Annual Schedule: May 2026

HOME NAME : Hallowell House

People who participated in the evaluation of this report

	Name and Desingation	Date of Evaluation
Quality Improvement Lead	Azaria Kanda - ED	June 5th, 2026
Director of Care	Blessing Obi DOC	June 5th, 2026
Executive Directive	Azaria Kanda - ED	June 5th, 2026
Nutrition Manager	April Jordan - FSM	June 5th, 2026
Programs Manager	Janie Denard - PM	June 5th, 2026
Clinical Consultant	Moises Ruiz	June 5ht, 2026
Resident Council Representative	Margaret Rassell	June 5th, 2026
Family Council Representative	N/A	N/A
Medical Director	Dr. Sanjaya Acharya	June 5ht, 2026
Other	Carolyn McCorkindale - Senior ED	June 5th, 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.

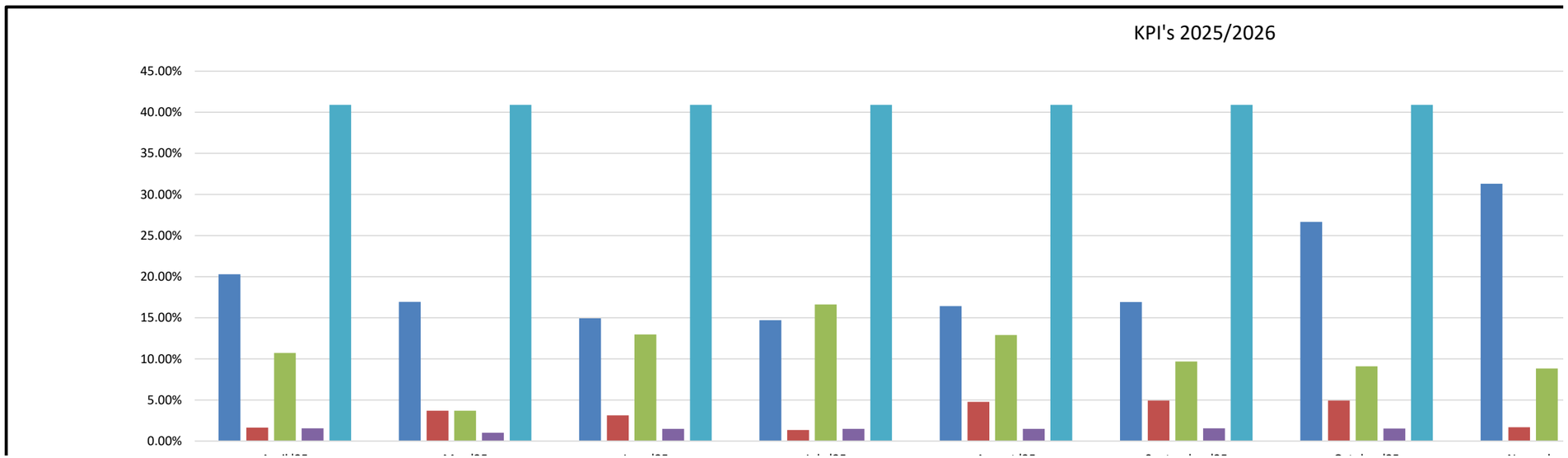
Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change Idea: Implement the new Falls Prediction and Prevention Report developed by the Operator** The Falls and Quality rolled out the use of the FPPR report Residents were reviewed, and strategies are in place to prevent falls Progress was monitored by the DOC -falls lead and the quality lead based on data from the report. **Change Idea: Enhance Post Falls Huddles** Falls are reviewed daily during the morning meeting Education was provided to the staff on falls prevention interventions annually. The falls lead, led the Post Falls Huddles and documentation to ensure compliance	Falls Management quality indicator improved to 15.98% in Q1 2026, approaching the corporate benchmark of 15.50%, with a sustained downward trend over the past three quarters. Number of residents triggering the indicator decreased from 41 (Q1 2025) to 28 (Q1 2026). Improved management of high-risk residents, with reduced frequency and impact of falls. Consistent implementation of layered interventions contributed to sustained improvement and enhanced resident safety.
Percentage of LTC residents without psychosis who were given	**Change Idea: Implement Extendicare's Antipsychotic Reduction program, which includes using the Antipsychotic Decision Support Tool (AD-DST)**	

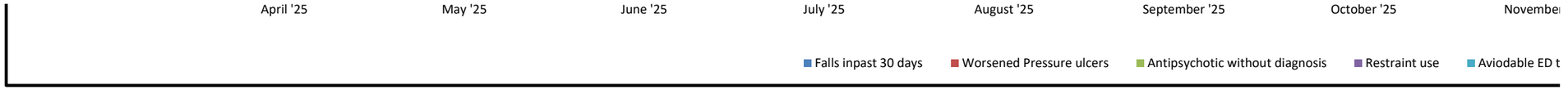
antipsychotic medication in the 7 days preceding their resident assessment	•The home established an AP reduction team •Education was provided by the clinical/quality support team on the antipsychotic reduction program •An action plan was created based on the AP decision support tool. •Team met monthly to review AP deprescribing **Change Idea: Collaborate with the physicians and Nurse Practitioners to ensure all residents using antipsychotic medications have a medical diagnosis and a rationale identified.** •Medication reviews were completed on residents on antipsychotic medications, including residents returning from the hospital. •The team reviewed the reason for Antipsychotic use for each resident. •Recommendations were made by the interdisciplinary team regarding Antipsychotic use and non-pharmacological interventions C**hange Idea: Enhanced Education for staff, including Registered staff on Antipsychotic usage and non-pharmacological methods to address responsive behaviors.** •Education was provided to the Reg. staff on the use of antipsychotics. •Staff were trained on PIECES and GPA. •External BSO resources were identified to support the home	By April 2026, antipsychotic use without psychosis reached 17.03%, the lowest rate in over three years, successfully achieving below corporate benchmark. Six residents successfully discontinued antipsychotics through the dose reduction initiative. Ongoing auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement.
I am satisfied with the quality of care from the dietitian	**Change Idea: Enhance resident and family members' knowledge of the Role of the Dietician vs Nutritional Care Manager, as well as enhance interaction between the Dietitian and residents.** •The home distributed a survey to compile information on areas that required further review •Results were reviewed and submitted to the dietician and the Food Service Manager •An action plan was created and forwarded to the resident council. •A six-month review was conducted after the implementation of the action plan. Residents and families had a better understanding of the roles of the Reg. Dietician and Food Service Manager	There were no results in 2025 under this category due to change in operator
I am satisfied with the quality of care from the doctors	**Change Idea: Review and improve the current process for MD and NP rounds** •Results of the survey were shared with the in-home doctors and NP NLOT •Process for NP/MD rounds was reviewed. Changes were implemented. •Education was provided to the Reg. Nurses in the process of NP/MD rounding •No further concerns were voiced by residents or families	There were no results in 2025 under this category due to change in operator
I am satisfied with the variety of religious and spiritual programs offered	**Change Idea: Do a complete review of the Religious and Spiritual programs offered at the home.** •A review of the home's religious and spiritual services was completed •All residents' denominations were identified to tailor religious and spiritual services for all residents •Evaluation is still pending completion •No further concerns have been brought forward by the residents or families. **Change Idea: Enhance the Cultural and Spiritual programs offered based on the Current population in the home.** •A survey was created and distributed on cultural background, festivities, and spiritual events celebrated by all residents. •An action plan was created based on survey results to include celebrations that were not being offered prior to the resident satisfaction survey. •The home reached out to external partners to review opportunities for mutual collaborations to support residents' cultural and spiritual needs where possible. •Post implementation survey to be completed	There were no results in 2025 under this category due to change in operator

Percentage of long-term care home residents in daily physical restraints over the last 7 days	**Change Idea: Provide information to families and residents on the least restraint Provide education for staff to use when discussing restraints with residents or families** •The home shared with residents and families a restraint brochure as part of the admission packages for new admissions •Education on the least restraint for residents and families is to be scheduled. •DOC provided education to the Nursing staff on the least restraint policy	The home has performed slightly above the provincial average of 1.30% over the past 12 months. As of April 2026, the home is at 1.55%. The home continues to be committed to a restraint-free environment.
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	**Change idea: Mandatory Training for all Registered staff on correct staging of pressure ulcers** •DOC reviewed requirements for skin and wound care education with the Reg staff via Memo and monthly Reg staff meeting. •In-house education was conducted through Medline •Skin, a wound care lead, monitored compliance with policy, completion of weekly skin assessments, etc. DOC informed of progress. **Change Idea: Review Current bed systems/surfaces for residents with PURS Score of 3 or greater** •Skin and wound care lead completed a review of PURS scores over 3 to determine the need for a pressure relief surface. •Pressure relief surfaces were implemented based on the MD/ NP order and recommendations from the skin and wound care lead •Physiotherapy and Dietician participated in the review **Change Idea: Improve the interdisciplinary approach to the Skin and Wound program** •Membership of the skin and wound care committee was reviewed based on the Terms of Reference. •Expressions of interest were rolled out to invite staff to participate in the committee. Some staff have come forward to join the team. •Skin and wound tracking tool has been implemented and rolled out •The physiotherapy Reg dietician are being consulted on skin and wound issues as required.	The home has gradually continued to improve since last year, over the past 6 months. As of April 2026, the home is performing at 2.60%, just slightly above the provincial average of 2.20 %.
2024 Resident Satisfaction Survey: Top 5 Opportunities 1) If I have a concern: I feel comfortable raising it with the staff and leadership = 78.17% 2) I would recommend this Home to others = 77.37% 3) I am satisfied with the quality of care from: Dietitian = 76.86% 4) If I have a concern: My concerns are addressed in a timely manner = 76.80% 5) I have access to foot care when needed = 76.19%	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. Encouring residents and families to voice concerns and provide feedback though multiple channels such as Resident and Family Council Committee, Satisfaction Surveys and direct conversation with the management team. The Management team continue to reinforce with the staff accountability to respond to concerns promptly, respectfully and professionally including adderssing any raised concerns in a timely manner. The Home continue 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. 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. The Home continue to provide ongoing training for all staff on Mandatory Reporting requirements, Resident Bill of Rights, Zero Tolerance of Resident Abuse and Neglect, and Customer Service and Complaint Resolution. There is a reinforcement of expectations for resident-centered care, dignity, and respectful interaction for all staff. And the Home continue to conduct a regular refreshers and competency reviews to ensure compliance	The expected impact of the 2024 Resident Satisfaction Survey was to improved resident satisfaction survey and engagement, enhanced access to key services such as foot care and dietary support, stronger staff accountability and service culture and safer, more responsive care environment. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) If I have a concern: I feel comfortable raising it with the staff and leadership = 96.81% 2) I would recommend this Home to others = 81.87% 3) I am satisfied with the quality of care from: Dietitian = 90.72% 4) If I have a concern: My concerns are addressed in a timely manner = 95.92% 5) I have access to foot care when needed = 83.22%

2024 Family Satisfaction Survey: Top 5 Opportunities 1) I am satisfied with the quality of: Laundry services for linens = 79.91% 2) The resident has access to foot care when needed = 79.88% 3) I am satisfied with the timing and scheduling of spiritual care services = 79.61% 4) I am satisfied with the quality of care from: Dietitian = 78.31% 5) Continence care product fits properly = 77.74%	Imlementation of plans to improved services in the Home is always the priority for resident comfort, dignity and satisfaction. Family's inout is valuable to the Home to ensure essential services are completed in a timely manner and would better align for resident care preferences. This also ensure stronger staff accountability and quality in our service. The Home had 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 shortages promptly. Timely access to foot care services was identified and prioritizeds 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. 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. 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. The Home continue to complete a regular individualized continence assessment and re-assessment with any change in resident condition. There are adequate stock of all sizes and proper staff training on proper sizing, fitting and application techniques completed. The Home continue to monitor and document issues and adjust products accordingly to ensure resident comfort and dignity is followed.	Similar to the Resident Satisfaction Survey, the expected impact of the 2024 Family Satisfaction Survey was to also improved family satisfaction survey and engagement, enhanced access to key services such as laundry, foot care, spiritual support, dietary support and Continence program. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) I am satisfied with the quality of: Laundry services for linens = 95.97% 2) The resident has access to foot care when needed = 83.65% 3) I am satisfied with the timing and scheduling of spiritual care services = 80.22% 4) I am satisfied with the quality of care from: Dietitian = 83.65% 5) Continence care product fits properly = 88.63%

Key Perfomance Indicators		
KPI	April '25	May '25
Falls inpast 30 days	20.30%	16.93%
Worsened Pressure ulcers	1.64%	3.69%
Antipsychotic without diagnosis	10.71%	4%
Restraint use	2%	1%
Aviodable ED transfers	40.90%	40.90%





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 inccorporated 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:	Oct-25
Results of the Survey (*provide description of the results*):	100% of residents participated, and 84.58% of families participated in the survey. Action plans were created for both residents and families, 5 top opportunities. These are reviewed at the resident council meetings and bi-annually during the town hall meetings which are held in lieu of family council.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	90.85% of the residents and 87.25% of family members would recommend this home to others; The Overall Satisfaction Resident Rate in 2025 is 86.08% over the 2024 of 85.36%. For Family Satisfaction Overall Survey in 2025 is 86%, also above the 2024 rate of 83.74%.

Client & Family Satisfaction	Resident Survey	
	2026 Target	2025 (Actual)
Survey Participation	100.00%	100.00%
Would you recommend	92.00%	90.74%
If I have a concern, I feel comfortable raising it with the staff and leadership	90.00%	87.04%

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Initiative	Target/Change Idea	Current Performance
'Initiative #1 - Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents	**Change idea :** Increase capacity within the Reg.Staff team to accurately and timely communicate to the interdisciplinary team of any acute changes in residents' conditions ,thus avoiding unnecessary ED visits when possible. **Change idea :**Building Capacity with the Registered staff in discussion around establishing early and ongoing Goals of Care during admission as well as when changes arise in resident health status Change idea Review of the ED Tracker by the DOC / ADOC and interdisciplinary team to determine common reasons for transfer to the ED and intervention to prevent unnecessary ED visits Target : 25%	March 2026: 30%
Initiative #2 - Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education -	**Change idea :** Complete Equity , Diversity , Inclusion and anti-racism training for staff through SURGE education and live training **Change idea :** Promote knowledge and understanding of the home's staff on equity, diversity, inclusion, and anti-racism by providing open forums for discussion and dialogue. **Change idea :** The home will explore opportunities to partner with external stakeholders to assist staff education on equity, diversity, inclusion, and anti-racism. Target : 100 %	March 2026 : 70%
Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment -	**Change Idea:** Complete Weekly Fall Huddles for each Unit with the interdisciplinary team . **Change Idea:** In collaboration with the Falls committee , the Falls Lead and interdisciplinary team, , residents who are at high risk of falls will be reviewed monthly and strategies and action plans will be created and ongoingly enhanced to reduce falls risks . **Change Idea:** Relaunch of Purposeful Rounding for residents at medium or high risk for falls. Target :17.5 %	March 2026 : 19.54%

Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	change idea :Ensure that all inhouse staff and new employees are educated on the Skin and Wound program including wound care management , assessment and skin care . DOC and Wound Care Champion to arrange for education for Registered staff and PSWs with products and the wound care program . change idea : Monthly Review in the Quality Meeting of residents with pressure-related wounds. Utilization of the Skin and Wound tracking tools to analyze pressure-related injuries in the home and development of the plan of care, determine trends, and appropriate prescribed wound and skin products change idea : Referral for wounds to the Skin and Wound Champion as well as outside resources for inhome consults. Refer to NLOT for wounds that fail to heal within 4-6 weeks after appropriate basic measures are not meeting the optimal healing process Target : 2%	March 2026 : 7.72%
Percentage of long-term care residents in daily physical restraints	change idea : The home will continue to provide information to families and residents on least-restraint policies and alternatives to assist families in making informed decisions regarding the use of restraints vs alternatives. Provide a restraint prevention and the use of alternatives to new admissions, care conferences, and during tours 2) Meeting with resident and family councils to provide education throughout the year on Least Restraints and risks associated with Restraints and alternatives. Target : 1.53%	March 2026: 1.54%
'Initiative #5 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment -	**Change idea** : The MD , NP, BSO internal and External members will review all residents with responsive behaviors . **Change idea :**The residents who are prescribed antipsychotics for the purpose of managing Responsive Behaviors will have a routine review. **Change idea** : Development of plans of care with non pharmacological approach, identification of triggers and interventions . Target : 11 %	March 2026: 11.02 %
2025 Resident Satisfaction Survey: Top 5 Opportunities **1. I have access to foot care when needed** **2. I am satisfied with: The variety of spiritual care services** **3. I am satisfied with the quality of: Cleaning services throughout the home** **4. I am satisfied with the temperature of my food and beverages.** **5. I am satisfied with the quality of: Cleaning within the resident's room**	1. I have access to foot care when needed Set up a schedule for footcare nurses Provide residents with notices/reminders for footcare services in their room. 2. I am satisfied with: The variety of spiritual care services Review Welbi insights on residents' religious/spiritual preferences, Expand the variety of spiritual and religious offerings, and Share clear updates at the next resident's council meeting 3. I am satisfied with the quality of: Cleaning services throughout the home Complete the QRMHL- Resident Room cleaning and QRMHL- Resident room Sanitation audit for the housekeeper weekly We will be increasing the number of on-the-spot housekeeping checks completed throughout the week.	2025 Resident Satisfaction Survey Results: 1) Home score - 83.22% 2) Home score - 82.81% 3) Home score - 82.50% 4) Home score - 82.22% 5) Home score - 80.90%

2025 Family Satisfaction Survey: Top 5 Opportunities **1) I am satisfied with the food and beverages served to residents** **2) I am satisfied with: Tthe timing and schedule of recreation programs** **3) I am satisfied with: The relevance of recreation programs** **4) I am satisfied with: The variety of spiritual care services** **5) I am satisfied with: The timing and schedule of spiritual care services**	Launch Spring/Summer menu at the end of May to increase variety and seasonal options. Audit using QRM-DS- food production audit and Daily management Dietary audit. FSM/FSS to attend monthly Family Council meetings to share upcoming themed events and gather input. 2) I am satisfied with: The timing and schedule of recreation programs The Council will review the current daily program schedule for resident activities and add more programs where needed. Council feedback is requested regarding the suitability of these times, resident participation levels, and any recommended adjustments to be made 3) I am satisfied with: The relevance of recreation programs An overview of the programs for Family Council, on information nights will be conducted including "Suggestion items" to be added to the Agenda The Five Domains for residents and families will be added to the Home's Newsletter 4) I am satisfied with: The variety of spiritual care services Review Welbi insights on residents' religious/spiritual preferences, Add to newsletter the religious programs in the home and the times Add to the activity board the religious services being provided Resource external churches Audit all residents Religion and spiritual care and provide input from Residents and family variety of services 5) I am satisfied with: The timing and schedule of spiritual care services Increased variety of spiritual and religious programs Increase the Opportunities for quiet reflection, prayer, and meditation Exploration of partnerships with local faith communities Plans to bring a chaplain into the home for one-to-one visits, spiritual guidance, and resident support	2025 Family Satisfaction Survey Results: 1) Home score - 80.72% 2) Home score - 80.22% 3) Home score - 80.00% 4) Home score - 79.00% 5) Home score - 79.00%

Process for ensuring quailty 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	Azaria Kanda	**June 5 2026**
Executive Director	Azaria Kanda	**June 5 2026**
Director of Care	Blessing Obi	**June 5 2026**
Nutrition Manager	April Jordan	**June 5 2026**
Programs Manager	Janie Denard	**June 5 2026**
Clinical Consultant	Moises Ruiz	**June 5 2026**
Resident Council Representative	Margaret Rasell	**June 5 2026**
Family Council Representative	N/A	**N/A**
Medical Director	Dr. Sanjay Acharya	**June 5 2026**
Other		
Other		