SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Pinecrest Manor

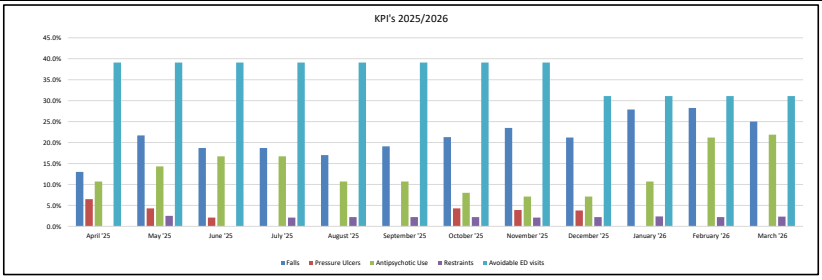
People who participated in the evaluation of this report		
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Lisa Stroeder - ED	29-May-26
Director of Care	Laureen Gracey - Interim DOC	29-May-26
Executive Directive	Lisa Stroeder - ED	29-May-26
Nutrition Manager	Taranpreet Kaur - FSM	29-May-26
Programs Manager	Hailey Wain - PM	29-May-26
Clinical Consultant	Jaclyn Goss	29-May-26
Resident Council Representative	Peggy Uquart	29-May-26
Family Council Representative	None at this time	NA
Medical Director	Damien Guaratne	29-May-26
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
I am satisfied with the quality of care from Doctors - Current performance 27.60%	A name tag was ordered for the physician and was received in the home by April 30, 2025. The process for utilizing the posted notification of scheduled visits was implemented at 100% compliance by June 30, 2025.	Outcome of the Resident Satisfaction Survey Oct 2025 - 82.78% Improvement achieved
I have input into the recreation programs available - 33.3%	Monthly Activity Program Planning meetings were continued to inform and engage residents in program decision-making. Real-time feedback tools, including program evaluations and resident feedback regarding program enjoyment and satisfaction, were utilized to assess resident experiences and inform program improvements.	Outcome of the Resident Satisfaction Survey Oct 2025 - 90% Improvement achieved
Percentage of LTC home residents who fell in the 30 days leading up to their assessment Target - 15.00	Change ideas: #1) Continue to focus on falls reduction with regularly scheduled meetings. #2) Education for front line staff for interventions to reduce falls Monthly falls meetings were scheduled and held regularly throughout 2025. The Falls Team reviewed falls data, recorded meeting minutes, and discussed fall prevention strategies for each high-risk resident, including a review of RAI-MDS data. The Falls Team continued to serve as a resource for frontline staff regarding falls prevention and management. Weekly falls meetings were conducted, and fall equipment audits were completed bi-weekly to monitor compliance with resident care plans	Outcome: March 2026 KPI is 20.00% target not achieved. This will continue to be an initiative for 2026/27
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment Target - 12.00	Change ideas: #1) Continue to use Extendicare's Antipsychotic Reduction Program which includes using the Antipsychotic Decision Support Tool (AP-DST). The deprescribing antipsychotic tool was reviewed monthly to ensure residents had an action plan in place for deprescribing. New admissions prescribed antipsychotic medications were entered into the tool as required. The home obtained a Nurse Practitioner who worked collaboratively with the internal BSO program to reduce antipsychotic use. Weekly meetings were held to discuss residents who triggered the key performance indicator (KPI) and to identify appropriate interventions	Outcome: March 2026 KPI is 14.68% target not achieved. This will continue to be an initiative for 2026/27
Percentage of Long-Term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 -0.0	By December 30, 2025, 100% of residents with a PURS score of 3 or greater had their mattress surfaces reviewed and reassessed as necessary. Quarterly reviews of audit results and data were implemented and discussed at PAC meetings by June 30, 2025. The home implemented a Skin and Wound Lead role, and ongoing education was provided to frontline staff regarding skin and wound prevention and management	Outcome: March 2026 KPI is 1.18% which is below the corporate average. Improvement achieved
Restraints - target 0%	Change Ideas: Utilize alternative interventions to prevent the use of restraints. Educate staff on the process of utilizing alternative interventions to prevent the use of restraints Restraint use discussed at quality meetings and quarterly PAC meetings in 2025	Outcome: March 2026 KPI is 2% Target not achieved, this remains a focus for 2026

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	13.0%	21.70%	18.70%	18.70%	17.00%	19.10%	21.30%	23.50%	21.20%	27.90%	28.26%	25.00%
Pressure Ulcers	6.5%	4.30%	2%	0.00%	0.00%	0.00%	4.30%	3.90%	3.80%	0%	0%	0%
Antipsychotic Use	10.7%	14%	16.70%	16.70%	10.70%	10.70%	8.00%	7%	7.10%	10.71%	21.21%	21.88%
Restraints	0.0%	3%	0%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Avoidable ED visits	39.1%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	31.10%	31.10%	31.10%	31.10%



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 01/2025 to October 31/2025
Results of the Survey (*provide description of the results*):	79.52% of the residents and 81.97% of family members would recommend this home to others. Overall, both residents and families expressed satisfaction with the care in the home. The Overall Satisfaction resident rate in 2025 is 84.05%. For family satisfaction overall is 86.33%. The highest area of satisfaction is with the continence care products for both residents 91.88% and families 95%. Residents feel they have relationships with others in the home and families feel they are satisfied with the communication from home leadership. Both expressed satisfaction with the meals, dining and beverages. Residents did express satisfaction with the laundry, cleaning and maintenance however it does remain below the LTC division overall.
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 of the satisfaction survey were shared with the Resident Council Feb 10, 2026, and families at Family Forum on Feb 17, 2026.

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	80.00%	62.86%	94.00%	83.90%	50.00%	24.00%	50%	18.80%	Residents will continue to be consulted on how they would like the survey to be conducted. Residents and families will be made aware through Resident Council and advertising in the home as well as through newsletters. Technologies will be used for easy access including QR code and email links to the survey.
Would you recommend	85.00%	79.52%	72.40%	84.60%	85.00%	81.97%	85.00%	88.90%	Upholding Southbridge values of living life to the fullest, implementing change through innovation, valuing freedom of choice and exceeding expectations. Maintaining open door policy and prompt response to concerns or complaints. Engaging programs for residents and families. Continued enhancements to maintenance and esthetics in the home.
If I have a concern, I feel comfortable raising it with the staff and leadership	90.00%	87.50%	72.40%	88.50%	95.00%	94.62%	86.40%	100.00%	Education staff on therapeutic communication Educate staff on process regarding Client Service Response SOP Ensure to review at Resident Council Ongoing and regular program audits

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: 21.9 Change Ideas: #1) Use of SBAR -Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer #2) Development of IV program in the home #3) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner	31.08% Date: Sept 30, 2025
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target: 100% Change Ideas: #1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; #2) Include Cultural and Diversity and our CQI meetings #3) Create a culture board; of the residents and team members in the home	77% Date: Dec 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target: 96% Change Ideas: #1) Review the Concern process in the home on admission and during annual care conference #2) Review of the Whistleblower policy #3) Enhance therapeutic communication	95% Date: Oct 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: 14.5 Change Ideas: #1) To facilitate a Bi-Weekly Fall Huddle; with the interdisciplinary team #2) To reduce the number of falls in the home #3) Collaboration with recreation, to implement recreation activities, to engage residents (analysis to when falls are occurring to develop timing)	14.92% Date: Sept 30, 2025
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 13.5 Change Ideas: #1) 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. This is standing item in CQI/PAC quarterly meeting agenda. #2) Residents who are prescribed for the purpose of management of responsive expressions, will have a quarterly review, for the potential of reduction or discontinuation of medication	13.76% Date: Sept 30, 2025
2025 Top Opportunities for improvement from Residents 1) I enjoy eating meals in the dining room 2)If I have a concern: My concerns are addressed when needed 3)I have access to a hairdresser when needed 4)I am satisfied with: The relevance of recreation programs 5)I have access to foot care when needed	Action Plan: 1) Ensure dining room appearance is discussed at resident council 2)Education staff on therapeutic communication 3) Ensure to post next Hairdressing visit on the Recreation Communication board 4) Ongoing recruiting efforts to ensure variety of recreation programs throughout the day and evening 5) Implement the in-house footcare program and post a schedule with up-coming dates of service	Oct 2025 Resident Satisfaction Survey Results: 1) 78.33% 2) 78.33% 3) 75.00% 4) 75.00% 5) 75.00%
2025 Top Opportunities for improvement from Families; 1) Overall, I am satisfied with the recreation and spiritual care services 2) I am satisfied with: The timing and schedule of spiritual care services 3) I am satisfied with the quality: Maintenance of the physical building and outdoor spaces 4) I am satisfied with the quality of care from Social Worker/Social Service Worker 5) I am satisfied with: The variety of spiritual care services	Action Plan: 1) Provide families with monthly updates on the Home Newsletter of both recreation programs and special events 2) Add Spiritual care services to the Family Forum Agenda to allow for discussion 3) Provide updates to family in the monthly newsletters on all repairs and improvements around the home in any given month 4) Post position and actively recruiting for a Social Worker 5) Encourage families to provide suggestions for spiritual care services that may be of interest to our residents	Oct 2025 Family Satisfaction Survey Results: 1) 80.00% 2) 79.90% 3) 79.32% 4) 78.75% 5) 75.91%

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 Signature:	*Print out a completed copy & obtain signature and fill:*	Date Signed:
Quality Improvement Lead	Lisa Stroder	29-May-26
Executive Director	Lisa Stroder	29-May-26
Director of Care	Laureen Gracey In-term	29-May-26
Nutrition Manager	Taranpreet Kaur	29-May-26
Programs Manager	Hailey Wain	29-May-26
Clinical Consultant	Jaclyn Goss	29-May-26
Resident Council Representative	Peggy Uquart	29-May-26
Family Council Representative	No active council	NA
Medical Director	Damien Gunaratne	29-May-26
Other		
Other		