Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Queensway

People Who Participated In The Evaluation Of This Report

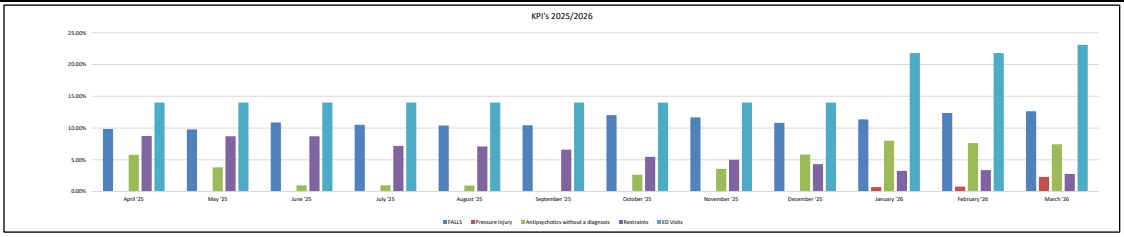
Name and Designation	Date of Evaluation
Quality Improvement Lead	Kim Faranick -RN/RAI -C	May 29 2026
Director of Care	Shanon McKellar -RN Director of Care	May 29 2026
Executive Directive	Ryan Yoanidis - ED	May 29 2026
Nutrition Manager	Mayara Soares - FSM	May 29 2026
Programs Manager	Stacey Kamerman - PM	May 29 2026
Clinical Consultant	Cindy Britton - RN Clinical Consultant	May 29 2026
Resident Council Representative	Cindy Bisback - Resident	May 29 2026
Family Council Representative	Janis Bisback - Family Member	May 29 2026
Medical Director	Dr. Farahnaz Farzadfar	May 29 2026
Other	Lovepreet Kaur -RN Assistant Director of Care	May 29 2026
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
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". 98.75%	Change Ideas: Whistleblower Policy The Whistleblower Policy is included in all admission packages provided to residents and families. The policy was shared with Resident Council on March 18, 2025, and Family Council on February 21, 2025. In addition, 100% of active staff completed Whistleblower Policy education through SURGE Learning or live educational sessions by December 31, 2025.While awareness initiatives were completed successfully, the home did not consistently review and document discussion of the Whistleblower Policy during resident care conferences. To address this gap, a standardized process was implemented in May 2026 to ensure the policy is reviewed and documented at all care conferences. Although the target was not fully achieved during the review period, ongoing monitoring and reinforcement of this process will continue to support full compliance. Change Ideas: Bill of Rights #29: The Resident Bill of Rights, with specific emphasis on Right #29, was communicated and shared with Resident Council on July 21, 2025, and Family Council on March 26, 2026. A contributing factor to the goal not being fully achieved was the transition within the home's leadership team, which impacted the consistent implementation and monitoring of the initiative. To strengthen compliance and resident awareness, effective March 1, 2026, the Resident Bill of Rights, including Right #29, became a standing agenda item at monthly Resident Council meetings and quarterly Family Council meetings. This process will continue to ensure ongoing education, discussion, and reinforcement of residents' rights. Change Idea: Admission Care Conferences: The home did not consistently review and document Whistleblower Policy information during admission and ongoing care conferences throughout the review period. As a result, the established target was not met. To address this opportunity for improvement, a formal process was initiated in May 2026 requiring review of the Whistleblower Policy during all care conferences, supported by appropriate documentation. The home will continue to monitor compliance with this process and reinforce expectations with staff to improve consistency and achieve future targets.	The home's survey results for "expressing my opinion without fear of consequences" for 2025 indicated the Resident's score of 98.75% compared to 2024 results of 100%. The Family satisfaction survey for 2025 score of 94.9% compared to 2024 of 90%. The home was successful in increasing family satisfaction by 4.9%.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Change Idea: Review of Antipsychotic Medications at Admission The home utilizes the BOOMER admission process, which involves the pharmacist, physician, and registered staff reviewing all medications prior to admission. In addition, quarterly medication reviews were completed for all residents over the past year. While medication reviews were consistently completed, documentation did not specifically indicate whether the appropriateness of antipsychotic medication use was reviewed at the time of admission. During the third and fourth quarters, the home experienced a high level of resident turnover and admissions. Several newly admitted residents arrived from hospital settings on antipsychotic medications without a documented diagnosis. In many cases, these residents required a period of adjustment and stabilization within the new environment before medication reduction efforts could be safely considered. Ongoing monitoring and review were completed to assess behavioural symptoms, quality of life, and opportunities for gradual dose reduction. Change Idea :GPA Training and Capacity Building: To strengthen the home's approach to responsive behaviours and reduce reliance on antipsychotic medications, a new Gentle Persuasive Approaches (GPA) Coach role was assumed by a staff member during the third quarter. Additionally, five staff members, including management, registered nursing staff, and PSWs, successfully completed GPA Certification training on December 3. This enhanced the home's internal expertise and capacity to support residents with responsive behaviours using person-centered, non-pharmacological approaches.	The Home has continued to be successful in reducing the KPI for antipsychotic medication use, decreasing from 17.0% in December 2024 to 4.85% in April 2025. During the fourth quarter , the KPI increased slightly month over month from 5.83% in December 2025 to 7.40% in March 2026;however, it remains below Corporate benchmark and reflects sustained improvements.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Change Idea : Falls Checklist: Fall Checklist was used for all Falls within past year. In addition all the required follow-up actions was documented and completed on the falls tracker to ensure timely review, accountability and implementation of fall prevention interventions. Change Idea: Weekly Fall Huddles : Immediate post fall huddles conducted for root cause analysis, with ongoing documentation under post fall assessments to ensure compliance and continuous improvement. Referrals to physiotherapy support individualized mobility, balance, and strength interventions. A gap was identified in the completion of falls huddles, as they were not consistently conducted in the past. One contributing factor was the transition within the leadership team, which affected the consistency of the process. Following the identification of this gap, expectations were reinforced and fall huddles are now being completed consistently to support timely review of falls, identification of contributing factors, and continuous quality improvement. Rounding practices were sustained throughout the four quarter as per the policy. Monthly Quality committee meeting identified high risk fall timeframes, which were reviewed by leadership and communicated to frontline staff to support enhanced rounding and fall prevention efforts during peak risk periods. 100% Post fall huddle completion rate was achieved during the reporting period, with registered staff completing a huddle after each resident fall.	KPI for March 2026 is 12.64% and one remains below Corporate benchmark .Consistent implementation of layered interventions contributed to sustained improvement and enhanced resident safety.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Change Ideas: Diversity, Equity, and Inclusion Surge Education: 100% of active staff completed Diversity training through Surge learning over the last four quarters. Change Ideas : Culture Diversity Events: Variety of cultural and diversity- focused events were celebrated throughout the year to promote Inclusivity, cultural awareness, and resident engagement. These included Eastwe celebrations on Arpil 16, 17, 18 and 20, Cinco de Mayo on May 5th, Civic Holiday on August 4th , Labour Day September 1st, Oktoverfest on october 10th, Remembrance Day on November 11th and Christmas celebrations throughout December ,and St. Patrick's da March 17th. Monthly Armchair Travel/Yum Box experiences further supported cultural learning and appreciation, featuring destinations such as Hawaii, Italy, Around the World, France and Brazil. During the period of May 1, 2025 to December 31, 2025, two CQI meetings were held. Cultural diversity and inclusion were discussed and incorporated into both meetings. Change Ideas: Open Door Policy: The leadership team consistently maintained an open door poicy throughout the year. Leadership remained committed to supporting the open communication, encouraging feedback, and advocating for regulatory compliance while fostering a culture of transparency and continuous improvement. The effectiveness of the open door policy between leadership and staff is evidenced by the staff survey results of the october 2025 and based on complaint process.	Current: 100% The home has proven successful in maintaining 100% compliance with the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education. As of December 31, 2025 100% of staff completed education on culture and diversity topics through Surge Learning.
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	**Change Ideas: Focused Health Assessments:** A total of 29,100 assessments were completed during the period of May 1, 2025 to December 31, 2025. The data included 58 residents in total, which reflects all residents assessed during the reporting period, including new admissions and residents who became deceased. The actual home capacity is 51 beds. And in 2025 resident immunization review was completed with the following vaccination rates:Influenza (Fluzone): 76%,COVID-19: 58%,RSV: 74%,Adacel/Td: 80%,Pneumovax/Prevnar 20: 92%,MMR: 33.33%. **Change Ideas: SBAR Communication Tool:** 100% SBAR Tool was used each time charge nurse contacted Doctor. **Change Ideas: ED visit Reduction by 50%:** ED tracker utilized for each transfer to hospital. Hospital transfers and related trends were discussed in 100% of monthly Quality meetings and quarterly PAC meetings, and this practice continues ongoing.	The current KPI for March 2026 is 23.10% whereas in April 2025 was 14.0%. Despite ongoing education and support provided to staff, the home's percentage of Emergency Department (ED) transfers remained higher than the Provincial Average. The escalation of transfers is recognized the increasing complexity, higher acuity levels, and multiple comorbidities within the home impacting clinical decision-making and transfer needs. The home continues to review contributing factors, monitor trends, and implement strategies to reduce avoidable transfers while ensuring residents receive appropriate and timely care.
2024 Resident Satisfaction Survey: Top 5 Opportunities **1) If I need help right away, I can get it = 83.92%** **2) Staff take the time to chat with me =82.95%** **3) I enjoy eating meals in the dining room = 82.89%** **4) Residents are friendly with each other =81.85%** **5) I am satisfied with the quality of care from: Doctors =76.79%**	1)The home reviewed the results at Residents Council and asked for further input. The home also reviewed at staff monthly meetings. Reviewed staff schedules/agency usage and recruitment processes. 2) The home provided training on Resident Centered Care at staff meetings. Reviewed current resident admission process/introduction of a new residents to the home. The home has encouraged staff to create positive relationships with resident's through conversation and participation in activities. 3) Home reviewed the seating arragements as needed or required throughout the yeat to promote social interaction to enhance the dining experience 4) The home provided programs that meet the five domain areas and where possible gathered residents of similar interests together. 5) Through Quarterly Professional Advisory Committee meetings the home enhanced residents and families understanding of the roles and responsibilities of the Medical Director/Attending Physicians	**2025 Resident Satisfaction Results:** 1) If I need help right away, I can get it =79.71% Not improved 2) Staff take the time to chat with me =85% Improved 3) I enjoy eating meals in the dining room =86.21 Improved 4) Residents are friendly with each other =90.71% Improved 5) I am satisfied with the quality of car from: Doctors =80.17% Improved
2024 Family Satisfaction Survey : Top 5 Opportunities **1) I am satisfied with the quality of care from the nursing staff =86.36%** **2) The resident has input into the spiritual care services =85%** **3) I am satisfied with the quality of care from the doctors =83.33%** **4) I am satisfied with the timing and schedule of the spiritual care services =82.69%** **5) I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces =78.95%**	1) The home continued the practice of specifically assigning a charge nurse to Physcian rounds ensuring residents were supported by knowledgable staff and that consistant updates were communicated to the interdisciplinary team. Resident care needs identified through observation were addressed promptly through discussions held in a secure area on the unit. Staff input was incorporated into the discussions, enhancing communication, supporting collaborative decision making, and enabling immediate responses to resident concerns. The home reviewed recruitment strategies to support and maintain an appropriate staffing compliment. 2) A list of Churches and Community Contacts was developed to promote a variety of Spiritual Care volunteers to augment current Volunteer pool and increase spiritual diversity for the residents. The list was then shared at Residents Council for their input. 3) The home has encouraged Physicans to attend Resident Care Conferences. 4) The home reviewed the timing and schedule of the Spiritual Care Services at the monthly Residents Council meetings which provided an opportunity for suggestions and feedback. 5) The home made upgrades to the home by painting all common areas including hallways and common areas, upgraded lighting in hallways and common areas and purchased new furniture for lounge areas. The home hired a new contractor to maintain the outdoor gardens.	**2025 Family Satisfaction Results:** 1) I am satisfied with the quality of care from the nursing staff =87.71% Improved 2) The resident has input into the spiritual care services =93.33% Improved 3) I am satisfied with the quality of care from the doctors =88.31% Improved 4) I am satisfied with the timing and schedule of the spiritual care services =77.44% Not improved 5) I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces =79.82% Improved

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	9.84%	9.78%	10.87%	10.50%	10.38%	10.44%	12.02%	11.67%	10.81%	11.35%	12.36%	12.64%
Pressure Injury	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.70%	0.78%	2.30%
Antipsychotics without a diagnosis	5.77%	3.81%	0.96%	0.98%	0.94%	0.00%	2.65%	3.57%	5.83%	8.00%	7.63%	7.44%
Restraints	8.74%	8.70%	8.70%	7.18%	7.10%	6.59%	5.46%	5.00%	4.32%	3.24%	3.37%	2.76%
ED Visits	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	21.80%	21.80%	23.10%



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/PDA'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 the Most Recent Year

Date Resident/Family Survey Completed for 2024/25 year:	The 2025 resident and family surveys, conducted between October 1 and October 31, show high overall satisfaction with the home. to others.
Results of the Survey (*provide description of the results*):	A strong majority of Residents (90.90%) and Family Members (80.41%) would recommend the home to others. The Overall Satisfaction Resident Rate in 2025 is 87.34% which was an increase from 2024 of 85.36%. For Family Satisfaction Overall Survey in 2025 is 85.08%, which is slightly higher than 2024 rate of 83.73%. To note, there was a significant increase in family participants for 2025 was 85.71% versus 43.14% in 2024 and the residents participation slightly decreased from 100% in 2024 to 94.14% 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)	The 2025 survey results and action plan were shared with Family Council on March 26, 2026 and Residents Council on February 24, 2026 and were posted on Quality board in home for staff to review.

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%%	94.14%	100.00%	82.60%	100%%	85.71%	43.14%%	80.49%	The Home will continue to promote participation in the Resident and Family Satisfaction Survey through multiple communication channels, including the Newsletters, Care Conferences, email communications, notice boards, and Resident/Family Council Meetings, to ensure broad engagement and awareness.
Would you recommend	**92.00%**	90.90%	91.25%	77.14%	**82.00%**	80.41%	92.11%	82.86%	To support improvement in the likelihood of residents and families recommending Queensway LTC to live, the Home will continue to focus on enhancing the quality of resident programs and services. Staff will be expected to consistently uphold the Home's Mission, Vision, and Values in daily practice and interactions with residents and families. Positive engagement and communication will be actively encouraged to strengthen relationships and overall satisfaction. The Home will also continue to highlight ongoing quality improvement initiatives and care outcomes through newsletters and Resident Council meetings, including updates and success on quality indicators, staffing levels, and care improvements. in addition,"Would you recommend this Home?" will remain a standing discussion item at Resident Council meetings, with follow-up completed on feedback and recommendations provided.
If I have a concern, I feel comfortable raising it with the staff and leadership	**95.00%**	93.40%	94.84%	72.73%	**92.00%**	90.05%	90.48%	82.86%	The Home remains committed to fostering an environment where residents and families feel safe and comfortable raising concerns. In alignment with the Home's HOO-OP improvement initiatives, the following strategies will continue: 1. Ongoing review and reinforcement of the Complaints and Concerns process upon admission, during annual care conferences, and through staff education and training sessions. 2. Continued engagement of residents in meaningful discussions during care conferences to encourage open expression of opinions, concerns, and suggestions. 3. Regular review of the Residents' Bill of Rights at Resident Council meetings, with emphasis on Resident Rights #29, which supports the right to raise concerns or recommend changes without fear of discrimination or reprisal, 4, Timely follow-up, discussion, and resolution of resident concerns raised through Resident Council Meetings related to home operations. These ongoing initiatives aim to strengthen resident voice, improve communication, and support continuous quality improvement within the Home.

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.	1) Continue to implement regular health screening through IPAC assessments and preventive care measures to help identify and prevent complications that may lead to hospitalization. 100% compliance with health screening through IPAC assessments completed by Registered staff as indicated by June 30, 2026. **Target**: 21% 2) Implementation of the Nursing PLEDGE initiative program to build capacity and improve overall clinical assessment skills of Registered Staff by supporting mentorship of nurses, enhancing quality of care and workforce stability. **Target:** 80% of ED visits were assessed appropriately based on resident outcome and transferred to the ED by December 31, 2026 3) Nursing Leadership to review and analyze the monthly ED trackers for root cause of transfers and determine appropriateness of transfer based on resident outcome **Target**: 10% reduction in avoidable ED visits by December 31, 2026	January 2026: 21.82%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1) To continue to facilitate ongoing open door policy amongst the management team **Target**: 100% of reminders to staff re: open door policy 2) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; **Target:** 100% of cultural events to be celebrated monthly 3) To increase diversity training through Surge education or live events; **Target**: 100% of active staff educated on topics of Culture and Diversity	December 2025: 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1) To exceed our current goal of 79% by engaging residents in meaningful conversations that allow them to express their opinions **Target:** 100% of all Care Conferences will review Resident Bill of Rights #29 by December 31 2026 2) Continue reviewing Resident's Bill of Rights # 29 at Monthly Resident council meetings **Target:** 100% of Resident council meetings minutes will have the Bill of Rights #29 reviewed by December 31 2026 3) Continue to review Resident Bill of Rights #29 at Family council quarterly meetings **Target**: 100% of all Family Council meeting minutes include Resident Bill of Rights #29 by December 31 2026	September 2025: 79.41%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1) To establish and facilitate an interdisciplinary approach to Weekly Fall Huddles **Target**: 100% interdisciplinary participation at Weekly Fall Huddles by June 20 2026 2) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss **Target:** 100% of residents who experienced a fall in the month will have completed a comprehensive post fall assessment and reviewed at the Falls weekly Huddle by June 30 2026	September 2025: 10.29%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1) The Nursing Leadership team will identify newly admitted residents prescribed antipsychotic medications for review if appropriate for diagnosis and indications for use **Target**: 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use by April 30 2026 2) During admission conference, review with families and resident, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health) **Target**: 100% of discussions will be documented, on admission, with resident/family for the prescribing of antipsychotic medication by April 30 2026 3) Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. **Target**: 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuation of antipsychotics by June 30 2026	September 2025: 0.00%
2025 Resident Satisfaction Survey Results: **Top 5 Opportunities:** 1) Overall, I am satisfied with the recreation and spiritual care services 2) Continence care products: Are comfortable 3) I am satisfied with the quality of care from: Social Worker/Social Service Worker 4) If I need help right away, I can get it 5) I am satisfied with: The relevance of recreation programs	The Top 5 areas of improvement that were identified with the Resident Satisfaction survey included: 1) The home to review the programs calendar/spiritual care programs at the monthly Residents Council Meetings. Implement suggestions on the programs calendar. 2) In March of 2026 Seaforth will be changing from the currently offered prevail product to Medline 'Fitright' continence products. In this changeover, all residents will be resized and refitted through the new algorithm. This process should ensure residents are in the most comfortable product. 3) The home will continue to recruit a SW/SWW with the Southbridge Acquisition team. 4) The home to implement a "buddy system" for staff breaks times to ensure coverage. Discuss problem times with Residents Council and adjust job routines as necessary. 5) The home to review the programs calendar and the monthly Residents Council Meetings. Implement suggestions on the programs calendar.	**2025 Resident Satisfaction Survey Results:** 1) Home Scores- 80.77% 2) Home Scores- 80% 3) Home Scores- 80% 4) Home Scores- 79.71% 5) Home Scores- 76%
2025 Family Satisfaction Survey Results: Top 5 Opportunities: 1) I am satisfied with the quality of care from: Administration/Office Staff 2) I am satisfied with the quality of: Cleaning within the residents room 3) I am satisfied with: The variety of spiritual care services 4) The residents have access to a hairdresser when needed 5) I am satisfied with: The timing and schedule of spiritual care services	The Top 5 areas for improvement that were identified with the Family Satisfaction survey include: 1). The home will adjust the monthly newsletter to include leadership updates. 2) The home to implement environmental service staff meetings to review processes. To provide 1:1 training for all housekeeping staff. 3) The home to review the programs calendar/spiritual care programs at the monthly Residents Council Meetings. Implement suggestions on the programs calendar. 4) Include hairdresser schedule in the monthly newsletter, and provide alternative options of local hair providers as an alternate option. 5) The home to review the programs calendar/spiritual care programs at the monthly Residents Council Meetings. Implement suggestions on the programs calendar.	**2025 Family Satisfaction Survey Results:** 1) Home Scores- 79.76% 2) Home Scores- 79.62% 3) Home Scores- 79.61% 4) Home Scores- 79% 5) Home Scores- 77.44%

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 and e completed copy - obtain signatures and ini.*	Date Signed:
Quality Improvement Lead	Kim Farfanick	**May 29 2026**
Director of Care	Shanon McKellar	May 29 2026
Executive Directive	Ryan Yoanidis	May 29 2026
Nutrition Manager	Mayara Soares	May 29 2026
Programs Manager	Stacey Kanaanman	May 29 2026
Clinical Consultant	Cindy Britton	May 29 2026
Resident Council Representative	Cindy Bisback	May 29 2026
Family Council Representative	Janice Bisback	May 29 2026
Medical Director	Dr. Farahnaz Farzadfar	May 29 2026
Other	Lovepreet Kaur Associate Director of Care	May 29 2026
Other		