

Ministry of Health

COVID-19 Guidance: Congregate Living for Vulnerable Populations

Version 1 – May 28, 2020

This guidance document provides basic information and is not intended to take the place of medical advice, diagnosis or treatment, legal advice or requirements.

In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health (MOH) [COVID-19 website](#) regularly for updates to this document, list of symptoms, other guidance documents (e.g., for Long-Term Care Homes and Retirement Homes), Directives and other information (e.g., mental health resources). Health care workers should refer to these documents for specific guidance and direction with respect to health and safety and providing patient care within these settings.
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date directives as well as other resources including the provincial COVID-19 testing strategy.
- Some congregate living settings may also be subject to emergency orders made under the [Emergency Management and Civil Protection Act](#), including staff mobility. All settings subject to emergency orders must follow the requirements of these orders.
 - Additional information regarding emergency orders can be found [here](#).

This document is intended to assist with minimizing COVID-19 transmissions from individuals working or residing in congregate living settings and to help prevent, detect and manage individual cases and outbreaks of COVID-19 within these settings.

All efforts should be taken to limit the risk of COVID-19 transmission in these settings.

The guidance applies to various congregate living settings identified in the [COVID-19 Action Plan: Vulnerable People](#).

- Adult correctional institutions are not included in the scope of this guidance document. Separate guidance has been created for corrections, in alignment with advice from the MOH and Public Health Ontario (PHO).
- Congregate living settings in a First Nation community should collaborate with the community's leadership, including Chief and Council, and if applicable the federal government and/or local public health unit, in order to determine the most appropriate ways to implement the recommendations provided in this guidance, including any processes to report and support COVID-19 outbreaks.

The guidance focuses on public health measures (i.e., non-medical interventions used to reduce the spread of disease). Different ministries with oversight for congregate living settings may provide additional sector or setting specific information and direction. Some additional sector specific information is included in a compendium document. This supporting document will be posted on MOH's website and maybe updated on an ongoing basis.

Please note that this document replaces the following previously released documents: Guidance for Group Homes and Co-Living Settings, Guidance for Homeless Shelters, and Guidance for Community-Based Mental Health and Addictions Service Providers in Residential Settings.

General Advice

All congregate living settings should implement the public health measures set out in this document to help protect their residents, staff, and essential visitors against COVID-19. These measures should build on those that respond to other communicable diseases (e.g., influenza, measles). Many of these recommended measures will be part of existing organizational plans developed for disease outbreaks or other emergencies (e.g., pandemic and/or business continuity plans).

- Collaboration with other organizations is important in developing strong local, sector plans. For example, where appropriate, plans may be developed in partnership with multiple local agencies or the federal government for the safe isolation of residents who require testing, those awaiting test results, and/or those who have tested positive for COVID-19.

- Existing clinical relationships should be identified and expanded upon to facilitate clinical assessments of symptomatic residents, testing and clinical care.
- Wherever possible, employers should work with staff and unions (if applicable) to limit the number of work locations where staff work in order to minimize risk.
- In order to reduce the risk of COVID-19 transmission, only staff and essential visitors who have no symptoms associated with COVID-19 and pass screening, should be permitted in the congregate living setting. New resident admissions should be screened appropriately.
 - Policies should be developed that limit non-essential visitors to each congregate living setting to reduce risk of transmission of COVID-19.
 - An operational definition of an essential visitor should be developed and defined in the policy. This may include a person performing essential support services, such as health care services, a parent/guardian, a person visiting a very ill or palliative resident, or a maintenance worker.
- Congregate living settings should promote physical distancing between residents, staff and essential visitors – at a minimum 2 metres should be kept between all individuals regardless if they are well or unwell.

Planning Activities

- It is important that congregate living settings review their services and operations to identify ways to reduce the risk of exposure to COVID-19.
 - Each congregate living setting should consider identifying a lead person to be responsible for infection prevention and control (IPAC) practices within the setting. This individual should take the lead in educating other staff, residents and essential visitors about IPAC practices, developing or reviewing policies and procedures, and should be involved in outbreak management activities. Please refer to PHO's [website](#) for additional resources.
- Policies and procedures related to outbreak management should be in place, reviewed, communicated and updated regularly (see section on Outbreak Management). These should include:
 - When to consult with the local [public health unit](#).
 - Staffing contingency plans including adequate staff to resident ratios.

- Communication requirements and processes (e.g., between the congregate living setting and the First Nation community (if applicable), the local [public health unit](#), residents, families of residents, the Public Guardian and Trustee, other key stakeholders).
- Enhanced cleaning activities, including the frequency of wiping down commonly touched and used items.
- General education, instruction and training about disease transmission and prevention should be reviewed regularly so that all residents, staff and essential visitors have the information to make the safest choices possible. A list of topics can be found in Appendix A.
- A training program to support the safe implementation of recommended precautions should be provided to all staff and essential visitors. It is the employer's responsibility to ensure all staff and essential visitors are instructed and trained on the safe use, limitations, conservation, as well as proper maintenance and storage of supplies and equipment, including but not limited to:
 - alcohol-based hand rub (ABHR)
 - personal protective equipment (PPE)
- Procedures should be in place to transfer the care of a resident, if at any time they are unable to safely support that resident because of COVID-19, including when they are self-isolating.
- Planning should also include:
 - How to leverage existing clinical relationships to support the care of ill residents. Residents who do not have a primary care provider may access clinical assessment through Telehealth Ontario at 1-866-787-0000.
 - How to make referrals to hospitals for residents who may require hospital care.
 - How to collaborate with specialized services that may be required for the care of residents (e.g., mental health services, harm reduction services/supplies, medical services, nicotine replacement for those who may need it, addiction treatment services, including opioid agonist treatment (e.g., methadone, suboxone).

- Services provided should be delivered virtually if possible, and if not, maintaining physical distancing and avoiding face-to-face discussion. This could include medical appointments, support services, counselling, etc.
- How to convert existing spaces within the congregate living setting to increase physical distancing by considering:
 - Where appropriate, ways to reduce bed occupancy/number of residents.
 - Converting spaces (e.g., offices) into temporary single bedrooms to support residents who need to self-isolate.
- How and what services must be provided to residents who are self-isolating.
- How to access:
 - extra cleaning products that may be needed; and
 - other supplies or equipment that may be needed to continue to provide services to residents, such as PPE.

Prevention of Disease Transmission

There are many things that congregate living settings can do to prevent and limit the spread of COVID-19; core among these are proper [hand hygiene](#), respiratory etiquette and physical distancing.

- Ensuring there are enough supplies for proper hand washing, including pump liquid soap in a dispenser, potable running water and paper towels or air dryers. If possible and appropriate, consider adding ABHR stations throughout the congregate living setting. Use ABHRs with 60% - 90% alcohol. ABHR should only be used when it does not cause harm to residents.
- Providing tissues and lined no-touch garbage bins (such as garbage cans with a foot pedal) are preferred for disposal.
- Posting [signage](#) throughout the setting reminding residents, staff, and essential visitors about the signs and symptoms of COVID-19, and the importance of measures such as proper hand hygiene, and respiratory etiquette.
 - Signage should be accessible and accommodating to residents and essential visitors (e.g., plain language, pictures, symbols, languages other than English and French).

1. Hand Hygiene

Proper hand hygiene refers to hand washing, or hand sanitizing to maintain clean hands and fingernails. Hand hygiene should be performed frequently with liquid soap and water or ABHR for a minimum of 15 seconds. Hand washing is preferred when hands are visibly soiled.

Residents should be reminded to perform hand hygiene frequently throughout the day, and where required, assistance should be provided to residents who may not be able to perform it on their own.

2. Physical Distancing

Physical distancing refers to keeping a distance (a minimum of 2 metres or 6 feet) from other individuals and limiting activities outside the congregate living setting.

Physical distancing may help reduce the transmission of COVID-19 by limiting the number of people that individuals come into close enough contact with to transmit the illness.

Strict physical distancing should be practiced to help protect all residents, including those with increased risk of severe outcomes from COVID-19 (e.g., older adults, individuals with underlying medical conditions and, those who are immunocompromised due to medical conditions or medications).

- Residents should be provided with the necessary means to physically distance without creating undue social isolation.
- Activities provided in the congregate living setting should be altered to optimize and maintain physical distancing. This may include:
 - Postponing or cancelling face-to-face activities.
 - Staggering meals and/or break times and creating schedules for common areas or shared bathroom facilities.
 - Ensuring there is adequate spacing between residents/staff while eating (at least 2 metres apart).
 - Enabling people to access phones, computers, internet, television, video games or other activities in a manner that keeps people at least 2 metres apart and promoting hand hygiene before and after use.
 - Clean and disinfect any shared equipment after use with a product that is compatible with the equipment.

- Moving furniture and creating visual cues such as tape on the floor to delineate 2 metre distances.
- Planning enhanced in-house/on the property recreation and structured activities that maintain physical distancing.
- For settings that are usually closed during the day (e.g., homeless shelters), considering extending hours/offering indoor or outdoor spaces (e.g., backyard, porch) to enable residents to maintain physical distances. This could help limit the time residents spend in the community where they may become infected.
- In shared bedrooms, space should be increased between beds to at least 2 metres apart. If this is not possible, consider different strategies to keep residents apart (e.g., place beds head to foot or foot to foot, using temporary barriers between beds).
 - Avoid using bunk beds.
 - Consider additional measures, such as private rooms or rooms with the fewest number of occupants.
- Facilitating interactions between residents and their family and friends through technology (telephone and video). Shared phones should be cleaned between uses or covered with a disposable plastic covering that is removed and thrown out after each use.

3. Cleaning and Disinfecting

- In addition to daily routine cleaning, all high-touch surfaces that are touched and used frequently by residents, staff and essential visitors should be cleaned and disinfected at least twice a day and when visibly dirty (e.g., door handles, kitchen surfaces and small appliances, light switches, elevator buttons, television, remotes, phones, computers, tablets, medicine cabinets, sinks and toilets).
- Items that are used by different residents should be thoroughly cleaned between each resident use.
- Common areas including bathrooms, should be thoroughly cleaned and disinfected at least twice per day and when visibly dirty.
- Mattresses should be cleaned and disinfected between residents and clean bedding should be provided to all residents. Bedding should be cleaned on a regular schedule.

- Clean towels should be provided to each resident with instructions not to share. Hand towels should be replaced by single use paper towels.
- Cleaning should also be extended to the exterior of the congregate living setting if there is a concern that residents may pick up cigarette butts and other debris from the areas outside of the setting.
- Vehicles used for transporting residents should be cleaned between uses.

For more information and guidance on environmental cleaning, please refer to PHO's on [Cleaning and Disinfection for Public Settings](#).

4. Routine Masking to Protect Others (for Source Control)

- Non-medical masks are recommended as an additional measure for source control to help protect other individuals from exposure to the respiratory droplets of the person wearing the mask.
 - Non-medical masks help keep the wearer's droplets contained to protect others around them.
 - Science around the use of non-medical masks is evolving. Staff should refer to the Public Health Agency of Canada's (PHAC) [guidance](#).
- It is recommended that all staff and essential visitors wear non-medical masks when in the congregate living setting for the duration of their shifts or visits.
- Residents may also choose to wear non-medical masks, especially in areas where they may not be able to consistently maintain physical distancing (i.e., less than 2 metres from others).
 - Some congregate living settings may choose to encourage mask use by residents while in common spaces. For example, in short stay settings, where resident groups change frequently or where residents are anticipated to have numerous social interactions outside of the congregate living setting.
 - When developing policies on mask use by residents, consideration must be given to the safety of resident groups. PHAC's [guidance](#) has more information about populations that are not recommended to use masks.
 - Masks are not recommended for children less than 2 years of age.
 - Masks may not be tolerated by everyone based on underlying health, behaviour issues or beliefs.

- Congregate living settings should establish policies regarding the use of non-medical masks in the setting. Consideration should be given to mitigating any possible physical and psychological injuries that may inadvertently be caused by wearing a face covering (e.g., interfering with the ability to see or speak clearly, or becoming accidentally lodged in equipment the wearer is operating).
- Masks should be changed if visibly soiled, damp, or damaged.
- Education must be provided about the safe use, limitations and proper care (e.g., cleaning) of non-medical masks. See Ontario's [COVID-19 website](#) and [PHO's website](#) for additional information.

5. Masking during the Provision of Direct Resident Care

- Staff providing direct care to residents (e.g., care provided within 2 metres) should assess the need for PPE based on the nature of the planned interaction with a resident and what is known about the resident's health status.
 - If PPE is currently being used in the congregate living setting to support existing policies and procedures, this should continue.
 - With respect to [IPAC purposes](#) related to COVID-19 specifically, PPE should be used when providing direct care to residents who have symptoms or have tested positive for COVID-19.
- Additional guidance about the selection of PPE can be found in PHO's document on [Risk Algorithm to Guide PPE Use](#).
 - Non-medical masks are not considered PPE. Recommendations for the use of PPE are based on risk assessments of specific environments and risk of exposure.

Screening

- All congregate living settings should undertake passive (using signage) and active (asking screening questions) screening for residents, staff and essential visitors.
- [Signage](#) should be posted on every entry door and throughout the congregate living setting to prompt anyone to self-identify if they feel unwell or screen positive for [signs and symptoms](#) of COVID-19.

1. Entry Screening for all Residents, Staff and Essential Visitors

- All individuals should be actively screened prior to entry. A formal process should be established to ensure rigorous screening activities. Settings may wish to adapt the screening tool found on the MOH's [COVID-19 website](#).
- During screening activities, organizations should consider:
 - Limiting points of entry into the setting to help facilitate screening.
 - Placing a physical barrier (e.g., plexiglass) that staff can be behind in order to conduct screening at entrances to protect from droplets.
 - Spacing and layout at the entrance so that physical distancing can be maintained while staff conduct screenings.
 - The need for medical (surgical/procedure) masks and eye protection, ABHR, tissue, and lined no-touch waste basket or bin to screening staff in situations where a physical barrier is not available and close contact with an individual is likely to occur.
 - Encouraging all residents, staff and essential visitors to use ABHR before entering.
- Staff and essential visitors who do not pass this screening should not be permitted to enter the congregate living setting.
- Residents who do not pass this screening should be directed to a designated space where they can self-isolate and wait for arrangements to be made for a clinical assessment.
- As part of screening, all residents, staff and essential visitors should be advised that if they start to feel unwell, they should immediately notify a designated individual (either staff or a supervisor).

Emergency first responders should be permitted entry without screening.

2. Screening New Admissions/Transfers

- Where possible, new admissions or transfers should be screened over the phone for [signs and symptoms](#) of COVID-19 before admission (intake).

Long Stay Settings

- Where operationally feasible, all new admissions or transfers into long stay settings (i.e., where residents are anticipated to stay for more than 14 days) should be tested for COVID-19 prior to admission. Regardless of the test results, new residents should also [self-isolate](#) for a period of 14 days upon arrival.
- Settings should consider whether it is necessary, safe and operationally appropriate to postpone the admission of those who test positive (under the advice of the local [public health unit](#) provided through case management activities). If admission is postponed, individuals should be referred to other organizations or services in the community where they can be housed for the self-isolation period.

Short Stay Settings

- If pre-admission screening is not possible/feasible, congregate living settings should screen in-person on arrival (see above).

3. Daily Screening of Residents, Staff and Essential Visitors

- All residents, staff and essential visitors should be instructed to [self-monitor](#) for COVID-19 [signs and symptoms](#) and inform staff or their supervisor as soon as they begin to feel unwell.
 - Staff should monitor residents that are unlikely to recognize or understand the importance of reporting symptoms and those who may not be able to self-monitor such as children and adults with developmental disabilities.
- Residents, staff and essential visitors should be screened twice daily for COVID-19 [signs and symptoms](#). Where operationally feasible, this could include temperature checks. Staff and essential visitors should be screened at the start and end of each shift or visit.
- Congregate living settings will need to consider how to operationalize these recommendations within their existing policies, procedures and other requirements.

4. Positive Screening: What to do

- If a resident develops [signs and symptoms](#) of COVID-19, they should be placed in a single room with a door that closes.

- If this is not feasible and they may come into contact with others, they should be placed in an area away from other residents and given a medical (surgical/procedure) mask to wear if it is safe for the resident.
- Staff should try to maintain physical distance between themselves and the resident (i.e., 2 metres or more) while monitoring and providing assistance to them.
- Congregate living settings should consider procedures for:
 - How and where the resident can be clinically assessed.
 - How testing can be arranged (e.g., assessment centre, health care provider on site). Information about assessment centres is located on the MOH's website.
 - For congregate living settings that have identified in their planning that they can not safely house someone who is self isolating for COVID-19, how to transfer them to a designated location.
 - What to do if a resident develops severe symptoms.
- If staff or an essential visitor develop [signs and symptoms](#) of COVID-19, they should tell their supervisor immediately and separate themselves from others.
- Staff who have been advised to self-isolate should notify their supervisor or the administrator of the congregate living setting.

Caring for Residents that need to Self-Isolate

- New admission in long stay settings, as well as residents who are unwell, those awaiting test results and those who have tested positive for COVID-19 should [self-isolate](#).
- Any resident who needs to [self-isolate](#), should be placed in a single room with a door that closes and if feasible, have access to a private bathroom.
- If there is not enough space in the congregate living setting for the resident to [self-isolate](#), the resident may be grouped (cohorted) with others who are in the same situation (e.g., group those who are unwell/symptomatic), while maintaining as much distance as possible from other individuals or groups (e.g., those who are not ill).

- Staff providing direct care should take appropriate precautions depending on the nature of the planned interaction and what is known about the health status of the resident. See [Risk Algorithm to Guide PPE Use](#).
 - See PHO's [Droplet and Contact Precautions Non-Acute Care Facilities](#) for additional information.
- Congregate living settings should consider:
 - How to protect staff who need to provide care to the resident, and how to decide when PPE will be needed.
 - How to isolate the resident in a private room for a period of 14 days or until they no longer have symptoms.
 - How to support the resident remaining in their room, including the ability to receive meals in their room, and, if possible, not sharing a bathroom with others.
 - If strict self-isolation is not feasible, a medical (surgical/procedure) mask should be provided to the resident if safe and tolerated, for the entire time they are outside of their room (including when accessing a shared bathroom). Everyone should perform hand hygiene when putting on and taking off their mask.
 - How to maintain physical distancing, staggering access, and undertaking thorough cleaning and disinfection to common spaces when the unwell resident uses common facilities.
 - Who will monitor the resident's symptoms and how often this will be done, how it will be logged, and how to determine when additional medical care and intervention is required.
 - How to access transportation (not public transportation) if there is a need to move the resident between locations.

Reporting

- COVID-19 is designated as a disease of public health significance (O. Reg. 135/18) and thus reportable under the [Health Protection and Promotion Act](#) (HPPA).
- In addition to any duty to report a suspected or confirmed case of COVID-19 under the [HPPA](#) and other legal reporting requirements, administrators of all congregate living settings are encouraged to contact their local [public health unit](#)

if a resident, staff or essential visitor has or may have COVID-19 to facilitate timely contact tracing and outbreak management within the setting.

- It is important to indicate the type of care setting to the local [public health unit](#) as they are tracking cases within congregate living settings.

Outbreak Management

- An outbreak within a congregate living setting is defined as one laboratory confirmed case in a resident or staff. Outbreaks are declared by the local medical officer of health or their designate in coordination with the administrator of the congregate living setting.
- Once an outbreak has been declared, the local [public health unit](#) will direct testing and associated public health management of all those impacted (staff, residents, essential visitors).
 - If large numbers of residents require testing, the local [public health unit](#) and the congregate living setting administrator may collaborate to make arrangements to either bring testing services to the setting or make arrangements with the local COVID-19 Assessment Centre.
- The local [public health unit](#) will provide guidance with respect to any additional measures that should be implemented to reduce the risk of COVID-19 transmission in the setting.
- As part of the outbreak management process, the congregate living setting should notify individuals/agencies about the outbreak as listed in the setting's procedures and policies.
- Residents, staff and essential visitors should be made aware of the outbreak measures being implemented at the congregate living setting.

1. Control Measures

Control measures are any action or activity that can be used to help prevent, eliminate or reduce a hazard. Once an outbreak is declared, the local [public health unit](#) will provide direction to the congregate living setting to help manage the outbreak, and the control measures they should implement. This includes:

- Defining the outbreak area (i.e., affected unit(s) or the whole congregate living setting) by:

- Considering all residents in the outbreak area to be either infected or exposed and potentially incubating.
- Cohorting all residents in the outbreak area as much as possible.
- Having staff in the outbreak area work with only one group of residents on each shift if possible.
- Providing direction on how staff can protect themselves when interacting with residents in the outbreak area.
- Providing in-room tray service meals within the outbreak area to avoid communal dining.
- Undertaking enhanced cleaning practices.
- Limiting or restricting new admissions:
 - Best practice is that no new resident admissions should be allowed into the outbreak areas until the outbreak is declared over.
 - Depending on the services provided by the congregate living setting, new admissions/re-admission may be required during an outbreak. In such instances, the administrator should connect with the local [public health unit](#) for guidance.

2. Personal Protective Equipment (PPE)

- The selection of PPE should be based on the nature of the interaction with the resident and/or the likely mode(s) of transmission of infectious agents. Selection of appropriate PPE should be based on a risk assessment (e.g., type of interaction, status of resident) that dictates what is worn to help break the chain of transmission. More guidance about the selection of PPE can be found in PHO's document on [Risk Algorithm to Guide PPE Use](#).
- In addition to other precautions as dictated by the nature of the patient interaction, see PHO's guidance on [IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#).
 - An N95 respirator is only recommended if an [aerosol-generating medical procedure](#) is being performed (this is unlikely to be required in most congregate living settings).

- Staff should wear a medical (surgical/procedure) mask, eye protection and gown when in the outbreak area where resident interactions are possible. Gloves are donned when providing direct care and hand hygiene performed when removed. See [Droplet and Contact Precautions](#). Gowns should not be worn in non-care areas such as staff-only areas or break rooms.
- Congregate living settings should ensure that an adequate supply of PPE is available for staff and essential visitors.

3. Declaring the Outbreak Over

The local medical officer of health or their designate will declare when the outbreak is over.

Generally, an outbreak is declared over when there are no new cases of COVID-19 in residents or staff after 14 days.

Occupational Health and Safety

- Employers have obligations under the [Occupational Health and Safety Act](#) (OHSA) to protect the health and safety of their workers¹, including from the transmission of infectious disease in the workplace.
- If COVID-19 is suspected or diagnosed in staff, return to work should be determined by the individual in consultation with their health care provider and the local [public health unit](#), based on provincial guidance. Detailed occupational health and safety guidelines for COVID-19 are available on the MOH [COVID-19 website](#) and the Ministry of Labour, Training and Skills Development [website](#).

¹ This section will refer to workers as defined under the *Occupational Health and Safety Act*.

Appendix A – General IPAC Education Topics

- The ongoing education of staff, essential visitors and residents about infection and outbreak prevention and related strategies is crucial to help control the spread of COVID-19. The congregate living setting should also implement COVID-19 screening measures for all residents, staff and essential visitors.
- Education for staff should include education/orientation programs and should include information and review of:
 - Information about COVID-19, including [prevention](#) and transmission.
 - The strategies to reduce disease transmission, such as [respiratory etiquette](#) and [hand hygiene](#).
 - Outbreak management and staff exclusion policies in the congregate living setting (as required).
 - Policies related to staff and essential visitors who may be experiencing symptoms of respiratory illness and should not be working or visiting the setting.
 - IPAC competencies and resources. See PHO's [website](#) for resources.
 - Current Ministry of Health and Public Health Ontario guidance and training resources on IPAC (including as they evolve and are updated).

Education for residents:

- Information about COVID-19, including prevention and transmission.
- Residents should be reminded about the importance of hand hygiene, respiratory etiquette, and physical distancing.
- Discourage residents from sharing items with other residents that touch the mouth or nose (e.g., personal care items, straws, utensils, cigarettes, drinks, vapes, drug paraphernalia).
 - Items such be labelled with the resident's name.

Hand Hygiene

- Hand hygiene should be performed often and especially before and after:
 - After entering the facility.
 - Before and after touching surfaces or using common areas or equipment.

- Before eating.
- Before and after preparing food.
- Before touching the face (including before smoking).
- After using the bathroom.
- Ensure supplies (i.e., liquid hand soap, ABHR, paper towels/tissues, garbage cans) are easily accessible and regularly maintained. Avoid use of bar soap.
- Disposable paper towels are preferred, but cloth towel that is only used by one person may be used.
- Designate a sink for staff hand washing (if possible).
- Avoid touching the face, eyes, nose, and mouth at all times, especially with unwashed hands.

Respiratory Etiquette

- When coughing or sneezing, all individuals should:
 - Turn their head away from others.
 - Cover their nose and mouth.
 - Cough or sneeze into sleeves/bend of the arm and not hands or use a tissue.
 - Disposing of used tissues as soon as possible in a lined, non-touch waste basket or garbage bin, followed by performing hand hygiene.

Appendix B – Additional Resources

Public Health Ontario – Public Resources

<https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/public-resources>

COVID-19 Preparedness and Prevention in Congregate Living Settings - English

<https://www.publichealthontario.ca/-/media/documents/nCoV/cong/2020/05/covid-19-preparedness-prevention-congregate-living-settings.pdf?la=en>

Managing COVID-19 Outbreaks in Congregate Living Settings - English

<https://www.publichealthontario.ca/-/media/documents/nCoV/cong/2020/05/managing-covid-19-outbreaks-congregate-living-settings.pdf?la=en>