

HOME NAME : Sumac Lodge

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Jennifer Black - BAC in Administration - Executive Director	15-Jun-26
Director of Care	Dana Laplante - Registered Nurse - Director of Care	
Executive Directive	Jennifer Black - BAC in Administration - Executive Director	
Nutrition Manager	Kaitlyn Chartrand	
Programs Manager	Tessa Meyer-Greenson - Recreation and Leisure - Program Manager	
Clinical Consultant	Juan Carlo Cruz - Registered Nurse - Clinical Consultant	
Resident Council Representative	Laurette Laviolette	
Family Council Representative	Bill Hoad	
Medical Director	Dr. D. Innes	
Other		
Other		

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
<p>Initiative 1: Reduce unnecessary ED visits for ambulatory care – sensitive conditions 11.7%</p>	<p>Change Idea 1. NP Support of Registered Team Education to Reduce Unnecessary Hospital Transfers The Nurse Practitioner provided education and clinical support to registered staff earlier in the initiative, focusing on assessment, early intervention, and appropriate escalation prior to hospital transfer. NP-led coaching and case discussions supported consistent clinical decision-making and use of in-house resources. During periods without an active NP, education and transfer decision-making practices continued to be reinforced by the interdisciplinary team while recruitment for the NP role remains ongoing.</p> <p>Change Idea 2. Use of SBAR by the Registered Team to Communicate with MD/NP SBAR was implemented and consistently used as the standard communication approach for all clinical escalations and transfer-related communications. Registered staff were educated on SBAR expectations to ensure complete and structured information sharing with the MD and NP when available. Ongoing use of SBAR was sustained through leadership oversight and integration into routine practice.</p> <p>Change Idea 3. Registered Team Education of Families to Support Informed Decisions Registered staff provided education to residents and families regarding goals of care, levels of intervention, and factors influencing hospital transfer decisions. Family discussions were completed during care conferences and changes in resident condition to support understanding and alignment with care plans. This approach supported informed, shared decision-making, regardless of NP availability, while maintaining continuity of communication.</p>	<p>ED transfer rate in Q4 2025 (29.4%) reflects increased resident acuity and complexity, with focused efforts to reduce avoidable transfers, including pursuing Nurse Practitioner (NP) onsite support, to align with corporate and provincial benchmarks (22.3%).</p> <p>Strengthened staff confidence and improved completeness of clinical reporting, as evidenced in mid-year audits (June 2025) Increased family engagement in care planning, reflected in care conference feedback (Sept–Dec 2025)</p>

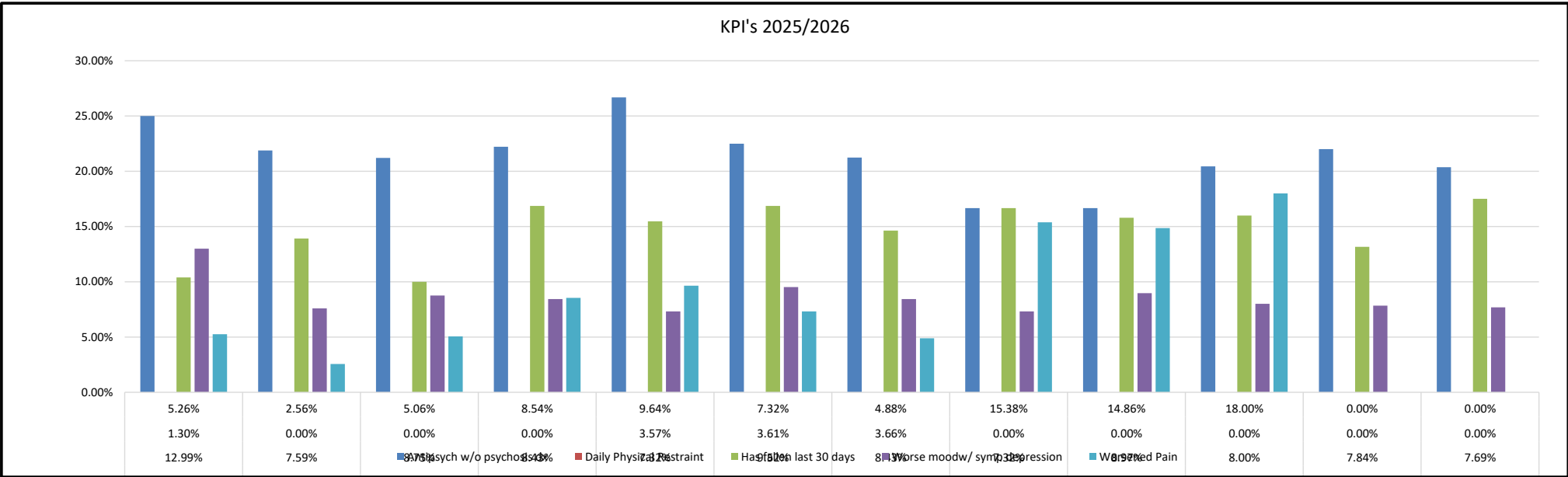
<p>Initiative 2: Reduce falls (maintain below corporate average of 15%)</p>	<p>Change Idea 1. Falls and Medication Risk Review – Step-by-Step Implementation A Falls Committee schedule was established and monthly meetings were held to review fall data, incident reports, and trends. Committee members reviewed current fall prevention interventions for residents identified as high risk. Based on findings, changes to interventions were agreed upon, documented, and communicated to the care team. Follow-up reviews were completed at subsequent meetings to confirm implementation and effectiveness of changes.</p> <p>Change Idea 2. A Deprescribing Committee met on a bi-weekly basis to review residents with increased fall risk related to medication use. High-risk residents were jointly reviewed by the Deprescribing and Falls Committees to ensure a coordinated approach. Medication-related recommendations were shared with the interdisciplinary team and incorporated into care plans as appropriate.</p> <p>Change Idea 3. Weekly interdisciplinary huddles were conducted to proactively identify residents at high risk for falls and review prevention strategies. Following each fall, a post-fall huddle was completed to review the circumstances of the incident. Root causes and contributing factors were identified, and targeted interventions were implemented to reduce the risk of recurrence. Outcomes and lessons learned were communicated to staff to support ongoing quality improvement.</p>	<p>Maintained a fall rate of 12.8% by Q4 2025, consistently performing below the corporate benchmark and demonstrating sustained effectiveness of prevention strategies. Beginning in July 2025, the team enhanced the identification and monitoring of high-risk residents through regular interdisciplinary reviews, allowing for more proactive and individualized care planning. This collaborative approach supported early intervention and strengthened overall risk management practices. In addition, a root cause analysis completion rate exceeding 90% was achieved, as evidenced in Q3–Q4 2025 audits, reflecting strong compliance, accountability, and a continued commitment to quality improvement and resident safety.</p>
<p>Initiative 3: Reduce inappropriate use of antipsychotic medications 17%</p>	<p>Change Idea 1. Establishment of Deprescribing Committee The home established an interdisciplinary Deprescribing Committee to review residents prescribed antipsychotic medications. Committee membership included the Director of Care (or designate), attending physician/Medical Director, Nurse Practitioner (NP), Pharmacy Consultant, and registered nursing staff. The committee was created to ensure a structured and consistent approach to medication review, with clearly defined roles, responsibilities, and regular meeting schedules to support oversight and accountability.</p> <p>Change Idea 2. Reduction and Discontinuation of Antipsychotic Medications The committee implemented a systematic process to gradually reduce or discontinue antipsychotic medications that were not clinically indicated. Each resident was reviewed individually, with consideration of diagnosis, behavioural symptoms, and current care needs. Where appropriate, gradual dose reduction plans were developed and carried out safely. Residents were closely monitored throughout the process to ensure stability, and non-pharmacological interventions were reinforced to support responsive behaviours and minimize the need for medication use.</p> <p>Change Idea 3. NP and Pharmacy Consultant Participation The Nurse Practitioner (NP) and Pharmacy Consultant actively participated in the deprescribing process, providing clinical oversight and evidence-based recommendations. Their involvement supported appropriate decision-making regarding medication adjustments, monitoring strategies, and risk mitigation. Collaboration between the NP, Pharmacy Consultant, and interdisciplinary team helped ensure that all deprescribing efforts were conducted safely, effectively, and in alignment with best practices.</p>	<p>Antipsychotic use without a diagnosis of psychosis was reduced to 16.7% by Q4 2025, reflecting a focused effort to promote appropriate prescribing practices and minimize unnecessary medication use. Between June and December 2025, the team increased the number of successful dose reductions through ongoing monitoring, physician engagement, and individualized resident care planning. Additionally, compliance with medication review timelines improved, as demonstrated in Q3 2025 audits, highlighting strengthened processes, enhanced accountability, and a continued commitment to safe and effective medication management.</p>

<p>Initiative 4: Improve resident and family satisfaction with physician care scored 51.6 from resident survey and 33.3 with families</p>	<p>Change Idea 1. Physician Rounding and Engagement Physician rounding was strengthened to ensure consistent assessment and engagement with residents during scheduled rounds. Procedures outline expectations for resident review, communication with the care team, and documentation of clinical findings. This support improved physician visibility and timely identification of resident care needs.</p> <p>Change Idea 2. Nurse Practitioner Role and Clinical Support Procedure Procedure was implemented to integrate the Nurse Practitioner (NP) role into the home to support resident assessments and clinical communication. NP involvement in timely assessments, follow-up, and collaboration with the interdisciplinary team. This role enhances responsiveness to changes in resident condition and supports continuity of care.</p> <p>Change Idea 3. MD/NP Collaborative Communication and Family Engagement Procedure Procedures were established to support collaboration between the Physician and Nurse Practitioner in addressing resident and family concerns. Protocols guide timely communication, shared clinical decision-making, and coordinated responses to care issues. Structured care conferences and feedback mechanisms support clear information exchange and ongoing engagement with residents and families.</p>	<p>Following the integration of both the Nurse Practitioner (NP) and physician, responsiveness and communication showed measurable improvement, as reflected in 2025 feedback trends. Satisfaction scores reached 87.44% among residents and 86% among families, indicating enhanced access to timely clinical assessment, clearer communication, and more coordinated care. The collaborative approach between physicians and the NP has supported more proactive decision-making, improved continuity of care, and strengthened confidence among residents and families in the safety and quality of clinical services provided.</p>
<p>Top Opportunities (Resident Survey 2024)</p> <ol style="list-style-type: none"> 1.) I am satisfied with the quality of care from doctors = 51.6% 2.) I am satisfied with the variety of food and beverage options = 63.2% 3.) I am satisfied with the food and beverages served to me = 65.8% 4.) I would recommend this home to others = 68.4% 5.) I enjoy eating meals in the dining room = 71.1% 	<p>1.) I am satisfied with the quality of care from doctors. Resident results demonstrated improvement, and continued efforts were made to strengthen communication and engagement with residents and families to further enhance perceptions of care quality. Regular care conferences were held to support ongoing dialogue, while physicians and the Nurse Practitioner provided proactive updates. Increased opportunities were created for residents and substitute decision-makers (SDMs) to ask questions and participate in care discussions. The interdisciplinary team maintained transparency by consistently documenting and communicating changes in care plans, which supported improved understanding and trust in the quality of medical care provided.</p> <p>2.) I am satisfied with the variety of food and beverage options. Collaboration with residents and departments was maintained to gather meaningful feedback and strengthen feedback loops for ongoing quality improvement. Menu flexibility was enhanced based on resident input, and resident engagement in menu planning and discussions was encouraged. Interdisciplinary collaboration supported improvements in satisfaction with the variety of food and beverage options.</p> <p>3.) I am satisfied with the food and beverages served to me. Ongoing collaboration between dietary and care teams was maintained, and resident feedback was actively collected and reviewed. Adjustments to food quality and service were implemented based on this feedback, and continuous quality improvement processes were applied to enhance overall satisfaction with meals and beverages served.</p> <p>4.) I would recommend this home to others</p>	<p>Residents Survey Result in 2025</p> <ol style="list-style-type: none"> 1. I am satisfied with the quality of care from doctors = 87.44% 2. I am satisfied with the variety of food and beverage options = 80.95% 3. I am satisfied with the food and beverages served to me = 80.10% 4. I would recommend this home to others = 86.96% 5. I enjoy eating meals in the dining room = 81.80% <p>Significant improvement across top opportunities.</p>

	<p>4.) I would recommend this home to others. Resident-centred approaches were maintained to support overall satisfaction, and engagement and feedback processes were consistently implemented. Satisfaction trends were monitored to identify opportunities for improvement, and quality improvement initiatives were applied to strengthen the overall resident experience and likelihood of recommendation.</p> <p>5.) I enjoy eating meals in the dining room. Resident engagement in dining experience discussions was supported, and efforts were made to enhance the dining environment and overall experience. Feedback from residents was incorporated into dining service improvements, and ongoing monitoring helped identify opportunities to improve comfort, atmosphere, and satisfaction in the dining room.</p>	
<p>Top Opportunities (Family Survey 2024)</p> <p>1.) I am satisfied with the quality of care from doctors = 33.3%</p> <p>2.) I am satisfied with the timing and schedule of spiritual care services = 55.0%</p> <p>3.) I am satisfied with the quality of care from physiotherapist = 58.3%</p> <p>4.) The resident has input into the recreation programs available = 59.3%</p> <p>5.) I am satisfied with the quality of care from occupational therapist = 60.0%</p>	<p>1.) I am satisfied with the quality of care from doctors Resident results demonstrated improvement; however, continued efforts were made to strengthen communication and engagement with residents and families to further enhance perceptions of care quality. This was achieved through regular care conferences, proactive updates from physicians and the Nurse Practitioner, and increased opportunities for residents and substitute decision-makers (SDMs) to ask questions and participate in care discussions. The interdisciplinary team maintained transparency in care planning by consistently documenting and communicating changes, which supported improved understanding and trust in the quality of medical care provided.</p> <p>2.) I am satisfied with the timing and schedule of spiritual care services Opportunities were identified to improve the timing and accessibility of spiritual care services. This was addressed through a review of current schedules, collaboration with spiritual care providers, and adjustments to service delivery times to better align with resident preferences and routines. Feedback from residents and families was actively gathered and used to guide scheduling changes. Ongoing monitoring ensured that services remained responsive to the evolving needs of the home, resulting in improved accessibility and resident satisfaction.</p> <p>3) I am satisfied with the quality of care from physiotherapist Satisfaction with physiotherapy services was supported through a structured interdisciplinary approach involving ongoing collaboration between the physiotherapist, nursing, and recreation teams. Care plans were regularly reviewed and updated to reflect each resident's individual goals, functional status, and progress. Residents were engaged in goal-setting to ensure therapy remained meaningful and aligned with their needs and preferences. Feedback from residents was consistently gathered and used to adjust therapy approaches, while staff were supported with guidance to reinforce physiotherapy interventions during daily care, promoting continuity, safety, and improved outcomes.</p> <p>4) The resident has input into the recreation programs available Resident input into recreation programming was strengthened through consistent collaboration between recreation, nursing, and the broader interdisciplinary team. Feedback was gathered through surveys, care conferences, and informal discussions, ensuring resident preferences were reflected in activity planning. Care plans were updated to align with individual interests and abilities, supporting a person-centered approach. Residents were encouraged to participate in decision-making and suggest new activities, fostering engagement and inclusivity. Participation levels and satisfaction were monitored on an ongoing basis, allowing programs to be adjusted to better meet resident needs and enhance overall quality of life.</p> <p>5.) I am satisfied with the quality of care from occupational therapist. Efforts to improve satisfaction with occupational therapy services focused on enhancing resident engagement and participation in care planning. This was achieved by involving residents more actively in goal setting, conducting regular functional assessments, and tailoring interventions to individual preferences and abilities. Feedback from residents and families was incorporated into program adjustments, and outcomes were monitored to evaluate effectiveness. The ongoing evaluation process informed continuous quality improvement initiatives and supported delivery of more responsive and person-centered occupational therapy services.</p>	<p>Family Satisfaction Survey Result in 2025</p> <p>1. I am satisfied with the quality of care from doctors = 86.00%</p> <p>2. I am satisfied with the timing and schedule of spiritual care services = 81.20%</p> <p>3. I am satisfied with the quality of care from physiotherapist = 85.65%</p> <p>4. The resident has input into the recreation programs available = 87.71%</p> <p>5. I am satisfied with the quality of care from occupational therapist = 85.65%</p> <p>Significant improvement across top opportunities.</p>

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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
Antipsych w/o psychosis dx	25.00%	21.88%	21.21%	22.22%	26.68%	22.50%	21.24%	16.67%	16.67%	20.45%	22.00%	20.37%
Daily Physical Restraint	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Has fallen last 30 days	10.39%	13.92%	10.00%	16.87%	15.48%	16.87%	14.63%	16.67%	15.79%	16.00%	13.16%	17.50%
Worse moodw/ symp depression	12.99%	7.59%	8.75%	8.43%	7.32%	9.52%	8.43%	7.32%	8.97%	8.00%	7.84%	7.69%
Worse Stage 2-4 PU	1.30%	0.00%	0.00%	0.00%	3.57%	3.61%	3.66%	0.00%	0.00%	0.00%	0.00%	0.00%
Worsened Pain	5.26%	2.56%	5.06%	8.54%	9.64%	7.32%	4.88%	15.38%	14.86%	18.00%	0.00%	0.00%



How Annual Quality Initiatives Are Selected	
<p>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.</p>	
Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2024/25 year:	The survey was conducted from October 1 to October 31, 2025
Results of the Survey (provide description of the results):	<p>Overall satisfaction was high. 86.96% of residents and 79.93% of family members would recommend the home. Strengths included quality of care, staff support, and resident choice. Opportunities for improvement included communication, dining services, and availability of private visiting spaces.</p>
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Results were shared through Resident Council and Family Council meetings, staff meetings, and posted within the home following the survey completion.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
<i>Survey Participation</i>	100.00%	84.91%	100.00%	84.10%	100.00%	74.39%	54.90%	20.00%	The home will continue to support meaningful engagement with residents and families by encouraging open communication and active participation in care. Feedback will be welcomed through accessible and respectful channels, helping to build trust and strengthen relationships.
<i>Would you recommend</i>	100.00%	86.96%	68.40%	NA	100.00%	79.93%	88.90%	92.30%	Efforts will focus on increasing survey participation by making feedback opportunities easy to access and reinforcing the value of shared experiences. Input will be used to guide improvements, with the goal of increasing overall satisfaction and confidence in recommending the home.
<i>If I have a concern, I feel comfortable raising it with the staff and leadership</i>	100.00%	91.93%	83.30%	75.70%	100.00%	90.52%	96.00%	84.60%	The home will maintain a safe and supportive environment where residents and families feel comfortable raising concerns. Staff and leadership will remain approachable and responsive, ensuring concerns are acknowledged, addressed, and followed up in a timely manner.

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.	Target: 27.36% Planned Improvement: Change Idea (1): Use SBAR for structured communication between registered staff and physicians/NPs to support decision-making before ED transfer. Planned Improvement: Change Idea (2): Strengthen early identification of high-risk residents through preventative care, education, and development of care plans with early warning indicators. Planned Improvement: Change Idea (3): Improve staff clinical assessment skills through needs assessments and targeted education supported by clinical educators/NP/MD.	29.36% as of January 2026
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target: 100% Planned Improvement: Change Idea (1): Create structured opportunities for open dialogue and deliver diversity and inclusion training through online modules and live sessions. Planned Improvement: Change Idea (2): Expand access to training by embedding diversity and inclusion education into onboarding and tracking completion for all staff.	100% as of 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target 92.15% Planned Improvement: Change Idea (1): Embed Resident Bill of Rights (Right #29) into resident council meetings and staff education to reinforce resident voice. Planned Improvement: Change Idea (2): Review whistleblower policy and complaint processes with residents, families, and staff at admission and care conferences.	84% as of 2025
Percentage of long-term care residents in daily physical restraints	Target: 0% Planned Improvement: Change Idea (1): Current performance meets the established target. The focus for this indicator is on sustaining a restraint-minimized approach through continued use of alternatives, education, and resident-centred care practices. Planned Improvement: Change Idea (2): Increase the use of safe and appropriate alternatives to restraints to support resident comfort, dignity, and safety.	0% as of April 2026

<p>Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened</p>	<p>Target: 1.80% Planned Improvement: Change Idea (1): Current performance meets and exceeds the established target. The focus for this indicator is on sustaining existing practices and outcomes through continued monitoring and collaboration. Planned Improvement: Change Idea (2): Ongoing collaboration with the Nurse Specialized in Wound, Ostomy and Continence (NSWOC) for in-home and virtual consultations. Routine review of residents at higher risk for pressure injuries. Continued use of existing tools and processes to support early identification, prevention, and management of pressure injuries.</p>	<p>1.9 as of April 2026</p>
<p>Percentage of LTC home residents who fell in the 30 days leading up to their assessment</p>	<p>Target:13.50% Planned Improvement: Change Idea (1): Facilitate weekly Falls Huddles on each unit with the interdisciplinary team to review residents at risk and identify prevention strategies. Planned Improvement: Change Idea (2): Establish documentation/charting partners so Personal Support Workers can complete documentation with residents at high risk for falls, supporting early identification of patterns or contributing factors. Planned Improvement: Change Idea (3): Reduce the overall number of falls in the home through consistent assessment, communication, and implementation of individualized interventions. Planned Improvement: Change Idea (4): Strengthen staff knowledge and confidence in falls prevention through ongoing education and the use of best practice guidance.</p>	<p>13.93 as of April 2026</p>
<p>Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment</p>	<p>Target 17.5% Planned Improvement: Change Idea (1): The Medical Doctor, Behavioural Support team, and nursing staff will meet monthly to review newly admitted residents who are prescribed antipsychotic medication. The review will focus on diagnosis, indication for use, and opportunities for reduction. This will also remain a standing item on the quarterly Continuous Quality Improvement/Professional Advisory Committee agenda. Planned Improvement: Change Idea (2): Residents who receive antipsychotic medication for the management of responsive expressions will have a quarterly review to determine whether a dose reduction or discontinuation may be appropriate. A tracking tool will be used to support monitoring and follow-up. Planned Improvement: Change Idea (3): Develop individualized plans of care that emphasize non-pharmacological approaches, including identification of triggers, resident preferences, and supportive interventions. Planned Improvement: Change Idea (4): Strengthen staff knowledge and confidence in managing responsive expressions through ongoing education and interdisciplinary collaboration.</p>	<p>23.94 as of April 2026</p>

<p>Top 5 Opportunities Resident Survey 2025</p> <p>1. My goals and wishes are considered and incorporated into the plan of care. 2. Residents are friendly with each other. 3. I am satisfied with the food and beverages served to me. 4. Communication from home leadership is clear and timely. 5. I can find a private place to visit with when I have visitors.</p>	<p>1 Resident Goals in Care Planning : Opportunity to strengthen person centered care. Implement All About Me at admission starting Feb 12 2026 with ongoing review at care conferences to ensure goals are reflected in care plans</p> <p>2 Resident Relationships: Opportunity to enhance social connection. Launch inter unit pen pal program, install resident mailboxes, and introduce monthly welcome luncheons by April 1 2026 to build friendships</p> <p>3 Food and Beverage Experience: Opportunity to enhance dining satisfaction. Expand beverage choices by Feb 23 2026 and improve dining experience through menu display enhancements, electronic ordering, and certified cook integration by June 30 2026</p> <p>4 Leadership Communication: Opportunity to improve clarity and timeliness. Install resident mailboxes and implement monthly leadership updates by March 31 2026 to strengthen communication</p> <p>5 Private Visiting Spaces: Opportunity to improve access to gathering areas. Identify and promote resident spaces and implement a booking system by March 1 2026 to support private visits</p>	<p>Top 5 Opportunities as of 2025</p> <p>1. 80.5% 2. 80.39% 3. 80.10% 4. 79.59% 5. 78.57%</p>
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<p>Top 5 Opportunities Family Survey 2025</p> <p>1. The resident has access to a hairdresser when needed. 2. The timing and schedule of spiritual care services 3. The resident's care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions. 4. My feedback on the residents' goals and plan of care is considered and adopted. 5. Overall, I am satisfied with laundry, cleaning, and maintenance services.</p>	<p>1 Hairdressing Services: Opportunity to enhance consistency and awareness. Implement weekly Tuesday hairdressing by Feb 28 2026 with improved communication to support resident experience</p> <p>2 Spiritual Care Scheduling: Opportunity to strengthen communication and alignment with preferences. Add services to monthly calendar by Feb 28 2026 and gather resident and family input to enhance participation</p> <p>3 Care Conference Quality: Opportunity to enrich interdisciplinary collaboration. Ensure SSW participation by Feb 28 2026 and use a structured approach to support meaningful discussions</p> <p>4 Resident Goals in Care Planning: Opportunity to strengthen person centered documentation. Complete All About Me for all admissions starting Feb 12 2026 and consistently update care plans</p> <p>5 Laundry Cleaning and Maintenance: Opportunity to improve service consistency and efficiency. Stabilize staffing within 60 days implement weekly audits and enhance maintenance reporting by Feb 28 2026</p>	<p>Top 5 Opportunities of 2025</p> <p>1. 81.48% 2. 81.20% 3. 81.12% 4. 80.59% 5. 80.00%</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	Jennifer Black - BAC in Administration - Executive Director	15-Jun-26
Director of Care	Dana Laplante - Registered Nurse - Director of Care	15-Jun-26
Executive Directive	Jennifer Black - BAC in Administration - Executive Director	15-Jun-26
Nutrition Manager	Kaitlyn Chartrand	15-Jun-26
Programs Manager	Tessa Meyer-Greenson - Recreation and Leasure - Program Manager	15-Jun-26
Clinical Consultant	Juan Carlo Cruz - Registered Nurse - Clinical Consultant	15-Jun-26