



Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Craiglee LTC Home

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Kim Ryley - RN, Interim Executive Director	8-May-26
Director of Care	Renee Magtoto - RN, Interim Director of Care	8-May-26
Executive Directive	Kim Ryley - Interim Executive Director	8-May-26
Nutrition Manager	Aashiyana Khetani - Dietary Manager	8-May-26
Programs Manager	Ayesha Young - Program Manager	8-May-26
Clinical Consultant	Cindy Britton - RN, Clinical Consultant	8-May-26
Resident Council Representative	Andrea Juvonen	8-May-26
Family Council Representative	Dee Sarwan	8-May-26
Medical Director	Gary Weinstein	8-May-26
Other	Claudia Petan - RPN Assistant Director of Care	8-May-26
Other	Brianna Rayson - Social Worker	8-May-26

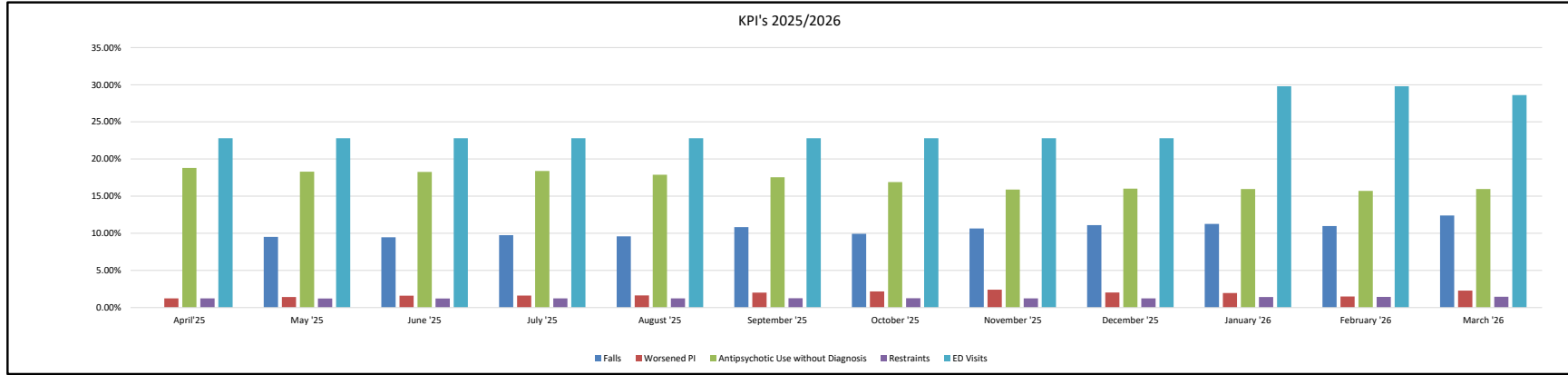
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
To reduce rate of Avoidable ED visits by 1% by March 2026 for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	<p>Change Idea; Utilize and Review ED Tracker - The home continue to track daily ED transfers with discussion of rationale for the transfers at Risk Management meetings. The Leadership team initially completed monthly drill -through meetings to the determine need for transfer. The results of the discussions lead to an increase in frequency of the drill-through meetings to weekly to assist in identifying residents who may be at risk based on diagnosis within a timely manner. There was a total of 86 ED visits in the last 4 quarters. Of these visits, 86.04% were initiated by the Nurse Practitioner or Physician and 12.79% were Family and/or Resident requests.</p> <p>Change Idea; Utilization of Nurse Practitioner and NLOT Resources - The Nurse Practitioner is on site 4 days per week for advanced physical assessments in the management of resident's health conditions. The Nurse Practitioner continue to provide on the spot education such as catheterization, chest assessment to staff utilizing critical thinking skills to identify and review a resident's health conditions prior to any ED transfer that may warrant an ED Transfer. The home continues to enlist the services of the External resource team, NLOT, to provide additional support for Registered staff education such as SBAR documentation training. The SBAR is a standardized communication framework providing concise, structured method to share essential information between the interdisciplinary team. The framework prevents miscommunication by organizing facts to assist Health care professionals in the decision-making process.</p> <p>Change idea; Development of IV program in the home; Nine Registered staff completed IV training in February 2025. In the past four quarters, the home initiated one IV therapy. The NLOT team will continue to provide education for new registered staff and as a refresher to maintain competency.</p> <p>Change Idea; Hydration - Registered staff continue to track daily fluid intake of all residents to ensure early identification of hydration status with follow up by the Registered Dietician referral process and hydration assessments. Education was provided to Registered Staff on the Hydration Policy. During Risk Management meetings hydration status is reviewed to identify residents at risk for timely intervention.</p>	<p>The Provincial Average for avoidable ED visits 2025/2026 was 21.9%. The home's KPI for March 2025 was 22.8% with a goal of reducing the KPI by 1% by March 2026. The home's KPI for December 2025 escalated to 29.8% with the Provincial Average at 22.3%. During the 3rd and 4th quarter, the home had experienced an increase in transfers to the ED for residents with declining health. While some transfers were medically necessary others were influenced by family and/or resident preference, as well as collaborative clinical decisions made by the Nurse Practitioner and Physician. The Home's ability to achieve the goal of 1% reduction was unsuccessful. As of March 31, 2026, The home's KPI remains at 29.8%. During the last quarter of the year, there has been a increased focus on education to the clinical team on recognizing early signs of deteriorating status of residents and enhanced discussions about goals of care at admission with a focus on residents with life limiting illnesses and revisited as a resident's condition evolves.</p>
To maintain 100% of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education by March 2026	<p>Change ideas; Diversity Training through SURGE education or live events; 100 % of staff completed SURGE education modules for equity and diversity. Mandatory "Working Better Together" education for all departments was scheduled in the 3rd quarter of the year presented by an external Senior Safety Consultant. Townhall meetings and operational planning days were held throughout the past year to create meaningful opportunities for different voices across all levels of the team to be heard and thoughtfully incorporated into our decision-making. The Leadership team upheld the "open door" policy throughout the year as evidenced by the results of the Resident Satisfaction Survey 92.96% and Family Satisfaction Survey 93.15%</p> <p>Change Idea; Implementation of Cultural programs; Throughout the year, the home proudly celebrated a variety of cultural events, including Diwali, Chinese New Year, Thanksgiving and Halloween. Each celebration included engaging activities, festive decorations highlighting the history and traditions of the events. Team members including residents wore traditional attire, participated in cultural dancing and enjoyed meaningful opportunities to discuss and learn about different cultures in an inclusive environment.</p>	<p>As of December 31, 2025, 100% of diversity training was completed by staff actively working in the home; Throughout the past year, the Open door policy remains a consistent form of communication between leadership, residents, staff and families. In November 2025, a total of six (6) sessions were scheduled on "Working Better Together" with a participation rate of 80.5% or 161 staff out of a possible 200 employees.</p>
To increase percentage of residents by 2% who responded positively to the statement: "I can express my opinion without fear of consequences by March 2026	<p>Change ideas: Resident and Family Participation in various meetings and education - Two residents have been appointed to Resident Council Chair and Co-Chair and act as Resident Ambassadors. The residents participated in the development of monthly Activity calendars. Food Council meetings and</p>	<p>In the last three quarters of the reporting period the co-chair of the family council attended 75% of the scheduled CQI meetings. Residents participated 100% in the quarterly CQI meetings and are involved in the development of the monthly calendar and in the food council monthly meetings</p>

	<p>quarterly CQI meetings. A Family member is invited to attend quarterly CQI meetings.</p> <p>Change Ideas:Customer Service and Resident Rights SURGE education: was completed by 100% of active staff in the home. The education content included enhancement of customer service skills, emphasizing empathy, active listening and effective communication. In the coming year, emphasis will be placed on additional education focussed on Customer Service.</p> <p>Change Ideas: Bill of Rights # 29: Ad Hoc multidisciplinary ongoing discussions continue to be held with the team to reinforce the importance of respecting resident choices while balancing the need to effectively assess and manage associated safety risks. Bill of Rights continues to be a standing agenda item at departmental meetings. Due to competing priorities, town hall meetings were not consistently scheduled in the last year. The home will refocus and schedule quarterly town hall meetings with Resident Bill of Rights as a standing agenda item with the focus on #29.</p> <p>Change Idea; Complaints and Concerns .The process continues to be reviewed with the Resident and Family during admission, post admission and annual care conferences .</p>	<p>and they continue to act as resident ambassadors.By December 31st 2025, 100% of departmental staff completed education on customer service.In the first quarter of the year additional education focusing on customer servive was provided to all registrered staff by external services(NLOT) .Informal ad hoc education on customer service was provided to all registeread staff throughout the year.Bill of rights #29 is included in all departmental meetings template.All admission packages includes inormation to guide residents and families through the complaint process.</p>
<p>To decrease percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment by 4% by March 2026</p>	<p>Change ideas:Improve the interdisciplinary collaborative approach: Residents who are prescribed antipsychotic medication for the management of responsive behaviours had and continue to have monthly review to assess the ongoing need for the medication supporting the diagnosis and indication for use by the BSO team in collaboration with the Nurse practitioner, pharmacist and physicians.The review focuses on evaluating the potential for those reduction or deprescribing .The interdisciplinary team remains active in suporting residents through the behavioural support Ontario(BSO) and Geriatric mental health(GMHOT),Baycrest for the residents with complex behavioral needs.The team assists in identifying individual startegy to optimize care and the reduce the reliance on antipsychotic medication.</p> <p>Change idea:Antipsychotic monitoring: The home continue to track the use inappropriate antipsychotic use at monthly and quarterly interdisciplinary rounds including status updates of behaviours and identification of residents who may benefit from reduction or deprescribing .</p>	<p>The home's antipsychotic use without diagnosis in April 2025 was 19.87%,in December 2025 16.02% and in March 2026 15.96%.The home was successful in exceeded the corporate benchmark of 17.5% with the implented change ideas .In November 2025 and February 2026 Gentle persuasive approach sessions were offered resulting in 60 staff members completin the education .In February 2026 two staff members became certified GPA coaches to support internal capacity for education and training.</p>
<p>Decrease percentage of LTC home residents who fell in the 30 days leading up to their assessment.</p>	<p>Change idea:Falls Huddle The home continues to have weekly huddles in place and continues to identify residents with multiple falls and focus on individualized approach to prevent falls. The restorative program has been re-established in the home and a registered staff is now co-leading the program.</p> <p>Change idea: Care plan review Over the last four quarters care plans were reviewed during post fall huddles to determine if the interventions in place were effective and if determined that was not effectiev, new strategies were discussed and incorporate din the care plan.In addition,on a monthly basis 5 % of care plan were completed the home conducted</p>	<p>The home's KPI for April 2025 was 9.84% which excedeed the corporate benchmark of 15%. The home will continue to maintain bellow the corporate benchmark.However thoroughout the reminder of the year,the KPI increased in December 2025 to 11.11% and 12.39% in March 2026. The home will have a continues focus of falls prevention strategies with a hyghthened focus with residents with repeated falls to reduce repeat falls among high risk residents through targeted prevention interventions.The home's goal is to achive and sustained the corporate benchmark while enhancing residets's safety and reducing fall related risk to imporve resident outcomes.</p>
<p>2024 Resident Satisfaction Survey</p> <p>Top 5 Opportunities</p> <ol style="list-style-type: none"> 1) Staff take time to chat with me = 71.83% 2) I am satisfied with the quality of care from: Dietitian = 71.50% 3) I am satisfied with the temperature of my food and beverages = 70.63% 4) Residents are friendly with each other = 70.63% 5) I would recommend this Home to others = 67.06% 	<p>1) The Home encouraged staff to engage in resident conversations and reinforce awareness of "All About Me" binders. At staff Town Hall meeting, the Home discussed the importance of resident engagement and On January 29, 2025, the Executive Director (ED) introduced the benefit of meaningful conversations with residents. Staff were encouraged to take time to chat with residents, giving their full attention when care is not being provided, to enhance personalized interactions. The "All About Me" binders, located on each unit and in resident wardrobes, were highlighted as a key tool to facilitate more personalized conversations.</p> <p>2) The Dietitian attended and continues to attend the Monthly Food Council meetings and will attend care conferences for residents identified as high nutritional risk to ensure all dietary reccomnadations are documneted and communicated to families. The Dietitian and Food Service Manager attend Resident Council Meetings monthly and attends care conferences for residents identified as high nutritional risk to ensure proper care planning.</p> <p>3) Through the Food Service Council Meeting residents have been informed of the request for staff of the food warming options. Through weekly audits the management team ensures that all equired food temperatures are measured and recorded and address any deviations promptly through corrective action and staff training.</p> <p>4) The Recreation Department organizes at least one new informal social event per month to create relaxed environments for connection. Events may include:Coffee & Conversation Gatherings;Game & Puzzle Socials;Music & Memory Sharing Circles;Cultural & Themed Meetups Focus on activities that encourage natural conversation and accommodate varying levels of participation.</p> <p>5) Management team members actively participated in residents programs and events in a casual setting,such as barbeque,musical entertrainment and birthdays parties.</p>	<p>2025 Resident Satisfaction Survey</p> <ol style="list-style-type: none"> 1) Staff take time to chat with me = 88.99% Improvement 2) I am satisfied with the quality of care from: Dietitian = 78.33% Improvement 3) I am satisfied with the temperature of my food and beverages = 81.21% Improvement 4) Residents are friendly with each other = 87.96% Improvement 5) I would recommend this Home to others = 81.33% Improvement

<p>2024 Family Satisfaction Survey Top 5 Opportunities</p> <ol style="list-style-type: none"> 1) I am satisfied with the quality of care from physiotherapist/occupational therapist = 79.99% 2) I am aware of the spiritual care services offered in the Home = 79.85% 3) Contenance care products are comfortable = 78.26% 4) I am satisfied with the timing and schedule of spiritual care services = 76.55% 5) I am satisfied with the variety of spiritual care services = 75% 	<ol style="list-style-type: none"> 1) The home was able to enhance family awareness of physiotherapy services, including service frequency, selection criteria, and residents rights, while ensuring PT/PTA engagement in care planning by including information in the family newsletter, at the residents' council. PT/PTA participated in annual care conference. 2) The visibility and accessibility of spiritual care services for residents and families was improved via increased communications and promoting available resources, by adding information in the family and residents newsletter, providing calendars with information at the reception, emailing calendars and adding the spiritual programs to the door of the chapel. 3) We worked at enhancing the effectiveness of incontinence product use by establishing accurate baseline and ensuring proper sizing for all residents, by completing 10% audit and establishing the new baseline. In March 2025, we implemented sizing adjustments and ensured staff receive training and continued monitoring and reassessing product effectiveness. 4) The home worked at enhancing the communication about spiritual services and provided accessible worship opportunities for residents and their families, by placing posters near the main elevator, on the chapel door with the services and time of service, adding information to the residents and family newsletter and making the chapel available to residents once more as their main space. 5) Residents were provided with consistent access to spiritual services that aligned with their faith and preferences, enhancing their emotional and spiritual well-being, by increasing awareness through postings and invitations each month. The chapel space was returned to fully being used as the spiritual space. Family and residents were informed via newsletters and at the residents' council meeting. 	<p>2025 Family Satisfaction Survey</p> <ol style="list-style-type: none"> 1) I am satisfied with the quality of care from physiotherapist/occupational therapist = 82.5% Improvement 2) I am aware of the spiritual care services offered in the Home = 82.69% Improvement 3) Contenance care products are comfortable = 80.64% Improvement 4) I am satisfied with the timing and schedule of spiritual care services = 80% Improvement 5) I am satisfied with the variety of spiritual care services = 83.85% Improvement
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Key Performance Indicators												
KPI	April '25	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Falls	9.59%	9.52%	9.47%	9.75%	9.59%	10.83%	9.93%	10.66%	11.11%	11.27%	10.97%	12.39%
Worsened PI	1.25%	1.42%	1.60%	1.62%	1.63%	2.01%	2.18%	2.41%	2.04%	1.97%	1.50%	2.28%
Antipsychotic Use without Diagnosis	18.80%	18.30%	18.26%	18.38%	17.89%	17.54%	16.89%	15.88%	16.02%	15.95%	15.70%	15.96%
Restraints	1.24%	1.23%	1.23%	1.24%	1.24%	1.26%	1.26%	1.24%	1.25%	1.43%	1.44%	1.46%
ED Visits	22.80%	22.80%	22.80%	22.80%	22.80%	22.80%	22.80%	22.80%	22.80%	29.80%	29.80%	28.60%



How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and incorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year

Date Resident/Family Survey Completed for 2024/25 year:	The 2025 Resident and family surveys were conducted from October 1st to 31st of 2025
Results of the Survey (provide description of the results):	The participation of the residents and family was 100% completion for the surveys given out. Overall our top strength for residents were, courtesy in the dining room 85.38%, access to foot care when needed 84.68%, feeling comfortable raising concerns with the staff and leadership 83.71%, being satisfied with laundry, cleaning, and maintenance services, 83.70% and being able to express opinion with out fear of consequences 83.46% . For Families: having the opportunity to provide input on food and beverage options 98.48%, Having someone to talk to about the resident's medications 94.55%, Residents being able to choose the time that they get up in the morning 93.98%, being able to express my opinion without fear of consequences 92.96%, and being satisfied with the food and beverages served to residents 89.91% Opportunities for improvements: Residents: I am satisfied with the quality of care from doctors, 73.31%, I am updated regularly about any changes in the home, 72.73%, I am satisfied with the variety of food and beverages,72.39%, I am satisfied with the temperature of my food and beverages 71.21% and I am satisfied with the food and beverage served to me , 70.90%. Family: Areas of improvements were, I am satisfied with the quality of care from,PSW 80.56%, Overall, I am satisfied with the recreation and spiritual care services, 80.42% , the timing and schedule of spiritual care services 80.00%, overall, I am satisfied with laundry, cleaning, and maintenance services 80.00% and the resident has access to a hairdresser when needed 79.08%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results were communicated to the residents' council on the 3rd of March 2026 at at the resident council meeting and posted for residents and staff . The social worker share the results with the family council.

Client & Family Satisfaction	Resident Survey					Family Survey				Improvement Initiatives for 2026
	85%	100%	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)		
Survey Participation	85.00%	100.00%	54.62%	92.45%	100.00%	100.00%	54.00%	92.34%	Family and residents will receive newsletters and monthly activity calendar each month, iPad will be available	
Would you recommend	90.00%	81.33%	67.06%	82.98%	97.55%	67.06%	88.39%	82.98%	The chapel will receive some aesthetics enhancement to provide a more chapel feel to the space. The timing and schedule of spiritual care services will be posted on the door of the chapel.	
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	92.96%	93.15%	83.18%	80.95%	93.15%	84.17%	83.18%		

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	Target/Change Idea	Current Performance
Rate of ED visits for modified list of ambulatory care--sensitive conditions* per 100 long-term care residents.	Change Ideas: 1) To reduce avoidable hospital transfers, through the use of on-site Nurse Practitioner, Physicians and NLOT 2) Implementation of the Nursing PLEDGE initiative program to build capacity and improve overall clinical assessment skills of Registered staff by supporting mentorship of nurses, enhancing quality of care and workforce stability 3)SBAR Documentation -Registered staff to communicate a comprehensive resident assessment to Physician or Nurse Practitioner , if able, to obtain direction prior to initiating an ED transfer. Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. 4) Advanced Care Planning/Goals of Care discussed with resident and families during care conferences; Education on palliative approach and end of life for staff, residents and families. Introduce the use of Gold Standard Framework to help with Identification Guidance-GSF (PIG), is a guide for clinicians to assist with earlier recognition of decline for patients considered to be in their final year(s) of life. 5) Build capacity and improve overall clinical assessment skills of Registered staff, through education supported by NP. Development of IV program in the home by supporting skills competency. (NLOT)	29.79% as of January 2026
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education?	Change Ideas: 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace 2) To increase diversity training through Surge education or live events 3)To facilitate ongoing feedback through open door policy and daily manager walkabouts 4)Development of Cultural Diversity team within the home comprised of staff, resident and family members- to assist with developing cultural and recognition events/programs within the home	99.54% as of December 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Change Ideas: 1) To maintain or exceed our goal of 98.55%. Engaging residents in meaningful conversations, and at care conferences, that allow them to express their opinions. 2) Continue reviewing Resident's Bill of Rights at Monthly Resident council meetings with a focus on Resident Rights #29; Review of the Whistleblower policy, Complaint/Concern process in the home 3) Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers 4) Add focus to review Resident Bill of Rights #29 at Family council quarterly meetings	98.55% as of October 2025

<p>Percentage of LTC home residents who fell in the 30 days leading up to their assessment</p>	<p>Change Ideas: 1)To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2)Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls 3)Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program) 4) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss 5)Create activity bins, for resident to assist with engagement. Collaboration with Program department, to implement recreation activities, to engage residents (analysis of when falls are occurring to develop timing of activities) 6)Purposeful rounding, for resident at high risk for fall 7)During admission process, a falls history and interventions will be reviewed with resident and/or family member</p>	<p>10.83% as of September 2025</p>
<p>Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment</p>	<p>Change Ideas: 1)During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health) 2)The MD, NP, BSO Internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. Meetings will be discussed as a standing item in CQI/PAC quarterly meeting agenda 3)Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic) 4)Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home.</p>	<p>16.08% as of September 2025</p>
<p>Percentage of LTC residents who develop worsening pain</p>	<p>Change Ideas: 1) Enhancement of the Palliative Care and End of Life program 2)Utilization of pain tracker, to monitor the use of PRN analgesic with discussion with resident how pain was previously managed and the goal for pain management</p>	<p>9.67% as of September 2025</p>
<p>2025 Resident Satisfaction Survey Top 5 Opportunities 1)I am satisfied with the quality of care from: Doctors 2)I am updated regularly about any changes in the home 3)I am satisfied with the variety of food and beverages 4)I am satisfied with the temperature of my food and beverages 5)I am satisfied with the food and beverages served to me</p>	<p>Action Plan: 1) In the upcoming newsletter, share information about what can be expected from the home's physician team Invite MD to present at RC Meeting letting residents know what they can expect from the physician team Solicit for feedback on the physicians at upcoming RC Meeting and document in the minutes 2) Home to lead Resident Town Hall on a monthly basis where updates can be shared Home to include section "Monthly Updates" in the monthly newsletter. Leadership team continues to practice open door policy which will be shared at upcoming RC Meeting Residents to continue to be invited to the quarterly CQI Meeting Add Monthly Updates poster to each home area resident communication board 3) FSM and RD to review upcoming menu cycle menu with residents in advance at FC and RC Meeting to obtain their input and approval for the next menu cycle Ginger ale to be offered on a weekly basis on the snack cart instead of every 3 weeks. This will be shared at the upcoming FC meeting. 4) Provide training to dietary staff on the Hot Holding policy FSM or designate to audit food temperatures randomly at least 3x per week Provide education to residents at FC on the complete meal service procedure including tray service Provide re-education to team members on the meal service and tray service procedure FSM to complete Taste Test Audit schedule for implementation with the leadership team 5) Share at FC that beverages are standard across the organization as per SB Menu and unable to change. FSM and RD to review upcoming menu cycle menu with residents in advance at FC and RC Meeting to obtain their input and approval for the next menu cycle</p>	<p>2025 Resident Satisfaction Survey Results: 1) 73.31% 2) 72.73% 3) 72.39% 4) 71.21% 5) 70.90%</p>

<p>2025 Family Satisfaction Survey Top 5 Opportunities 1) I am satisfied with the quality of care from:Personal support staff 2) Overall, I am satisfied with the recreation and spiritual care services. 3) The timing and schedule of spiritual care services. 4) Overall, I am satisfied with laundry, cleaning, and maintenance services 5) The resident has access to a hairdresser when needed.</p>	<p>Action Plan: 1) Implement Welcome Meeting for new admission and family when they are admitted so that they can familiarize themselves with the home's practices and care team Including front line staff in the care conferences moving forward 2) Home to send residents and families newsletter and monthly activity calendar each month Decorate and enhance aesthetics of the chapel so that it looks like a chapel Program Manager to provide update to FC Assistant for each meeting every month 3) Post timing of spiritual care services on the Chapel door. Include timing and schedule of spiritual services in the activity calendar and monthly newsletter. 4) Streamlining and re-aligning of EVS services Re-education with EVS staff on their job description Communicate of re-alignment and processes in EVS services to RC and FC Implementation of the on floor Linen Carts vs the current closet procedure Implementation of the Daily HK Audit by the HK Supervisor 5) Communicate schedule of hairdresser for the next month in the monthly Resident and Family Newsletter Create advertisement for hair salon services, present at FC and post in the home and add to TV Share information on hair services at the New Admission Meeting</p>	<p>2025 Family Satisfaction Survey Results: 1) 80.56% 2) 80.42% 3) 80.0% 4) 80.0% 5) 79.08%</p>
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Process for ensuring quality initiatives are met

Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures	<i>Print out a completed copy - obtain signatures and file.</i>	Date Signed:
Quality Improvement Lead	Kim Ryley	8-May-26
Executive Director	Kim Ryley	8-May-26
Director of Care	Renee Magtoto (Interim DOC)	8-May-26
Nutrition Manager	Aashyana Ketani	8-May-26
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