SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : The Village Seniors Community

People who participated in the evaluation of this report

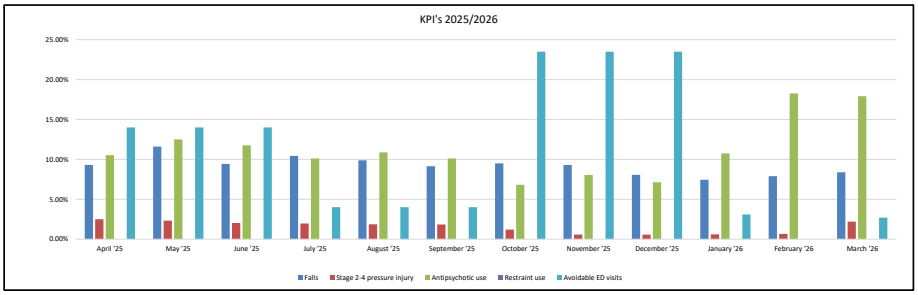
	Name/Designation	Date
Quality Improvement Lead	Danielle Cameron RN/ED	26-May-26
Director of Care	Jason Liddle RN/DOC	26-May-26
Executive Directive	Danielle Cameron RN/ED	26-May-26
Nutrition Manager	Nikita Shaw FSM	26-May-26
Programs Manager	Amber Foyston PM	26-May-26
Clinical Consultant	Julia Levreault/ Jaclyn Goss	26-May-26
Resident Council Representative	Stanton Bowman	26-May-26
Family Council Representative	None at this time	NA
Medical Director	Dr. Cheryl White	26-May-26
IPAC Manager	Mariah Sachs RPN/IPAC	26-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
Improving resident satisfaction with care conference experience	Built out a catch-up schedule for all outstanding care conferences in the facility and completed them over the course of August-December 2025. We then built out a process for booking, managing and maintaining a schedule of care conferences for our admissions and annual conferences, including delegating specifics of who would handle each piece of communication.	All outstanding care conferences were completed by January 2026, and new schedule and in-home procedure was put into practice in January 2026. Schedule has remained on-target.
Improving family satisfaction with physiotherapy services offered in the home	Physiotherapist was to be engaged with family and resident council where appropriate - physio process changed hands to a new company with some new procedures in Q3 2025. The home receives regular reports of the PT/PTA performance and shares these at our quarterly PAC and monthly quality committee meetings when appropriate, both of which are shared with resident's council. Physiotherapy conversation and an introduction to the basic services and process offered to determine eligibility for services is introduced at admission and opportunity given for family to ask questions.	Family survey completed Q3 2025 provide results that indicate family satisfaction with physiotherapy services in the home increased significantly (50% in 2024 to 86% in 2025)- we believe this is due to increased family engaging overall, increased survey participation, and increased communication and awareness of services and how residents qualify for services.
Maintaining below benchmark performance for worsened pressure injuries stage 2-4	Wound care champion completed SWAN training with direct support from the facility in early 2026. Medline training provided to all staff in Q3 2025 as the home switched to streamline wound care services. Began new approach with streamlined services and wound care supply management in Q3 2025. We continue to inherit residents with complex wounds from the community and have a high rate of success at healing and preventing recurrence of these wounds. Medline Fitright training has been conducted in April when the home switched to Medline Fitright products. Some fluctuation in this KPI is typical as the home has a low denominator (53 residents) however remains stable below benchmark in Q3, Q4 2025 and Q1 2026.	Home continues to experience minor fluctuations in score due to low denominator however score remains below benchmark in the rolling 4-quarter average into Q2 2026. See below KPI report. April 2026 - 2.21%
100% completion of required DEI training for staff	Home implemented Surge training program for all staff in 2025, with 100% of staff having completed the required annual education by end of year 2025. Staff continue to complete modules as directed by the schedules within the system set by organizational policy, including diversity, inclusion, equity and workplace safety modules for every staff member.	Home remains in compliance with 100% of staff having completed the training as assigned and required.
Improving percentage of residents who agree with the statement "if I need help right away I can get it" on the annual resident survey	Discussed the survey question in staff huddles in Q2 2025 - completed on-the spot testing of call bell response in random audits during management by walkabouts by managers. Discussed call bell answering and any related questions with residents' council to address any concerns or challenges. The home continues to work with the vendor to gain access to reports and automatic tracking information of the call-bell system.	Survey scores have improved significantly - 65% in 2024, and 88% in 2025.
Maintain below benchmark performance for residents who fell in the past 30 days leading up to date of assessment	The home implemented LTCF in December 2025, which included refresher training on all care staff regarding tracking and reporting of falls. With new falls management procedures in place related to organizational transition in May 2025, all registered staff were trained to the new falls procedure and protocol to ensure compliance. Falls prevention committee meetings continue as part of our quality committee meetings - the home continues to recruit for a specific committee to review and address falls risk. The home has recruited a nurse practitioner in Q2 2026 with experience in falls and injury prevention to work with our physicians to assess and ensure pharmacological risk management practices are in place to reduce injuries. Fall risk screening is being conducted on admission with appropriate falls measures being implemented.	KPI performance has remained below the provincial target throughout the last 12 months (see below KPI report). April 2026 - 6.91%
Percentage of residents taking antipsychotic without diagnosis	The home maintained below benchmark scores in this area while navigating transition to LTCF in December 2026. All staff received training and education specific to their roles in October-December 2026 which included review of coding, documentation and observation required for residents with responsive behaviours, and those receiving antipsychotic medications. With changes in admissions and documentation requirements and audits in progress, our KPI in this area has continued to climb to better truly represent the scores in the home. Related to this adjustment and increase in scores, the home implemented a system with weekly progress note reminders in the MAR in q2 2026, to increase compliance with registered staff reviewing resident behaviours and charting exceptions and incidences managed by the residents use of antipsychotics. RAI reports this has started to improve the reporting of this QI and we will continue to monitor each month for return to compliance. Coach certification obtained and GPA training is being scheduled.	Score remains elevated - ongoing action required. Remains a goal for 2026 year. April 2026 -18.35%
2024 Top opportunities for improvement from Family Satisfaction Survey; 1) I am satisfied with the quality of care from the physiotherapist - 50% 2) I am satisfied wtih the quality of care from the social worker (66.7% - note no social worker in the home at this time) 3) I am satisfied with the variety of spiritual care services - 75% 4) Bladder care products keep the resident dry and comfortable - 75% 5) I am satisfied with the quality of care from doctors 80%	Actions Completed: 1) Reintroduce physiotherapist to families via newsletter and physio participation in care conferences as able. Retained home's dedicated physiotherapist through business transition and encourage contact between families and physio through care conferences, in-person meetings, and other means. Physiotherapist participated in resident's council to reintroduce self and the program- there remains no family council in the home. 2) Facility entered into recruitment of a social worker and has retained one to begin in June 2026. Social worker is in place and meets with families and residents by referral. 3) Retained the home's dedicated contracted chaplain who completes regular hours in the home - added additional prayer meeting service to her duties at hers and residents' request. Notified families and reintroduced chaplain via newsletter as well as continuing to provide monthly activity calendars with billing that describe the spiritual services in the home and when they are held. 4) Restarted care conferences to provide families opportunity to discuss continence care and satisfaction to find areas to improve and explain rationale for current product use. 5) Recruit and retained 2 additional attending physicians to share resident roster with our medical director - restarted care conferences to encourage families to participate in reviews of care and speak with physicians as desired in their care conference sessions or as needed.	Results and Outcomes: 1) 81% satisfaction with physiotherapist on 2025 Family Satisfaction Survey. 2) 87% satisfaction with social worker in the home on 2025 survey. 3) 85% satisfaction with spiritual care variety, 85% satisfaction with timing and schedule of spiritual services, and 81% state awareness of spiritual care offered in the home on the 2025 survey. 4)87% overall satisfaction from family on the continence care products offered in the home on the 2025 family satisfaction survey. 85% agree products are comfortable, 80% agree they fit properly, and 90% agree they keep the residents dry. 5) 85% satisfaction with quality of care from physicians in the home on the 2025 survey.

2024 Top opportunities for improvement from Resident Satisfaction Survey; 1) In my care conference we discuss what's going well, what could be better and how we can improve things - 65.4% 2) If I need help right away, I can get it - 65.5% 3) I am satisfied with the quality of care from doctors - 72% 4) Communication from the home leadership (Admin, ED and Managers) is clear and timely - 75.9% 5) Bladder care products keep me dry and comfortable - 76%	Actions Completed: 1) Re-initiated care conferences including admission and annual, and as-needed. Schedule developed and maintained to ensure care conferences were completed and all available and required parties were aware of the conference and able to attend as needed and desired. 2) On-the spot auditing completed of call bell response times throughout 2025, and added standing discussion item to staff meetings and staff huddles weekly to ensure staff were aware of the initiative and improvement goal. 3) Recruit and retained 2 additional attending physicians to share resident roster with our medical director - restarted care conferences to encourage families to participate in reviews of care and speak with physicians as desired in their care conference sessions or as needed. 4) ED or DOC attends resident's council as invited which is frequent/most monthly meetings, and ED provides update monthly whether in attendance or not. Update includes physical improvements to the home, redevelopment updates, staffing changes, and opportunity to explore feedback and discuss quality improvement. 5) Continence leads educated on use of products with Prevail team as well as online product calculator. Continence leads completing monthly reviews of sizing and auditing for necessary changes.	Results and Outcomes: 1) 88% satisfaction on the 2025 Resident Satisfaction Survey 2) 87% agree "if I need help right away, I can get it" on the 2025 satisfaction survey. 3) 88% satisfaction with care from physicians on the 2025 survey. 4)80% agree "The communication from the home leadership is clear and timely", 85% agree "I am updated regularly about any changes in the home" on the 2025 survey. 5) 84% overall satisfaction with the continence products available in the home on the 2025 survey - 98% agree there is a good choice of products, 85% agree the products are comfortable, 89% agree they fit properly, 85% agree they keep the resident dry, and 94% agree they are available when they need them.

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	9.30%	11.61%	9.43%	10.43%	9.88%	9.14%	9.50%	9.29%	8.06%	7.45%	7.89%	8.38%
Stage 2-4 pressure injury	2.50%	2.33%	2%	1.97%	1.86%	1.83%	1.20%	0.58%	0.57%	1%	1%	2%
Antipsychotic use	10.53%	13%	11.76%	10.11%	10.87%	10.11%	6.82%	8%	7.14%	10.75%	18.27%	17.92%
Restraint use	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED visits	14.00%	14.00%	14.00%	4.00%	4.00%	4.00%	23.50%	23.50%	23.50%	3.10%	0.00%	2.70%



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 1-31, 2025
Results of the Survey (*provide description of the results*):	Residents report increased scores in all target areas on the action plan from the 2025 survey, with lingering increases related to procedure changes still in place from the 2024 goals as well. All scores are elevated with the 'lowest scoring' areas for improvement still rating in the high 70% or 80s for satisfaction. Residents would like to continue to have high quality programming and entertainment provided that feels relevant and inclusive. Areas for growth included improving use and overall aesthetics of the central courtyard; exploring what 'relevant programming' means for residents and including them in monthly calendar planning meetings; increasing the atmosphere and pleasurable dining in our dining rooms at meal services; recruitment of a social worker, and recruitment of a dedicated foot care nurse. For the family survey, families remain highly satisfied with the care, services and atmosphere in the home with the lowest scoring questions landing in the mid to high 80% across all metrics. The home aims to increase overall family participation in the survey to 40% to increase data quality. Overall we aim to increase awareness of services and programming in the home to increase satisfaction including with laundry services, laundry processes, spiritual care services, recreation services and the physiotherapist (which has already seen a marked increase in satisfaction reported - 50% in 2024 to 80% in 2025).
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 presented to the resident's council at their monthly meeting in February 2026 along with review of the action plan in place to improve the quality goals in the home. Results are printed and available as part of our quality postings in the home for staff, residents and families to review. Results were reviewed with staff as well as the action plans associated at our quality meeting in January 2026 and March 2026, to review the ongoing progress on plans in place.

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)	
Survey Participation	100.00%	100.00%	85%	67%	35.00%	28.00%	18.00%	73.00%	Continued strategizing and alterations of staffing to allow a familiar staff member to dedicate time to residents who require support with answering the survey. We plan to get out early and ahead of the survey to increase family awareness - inclusion in billing mail, additional mailouts, postings in the home, phone calls and emails to our family lists on a set schedule to increase awareness and support with participation.
Would you recommend	85.00%	81.00%	79%	89%	8500.00%	83.00%	100.00%	81.00%	continued aesthetic updates and upgrades to the property, particularly the outdoor spaces, including photographs for resident awareness along with next survey.
I can express my concerns without the fear of consequences	90.00%	90.00%	79.00%	88.00%	90.00%	85.00%	10000.00%	97.00%	Quality care conference process continues with encouragement to voice concerns. A solidified complaint management process is in place. Residents' council concerns form process in place to detect and mitigate more minor concerns for residents to improve quality of services.

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**
Reducing rate of avoidable ED visits	Target 20% Change Idea: We are aiming to increase capacity in our registered staff team by requiring education on IV insertion, maintenance and initiation which was completed in Fall 2025, including signing off on the SOP for these procedures and monitoring the number of ED visits specifically related to treatable infection. We will continue with regular completion of PPS assessments and care conferences to ensure that families are aware of their loved ones' care needs and health status and to review and update advanced directives regularly and when there is a resident change in status.	21% Date: Sept 30, 2025
Percentage of staff who have completed required diversity, equity and inclusion training and anti-racism education	Target 100% Change Idea: Continued use and compliance with Surge education schedule which includes diversity, equity and inclusion and anti-racism training for all staff.	100% Date: Dec 31, 2025
Percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences" on the annual resident survey	Target 90% Change Idea Continued monthly residents' councils with participation from management as requested, review of resident's rights including right #29 each month, use of the president's council concern forms and continued use of the complaint management process. Recruitment of a social worker for the home to be available to residents and families.	90% Date: Oct 2025

Percentage of residents who fell in the last 30 days leading up to their assessment	Target 9%. Change Idea: Recruitment of a falls committee of interdisciplinary staff members. Increased compliance with pharmacological fracture risk reduction strategies as eligible on review by the NP. Continued review of incident data and patterns at monthly quality committee meetings to detect and address trends in falls throughout the home.	10% Date: Sept 30, 2025
Percentage of residents whose stage 2-4 pressure ulcer worsened	Target 2.25%. Change Idea: Skin and wound program education continues for all new hires and existing staff including introduction to new products, procedures and policies, and in-person education continues with Medline. Completion and review of the skin and wound tracker by the wound care champion to boost awareness and monitoring of ongoing wounds, trends in the home and to prioritize and address at-risk residents.	2.25% Date: Sept 30, 2025
Percentage of residents who experience worsened pain	Target 8.5%. Change Idea: We have implemented and will provide ongoing education and monitoring for staff regarding the PRN analgesic tool to provide high quality current information to the physicians and NP regarding analgesic use and pain management. Weekly rounding on the tracker with the nurse practitioner will allow timely intervention for residents experiencing worsening pain and address it with non-pharmacological or medication interventions.	9.83% Date: Sept 30, 2025
2025 Top opportunities for improvement from Resident Satisfaction Survey: 1) I am satisfied with laundry, cleaning and maintenance services 2) I am satisfied with the relevance of recreation programs 3) I enjoy eating meals in the dining room 4) I am satisfied with quality of are from the social worker 5) I have access to foot care when needed	Action Plan: 1) Reintroduce the courtyard space with a family and resident event in early summer 2026. Review of home upkeep and suggestions with residents' council. Re-implementation of personal laundry inventory. 2) Conducting further information gathering with residents on meaning of "relevance". Continue with resident involvement in calendar planning process as previously implemented. Ensure implementation of outdoor programming when safe and temperatures allow throughout summer to encourage common area use. 3) Spot audits during meal service. Review of table layout in dining rooms to assess for any improvements or better utilization of space. Exploring pleasurable dining training for dietary and nursing staff. 4) Review and determine role and responsibilities of a social service worker in our home. Recruit for SSW. 5) Implement a foot care program in the home with routine scheduled dates for care.	Satisfaction Score Oct 2025: 1) 79.17% 2) 78% 3) 76.79% 4) 0% 5) 0%
2025 Top opportunities for improvement from Family Satisfaction Survey; 1) I am satisfied with the quality of Laundry services for personal clothing. 2) I am satisfied with the quality of care from the physiotherapist/occupational therapist. 3) I am aware of the spiritual care services offered in the home. 4) Continence care products fit properly. 5) I am satisfied with the timing and schedule of recreation programs.	Action Plan: 1) Re-implementation of personal laundry inventory. Provide staff education regarding clothing inventory process. Provide education to laundry regarding inventory process and discard process. Targeted audits of the personal laundry system – checking discard log, auditing with staff on the floor regarding any laundry issues. 2) Include a listing of service providers to the home with family newsletters, improve visibility of physiotherapist and physiotherapy assistant. 3) Include a listing of contracted service providers in the home, religious services routinely scheduled and extended, in family newsletter. Review Chaplaincy agreement and make additions specifying routine, visit cadence, and any other improvements necessary to meet the needs of the residents and families. 4) Fitright rollout to new products in Q1 2026. Notifying families and residents of change, refitting process, and product selection. Implementing new products and auditing for fittingness and resident satisfaction. 5) Continued routine provision of the recreation calendar with monthly billing, posted in the home, and available online. Create a purpose-built survey for families to suggest activities or other feedback to the home for future calendar building. Incorporate family participation in resident and social events in the home quarterly (starting q2).	Satisfaction Score Oct 2025; 1) 80.75% 2) 80.71% 3) 80.56% 4) 80.42% 5) 80%

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:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Danielle Cameron	26-May-26
Executive Director	Danielle Cameron	26-May-26
Director of Care	Jason Liddle	26-May-26
Nutrition Manager	Nikita Shaw	26-May-26
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