfaces that are frequently touched and used should be cleaned and disinfected at least twice 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*. This includes implementing 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.
- Cleaning should be performed using a health care grade cleaner/disinfectant with a drug identification number (DIN).
- 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.

## Cohorting

- 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.
- Directive #3 now allows for residents to participate in communal dining and organized indoor activities/gathering in homes that have met an immunization coverage threshold as defined by MLTC and MSAA for LTCHs and RHs, respectively (also see COVID-19 Specific Policies and Procedures and Appendix D for more information). Homes are asked to group residents into small cohorts to facilitate this. This means:
    - Residents are to be cohorted into small groups that dine and participate in activities together. These groups should be kept consistent.
    - Cohorts for indoor social activities should be the same as the dining cohorts. This is to minimize potential number of high risk contacts and to reduce the risk of transmission across the home.
    - In these groups, residents are not required to mask and practice physical distancing during dining and group activities.

  - To the extent possible, residents should be cohorted within a single floor/unit.
  - Within homes that meet the immunization coverage thresholds, cohorts can consist of fully immunized, partially immunized, and/or unimmunized residents.
  - Cohort 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.
  - Each cohort should practice physical distancing from other cohorts and wear masks (as tolerated) if physical distancing from other cohorts cannot be ensured.

- In general, regardless of the immunization status of the home, 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 immunized 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 immunized; 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.

- Please see section on Outbreak Management on cohorting principles for outbreak situations.

## COVID-19 Specific Policies and Procedures

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.

As per Directive #3, all LTCHs and RHs are required to have policies and procedures in the following areas:

- Admissions and Transfers;
- Absences – including short term (day) and temporary absences;
- Visitors;
- Communal Dining; and
- Organized Indoor Activities/Gatherings.

While Directive #3 sets out minimum requirements with which all LTCHs and RHs must comply, specific guidance and operationalization of these requirements vary across LTCH and RH settings due to the inherent differences between these two sectors. In co-located long-term care and retirement homes that are not physically and operationally independent, the policies for the LTCH and RH should align where possible or follow the more restrictive requirements.

Given the high rates of COVID-19 immunization and the protective effect that the vaccine has had in mitigating the number of COVID-19 cases and outbreaks in LTCH and RH settings, homes are now permitted to safely and cautiously modify some of the measures currently in place to restore a sense of normalcy for the residents.

As per MLTC and MSAA/RHRA policy, all LTCHs and RHs are now:

- Asked to collect COVID-19 immunization of their staff, essential caregivers, and residents through a consent based process;

- Based on the information collected, calculate an immunization coverage rate (see Appendix D);
- Determine whether the home meets the immunization coverage thresholds that have been established by MLTC for LTCHs and MSAA/RHRA for RHs, respectively (see Appendix D); and
- Review and update this information periodically.

LTCHs and RHs that meet or exceed the immunization coverage thresholds will be permitted to start resuming communal dining and organized indoor activities/gatherings for their residents. **These precautions are intended to build upon the core IPAC principles and requirements described in the previous section (Prevention of Disease Transmission), as these measures will continue to provide the first line of defense against COVID-19 as the pandemic continues to evolve.**

For detailed sector-specific information, including how to calculate and maintain immunization records, please refer to:

- The Ministry of Long-Term Care's (MLTC) COVID-19 Guidance Document for Long-Term Care Homes in Ontario for LTCHs; and
- The Ministry of Seniors and Accessibility's (MSAA) Retirement Home Guidance to Implement Directive #3 for RHs.

**Appendix D provides a summary table of the required precautions based on the individual and/or the home's immunization status.**

PHUs continue to have the discretion to modify or discontinue any of the activities in this section as part of their outbreak investigation and management.

# Case and Contact Management

This guidance document provides supplemental considerations for LTCH and RH settings. For more information on COVID-19 case and contact management, see:

- Public Health Management of Cases and Contacts of COVID-19 in Ontario;
- COVID-19 Quick Reference Public Health Guidance on Testing and Clearance; and
- COVID-19 Variant of Concern: Case, Contact and Outbreak Management Interim Guidance.

## Management of Symptomatic Individuals

- All individuals in a home who are exhibiting signs and symptoms consistent with COVID-19 must be isolated.
    - This includes all individuals who fail their active screening (if they are a staff, visitor, or a resident returning from an absence) or their daily symptom screening (if they are a resident).
- **When a resident is symptomatic:** Residents must be isolated and placed on Droplet and Contact Precautions, be clinically assessed, and tested for COVID-19 using a laboratory-based PCR test or a rapid PCR test (e.g., ID NOW COVID-19).*
    - **If the test result is positive:** see Case Management below.
    - **If the test result is negative:** discontinue precautions if there has not been an exposure. Consider assessing and testing for other respiratory infections as appropriate (e.g., seasonal respiratory multiplex testing).
    - Asymptomatic residents living in the same room or cohort as the case should be tested and placed on Droplet and Contact Precautions immediately along with the symptomatic resident under the direction of the local PHU.
- **When a staff or a visitor is symptomatic:** Symptomatic staff or visitors should be isolated until they can safely leave the home's property and/or be asked to leave immediately. They should be instructed to self-isolate, seek medical assessment as required, and be encouraged to get tested for COVID-19.

## Case Management

- All individuals who are identified as a confirmed or a probable COVID-19 case must be isolated. This is regardless of the individuals' immunization status.
- **When a resident is a case:** Residents must be isolated and placed on Droplet and Contact Precautions to prevent the spread of infection to others in the home.
    - As much as possible, symptomatic or COVID-19 positive residents should be placed in a single room. If this is not possible, COVID-19 positive residents may be placed in the same room together, ensuring their beds

* Please refer to MOH's Appendix 9: Management of Individuals with Point-of-Care Testing Results document for more information on interpreting rapid PCR test results. Rapid antigen tests cannot be used for diagnostic purposes in high risk individuals, such as in symptomatic individuals or for contacts of known COVID-19 cases.

are minimum 2 metres apart, with Droplet and Contact Precautions for each bed space.

- Asymptomatic residents living in the same room as the case should be tested and placed on Droplet and Contact Precautions immediately along with the infected resident under the direction of the local PHU (see Contact Management, below).

- **When a staff or a visitor is a case:** 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 isolate at their own home.
    - Staff and visitors who are diagnosed with a laboratory-confirmed COVID-19 infection may not be permitted to return to the home until after they are cleared by local public health.
- Clearance of cases and release from isolation is at the direction of the local PHU, guided by the COVID-19 Quick Reference Public Health Guidance on Testing and Clearance.
    - Negative clearance tests (e.g., requiring a proof of negative test result in order to return to work) is neither recommended nor required from a public health perspective.

## Contact Management

- Contact management decisions are made by the local PHU. Accordingly, all individuals who are identified as a close contact of a known COVID-19 case or an outbreak are required to follow the direction of the local PHU.
- At any time, when an asymptomatic contact develops COVID-19 symptoms, they should be tested for COVID-19 as soon as possible, using a laboratory-based PCR test or a rapid PCR test.
- If a contact tests positive for COVID-19, manage the individual as a COVID-19 case.
- **When the resident is a contact:** Residents who have had a high risk exposure to a known case of COVID-19, as determined by the local PHU, should be isolated on Droplet and Contact Precautions and tested for COVID-19 using a laboratory-based PCR test or rapid PCR test as per the COVID-19 Provincial Testing Guidance Update.
    - This is regardless of the resident's immunization status.

- **When the staff or a visitor is a contact:**
    - As per the Interim Case & Contact Management Guidance for Fully Vaccinated Individuals, asymptomatic individuals who are fully immunized are not required to self-isolate but should be tested as per the COVID-19 Provincial Testing Guidance Update.
    - Asymptomatic individuals who are partially immunized or unimmunized should be managed accordance with Public Health Management of Cases and Contacts of COVID-19 in Ontario (i.e., self-isolate and be tested for SARS-CoV-2 immediately).
    - Regardless of their immunization status, if an asymptomatic contacts develops symptoms, they must self-isolate and be tested for SARS-CoV-2 immediately in accordance with Public Health Management of Cases and Contacts of COVID-19 in Ontario.

# 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 Provincial Testing Guidance Update; and
- COVID-19 Variant of Concern: Case, Contact and Outbreak Management Interim Guidance.

## 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 lab-confirmed COVID-19 case in a resident.
    - **A confirmed outbreak** in a home is defined as two or more lab-confirmed COVID-19 cases in residents and/or staff (or other visitors) in a home with an epidemiological link, within a 14-day period, where at least one case

could have reasonably acquired their infection in the home. Examples of reasonably having acquired infection in a home include:

- No obvious source of infection outside of the LTCH setting; OR
- Known exposure in the LTCH setting.

- **Note:** the definitions above are for surveillance purposes only. PHUs have the discretion to declare a suspect of a confirmed outbreak based on the results of their investigation, including when the above definitions are not completely met.

- Declaring an 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, OR
  - When only asymptomatic staff or essential caregiver with positive results are found as part of routine surveillance testing with no known high-risk exposure.
    - If the staff or the essential caregiver is fully immunized, re-test immediately and follow the protocol for managing asymptomatic individuals with an initial positive result and a low pre-test probability as per the Management of Cases and Contacts of COVID-19 in Ontario document.

## Suspect Outbreak Management

- Suspect outbreak management should include the following steps at minimum:
  - Case(s) 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 immediately and managed appropriately;
  - Staff and residents should be cohorted to limit the potential spread of COVID-19;
  - Enhanced cleaning and disinfection of the affected area;
  - 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).
- A 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 immunization 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;
    - Facilitate assessment of IPAC and outbreak control measures (as needed).
    - Enhanced cleaning and disinfection practices;
    - The need for staff to follow Droplet and Contact Precautions for all resident interactions in the outbreak area;
    - Modification of dining and indoor social activities (as required);
    - Limiting or restricting new admissions and transfers; and
    - Limiting or restricting visitors, depending on the nature of the outbreak.

### 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 unit/outbreak area) and following the most recent COVID-19 Provincial Testing Guidance Update.
- Those who had exposure to the case(s) in the 14 days prior to illness onset should be assessed to identify potential source cases as well as those who had exposure to the case(s) while the case(s) were infectious and not in isolation with Droplet and Contact Precautions in place.
- All fully immunized individuals should continue to be tested as part of outbreak investigations.

- Re-testing of asymptomatic individuals who initially test negative is recommended if they develop symptoms.
- 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 are identified, continue repeat testing of residents and staff who tested negative every 3-7 days until no new cases are identified.
- PHUs are responsible for following usual outbreak notification steps to the PHO Laboratory to coordinate/facilitate outbreak testing.

### Declaring the Outbreak Over

The outbreak may be declared over by the PHU when there are no new cases in residents or staff after 14 days (maximum incubation period) from the latest of:

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

## Occupational Health & Safety

### Staff Exposure/Staff Illness

- All staff who fail active screening questions must report to their supervisor/manager or occupational health and safety representative and discuss any work restrictions.
- Staff who test positive for COVID-19 should report their illness to their manager/supervisor or to Employee Health/Occupational Health and Safety as per usual practice.
    - The manager/supervisor or Employee Health/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.

- If COVID-19 is suspected or diagnosed in a staff, return to work should be determined in consultation with their health care provider and as per the Quick Reference Guidance on Testing and Clearance.
    - Staff must report to Occupational Health and Safety 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 not be at work and should not be returning to work until 10 days after symptom onset and 24 hours post improvement of symptoms with resolution of fever, or as directed by their employer/Occupational Health and Safety representative.

**Reporting staff illness**

- Workers who are unwell should not attend at a workplace. They 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 LTCHs

| | Staff, Visitors, and Anyone Entering the Home | Current Residents of the Home |
|---|---|---|
| **Who does this include?** | Staff working at the LTCH and all visitors, including essential visitors and anyone else entering the home.<br><br>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 (at the beginning of the day or shift). At a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes.<br>• Temperature checks are not required.<br>• All visitors coming into the home must adhere to the home's visitor policies. | • Conduct symptom assessment of all residents at least twice daily (at the beginning and end of the day) to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms.<br>• Twice daily symptom screening includes temperature checks.<br>• All residents returning from any type of absence must be screened at entry upon their return. |
| **What if someone does not pass screening (i.e., screens positive)?** | Staff, visitors, and those attempting to enter the home who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive must:<br>• Not enter the home,<br>• Instructed to immediately to self-isolate, and<br>• Be encouraged to be tested for COVID-19 at an assessment centre. | Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) must be isolated under Droplet and Contact Precautions and tested. For a list of typical and atypical symptoms, refer to the COVID-19 Reference Document for Symptoms. |

## Appendix B: Required PPE Precautions

- Where it is not possible to use other control measures to sufficiently reduce a worker's risk of exposure, personal protective equipment (PPE) will be needed. As much as possible, PPE should be used in combination with other controls.

- It is important that any PPE that workers use is appropriate for the purpose. While caring for a suspected or confirmed patient with COVID-19 appropriate PPE consists of a medical mask, eye protection (e.g., face shield, goggles), gloves and a gown. Under the appropriate circumstances a fit-tested N95 respirator or equivalent protection should be used in place of a medical mask.

| Activity | Precautions |
|---|---|
| Before every resident interaction | Staff must conduct a point-of-care risk assessment to determine the health and safety measures required. |
| All interactions with and within 2 metres of residents who screen negative | • Medical mask required<br>• Eye protection (e.g. goggles, face shield) must be worn when delivering care within 2 metres.<br>• Perform hand hygiene before and after contact with the resident and the resident's environment and after the removal of PPE. |
| All interactions with and within 2 metres of residents who screen positive, symptomatic, identified as a high risk contact of a known COVID-19 case, or have a confirmed COVID-19 infection | Droplet and Contact Precautions:<br>• Medical mask<br>• Isolation gown<br>• Gloves<br>• Eye protection (e.g., goggles, face shield)<br>• Perform hand hygiene before and after contact with the resident and the resident's environment and after the removal of PPE |

## 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: COVID-19 Immunization based Precautions in a LTCH/RH

Where applicable, **fully immunized** means that the individual has received all doses in their COVID-19 vaccine series (e.g., both doses of a two-dose vaccine series, or one dose of a single-dose vaccine series) **AND** more than 14 days have passed since the receipt of their last dose.

The following does not apply to individuals who are in quarantine/isolation under Droplet and Contact Precautions due to symptoms, high risk exposure, or confirmed case. Local PHUs may provide further advice in the event of an outbreak in the home, which may require additional precautions and/or cessation of group activities as appropriate.

**For detailed sector-specific information, including how to calculate immunization coverage rates and maintain immunization records, please refer to:**

- The Ministry of Long-Term Care's (MLTC) COVID-19 Guidance Document for Long-Term Care Homes in Ontario for LTCHs; and
- The Ministry of Seniors and Accessibility's (MSAA) Retirement Home Guidance to Implement Directive #3 for RHs.

## Immunization Coverage Thresholds

LTCHs and RHs must meet or exceed the immunization coverage thresholds in Table 1 in order to be able to safely resume communal dining (see Table 3) and organized indoor activities/gatherings (see Table 4) in the home.

**Table 1: Immunization thresholds for LTCHs/RHs**

| | LTCHs | RHs |
|---|---|---|
| Minimum **resident** immunization rate | 85% | 85% |
| Minimum **staff*** immunization rate | 70% | N/A |
| Minimum overall home immunization rate (resident + staff) | N/A | 70% |

* For the purposes of calculating immunization rates in the home, "staff" is as defined by the *Long-Term Care Homes Act* for LTCHs and by the *Retirement Homes Act* for RHs.

## Admissions and Transfers

In general, admissions and transfers are permitted when the home is not in an outbreak and the resident is not on Droplet and Contact Precautions due to symptoms, exposure, or diagnosis of COVID-19. For exceptions, please see Directive #3.

**Table 2: Admissions and Transfers Based on Resident Immunization Status**

| | **Fully immunized resident** | **Partially immunized or unimmunized resident**<br>*Opportunity to be immunized should be offered as soon as possible on admission/transfer to the home* |
|---|---|---|
| **Testing required?** | **YES**<br>- Negative laboratory-based PCR test required at admission/transfer (day 0) | **YES**<br>- Negative laboratory-based PCR test required at admission/transfer (day 0)<br>- Second negative laboratory-based PCR test result collected on day 8 to exit self-isolation on day 10 |
| **Self-isolation required?** | **NO** with a negative result<br>- Note: Resident should be isolated on Droplet and Contact Precautions until a negative laboratory-based PCR test result is received | **YES on Droplet and Contact Precautions**<br>- 10 days of self-isolation with a second negative laboratory-based PCR test result collected on day 8<br>- Otherwise, self-isolate for 14 days following arrival |

## Absences

Please refer to Directive #3 for the definitions of the four (4) types of absences and the requirements and exceptions for each type of absence. **Currently, there are no differences in the types of absences permitted for fully immunized resident versus a partially immunized or an unimmunized resident.**

- Note: At this time, the province of Ontario is under a Stay-at-Home Order (O. Reg 265/21) that has been issued under s 7.0.1 (1) of the *Emergency Management and Civil Protection Act* (EMCPA).
    - Only medical, compassionate/palliative, and essential absences are permitted at this time.

    - Essential absences are permitted when the home is not in an outbreak and the resident is not on Droplet and Contact Precautions due to symptoms, exposure, or diagnosis of COVID-19.
  - Social absences and temporary absences are currently not permitted.
  - **Further direction will be provided shortly, which will include allowances for fully immunized individuals to participate in social and temporary absences.**

## Communal Dining

- In general, communal dining among small cohorts is permitted when the home is not in an outbreak and the resident is not on Droplet and Contact Precautions due to symptoms, exposure, or diagnosis of COVID-19.
- Cohorts for dining should be the same individuals as in the indoor social activity cohorts.
- **See Table 1 for the immunization thresholds.**

**Table 3: Immunization Coverage and Dining**

| | **Home is at or above immunization threshold** | **Home is below immunization threshold** |
|---|---|---|
| **Resident precautions** | - Communal dining permitted among a small cohort of residents<br>- Physical distancing and masking in hallways/communal areas going to/coming from dining area if potential to interact with other cohorts<br>- Plexiglass/barriers between seats not required<br>  o Fully immunized essential caregivers may join a resident during mealtime | ENHANCED PRECAUTIONS REQUIRED<br>- Communal dining permitted only with physical distancing between diners during meals<br>- Decreased dining room capacity<br>- Consistent seating and physical distancing strongly recommended<br>- Masking when not eating/drinking strongly recommended |
| **Staff precautions** | - Universal masking/eye protection for workers<br>- No buffet style service<br>- Frequent hand hygiene<br>- Maintain physical distancing from residents (when not serving) and other staff | |

## Organized social activities

- In general, organized social activities are permitted when the home is not in an outbreak and the resident is not on Droplet and Contact Precautions due to symptoms, exposure, or diagnosis of COVID-19.
- Cohorts for indoor social activities should be the same as the dining cohorts.
- **See Table 1 for the immunization thresholds.**

**Table 4: Immunization Coverage and Organized Indoor Social Activities**

| | **Home is at or above immunization threshold** | **Home is below immunization threshold** |
|---|---|---|
| **Resident precautions** | - Resume normal activities in cohorts<br>- Masking and physical distancing recommended in common areas if potential to interact with other cohorts<br>- Continue to avoid high risk activities (e.g. singing, indoor physical activity)<br>- Cleaning and disinfection of high touch surfaces between activities/room use<br>- Maintain same activity groups as much as possible | ENHANCED PRECAUTIONS REQUIRED<br>- Limited capacity in a room by ability to physically distance in the room<br>o Consider having maximum capacity limits (e.g. provincial framework or otherwise)<br>- Participants (residents and staff) should physically distance from one another<br>- Masking strongly recommended<br>- Cleaning and disinfection of high touch surfaces between activities/room use<br>- Maintain same activity groups as much as possible |
| **Staff precautions** | - Universal masking/eye protection for workers<br>- Frequent hand hygiene<br>- Maintain physical distancing from residents (when not serving) and other staff | |