

HOME NAME : Southbridge Pinewood

People who participated in the evaluation of this report

	Name / Designation	Date of Evaluation
Quality Improvement Lead	Darcy Richards Executive Director	20-May-26
Director of Care	Kristina Schelhaas Director of Care	20-May-26
Executive Directive	Darcy Richards Executive Director	20-May-26
Nutrition Manager	Hena Medepalli Food Service manager	20-May-26
Programs Manager	Clifford Shawanamash Programs Manager	20-May-26
Medical Director	Dr. David Janhunnen	20-May-26
Resident Council Member	Erica McEachren	22-May-26
Family Council Member	Cheryl Calvert	22-May-26
Other	Erika Jenner - Associate Director of Care Registered Practical Nurse, Maria Ball - Resident Services Manager, Priscilla Owusu - Infection Prevention and Control Lead, Registered Practical Nurse, Madeline Santorelli - RAI Coordinator, Registered Practical Nurse, Amal Wilson - Environmental Services Manager, Kristy Turk - Clinical Consultant Assistant, Registered Practical Nurse	20-May-26
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.

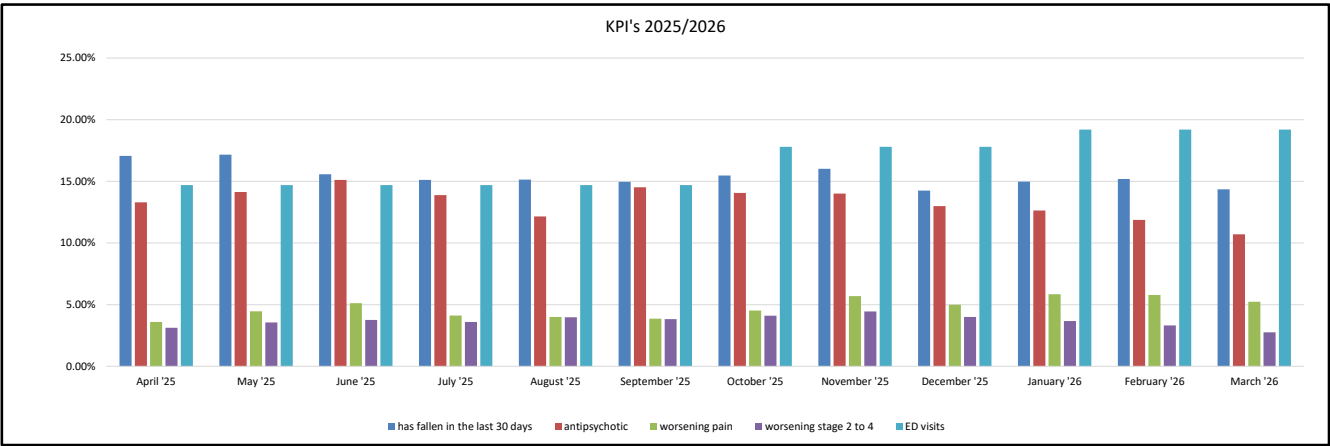
Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Percentable of residents in which had Avoidable ED visits	<p>Educate registered staff on SBAR tool for standardized communication SBAR education was completed last year and staff are encouraged to continue to use the SBAR focus documentation in the Progress Notes and communication with the MD/NP.</p> <p>Educate families and residents related to the benefits of avoiding ED visits The home continues conversations related to goals of care at all care conferences, on admission, annually and with changes in care. The MD and NP also continue to have conversations in the moment and with communications of changes in health related to what the home can offer for treatment options, as well the effects of ED transfers. The Home continues to provide preventative care and early treatment for common conditions leading to potentially avoidable ED visits by maximizing the current Medical Director and Nurse Practitioner. Further education was provided to registered staff related to clinical assessments and common conditions leading to ED transfers.</p> <p>Hospital tracker The DOC and clinical management team monitor and evaluate the hospital tracker tool to analyzes each ED transfer for potential cases where the resident could have been treated in the home. ED transfers are a part of the homes CQI and PAC meeting with care taken for follow up and further educational opportunities.</p> <p>Care planning The home completed conversations related to goals of care at all care conferences, on admission, annually and with changes in care. They have also involved the BSO team, clinical team and families to taking opportunities in evaluation of responsive behavioural care plan for triggers and interventions to avoid potential ED transfers related to expressions / code whites or form 1's.</p>	<p>Current performance 17.8% Dec 2025 The home did not meet their target goal of 14%, continues to exceed provincial average of 22.3%. Noted increase of ED transfers related to family and resident request. The home continues to implement change ideas, monitor and evaluate. Indicators demonstrated sustained improvements, particularly in SBAR utilization, staff engagement in clinical education, and overall awareness of early deterioration and escalation processes, and family education of care goals.</p>
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	<p>Training All staff and mangers completed SURGE online education related to diversity, inclusion, equity and anti-racism in the workplace. The management team continues to provide an open door policy and encourage feedback in order to address any concerns or issues at the moment. We also welcome all suggestions and ideas to further improve.</p> <p>Celebrate culture and diversity events The home has hosted several events throughout the year to display and celebrate cultural events, display diversity and inclusion. They celebrated pride month, Canada Day, Festival of India, Christmas, and Indigenous circles.</p> <p>Monthly Meetings All CQI meetings now include a discussion related to diversity and further ideas for improvement, as well as evaluation of current actions.</p>	<p>Current performance 100% of staff complete training in 2025 The home has met their goal of 100% of all staff and managers receiving education on diversity, inclusion, equity and anti-racism. All staff completed SURGE education in 2025. Diversity and inclusion is discussed at CQI meeting monthly. The existing initiatives were sustained and further reinforced to ensure consistency across all departments and levels of leadership.</p>
	<p>Weekly meeting The home is completing weekly falls huddles on each unit and include collaboration with the Falls committee and external partners. Environmental assessments, care plan interventions and EPS programs are taken into consideration with each fall review of</p>	<p>Current performance 14.25% Dec 2025 The home has met and exceeded their target</p>

Percentage of LTC home residents who fell in the 30 days leading up to their assessment	<p>Interventions and FRS scores are taken into consideration with each fall, review of current falls interventions and additional interventions post fall.</p> <p>Education The home falls lead has completed education with all staff and continues to provide education on hire to new staff. Falls education includes prevention, monitoring, documentation, interventions, care planning, and family communication.</p> <p>Fracture Prevention All residents are monitored and reviewed for possible fracture prevention medication intervention on admission, quarterly and with significant changes in condition. The home utilizes the FRS score form InterRAI to determine the fracture risk of the residents individually.</p> <p>Falls Analysis Each fall is reviewed with the ongoing huddles, MD/NP, input and notifications to family. Input from family with notifications and care plan reviews is considered and evaluated. The home uses the falls tracker as a tool to monitor, evaluate and ensure policies are followed. PT has completed education to residents and families related to walker and w/c safety. Registered staff are provided education and importance of post fall huddles and analyse in developing intervention and care plan.</p>	<p>exceeded their target performance of 15%. The home continues to exceed provincial average of 16.2%. The home continues to implement change items monitor, and evaluation of performance is ongoing. Improved management of high-risk residents, with reduced frequency and impact of falls. Consistent implementation of interventions, fracture prevention medications, falls analysis contributed to sustained improvement and enhanced resident safety.</p>
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	<p>Meetings Monthly reviews of all residents triggering antipsychotic medication QI are completed with MD, NP, BSO and clinical managers / leads. Any newly admitted residents are reviewed related to medications, medication alternates, and non medication interventions. Antipsychotic use continues to be reviewed and discussed at all CQI and PAC meetings.</p> <p>Reviews The home continues to complete quarterly medication reviews to access management of Responsive expressions, interventions and the use of antipsychotic medications. During admission conference, medications are reviewed with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions.</p> <p>Care planning All residents exhibiting expression behaviours are reviewed Bi weekly at care rounds, quarterly, and with significant changes. All care plans are reviewed for non-pharmalogical approaches, triggers, and effective interventions. Care plans are updated with the involvement of staff, MD/NP, BSO team, and families input.</p>	<p>Current performance 12.99% Dec 2025 The home has met their goal of 17.55 and continues to exceed provincial average of 19.7%. Noted increase of residents being admitted to the home with antipsychotic medications ordered. The home continues to implement antipsychotic drug reduction program with residents after the initial transition period to LTC. The home continues to implement change ideas, monitor, and evaluation of performance is ongoing</p>
Percentage of long-term care home residents who had a pressure ulcer that worsened to a stage 3 or 4 (Goal is to meet corporate average 2.5%)	<p>Education All registered staff have received education on wound assessment, the skin impairment checklist tool, preventative wound care interventions and tools. We continue to assess all residents on a daily basis for skin impairments during care for early identification.</p> <p>Review of residents with high risk of pressure ulcer development The PURS score are assessed and used to implement skin care interventions such as cream, turning wedges, repositioning, pressure relieving devices, and therapeutic surfaces. All residents are assessed taking in account residents identified as high risk for skin issues and concerns. (PURS of 3 or more)</p> <p>Tracking tools The home continues to monitor wounds / impaired skin integrity by using a skin and wound tracker. The tracker tool assists to ensure policies and procedures are being followed with all skin impairments.</p>	<p>Current performance 3.99% Dec 2025 The home did not meet their target goal of 2.5%.The home continues to implement change ideas, monitor and evaluate. Noted increase in QI numbers with the InterRAI change over with no exclusion. Through education to all staff by Medline related to preventative skin care. Education to wound care leads, implementation of proven successful intervention the home aims to meet their goal. Implemented auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement.</p>
Resident with worsen pain during MDS 7 day lookback period (Goal continue to exceed corporate benchmark 8.5%)	<p>Through assessment of residents care needs and goals The home has conducted through assessments of the residents' goals, palliative care, and end of care. Through the completion of PPS assessments on admission, quarterly, and with significant changes the home has developed early identification of changes. Is able to address possible medication regiment changes, involve the interdisciplinary team, family and resident with care planning decisions.</p> <p>Establish Palliative Care / End of Life, medication order sets The home has implemented, monitored and evaluated their palliative / end of life medication regime order set. This ensures comfort care is being provided in a timely manner, based on the goal of comfort and successful end of life experience. The home continues to review medication order sets and implement any changes noted.</p> <p>Trackers / Monitoring The home continues to use the PRN medication tracker to assist with changes in residents' pain and increased use of medication interventions. They are able to communicate to the MD and NP to have medication reassessed and updated to meet the goals of the resident. The home has also implemented referral or collaboration with the pain management specialist. All residents are assessed for pain, increased pain and intervention effectiveness on admission, re admission, quarterly, with significant change.</p>	<p>Current performance 4.94% Dec 2025 The home has met and exceed their goal of 8.5%, and continues to exceed the provincial average. The home continues to implement change ideas, and evaluate quality improvement plan. PPS assessments continue to be completed on admission, quarterly, and with significant change in condition. Daily review of the PRN tracker is completed. Implementation of the palliative end of life order set has provided successful goals of care during end of life process, decreasing pain.</p>

<p>Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".</p>	<p>Review of residents Rights The home has engaged residents in meaningful conversations, and care conferences, that allow them to express their opinions. A review of the "Resident's Bill of Rights" has occurred at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themselves or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else" Education The home continues to provide education to staff on hire, annually and as required related to residents rights, customer service and resident engagement. Policies are also reviewed at staff meetings monthly. Whistleblowers policy The home has also reviewed the Whistleblower policy with Residents' Council. The home has reviewed the complaint and concern process in the home with residents and families on admission and during annual care conference</p>	<p>Current performance 92.92% 2025 The home has met and exceed their goal of 90%, which also, exceeds the provincial average of 86%. The home continues to implement change ideas, and evaluate quality improvement plan. This improvement reflects our commitment to actively engage families and residents in providing feedback, addressing concerns, and implementing targeted interventions to improve their over all experience.</p>
<p>2024 Resident satisfaction survey Top 5 opportunities 1) If I need help right away, I can get it = 80.00% 2) I am satisfied with:The timing and scheduling of spiritual care services = 78.57% 3) I have access to foot care when needed = 76.79% 4) I am satisfied with the quality of care from: Physiotherapist/Occupational Therapist = 76.14% 5) I am satisfied with the quality of care from: Dietitian = 69.23%</p>	<p>The home continues to promote open communication and responsiveness to residents and families through promoting a culture of open, transparent communication to all parties involved. Encouraging residents to voice concerns and provide feedback through multiple channels such as Resident Council, Satisfaction Surveys and direct conversation with the management and staff. The Management team continue to reinforce with the staff accountability to respond to concerns promptly, respectfully and professionally including addressing any raised concerns in a timely manner. During the 2025 year personal support staffing levels were increased to ensure resident needs were being met in a prompt and timely manner, as per their requests and preferences. This increase saw one full staff member added to each home area complement. Spiritual care has been assessed with resident council involvement to determine requests for different spiritual care, as well as the timing and co ordination of events. The home has also implemented virtual spiritual care access, which is also offered at the bedside. Timely access to foot care services was identified and prioritized including streamlining of regular on-site foot care clinics every 6 weeks and as needed. Collaboration with the Home, residents and its families was the key of this service to be a success. The Home continues to monitor foot care access to ensure residents receive timely and appropriate care through referrals and working with the service provider to optimize scheduling and availability based on resident needs. Continued collaboration with the physiotherapy team to review and respond to resident feedback such as incorporating new and reviewed planning and individualized care plans including support with ongoing improvements in our PT programs / care and resident/ family satisfaction. There is a continued collaboration with the dietary team and Registered dietitian to review and respond to resident feedback in a timely manner, with 1:1 resident interaction. The home has also posted the Registered dietitian hours of work and contact information, to allow easy access.</p>	<p>The goal of the resident satisfaction survey is to gain a better understanding of resident's goals and overall satisfaction of services. Our goal is always to provide the best possible care and services to the residents we server. In working collaboratively as a team, the outcome of the 2025 satisfaction survey saw the following results. If I need help right away, I can get it = 93.80% I am satisfied with:The timing and scheduling of spiritual care services = 76.29% I have access to foot care when needed =81.85% I am satisfied with the quality of care from: Physiotherapist/Occupational Therapist = 85.82% I am satisfied with the quality of</p>
<p>2024 Family satisfaction survey Top 5 opportunities 1) The resident has access to foot care when needed = 73.44% 2) I am satisfied with the quality of care from Dietitian = 73.44% 3) I am satisfied with:The timing and scheduling of spiritual care services = 73.33% 4) I am satisfied with the quality of: Laundry services for personal clothing = 71.89% 5) I am updated regularly about any changes in the home = 64.06%</p>	<p>Implementation of plans to improved services in the Home is always the priority for resident comfort, dignity and satisfaction. Family's input is valuable to the Home to ensure essential services are completed in a timely manner and align with resident preferences. This also ensures staff accountability and quality in our service. Timely access to foot care services was identified and prioritized including streamlining of regular on-site foot care clinics every 6 weeks and as needed. Collaboration with the Home, residents and its families was the key of this service to be a success. Similar with the Resident Satisfaction Survey, there is a continued collaboration with the dietary team and Registered dietitian to review and respond to resident feedback such as incorporating menu planning and individualized care plans including support with ongoing improvements in meal quality, nutritional care and resident/ family satisfaction. For Spiritual Care services, the Home continue to coordinate with community spiritual leaders/ volunteers to expand their availability and promote services as per resident spiritual preference. Ongoing communication with the Resident Council are enhanced to continue to engage in dialogue with spiritual services items that can continue to improve quality of resident life at the Home. The Home has implemented a linen inventory and ongoing tracking system to ensure adequate supply of linens at all times including increase par levels of linens to maintain and have backup of linens at all times. Education was completed to staff on proper linen handling and reporting of missing items in a timely manner. The management team has adapted an open door policy and welcome residents and families to visit. Email communications have increased with updates regularly, and mangers take pride in walks abouts throughout the home.</p>	<p>The family satisfaction survey goal also guides the home in quality improvement from an alternate perception and further customer service. Guiding the home to further quality improvement goals from a multidisciplinary level. Our goal is always to meet or exceed the goals of everyone involved in our care and services. The 2025 satisfaction results from a family point of view are as follows. The resident has access to foot care when needed = 93.04% I am satisfied with the quality of care from Dietitian = 92.19% I am satisfied with:The timing and scheduling of spiritual care services = 86.56% I am satisfied with the quality of: Laundry services for personal clothing = 88.58% I am updated regularly about any changes in the home = 93.13%</p>

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	
has fallen in the last 30 days	17.06%	17.16%	15.57%	15.12%	15.14%	14.96%	15.47%	16.02%	14.25%	14.98%	15.20%	14.35%	
antipsychotic	13.30%	14.14%	15%	13.89%	12.16%	14.52%	14.06%	14.01%	12.99%	13%	12%	11%	
worsening pain	3.60%	4%	5.12%	4.11%	4.00%	3.86%	4.52%	6%	5.00%	5.85%	5.78%	5.23%	

worsening stage 2 to 4	3%	4%	4%	4%	4%	4%	4%	4%	4%	4%	3%	3%
ED visits	14.70%	14.70%	14.70%	14.70%	14.70%	14.70%	17.80%	17.80%	17.80%	19.20%	19.20%	19.20%



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:	October 1st to October 31st, 2025
Results of the Survey (provide description of the results):	<p>88.98% of the residents and 95.41% of family members would recommend this home to others. The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025. For participation, the numerator represents the number of residents and family members that completed a survey. The denominator represents the number of residents and family members that were eligible to complete the surveys.</p> <p>Resident survey 5 top Opportunities I am satisfied with the quality of care from: Administration/Office Staff = 80.51% I am satisfied with the quality of care from: Social Worker/Social Service Worker = 80.00% I am satisfied with the quality of: Laundry services for personal clothing = 79.92% I enjoy eating meals in the dining room = 78.28% The timing and schedule of spiritual care services = 76.2%</p> <p>Family survey Top 5 Opportunities I am satisfied with: The timing and schedule of spiritual care services = 86.56% The resident has input into the recreation programs available: Spiritual care services = 86.25% I am satisfied with: The relevance of recreation programs = 84.69% I am satisfied with the quality of care from: Physiotherapist/occupational therapist = 84.57% I am satisfied with: The variety of recreation programs = 84.38%</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)	Resident and Family Satisfaction Survey Results posted on the CQJ Board on January 30, 2026, Survey reviewed at Resident Council on March 10, 2026 and Family Advisory Committee January 2026. CQJ program evaluation is also posted publicly on our information board in the main lobby of Southbridge Pinewood. Satisfaction survey results have been reviewed with staff during staff meetings.
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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>	86.00%	88.64%	85.36%	45.64%	91.00%	72.65%	83.73%	14.85%	Continue to encourage participation annually. Ensure volunteers are available to assist residents. Early communication related to surveys
<i>Would you recommend</i>	89.00%	88.98%	85.00%	85.79%	96.00%	95.41%	79.47%	73.00%	Open door policy, post if you have a concern posters, managers complete on the floor walk abouts. Be visible on the care units and commandating with times and dates of meetings. All managers join monthly coffee break.
<i>If I have a concern, I feel comfortable raising it with the staff and leadership</i>	93.00%	91.65%	86.61%	82.59%	93.00%	90.74%	87.65%	71.30%	Open door policy, post if you have a concern posters, managers complete on the floor walk abouts. Be visible on the care units and commandating with times and dates of meetings. All managers join monthly coffee break.

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative		Current Performance
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	1)Continue to discuss resident right #29 on monthly basis, during Resident Council meeting 2)Re-education and review with all staff Resident Bill of Rights specifically #29 at department meetings monthly	92.92% as Oct 2025
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed	100% December 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) to increase training and/or education of Falls program; 3) Resident list of FRS of 3 or greater, offer fracture prevention medication 4) Education and re-education provided to registered staff on the completion of post fall analysis	14% December 2025
Percentage of long-term care home residents who had a pressure ulcer that worsened to a stage 3 or 4	1) Arrange education for Registered staff and PSW, with Medline consultant and NSWOC 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care	3.83% December 2025
Rate of avoidable ED visits per 100 long-term care residents.	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; 3) The MD on site will provide education theoretically and at bedside. 4) Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings 5) Care plan for residents with responsive expression - indication of triggers and interventions	17.6% December 2025
Top 5 Resident satisfaction survey opportunities 2025 1) am satisfied with the quality of care from: Administration/Office Staff 2) am satisfied with the quality of care from: Social Worker/Social Service Worker 3) am satisfied with the quality of:Laundry services for personal clothing 4) enjoy eating meals in the dining room. 5)The timing and schedule of spiritual care services	1) Shift start times were moved one hour earlier to ensure laundry reaches each floor sooner, allowing Personal Support Workers to provide clothing to residents in a timely manner. A monthly Lost and Found process was introduced to help track and return misplaced items more efficiently. All laundry hanging tags were replaced with new ones to reduce name-reading errors and improve accuracy for nursing staff. Laundry QRM audit to be completed monthly to determine success. 2)New Food Services Manager on-boarded New Assistant Foor Services Manager on-boarded Dining room experience to be added to Food Committee standing agenda. 3)Reach out to churches in the community to add to the services that are already in place. Implement bible study program in the evenings/off times when no service is available. 4)New Resident Services Coordinator onboarded: Maria Ball. Education to Resident Council regarding referral services. Location of Resident Services Coordinator office to be posted outside of Hummingbird Home area for wayfinding. 5)Administration and office staff update to be added to standing agenda on Resident Council Monthly "Coffee Break" program to be implemented for residents to attend the	The Homes 2025 Resident survey results 1) 80.51% 2) 80.00% 3) 79.92% 4) 78.28% 5) 76.29%

<p>Top 5 Family satisfaction survey opportunities 2025</p> <p>1) am satisfied with: The timing and schedule of spiritual care services</p> <p>2)The resident has input into the recreation programs available: Spiritual care services</p> <p>3) am satisfied with: The relevance of recreation programs</p> <p>4) am satisfied with the quality of care from: Physiotherapist/occupational therapist</p> <p>5) am satisfied with: The variety of recreation programs.</p>	<p>1)Reach out to churches in the community to add to the services that are already in place. Implement bible study program in the evenings/off times when no service is available. Conduct a family survey regarding timing and schedule of spiritual services.</p> <p>2)Implement Calendar Planning on the Activity Calendar, as a program. Post signage regarding program planning at Resident's Council. Add resident programming suggestions to the Family Council/Family Advisory Committee.</p> <p>3)Implement Calendar Planning on the Activity Calendar, as a program. Implement a Monthly Theme each month (e.g. Black History Month) Conduct a family survey regarding how families view the relevance of programs to resident's needs.</p> <p>4)Physiotherapist Office hours to be posted outside of office with both Physiotherapist and Physiotherapist Assistant times. Physiotherapist voicemail to be implemented and contact information posted outside of office. Physiotherapist general updates to be added to the standing Family Council/Advisory Committee. Profile of Physiotherapist and Physiotherapist Assistant to be added to Family Council/Advisory Committee and Resident Council.</p> <p>5)Implement Calendar Planning on the Activity Calendar, as a program. Implement a Monthly Theme each month (e.g. Black History Month) Implement cultural days each month. Working with the City of Thunder Bay towards re-initiating outings for the homes in the city utilizing Lift+.</p>	<p>The Homes 2025 Family survey results</p> <p>1) 86.56%</p> <p>2) 86.25%</p> <p>3) 84.69%</p> <p>4) 84.57%</p> <p>5) 84.38%</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:
CQI Lead	Darcy Richards	20-May-26
Executive Director	Darcy Richards	20-May-26
Director of Care	Krisinta Schelhaas	22-May-26
Medical Director	Dr. David Janhunnen	20-May-26
Clinical Consultant		
Resident Council Member	Erica McEachren	22-May-26
Family Council Member	Cheryl Calvert	22-May-26