Holland Christian Homes

HCH *Here to Care.*

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Continuous Quality Improvement Report for Grace Manor 2025 into 2026-2027

Grace Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton and includes another Long-Term Care Home (Faith Manor) and six apartment towers. The mandate of Holland Christian Homes is to provide a supportive, caring, quality Christian environment in order to preserve dignity and enhance the quality of life for people who require long-term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review, and evaluation of the following activities: Resident Satisfaction and Family Experience Surveys, Accreditation Assessment, Results, And Action Plans; Staff Engagement Survey And Action Plan; Department Goals/Audits/stats tracking; Funding Agreements, Funding Indicators And Grants; Formal Program Reviews; Advocacy Initiatives (Resident And Family Engagement) – Residents Council, Family

Council, Food Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training.

QUALITY PRIORITIES FOR 2026/27

Grace Manor is pleased to share its 2026/27 Quality Improvement Priorities.

The QIP aligns with the Strategic Plan, while navigating challenges and opportunities in our environment. We are launching a new strategic planning process for 2026-2030. This will determine how we continue to provide compassionate, high-quality care for the people we serve. Collaborative we can ensure that our services will continue to meet the needs of those we serve and align with our Vision, Mission, and Values.

Grace Manor's QIP is aligned with our Quality Framework embedded within Holland Christian Homes Core Values, and Success Factors. The high-level priorities for this year's QIP are informed by the quality and safety aims under the various goals of our Holland Christian Homes framework, as determined by the Holland Christian Homes' Board of Directors:

- Safe- Keeping Residents Safe
- Effective- Keeping People Healthy
- Resident Centered
- Efficient
- Accessible- Access to Long-Term Care Homes and Community Support Services
- Appropriately Resourced- Staffing

QUALITY OBJECTIVES FOR 2026/27

- Priorities are divided into 4 categories based on the projected scope of work anticipated for the year. Areas for action are included in this report.
- Our QIP Priorities are following Health Quality Ontario Performance Measures and Indicators
  1) Access & Flow
  2) Equity
  3) Experience
  4) Safety

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	24.48	23.74	Want to improve at least by 3% in 2026/2027.	William Osler Health System, Brampton Civic Hospital

Change Ideas

Change Idea #1 Improve services offered within the home through the use of IV Therapy.

Methods	Process measures	Target for process measure	Comments
Educate all new onboarding registered lead care partners on the use of IV Therapy.	Percentage of new onboarded registered care partners trained on the use of IV Therapy.	100% of new onboarding registered care partners are trained on IV Therapy in 2026/2027.	

Change Idea #2 Ensure that the SBAR tool is being completed for all non-emergent transfers to the hospital between January 2026 and December 2026.

Methods	Process measures	Target for process measure	Comments
The Nurse Practitioner or designate to ensure that the SBAR tool is being completed by nurses for conversation with physician prior to considering ED transfer. All SBAR tool will have reason for transfer identified. To be completed each month from January 1, 2026 to December 31, 2026.	Number of SBAR tools completed with reasons identified each month/total number of ED transfers each month (for period between January 1, 2026 to December 31, 2026).	100% of SBAR tools are being completed for non-emergent transfers to the hospital for each month between January 1, 2026 and December 31, 2026.	

Change Idea #3 Implement the Transition in Care RNAO BPG guidelines.

Methods	Process measures	Target for process measure	Comments
Gap analysis to be completed followed by the implementation of the suggested action items.	Number of gap analysis completed. Number of action items implemented.	One gap analysis completed by March 31, 2027. At least 2 action items implemented.	

Change Idea #4 Achieve a 1-year certification through the Provincial PoET program.

Methods	Process measures	Target for process measure	Comments
We will meet the PoET certificate standards including: meeting legal and professional consent-related obligations; maintain role clarity related to consent; recognize and respect resident autonomy and embed good consent-related practices into the decision-making infrastructure of the home.	Implement two different change ideas related to PoET goals.	Achieve a 1-year PoET certification by December 31, 2026.	PoET aims to reduce unnecessary transfers to acute care in alignment with the health care consent act and the resident values, wishes and beliefs. The PoET program has demonstrated a reduction in acute care transfers especially within the last two months of life and shows increased rates of palliative care encounters.

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	Continue with having all staff trained on Diversity, Equity, anti-racism and Inclusion Education in 2026/2027.	

Change Ideas

Change Idea #1 Mandatory Diversity, Equity, Anti-racism and Inclusion education in 2026/2027 for all care partners.

Methods	Process measures	Target for process measure	Comments
Using online training that includes topics of Diversity, Equity, Anti-racism and Inclusion for all care partners.	Percentage of care partners that complete Diversity, Anti-racism Equity and Inclusion training.	100% of all care partners to be trained in Diversity, Equity, Anti-racism and Inclusion in 2026/2027.	Total beds 120 meeting LSAA local obligations.

Experience

Measure - Dimension: Patient-Centered

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	75.00	100.00	Want to improve by 25% in 2026.	

Change Ideas

Change Idea #1 Incorporate all new onboarding care partners on training for person centered care and Eden Philosophy.

Methods	Process measures	Target for process measure	Comments
Education to be provided to all onboarding care partners by the Dementia Care Services Lead on person centered care and Eden philosophy in 2026.	Percentage of care partners trained on person centered care and Eden Philosophy.	100% of new onboarding care partners trained on person centered care and Eden philosophy by December 31, 2026.	Total Surveys Initiated: 100

Change Idea #2 Provide Customer Service education to all care partners in 2026.

Methods	Process measures	Target for process measure	Comments
Using in house developed education slides specific to scenarios that include topic of customer service for all care partners using the surge learning platform.	Percentage of care partners that complete training.	100% of care partners trained on customer service by December 31, 2026.	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	16.28	16.00	To continue to be in align and below the Provincial average. Current Provincial average is 16.83%.	

Change Ideas

Change Idea #1	Review new and current residents on antipsychotic medications to determine proper indication for usage and consideration of alternative interventions when required.

Methods	Process measures	Target for process measure	Comments
Interdisciplinary Antipsychotics Reeducation Committee will review monthly residents that are on antipsychotics medication to determine proper indication for usage and consideration of alternative interventions when required.	Percentage of residents reviewed by the Antipsychotics Reeducation Committee per quarter.	100% of new admission and current residents that are on antipsychotics medication will be reviewed by Antipsychotics Reduction Committee to determine proper indication for usage and consideration of alternative interventions by March 31, 2027.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents using audible bed or chair alarms.	C	% / LTC home residents	Local data collection / April 1 2026 to December 31, 2026.	CB	100.00	Our target of a 100% reduction in position-change alarms by Q4 is based on an evidence-informed, phased-pilot approach.	

Change Ideas

Change Idea #1 Pilot a phased alarm retirement: Start with one home area (Meadow Lane) and replace audible bed/chair alarms with "Enhanced Active Rounding" "4 Ps" rounding (Pain, Personal Needs, Position, Possession). (checking every 30 min) for a 3 month period expanding home-wide by December 31, 2026.

Methods	Process measures	Target for process measure	Comments
1. Develop and Implement “The 4 P’s Competency Checklist and coaching for PSWs complete 3 checklists per week. 2. Review fall data in post fall huddles for any resident whose alarm was recently retired and if the removal of alarm was contributing factor. 3. Develop and Implement Weekly Alarm Retirement Audit.	Percentage of 4 P’s rounding compliance checklist completed. Percentage of resident fall with the removal of an alarm as a contributing factor. Percentage of weekly alarm Retirement Audits.	100% of 4P’s compliance checklist completed. 0% of residents who fell with the removal of the alarm as the contributing factor. 100% of weekly alarm retirement audits completed.	This phased rollout ensures staff competency is validated on a pilot neighbourhood before expanding the initiative home-wide, maintaining a stable fall rate as our primary balancing measure.

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2026

Holland Christian Homes

Ontario Health

OVERVIEW

Grace Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton, and includes another Long-Term Care Home (Faith Manor) and six apartment towers. The mandate of Grace Manor is to provide a supportive, caring, quality Christian environment in order to preserve the dignity and enhance the quality of life for people who require long term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review and evaluation of the following activities: Resident Satisfaction and Family Experience Surveys, CARF Accreditation Assessment, Results and Action Plans; Staff Satisfaction Survey and Action Plan; Department Goals/Audits/stats tracking; Funding Agreements, Funding Indicators And Grants; Formal Program Reviews; Advocacy Initiatives (Resident And Family Engagement) – Residents Council, Family Council, Dining Room Food Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training. The home is CARF accredited. This accreditation report identifies no recommendations. This accomplishment is achieved on only 3 percent of CARF Surveys completed. We take pride in achieving this high level of accreditation. The accreditation report is also intended to support our continuation of the quality improvement of programs and services and the people we serve.

The medical staff at Holland Christian Homes participates in an independent medical record review; infection control; pharmacy

and therapeutics review; medical advisory review, mortality review; ethical issue reviews, utilization management, review of transfers to other facilities; and serve on several committees including the CQI Committee.

The complex care needs of our long-term care residents have increased. Residents coming into the home are increasingly frail, more medically complex and for those with various forms of dementia; are displaying increased personal expressions. The majority of our residents have some form of Alzheimer's or dementia and almost all need assistance with eating, bathing, toileting and getting in and out of bed. These increased acuity levels; along with the high level of expectation of residents and families is a challenge when compared to the funding received to meet these needs.

Our 2026/2027 Quality Improvement Plan will focus on Access and Flow, Equity and Indigenous Health, Resident Experience, Safety, Provider Experience, Palliative Care and Population Health Management as required by the Ontario Health Quality Improvement Plan (QIP).

Access and Flow will be achieved through the reduction of unnecessary hospitalizations by the home providing registered lead care partners training on IV therapy, offering residents and families information about what is offered within the home for End of Life Care and by the development of a "did you know" resource fact sheet on the topic of End of Life services available in the home. We will be continuing to utilize the Prevention of Error Based Transfers (PoET)Program to ensure residents goals, values, wishes, and beliefs are documented in order to assist with goals of care conversations that guides proposed treatment options such as emergency room transfers and by implementing Transitions in Care Best Practice Guideline completing the gap analysis to improve rate of hospital transfers. Equity improvement will be addressed by requiring 100% of all care partners to complete Diversity, Equity and Inclusion education. We will enhance Experience by requiring 100% of our care partners to be trained in person directed care, Eden Philosophy and Customer Service education. We continue to provide Safety to our residents through continuing to utilize our interdisciplinary team and review 100% of new admissions and current residents that are on antipsychotic medications to determine proper indication for usage by March 31, 2027. In alignment with our commitment to Resident-Centred Care and Safety, our home is transitioning away from audible bed chair alarms. Evidence shows that alarms can increase agitation and do not reduce fall-related injuries. Starting in our Meadow Lane pilot neighborhood, we are replacing alarms with Enhanced Purposeful Hourly Rounding. Success will be measured by a decrease in alarm reliance without an increase in the injury-related fall rate. This integrated approach ensures our residents receive care that respects their dignity while maintaining a high standard of safety.
These established priorities, targets, and activities we believe will improve resident quality outcomes.

ACCESS AND FLOW

We are proud of our many partnerships, all of which support integration and continuity of care. Our partnership with Ontario Health atHome ensures LTC applications are processed in a timely manner to avoid any placement delays. Many education and training initiatives which are critical to the success of our Quality Improvement Plan would not be possible without our partnerships

with BSO, PSHSA (staff safety), the Regional Infection Control Network, the RGP Program, Wound Care and mobility specialists, and our many contracted service providers (ie. dental, foot-care, pharmacy, physiotherapy, banking, hairdresser etc). Our memberships with AdvantAGE Ontario, Eden Alternative (person centered) and being a RNAO Best Practice Spotlight Organization (BPSO) is beneficial to support our advocacy and quality improvement initiatives.

Leadership care partners sit at various sector table groups ensuring we are informed of current trends and changes in the healthcare system affecting our home and resident care. Grace Manor has been very strong proponents of providing as much care as possible without transferring or admitting residents to hospital. We have enhanced our ability to do this through several initiatives. Our full-time Nurse Practitioner has enabled us to provide treatments and diagnosis for our residents to prevent the need to transfer to hospital. When a resident is admitted to hospital, the NP is able to coordinate and facilitate a faster discharge by ensuring care is available upon their return home. In addition, our NP provides training to our registered staff to increase their ability to do critical thinking and increase their skills within their scope of practice. Additionally, we utilize our partners such as the Nurse Lead Outreach Team (NLOT) out of William Osler and a specialized Neurobehavioral Nurse Practitioner Team to assist in management of individuals living with dementia. Our Quality Improvement Plan ensures that these partnerships /networking continue as a priority indicator.

Grace Manor offers a variety of in-house diagnostic and imaging services through our contracted partnerships. This allows the residents to stay in their home to receive services such as blood work, ECG, X-rays/Ultrasound. We have also invested in equipment such as a bladder scanner, suction machine and hand-held doppler which can be helpful in preventing avoidable ED transfers. We have recently trained all of our registered nurses on the ability to continue IV therapy so we can reduce the length of stay and readmission rate to the hospital. We also utilize technology such as secure video conferencing and e-Consultation through OTN to bring services to the bedside.

Optimizing system capacity, timely access to care, and patient flow ultimately improve outcomes and the experience of care for our residents. We continue to partnership across care sectors on initiatives to avoid unnecessary hospitalizations and avoid visits to emergency departments through improving our communication within the home through the use of the SBAR Tool to align towards the provincial average to ensure the right care in the right place at the right time.

Grace Manor has adopted the Eden Alternative Philosophy as an person directed approach to care, enhancing the environment and resident experience through a more collaborative approach between residents, families and care partners.

We recognize the importance of advanced care planning. We continue to utilize the PoET form to guide conversations related to residents values, wishes, and beliefs around their healthcare. This has been an important tool to help guide conversations related to goals of care, and prevent unnecessary hospital transfers. We recognize the importance of advanced care planning. We utilize the PoET form to guide conversations related to residents' values,

wishes, and beliefs around their healthcare. This has been an important tool to help guide conversations related to goals of care, and prevent unnecessary hospital transfers. Our goal this year is to Achieve PoET Certification by December 31, 2026. PoET aims to reduce unnecessary transfers to acute care in alignment with the health care consent act and the resident values, wishes and beliefs. The PoET program has demonstrated a reduction in acute care transfers especially within the last two months of life and shows increased rates of palliative care encounters.

EQUITY AND INDIGENOUS HEALTH

Holland Christian Homes is committed to fostering diversity, inclusion, and cultural competency. Holland Christian Homes seeks to identify opportunities for ongoing enhanced education and training in the following areas: cultural competency, age, gender identity/expression/orientation, spiritual beliefs, socioeconomic status, disability, and language. When resources are not available internally, Holland Christian Homes will seek to develop resources so that all team members are provided the opportunity to develop a greater awareness and sensitivity to the needs of person's served, stakeholders, and the community.

We have a Diversity, Equity, Inclusion Plan that includes Health Equity, Antiracism, First Nations, Inuit, Metis, and Urban Indigenous (that include existing provincial priorities such as French language health services, Disabilities Act, Black Health Plan, etc.) based on Service Accountability Agreement obligations.

Holland Christian Homes is an Equal Employment Opportunity employer. We are committed to the elimination of barriers that restrict the employment opportunities.

Holland Christian Homes provides equal employment opportunities for the good of the public without regard to race, color, national origin, ancestry, sex, religious creed, age, mental or physical disability, veteran status, socioeconomic status, medical condition, marital status, sexual orientation, sexual harassment, or pregnancy.

We will continue to provide training requirements for care partners that are listed in Holland Christian Home's employee manual. Training will not be influenced by race, ethnicity, age, gender, color, religion, national origin, sexual orientation, veteran's status, socioeconomic status, or disability.

All Managers and Leadership care partners are trained and will continue to be trained in equity and indigenous Health programs in order to be ensure that our approaches to care are culturally appropriate as we endeavor meeting community needs and priorities.

The home has committed to continue that 100% of all care partners to complete Diversity, Equity, Inclusion training by December 31, 2026. All care partners receive annual code of conduct policy to affirm they will act ethically at all times.

INDIGENOUS LAND ACKNOWLEDGEMENT

Land acknowledgements are the first step to reconciliation because they allow us to recognize how colonialism continues to impede on the lives of Indigenous generations. Acknowledgement gives us the opportunity to reflect on our privileges as settlers on traditional territory. At Holland Christian Homes, we approach this land

acknowledgement with the commitment to walk side-by-side with Indigenous communities by listening and learning from Indigenous voices towards the road to reconciliation.

A plaque continues to be displayed in the entrance of Grace Manor stating the following:

“Holland Christian Homes acknowledges that its operations are located within Treaty 19 (Ajetance Treaty) territory, the treaty lands of the Mississaugas of the Credit. We further recognize that these lands comprise the traditional territory of several indigenous peoples, including the Wendat, Haudenosaunee and Anishinaabeg (including the Mississaugas of the Credit First Nation). We are grateful to work and provide care within these lands, which continue to be home to many diverse First Nations, Métis and Inuit peoples. With a spirit of reconciliation, Holland Christian Homes is committed to walking side-by-side with indigenous communities, respecting their long-standing relationships with the land, and learning from their traditions and stewardship practices.”

The above acknowledgement is read and acknowledged at special meetings of the organization and whenever external partners meet at HCH.

CULTURAL COMPETENCY, DIVERSITY, AND INCLUSION ACTION PLAN

To further enhance Holland Christian Homes commitment to cultural competency, a Cultural Competency, Diversity, and Inclusion Action Plan is reviewed and updated annually.

The plan is updated as needed to ensure that our care partners, residents, tenants, and other stakeholders develop awareness and sensitivity specific to the diversity of our service population. This plan addresses diversity in terms of culture, age, gender, identify/expression, sexual orientation, spiritual beliefs, socioeconomic status, language, and other factors relevant to Holland Christian Homes service population.

Goals of the Cultural Competency, Diversity, and Inclusion Action Plan

1. To assess the cultural diversity of stakeholders within Holland Christian Homes
2. To recognize cultural and multi-faith celebrations
3. To recognize that food plays a significant role in cultural diversity and faith traditions
4. Develop and maintain communication tools to enhance team member and resident engagement
5. Continue to engage and develop partnerships with community stakeholders to further enhance our tag line of “Here to Care”
6. Advance Indigenous Health Strategies and Outcomes
7. Advance equity, inclusion, diversity, and anti-racism strategies to improve health outcomes
8. To recognize that cultural considerations are not limited to ethnicity but include spiritual beliefs, language, financial status, gender identity/expression/orientation, disability, and other attributes.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Holland Christian Homes (HCH) tagline of being "Here to Care" sets the foundation of our community that we are serving on a day-to-day basis. Our community consists of our vulnerable seniors that reside in the manors, our families, stakeholders, and our dedicated

care partners that help us fulfill our mission.

Grace Manor is continuing on the Eden Philosophy of Care and person-directed care movement that improves the well-being and quality of life of our residents. We are reframing the culture of aging, we want to increase resident, family care partner and employee care partner satisfaction and strengthen relationships. Together, we will create home by introducing pets, plants, ambiance and encouraging intergenerational connections and visits. Aging is a normal part of human life. We are all complete human beings as we age or live with different abilities. A caring, inclusive and vibrant community enables all of us, regardless of age or ability, to experience well-being. Everyone has a great value to our community and should be seen and honored for that value. No matter our age, or life challenges, residents want to be included as active, vital partners in their own care.

We believe in eliminating loneliness, helplessness, and boredom for everyone on the care partner team.
We will support choice, dignity, respect, self-determination, and purposeful living for everyone we serve.
We believe that care means helping another to grow.
We promote a person-directed approach to care that puts the person first.
We believe in an approach that doesn't see the needs of caregivers as separate from care receivers but promotes the well-being of the whole care partnership.
We are all partners in care.
Care partner teams work together collaboratively to eliminate loneliness, helplessness, and boredom.

We are empowering all care partners to live the EDEN Alternative philosophy every day, seeking to remake the experience of ageing and creating a better world for our residents and care partners.
There is a commitment to keep residents secure, content and joyous in their home and through person-directed care we strive to combat loneliness, helplessness, and boredom. It is about creating a real home, providing opportunities for building relationships, placing residents first and setting a standard of excellence. The EDEN Alternative enables us to move away from the departmentalized, task-orientated, institutional models. By changing the culture to bring decision making closer to the resident, we support creating a meaningful life for them. This approach empowers our residents to direct their lives, creating a true atmosphere of home. Each of our neighborhoods is home to our residents, and each neighborhood has a name with community and historical significance. This fosters a sense of connectedness and enhances the feeling of home for all members of the Holland Christian Homes community.

Holland Christian Homes believes that the organizational health and wellness are important to each individual employee. Individual health may affect the ability of employee's contribution to meet the mission and values of HCH. To promote a positive and healthy culture in the workplace, HCH has organized a dedicated Workplace Social and Wellness Committee. This committee will plan and execute social events to help HCH promote a culture of engagement, belonging and fun among all HCH employees e.g care partner appreciation week, holiday parties etc.

Holland Christian Homes values the opinions and suggestions of care partners for improving the work environment while enhancing

resident care. In addition to the Workplace Social and Wellness Committee, Holland Christian Homes invites all care partners to be a voluntary member of 12 additional committees that steer the organization's goals and objectives to enhance the quality of care we provide to enhance the resident experience. We believe that including s care partners as members of these committees brings an important perspective, allowing their voice to be heard, as key members of the Holland Christian Homes family.

Holland Christian Homes partners with an Employee and Family Assistance Program that provides onsite counseling support and shares important resources to care partners such as: Highlighting Resilience: Bouncing back from Burnout, Coping with Anxiety, Adjusting after the Pandemic Response, Feeling Safe and Engaged, Fostering Trust and Commitment.

It continues to be a challenging time for health care organizations with unprecedented human resources
challenges. Our home is currently implementing innovative practices to improve workplace culture,
through employee engagement surveys and outcome analysis and development of action plan in areas of needed improvement and is shared with care partners. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, care partner wellness committee to further enhance our employee satisfaction.

Holland Christian Homes is committed to operating our long-term care homes with transparency and accountability. We support and encourage ways that provide opportunities for residents and families to stay engaged in all aspects of the home. Our poster called, “Your Voice Counts” lets residents and families know how they can get involved and share in the management of our home and create a voice for all residents at Grace Manor. Residents and Families are also able to complete CQI suggestion forms and/or concern forms.

Residents participate in our Dining Room Committee, Care Conferences and Residents Council. Families participate in Family Council. There is a designated staff assistant to ensure these councils are easily able to meet and have their meetings documented. The leadership team is made aware of concerns, complaints and comments and there is immediate follow-up by Leadership/Administration. Residents and families also participate in our annual program reviews and evaluations. An annual Resident Satisfaction Survey was completed by competent residents (with or without impartial assistants). The Family Experience Survey was completed by families and friends for residents who are not mentally capable to complete them.

We conducted our annual program evaluation day on Wednesday February 25, 2026 in which we reported on and evaluated 31 programs and set goals for those programs to be completed in 2026. Staff, CEO, managers, board members, medical director, pharmacist, dietician, physiotherapist, family and resident council representatives, a pastor, and residents all participate in this evaluation day. It is a great opportunity for everyone to share in the successes and to learn more about how we will work to improve in the areas needing improvement. Families and residents were very appreciative of being invited to participate and commented about how much they learned from participation in this day and appreciated the transparency that our home was providing.

The Grace Manor leadership team and care partners are engaged in an organizational wide (Holland Christian Homes) Risk Management and Quality Improvement Program. We have developed many programs which are interdisciplinary through committees, evaluations, huddles, and communication methods such as audits, reports, in-services and feedback forms. These programs and initiatives are coordinated through our CQI Program Coordinator who compiles the results in the form of reports which provide analysis, feedback and direction for future initiatives.

All volunteers and employees of Holland Christian Homes are expected to participate in ongoing and systematic quality improvement efforts through quality assessment activities, such as annual volunteer and staff engagement surveys, specialized program review meetings, infection control surveillance, utilization management, and medical record review.

Our interdisciplinary specialized program teams look at particular issues to identify opportunities to improve processes and outcomes through the establishment of goals. Goals are acted upon, monitored, reported at and evaluated by the applicable in-house team and/or department(s). Front line staff and even residents and families are often engaged through this process.

PROVIDER EXPERIENCE

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Holland Christian Homes values the opinions and suggestions of care partners for improving the work environment while enhancing resident care at Holland Christian Homes. In addition to the Workplace Social and Wellness Committee, HCH invites all care partners to be a voluntary member of 12 additional committees that steer the organization's goals and objectives to enhance the quality of care we provide to enhance the resident experience. We believe that including care partners as members of these committees brings an important perspective, allowing their voice to be heard, as key members of the HCH family.

Holland Christian Homes partners with an Employee and Family Assistance Program that provides onsite counseling support and shares important resources to care partners such as: Highlighting Resilience: Bouncing back from Burnout, Coping with Anxiety, Adjusting after the Pandemic Response, Feeling Safe and Engaged, Fostering Trust and Commitment.

It continues to be a challenging time for health care organizations with unprecedented human resources challenges. Our home is

currently implementing innovative practices to improve workplace culture, through employee engagement surveys and outcome analysis and development of action plan in areas of needed improvement and is shared with. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, care partner wellness committee to further enhance our employee satisfaction.

SAFETY

Senior management is committed to guiding the execution of the Long-Term Care Resident Safety Plan across all the Holland Christian Homes Long Term Care homes and Seniors Services programs.

Our mission is to provide effective, high-quality, safe and efficient long-term care services in a home-like setting. Our purpose is to ensure our residents feel safe while in our homes. This Resident Safety Plan drives continuous improvement to quality and safety throughout our home and builds upon our mission, vision and values.

Our Long-Term Care Resident Safety Plan is developed in conjunction with Resident Safety Goals within the resident safety areas of culture, work life/workforce, communication, medication use, infection control, falls prevention, and risk management. The goal is to enhance resident /client safety and to minimize risk.

This document articulates the go forward strategy for quality and safety at Grace Manor, Holland Christian Homes Long Term Care Homes and Seniors Services Programs. Strong multi- disciplinary experience, quality improvement practices, collaboration, and Leadership throughout our programs, services and departments will foster attention to continuous quality improvement and drive improved performance in quality and safety for Residents, families, care partners and our community.

The Resident and Tenant Safety Plan is readily available to all residents, families and staff. The Plan is reviewed and updated annually. All care partners receive and sign off annually the Code of Conduct reaffirming their commitment to act ethically at all times.

In 2024 Holland Christian Homes received CARF Accreditation with no recommendation until 2027 meeting our LSAA Agreement.

For 2026/27 Grace Manor is committed to a safety culture by transitioning away from the use of audible bed and chair alarms, which have been shown to increase resident anxiety and contribute to alarm fatigue among care partners and studies indicate that bed chair alarms do not prevent falls and only alert once fall has occurred and can be a false sense of safety.

We are launching a 'Quiet Care' pilot in our Meadow Lane neighborhood, where we will replace all audible alarms with a proactive Purposeful Enhanced Rounding protocol. This approach shifts our focus from reactive monitoring to preventative care, addressing the '4 Ps' (Pain, Position, Personal Needs, and Possessions).
To ensure a robust safety net, we will develop a 4 p's competency check list and develop and implement a Weekly Alarm Retirement Audit and will continue our Post-Fall Huddles to conduct root-cause analyses of all incidents within 24 hours. These interdisciplinary reviews allow us to implement immediate, personalized

interventions rather than defaulting to an alarm. Our goal is to demonstrate that by enhancing resident dignity and reducing environmental noise, we can maintain—or even improve—our rates of 'Falls with Injury'. Following a successful three-month pilot and evaluation of safety data, we plan to roll this 'Quiet Care' model out home-wide by December 31, 2026.

PALLIATIVE CARE

We have worked hard to provide our care partners with palliative care training, which not only prepares them to provide end-of-life care in a comfortable home-like environment, but also to educate families on how their home is usually the best place for their loved one during palliation, but also to engage resident and families in the palliative and EOL journey. We also utilize the Prevention of Error Based Transfers (PoET)Program to ensure residents goals, values, wishes, and beliefs are documented in order to assist with goals of care conversations that guides proposed treatment options such as emergency room transfers.

Over the past year we have made some enhancements to our EOL program with the addition of a guide which provides information for families and residents nearing the end of life. We now offer a special EOL Care Team Meeting should the resident and family choose to specifically explore any particular wishes and needs related to their care plan at the end of life.

In 2026 we brought back our end-of-life volunteer program which will continue to enhance the care we offer during the residents' final days.

POPULATION HEALTH MANAGEMENT

Population health–based approaches involve a broadening focus to include being proactive in meeting the
needs of our residents. This includes providing proactive services to promote health, prevent disease,
and help people live well with their conditions in every interaction.
We provide care from a person directed approach
and work in partnership with other health providers as needed to care for the unique needs of our residents within our home.

Grace Manor understands the importance of preventative health approach. As such, we have several inhouse clinics such as Eye Clinics, Dental Clinics, Foot Care Clinics, Hearing Devices.

Additionally, we have in-house laboratory and diagnostic imaging services that come into the home and this can be helpful in chronic disease management. We have a strong Medical Team including Nurse Practitioner, Dietician and Pharmacist who meet quarterly and annually to analyze the medical care of our residents. We work closely with Public Health to ensure that our vaccination is up to date. Public Health representative attends our IPAC Meetings.

We have an Infection Prevention and Control (IPAC) Program, a full-time Lead and Committee that focuses its efforts on policies and procedures on IPAC with a goal of reducing the risk of transmission of infections agents, surveillance, hand hygiene program, education for residents, care partners and families. The IPAC Lead ensures that enhanced precautions are strictly observed and carried out by all department care partners at all times. This is managed through various activities daily, monthly or annually as required.

CONTACT INFORMATION/DESIGNATED LEAD

Justine Dudziak
Administrator
justine.dudziak@hch.ca
905-463-7002 EXT. 5255

Kristine Nielsen
CQI and Risk Mitigation Specialist
kristine.nielsen@hch.ca
905-463-7002 ext. 5240

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 26, 2026**

Tracy Kamino, Board Chair / Licensee or delegate

Justine Dudziak, Administrator /Executive Director

Kristine Nielsen, Quality Committee Chair or delegate

Other leadership as appropriate

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Grace Manor has developed QIPs as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO) every April. Grace Manor's QIP planning cycle typically begins in January, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- Resident Satisfaction, Family Experience, and staff engagement survey results;
- emergent issues identified internally (trends in critical incidents) and/or externally;
- input from residents, families, staff, leaders, and external partners, including the MLTC.
- Health Quality Ontario (HQO)
- Central West Ontario Health Team (CWOHT)

Preliminary priorities are subsequently presented and discussed at various forums to validate priorities and identify additional priorities that may have been missed. These forums include the broader leadership team, Resident Council, Family Council, and the Care Committee of the Board of Directors. This is an interactive process with multiple

touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. The final review of the QIP is completed by the CEO, who then shares with the Care Committee of the Board.

GRACE MANOR'S APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS)

Every staff has a responsibility for CQI. Grace Manor's nursing, departmental, and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. Interprofessional quality improvement teams, including resident and family advocates, work through the phases of the annual quality improvements.

DESIGNATED LEAD

Grace Manor CQI and Risk Mitigation Specialist contact information is as follows:

Kristine Nielsen
CQI and Risk Mitigation Specialist
kristine.nielsen@hch.ca
905-463-7002 ext.5240

****We encourage all staff, residents, and families to get involved, join a committee, and make a suggestion. Contact the above designated lead for more information on how to make a difference!*

Comparative Databases, Benchmarks, Professional and Best Practice Standards:

Holland Christian Homes uses comparative data (such as but not limited to InterRAI-LTCF, CIHI, HQO, and RNAO Best Practice Guidelines) (whenever available) to incorporate a process for continuous assessment with similar organizations, standards, and best practices. This assessment then leads to action for improvement as necessary.

Continuous Quality Improvement Processes and Methodology:

The Continuous Quality Improvement Plan is a framework for organized, ongoing, and systematic measurement, assessment, and performance improvement activities. The components of this plan include:

- A quick fix process will be used for problems that do not need a comprehensive approach to problem-solving and solution implementation (i.e. concern and suggestions forms).
- Quality assessment activities, such as quality of life resident satisfaction, family experience surveys, staff engagement surveys, infection control surveillance, utilization management, and medical record review.
- CQI Summary Report, which provides summary data about selected indicators, prepared for the Board, Continuous Quality Improvement Committee, and medical staff.

- Outside sources/comparative databases, such as InterRAI-LTCF, CIHI, HQO, AdvantAGE, and professional practice standards (RNAO, etc.) for benchmarking, will be used to compare our outcomes and processes with others, identifying areas to focus on continuous quality improvement efforts.
- Central Ontario Health designated quality Indicators as outlined in the L-SAA Funding Accountability Agreements.
- Medical Directors attend quarterly and annual Continuous Quality Improvement reviews to provide input on activities, assessments and performance improvement. They are held accountable to their contract.
- Quality Improvement Teams consisting of departmental and established interdisciplinary in-house committees which look at particular issues to identify opportunities to improve processes and outcomes through the establishment of goals. Goals are acted upon, monitored, reported at, and evaluated by the applicable inhouse committee and/or department(s). They are accountable to report goal outcomes monthly, quarterly and annually to the CQI Committee.
- Establishment of high-level interdisciplinary priority improvement targets and initiatives to measure outcomes. This includes establishing the improvement initiative, methods, and results tracking. Such improvement targets and initiatives are measured against the previous year's actual outcome to the current year’s improved targeted outcome.

The continuous quality improvement methodology used for acting on the high-level interdisciplinary priority improvement targets and initiatives is as follows:

Step One - SET STANDARDS

Standards are written statements outlining expectations, policies, procedures, and workplace rules related to a goal/improvement initiative. Each goal/improvement initiative will have a standard or a set of rules that tells everyone in Holland Christian Homes what to do, how to do it, and when. The standards determine the program and make it clear what is expected - how, when and from whom. They also clarify what employees can expect from management.

Standards provide the ‘bar’ or ‘starting point’ against which we evaluate whether what we are trying to accomplish or achieve is working. Implementing clear, effective, approved standards is an indication of the strong leadership that is essential for an effective and successful goal/improvement initiative.

Step Two - COMMUNICATE

Communicating standards means ensuring that all appropriate people in Holland Christian Homes have a clear understanding of what is expected of them as employees, and what they can expect from others regarding the goal/improvement initiative. Communication increases awareness of the goal/improvement initiative and encourages

employees to give us feedback and tell us their observations about the goal/improvement initiative and how it can be improved.

What is communicated?

- Specific information, rules, or workplace expectations that have been set for the goal/improvement initiative to appropriate people, etc.
- Updates on improvements to meet the goal/improvement initiative.

How we communicate?

We use the most effective means of communication to ensure that everyone in Holland Christian Homes knows what is expected of them. This can mean notices on bulletin boards, emails, meetings, newsletters, posters, pictures, memos, or guest speakers. We have invested in software that allows us the ability to send mass messages using Staff Schedule Care for staff and “Cliniconex“ and “Evoke” for families, which is extremely helpful for immediate messaging. We make sure that literacy and language issues are accommodated.

One of the best ways we communicate positive messages about a goal/improvement initiative is by getting people to actively participate in achieving the goal/improvement initiative. This shows that people value the effort put into achieving the goal/improvement initiative.

To whom we communicate?

We communicate to employees, families, residents, volunteers, and visitors as identified in our goal/improvement initiative standard. This may include all employees or a selection of them. We may need to communicate different information to employees and different information to residents and families. We think about what people need to know and when they need to know it and who needs to know it.

We make communication two-way

We give information and ask for feedback. We make adjustments when employees offer good suggestions and then show them how we used their suggestions.

- We formulate the information in a language and manner that people will understand, and deliver it at a time and place that will maximize their comprehension.
- We vary the ways that we communicate so that new information is noticed and does not become mundane.

Step Three - TRAIN

Training means that management, supervisors, and workers all attain the knowledge and skills appropriate for their jobs. For each goal/improvement initiative, we determine who needs what knowledge and skills, and how they will be developed. To meet the goal/improvement initiative requirements, training is completed, or verified, within each year (January 1 to December 31).

How training is done?

Workplace training can be delivered in various ways (i.e. In-services, webinars, outside training, etc.). What is important is that the knowledge and skills needed to achieve the goal/improvement initiative are learned and practiced.

Effective training:

- Follows adult learning principles.
- Is delivered in the way that allows employees/residents/families to benefit most. For example, classroom training works where group discussion and sharing of ideas is important.
- For specific training, practical one-to-one hands-on experience training using tools or equipment is needed.
- Computer-based training works where independent learning is needed. We include opportunities to practice and demonstrate what is learned.
- Training is relevant and applicable to the learner's duties.

What training is done?

Training on our standards for each goal/improvement initiative is provided to those who have responsibility and accountability for knowing and using the information. For example, orientation training is important for everyone when they are first hired, when they change locations or jobs, or after a long absence from Holland Christian Homes.

Training or retraining in safe work procedures is ongoing. We keep written records of who was trained in what and when the training occurred.

- We vary the ways that we do training to help keep it interesting.
- We use visual aids and real-life case studies as tools for learning.
- We discuss our training needs with other managers to create opportunities to share resources or information.
- We consider train-the-trainer courses, so we can have a qualified trainer to deliver programs on-site.
- We provide a training checklist and sign-off sheet for the supervisor and workers so we are sure each topic is covered and acknowledged.
- We keep training records, meeting notes, sign-off sheets, attendance forms, certificates or record of training and training evaluation forms with our goal documentation.

Step Four - EVALUATE

<u>Evaluating a goal/improvement initiative</u>

Evaluating each goal/improvement initiative is an important process; it helps us make sure we are carrying out the standard, the goal/improvement initiative is properly communicated, and effective training has taken place. It is also an opportunity to see if the goal/improvement initiative is working — is it effective and up-to-date?

Evaluating our goal/improvement initiative helps us to see where the strengths and weaknesses are. We are then better able to make effective improvements with the feedback we receive.

Going through the process of evaluation also helps keep our goal/improvement initiative fresh and top-of-mind for residents, families, volunteers, workers and supervisors as we ask questions and check to see the status of the goal. This is a good time to give positive feedback, which will encourage more good work.

How and when do we evaluate?

Once Steps 1, 2 and 3 have been completed, the evaluation may begin. The evaluation step is completed during the calendar year. However, it may not be practical to evaluate our goal near the end of the year if it was very recently implemented. We follow our action plan and have it implemented no later than February 1st of the following year.

Ways we evaluate:

- Observing: walk around to see if a process or task is being completed according to the standard. This is done during our regular workplace inspections.
- Looking for trends: examine workplace records.
- Asking questions about the implementation of the standard: employees will often give the best feedback.
- Asking a third party: have them look at the work processes and give us feedback.

Some questions we ask:

- Has legislation changed? Are there new best practices in the industry?
- Is the goal/improvement initiative standard being implemented and met?
- Is communication about the standards, both to and from employees, clear and understood?
- Is training to the goal/improvement initiative standards being completed and are employees, residents, families, and volunteers benefiting from it?
- Are employees following the goal/improvement initiative?

Ways we evaluate our goal/improvement initiative:

- We use a program evaluation template and evaluate the goal/improvement initiative as part of an applicable or associated program review.
- We keep logbooks that we refer to at evaluation time. We record the good practices, as well as those needing improvement.
- We keep notes throughout the year. For example, if we do training, audits, inspections, or if there are incidents, then we write them down as we go so that when it is time to evaluate we can refer to your notes.
- We try to build confidence by keeping expectations reasonable. Standards, and ways to evaluate them, will be improved over time.
- We are not afraid of negative results. We cannot improve if we do not try different methods and approaches. We will take action aimed at improving the goal/improvement initiative, even if the evaluation results show problems.

Step Five - ACKNOWLEDGE SUCCESS AND MAKE IMPROVEMENTS

Based on the results of our evaluation, we look for opportunities for improvement and create a documented plan or recommendations to implement changes. When evaluation indicates a need for improvement, we use cooperative mechanisms to significantly improve our performance.

Our objectives include:

- Raise performance to Holland Christian Homes standards.
- Raise Holland Christian Homes standards and expectations.

We keep everyone informed of the plans for improving the goal/improvement initiative such as:

- Sending a letter from the Board of Directors/department heads congratulating all staff for their contribution to meeting the goal/improvement initiative.
- Run an article in the CQI newsletter or on the website highlighting successes.
- Include commendations in the minutes of the annual general meeting.
- Acknowledge and congratulate those who have contributed to our goal/improvement initiative. We do this by publicly recognizing Holland Christian Home's overall performance and improvements and individual contributions to improved performance. We also explore employee recognition, incentive programs, and performance appraisals.

These 5 steps are used in a repeating cycle to allow continuous reflection and improvement of the care and services provided to our residents.

Communication:

The Continuous Quality Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the home. The CQI Committee tracks, trends, and aggregates data from all sources to prepare reports for the Board of Directors and the medical staff. An Annual CQI Report is published on our CQI Board to update residents, tenants, families, staff, and volunteers on CQI activities done within the first 3 months of the year.

Education:

All staff and volunteers are given the responsibility and authority to participate in our Continuous Quality Improvement Plan. To fully accomplish this, all volunteers and staff are provided with education regarding the CQI Plan during their initial orientation, and on an annual basis thereafter. This education will include a description of the CQI Plan and how they fit into the plan, based on their particular job or volunteer responsibilities. Education is also provided to contractors and agencies who are involved in resident care. We also welcome and embrace resident and family involvement in our committee(s).

Evaluation (Monthly, Quarterly, Annual):

Progress is evaluated monthly during our committee working groups where all CQI activities for all programs and services offered within Grace Manor are benchmarked against our set goals. Action plans are revised to ensure a focus on continuous improvement. Our established CQI Committee meets quarterly with identified key stakeholders, including representation from family/resident councils where Faith Manor reviews quarterly metrics and completes a comparative analysis of all action items and sets further action priorities. Our overall CQI Plan (and all associated activities, program matrices, benchmarks) is evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care and services are being provided to our residents, tenants, and clients. This will be done following the Holland Christian Homes standard template provided for this purpose. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this CQI Plan, are compiled and maintained on file.

Documentation and Reporting:

A detailed summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this Quality Improvement Plan, are compiled and maintained on file. In addition to regular CQI updates, a detailed formal summary highlighting the quality improvement activities for

the year is prepared and posted publicly within the home on the CQI Bulletin Board and on the Holland Christian Homes website.

OVERALL SUMMARY – OUR PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not. If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in compliance, etc.

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on the Grace Manor Quality Improvement Board, in common areas, and in staff lounges
- Publishing stories and results on the website and on social media

- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents
- Presentations at staff meetings, townhalls, Resident Councils, Family Councils
- Huddles at change of shift
- Use of Champions to communicate directly with peers

Quality Improvement Plan / Progress Report on the 2025/26 QIP

See Below

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #5 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Grace Manor)	**30.34** Performance (2025/26)	**27** Target (2025/26)	**24.48** Performance (2026/27)	**19.31%** Percentage Improvement (2026/27)	**23.74** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improve services offered within the home through the use of IV Therapy.

Process measure

- Percentage of registered lead care partners trained on the use of IV therapy.

Target for process measure

- 100% of registered lead care partners are trained on IV therapy in 2025.

Lessons Learned

Change idea was very effective. The success was we had residents able to return from hospital back to the home where they were able to receive continued IV Therapy and reduce re admission rates.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Increase Residents and Families knowledge about what services the home can provide at End of Life.

Process measure

- Offer End of Life information package to resident and families during annual care conference and hold one information evening for resident and families about what the home can offer as End of Life Care.

Target for process measure

- 100% of residents and families are offered End of Life Care service information during care conferences. The home hosts one information evening for resident and families about available End of Life Care services available within the home by December 31, 2025.

Lessons Learned

We were able to improve performance by 19.31% We have had successful conversations about what the home can offer for End Of Life Care to reduce family requests for ED transfers.

Comment

Change idea was very effective. Grace Manor was able to improve performance by 19.31%

Equity | Equitable | Optional Indicator

Indicator #4	Last Year		This Year		
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Grace Manor)	**100.00** Performance (2025/26)	**100** Target (2025/26)	**100.00** Performance (2026/27)	**0.00%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Mandatory Diversity, Equity and Inclusion education in 2025 for all new non union that are onboarding.

Process measure

- Percentage of non unionized care partners that complete Diversity, Equity and Inclusion training against new hires.

Target for process measure

- 100% of all non union care partners to be trained in Diversity, Equity and Inclusion upon hire in 2025.

Lessons Learned

100% of all non-union onboarding have received mandatory Diversity, Equity and Inclusion education

Comment

100% of all non-union onboarding have received mandatory Diversity, Equity and Inclusion education. We had our Training and Development Coordinator ensure newly onboarded staff completed the mandatory education 2026/2027.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you? (Grace Manor)	**96.00** Performance (2025/26)	**100** Target (2025/26)	**75.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Incorporate all care partners on training for person directed care and Eden philosophy.

Process measure

- Percentage of care partners trained on person directed care and Eden philosophy.

Target for process measure

- 100% of care partners trained on person directed care and Eden philosophy by December 31, 2025.

Lessons Learned

25% of residents answered unsure on the resident satisfaction survey and this was not counted towards the "how well staff listen to you". We will provide Eden person centered education to all new onboarding care partners as well as customer service education to improve this performance and ensure all onboarding care partners have training.

Comment

25% of residents answered unsure on the resident satisfaction survey and this was not counted towards the "how well staff listen to you" we will provide Eden person centered education to all new onboarding care partners to improve this performance.

Indicator #3	Last Year		This Year		
	100.00	100	90.00	--	NA
Percentage of residents who responded positively to the statement: " I can express my opinion without fear of consequences". (Grace Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue to maintain 100% of all residents to respond positively to the statement" "I can express myself without fear of consequences".

Process measure

- Percentage of care partners trained on person centered care and EDEN Philosophy.

Target for process measure

- 100% of care partners trained on person centered care and EDEN Philosophy by December 31. 2025.

Lessons Learned

The analysis showed that 10% of residents responded no comment and could not be counted into the total.

Comment

The analysis showed that 10% of residents responded no comment and could not be counted into the total. 90% answered yes and 0% answered no. We will be implementing customer service training for all care partners by December 31, 2026.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Grace Manor)	**21.88** Performance (2025/26)	**20** Target (2025/26)	**16.28** Performance (2026/27)	**25.59%** Percentage Improvement (2026/27)	**16** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Review new and current residents on antipsychotic medications to determine proper indication for usage and consideration of alternative interventions when warranted.

Process measure

- Percentage of residents reviewed by the antipsychotics Reduction Committee per quarter.

Target for process measure

- 100% of new admissions and current residents that are on antipsychotics medication will be reviewed by Antipsychotics Reduction Committee to determine proper indication for usage and consideration of alternative interventions by March 31, 2025.

Lessons Learned

The change idea worked and we were able to improve by 25.59%

Comment

The change idea worked and we were able to improve by 25.59%

DATE OF THE ANNUAL PROGRAMS EVALUATION AND WHO PARTICIPATED

Our 2025 Annual Programs Review and Evaluation occurred on **February 24, 2026.**

The following people participated:

#	Name	Position
1.	Tracy Kamino	CEO
2.	Justine Dudziak	Administrator
3.	Priyanka Sharma	DRC
4.	Benz Tran	RPN (BSL)
5.	Dr. Omar Elahi	Medical Director
6.	Amarjot Boughan	Nurse Practitioner
7.	Sharmane Martin	Housekeeping & Laundry Supervisor
8.	Chelsea Anne Nevins	Personal Support Worker (PSW)
9.	Dora Quarshie	RPN Program Lead Restorative Care
10.	Behije Mulaj	Housekeeping & Laundry Manager
11.	Kristine Nielsen	Resident Advocate and Programs Manager
12.	Sujitha Jayakumar	Director of Human Resources
13.	Amanda Ally	Training & Development Coordinator
14.	Rohit Sharma	Dietary Manager
15.	Gina Hooiveld	Dietary Worker
16.	Gurvir Cheema	RPN
17.	Mebratu Gebru	Spiritual Care Coordinator
18.	Michelle VanBeusekom	Family Council Chair
19.	Trish Krale	CQI & Risk Mitigation Specialist

20.	Luyen Loc	IPAC Lead
21.	Chloe Turgeon	Registered Dietician
22.	Case Geleynse	Chair of the Board
23.	Cheryl Abid	Recreation Facilitator
24.	Glenda McKay	Volunteer Coordinator
25.	Ewa Chac	Laundry Worker
26.	Rohit Sharma	Dietary Manager
27.	Amanpreet Kaur	Food Service Supervisor
28.	Jacquie Vezeau	Community Mentor
29.	Charles Sjaarda	Board Member
30.	Lorraine Griffith	Maintenance Assistant
31.	Gus Van Weert	Resident Council Chair
32.	Omer Rogers	Senior Manager of Environmental Services
33.	Jashan Birring	Specialized Program Lead
34.	Donna Wood	Board Member
35.	Dermal Dias	Residents' Council Co-Chair
36.	Sejal Maheta	Physiotherapist
37.	Ashima Chhabra	ADRC
38.	Keith Ambtman	Board Member

Holland Christian Homes

RESIDENT SATISFACTION AND FAMILY EXPERIENCE ANNUAL SURVEYS

A Resident Satisfaction and Family Experience survey is prepared annually, in consultation with the Residents' and Family Councils. Once consultations are completed the survey is distributed. The residents and families are given time to complete the survey. Once the data from the survey are in they are analyzed and an action plan is developed.

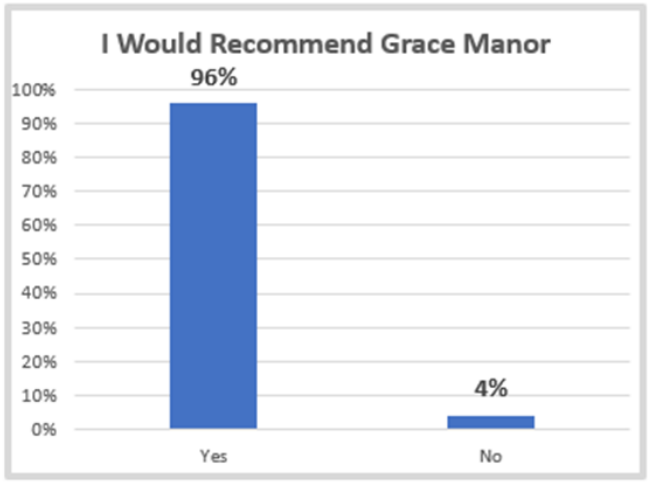
The action plan is then shared with Residents' Council and Family Council as well as posted on the CQI board in each Manor for staff, families, and visitors to view.

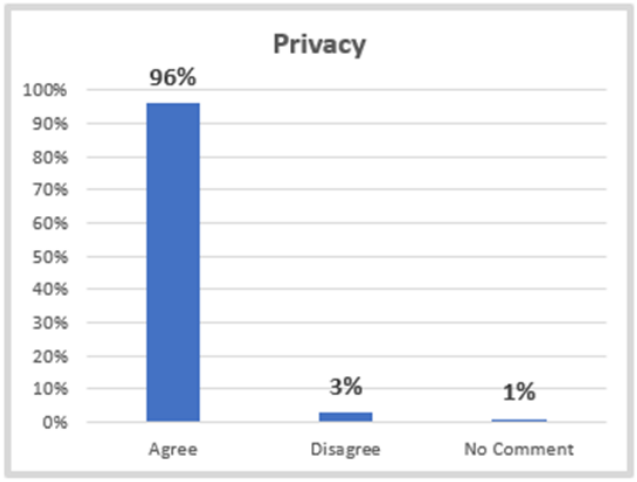
The Grace Manor management team shared revised/updated versions of the Action Plan with Family Council Chair and Working Group on February 10, February 19, March 13 and March 18, 2026.

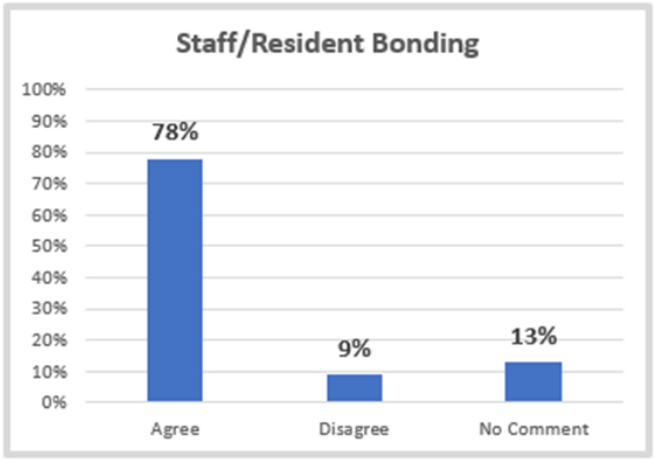
Grace Manor Quality Improvement Completion Dates			
Resident Satisfaction Survey		**Family Experience Survey**	
Surveys taken to Residents' Council (draft)	October 27, 2025	Survey taken to Family Council (draft)	October 8, 2025
Date survey distributed to residents	November 17, 2025	Date survey distributed to families	November 17, 2025
Distribution method	Paper and online through Survey Monkey, with assistance from volunteers.	Distribution method	Online through Survey Monkey, sent via family portal, message to families via Cliniconex, posters in the home, and paper copies available.
End date to complete survey	December 12, 2025	End date to complete survey	December 12, 2025
Duration to complete survey	November 17 to December 12, 2025	Duration to complete survey	November 17 to December 12, 2025
Date results and action plan presented to Residents' Council for review	February 10, 2026	Date results and action plan presented to Family Council for review	February 10, 2026
Date 2025 Annual Program Review and Evaluation held		February 24, 2026	

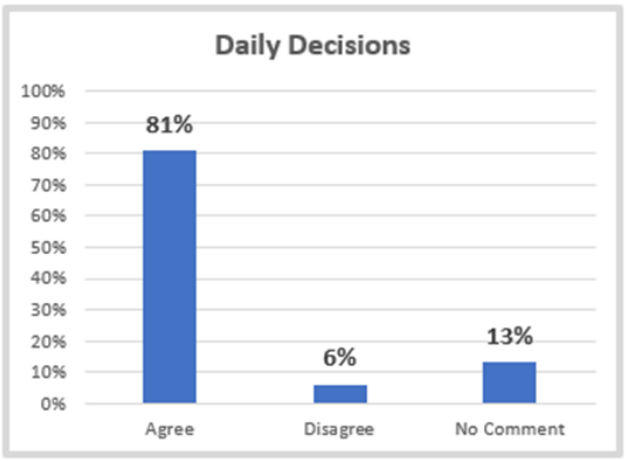
HOW ARE WE DOING AT GRACE MANOR?

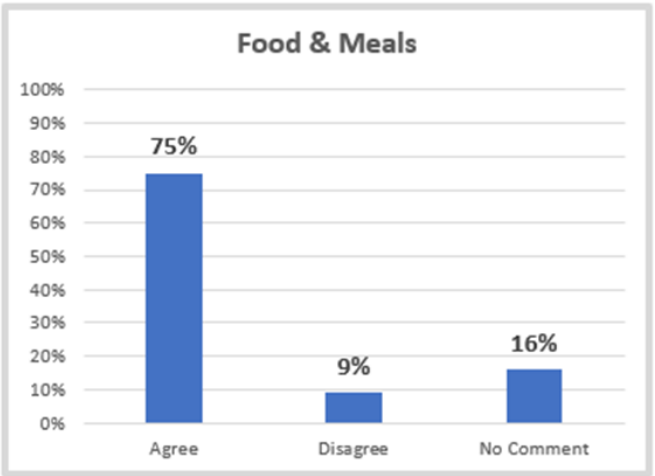
Resident Satisfaction 2025

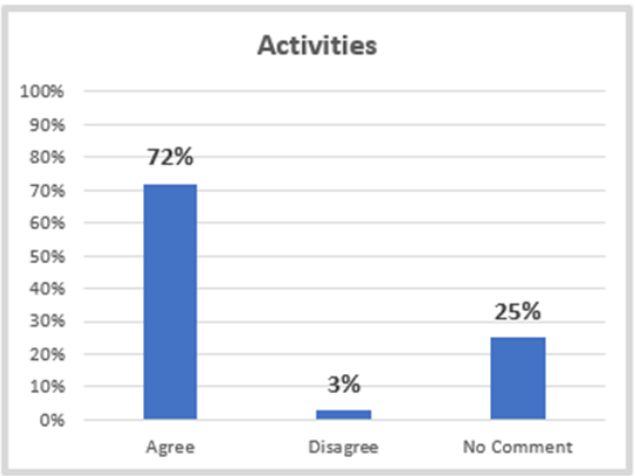


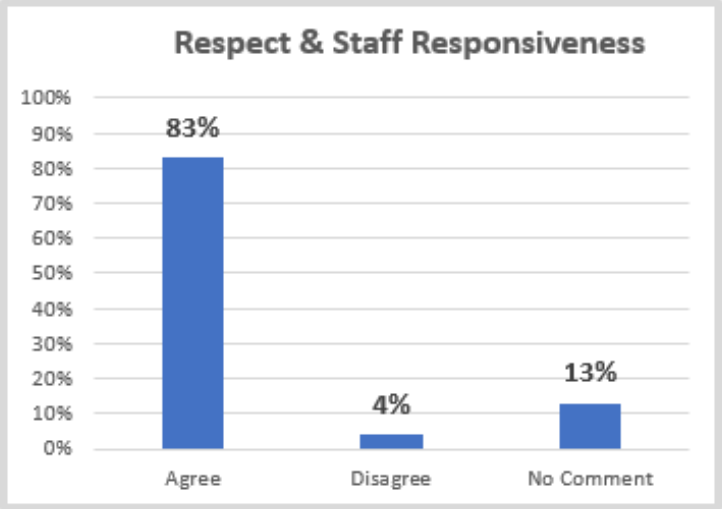


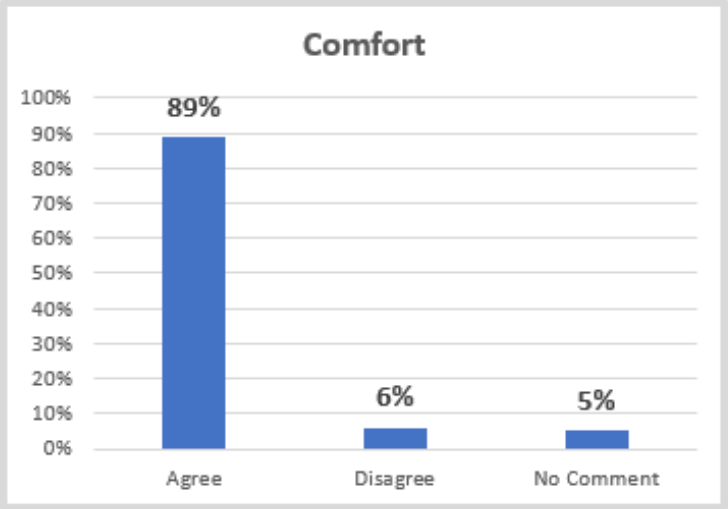


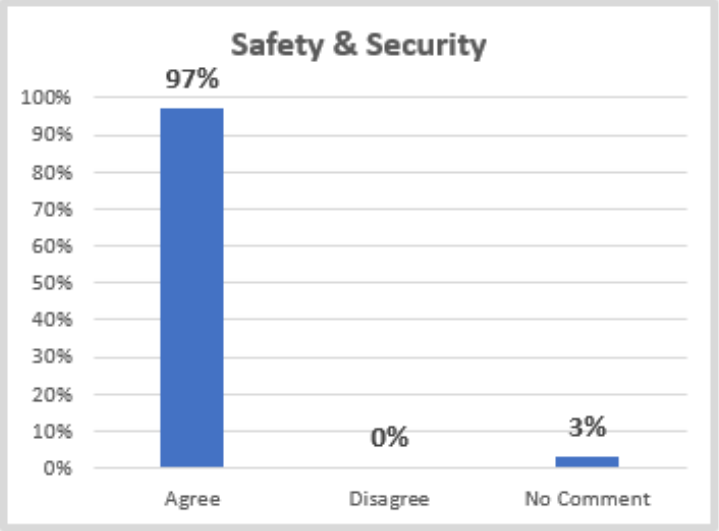


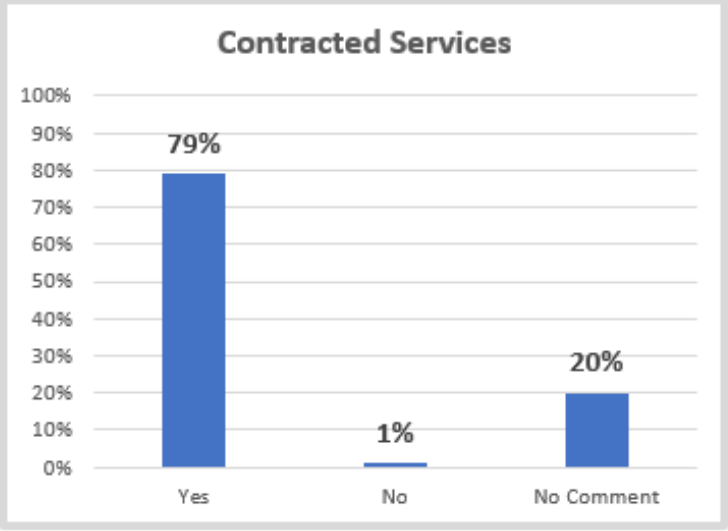


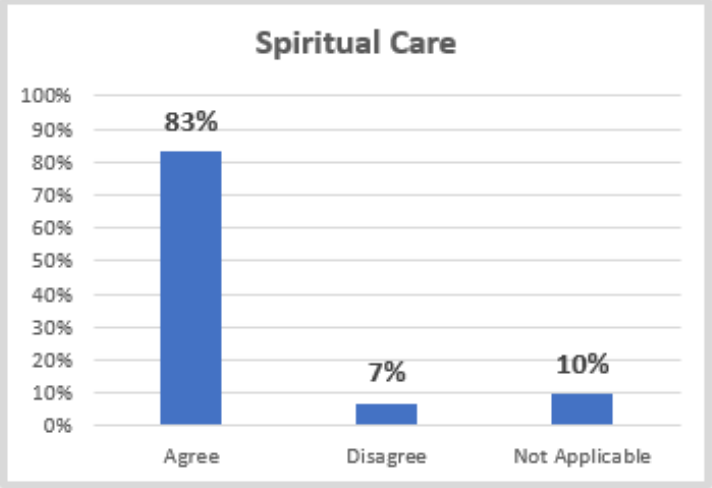


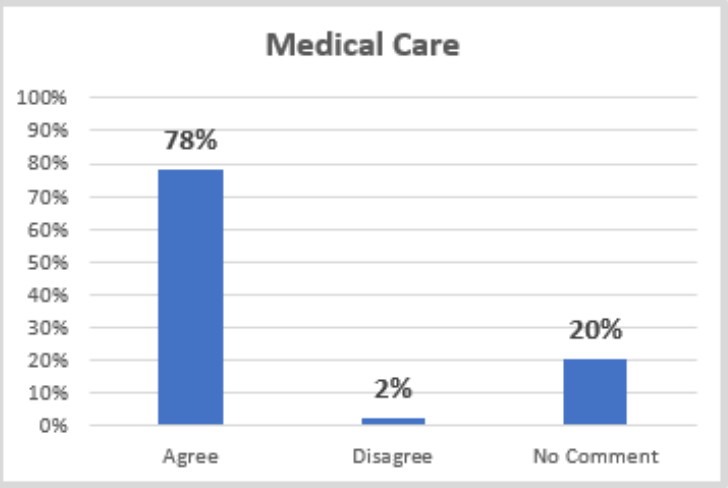

Respect & Staff Responsiveness
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83%
4%
13%
Agree
Disagree
No Comment

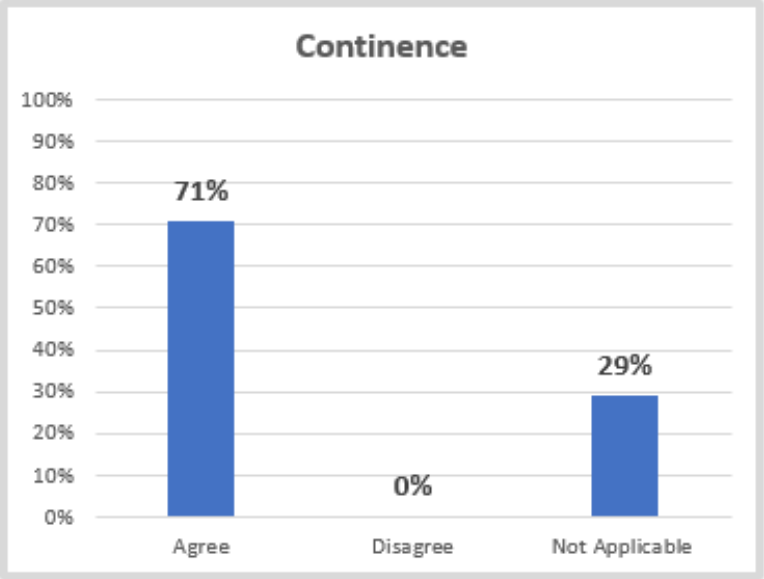

Comfort
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
89%
6%
5%
Agree
Disagree
No Comment

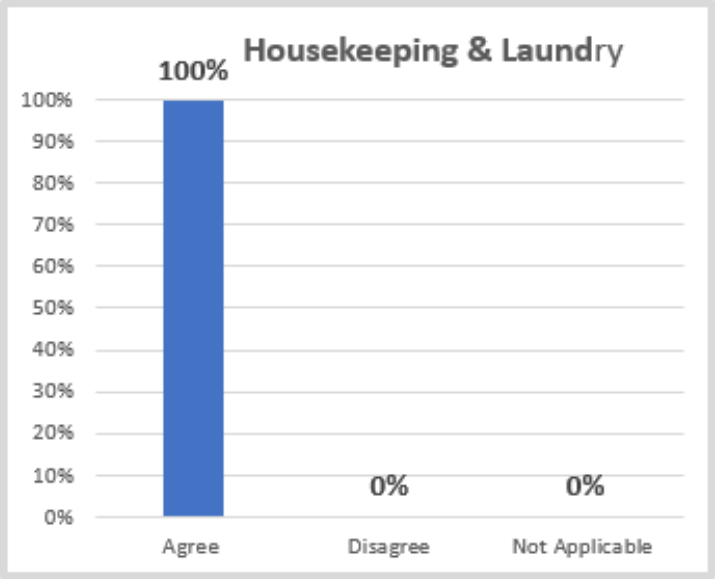

Safety & Security
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
97%
0%
3%
Agree
Disagree
No Comment


Contracted Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
79%
1%
20%
Yes
No
No Comment


Spiritual Care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83%
7%
10%
Agree
Disagree
Not Applicable


Medical Care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
78%
2%
20%
Agree
Disagree
No Comment

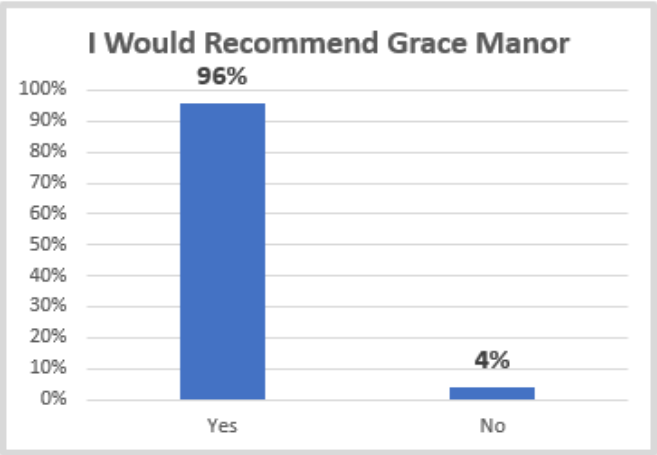


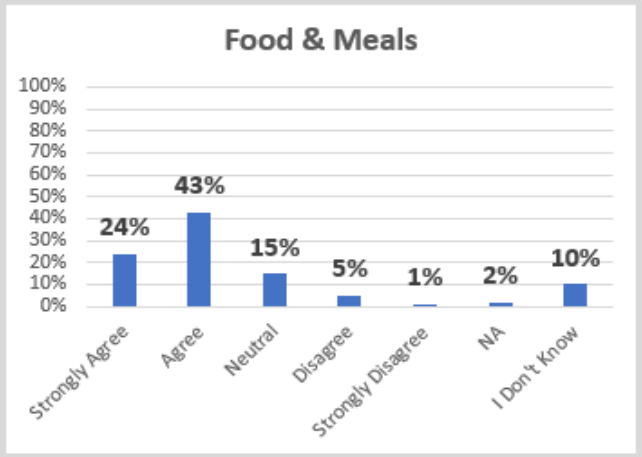


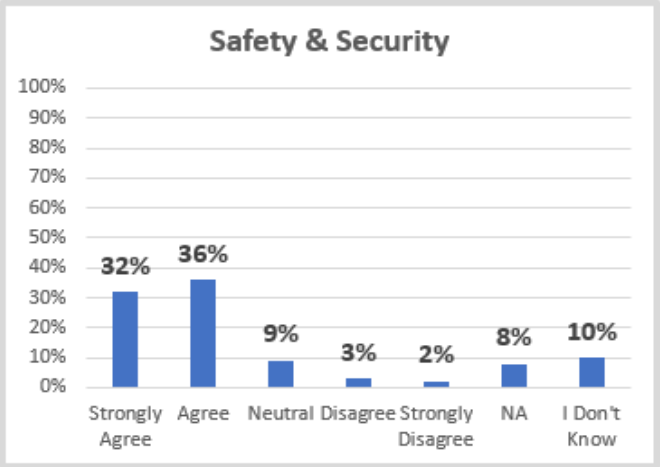
HQO Questions	Agree	Disagree	No Comment
Rate how well the staff listen to you – 1 = they don't listen, 5 = they always listen (question 25 from the survey)	1 = 0% 2 = 0% 3 = 25% 4 = 21% 5 = 54%		
I can express my opinions without fear of Consequences	90%	0%	10%
I would Recommend This Home	96%	4%	0%

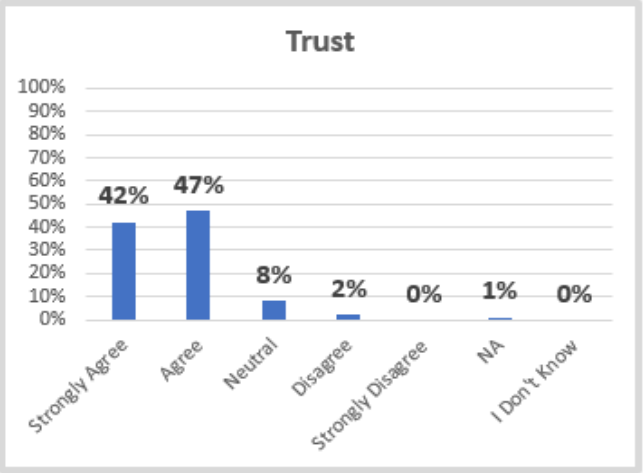
HOW ARE WE DOING AT GRACE MANOR

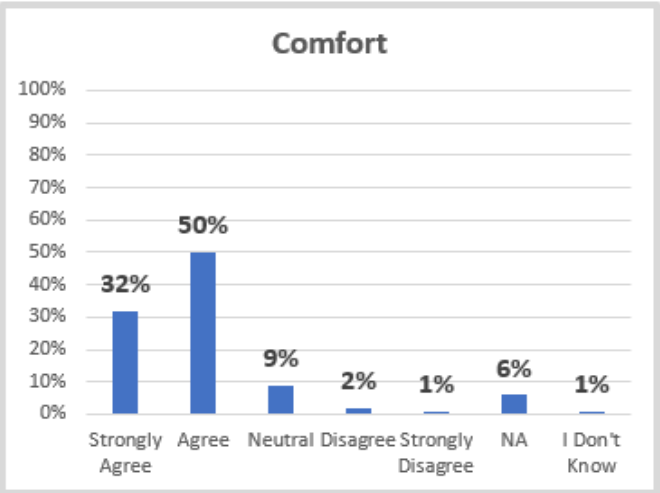
Family Experience 2025

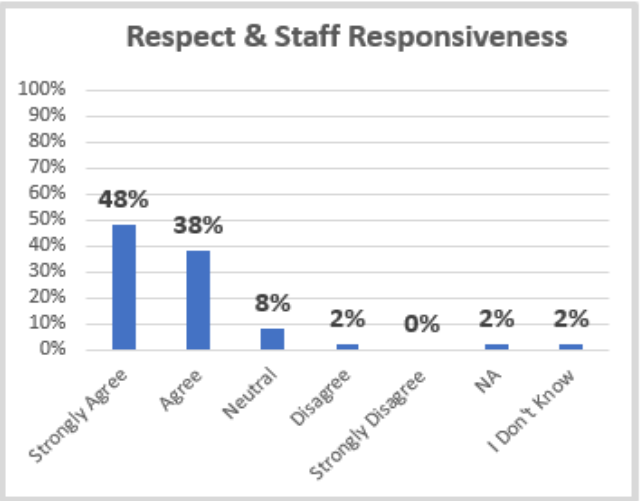


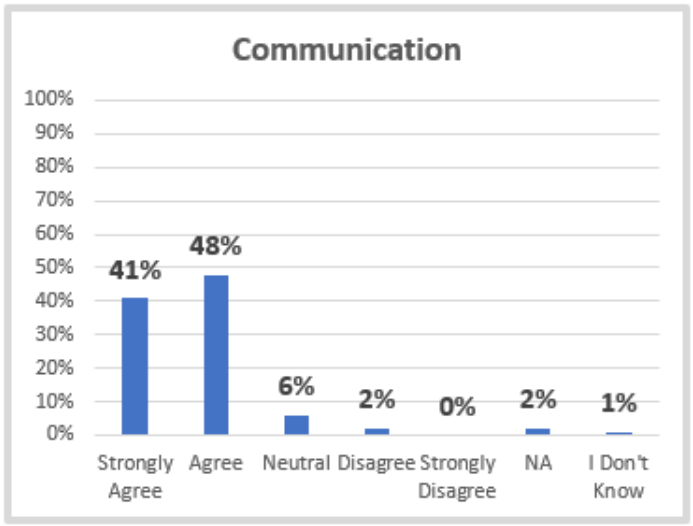


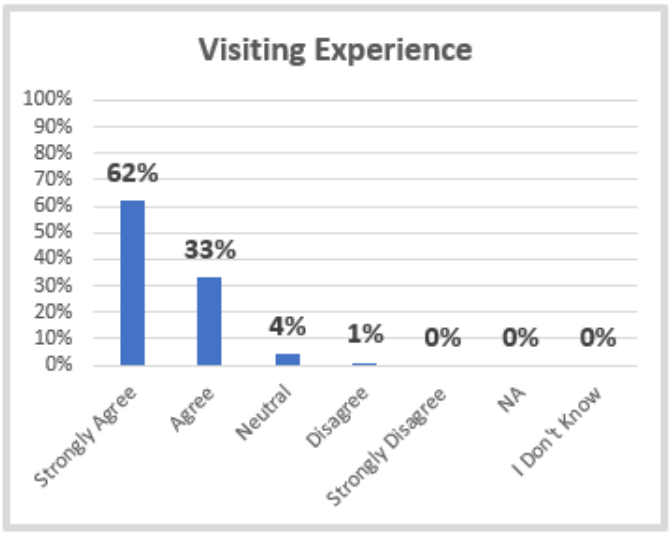


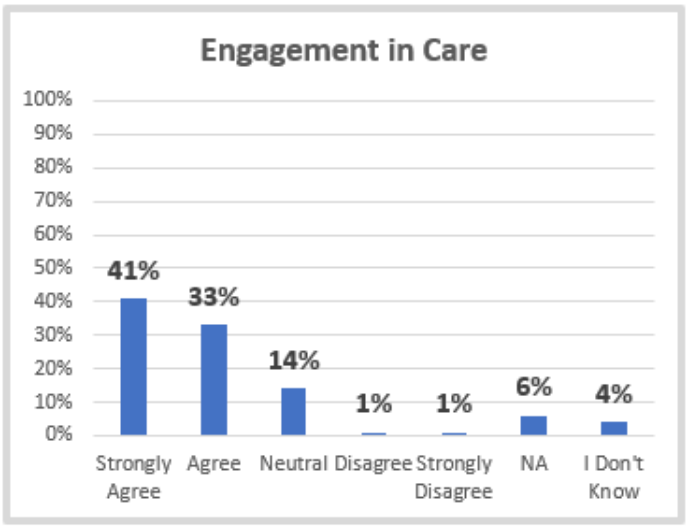


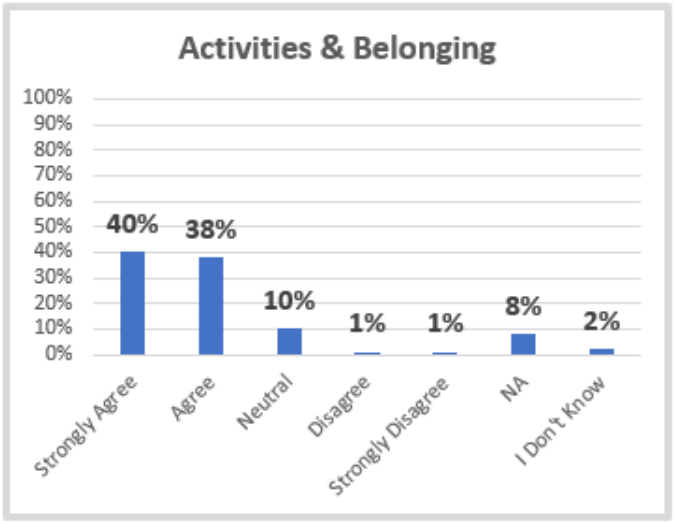


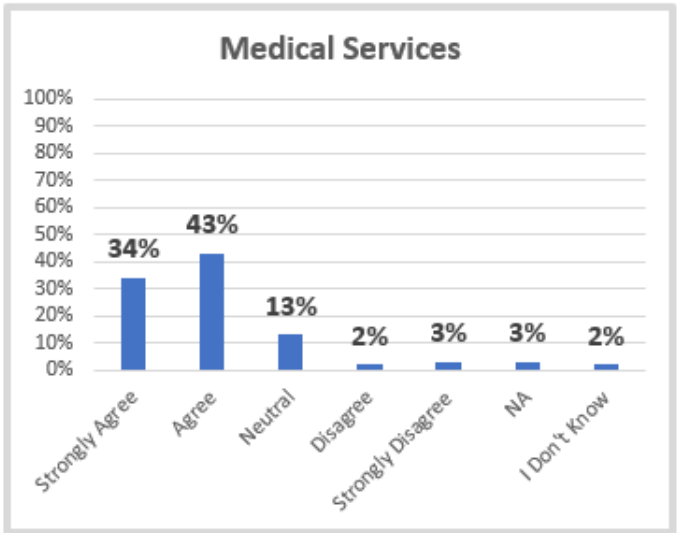


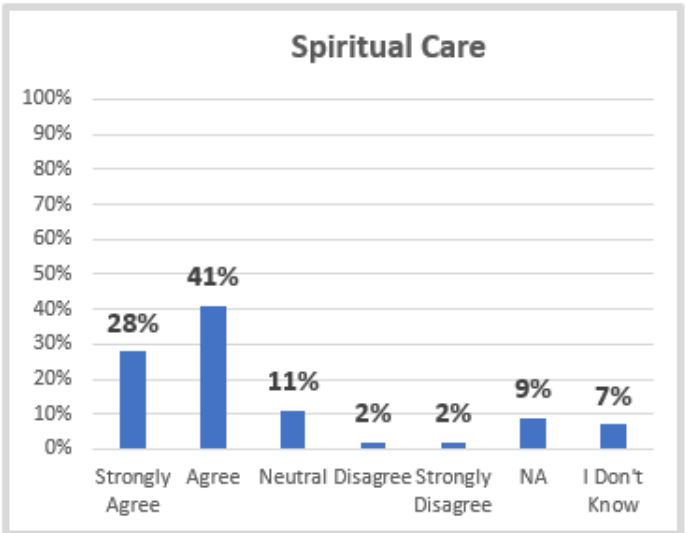

Communication
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
41%
48%
6%
2%
0%
2%
1%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know

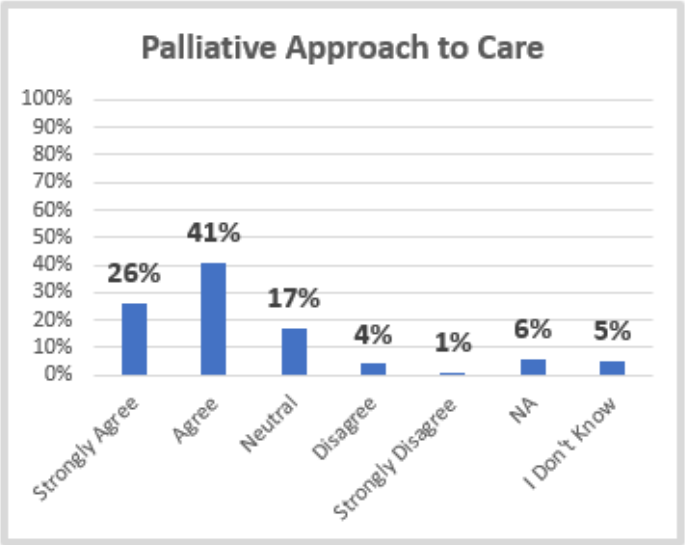

Visiting Experience
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
62%
33%
4%
1%
0%
0%
0%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know

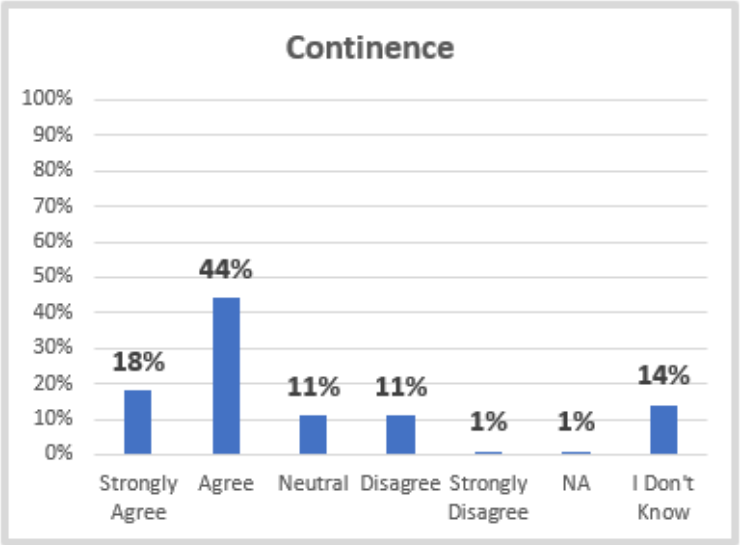

Engagement in Care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
41%
33%
14%
1%
1%
6%
4%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know

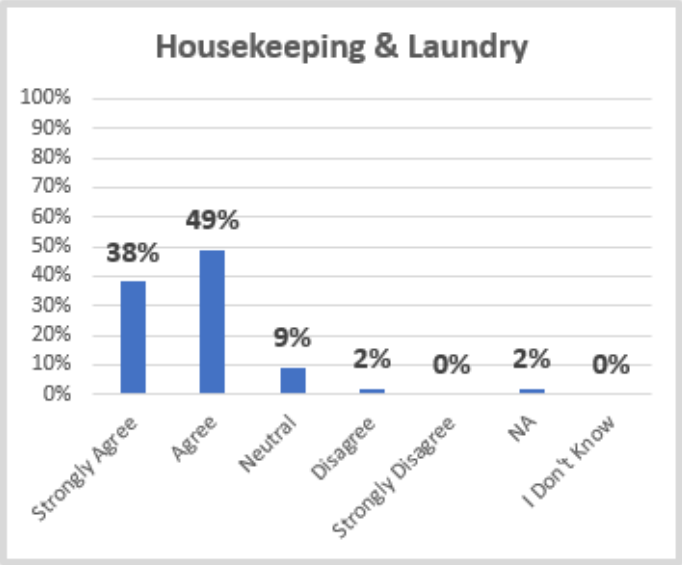

Activities & Belonging
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
40%
38%
10%
1%
1%
8%
2%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know

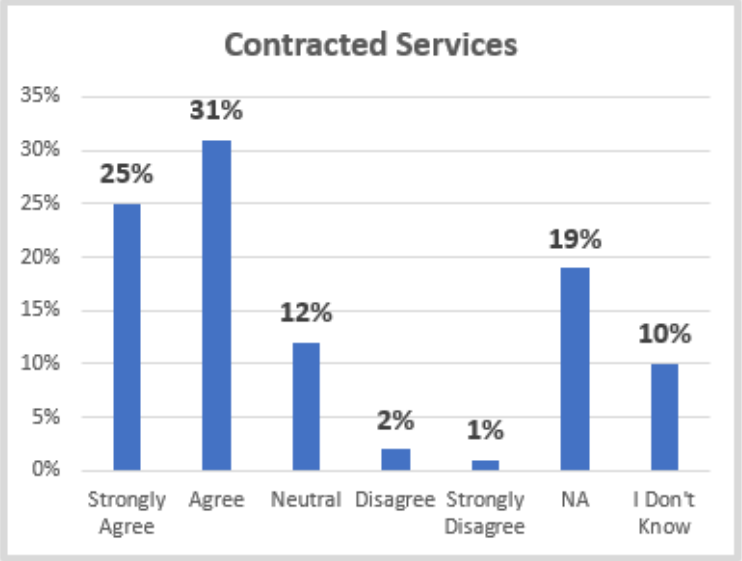

Medical Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
34%
43%
13%
2%
3%
3%
2%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know


Spiritual Care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
28%
41%
11%
2%
2%
9%
7%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know


Palliative Approach to Care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
26%
41%
17%
4%
1%
6%
5%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know


Continence
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
18%
44%
11%
11%
1%
1%
14%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know


Housekeeping & Laundry
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
38%
49%
9%
2%
0%
2%
0%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know


Contracted Services
35%
30%
25%
20%
15%
10%
5%
0%
25%
31%
12%
2%
1%
19%
10%
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
NA
I Don't Know

Holland Christian Homes

Grace Manor
2024 Resident Satisfaction Survey
2024 Family Experience Survey
2025 Action Plan

Description

Our Grace Manor Annual Resident Satisfaction and Family Experience Survey was launched on November 12, 2024 and November 20, 2024 with a deadline of December 17, 2024. The CQI Coordinator tabulated both resident satisfaction and family experience survey results which were then shared on February 12, 2025 with both Resident and Family Council. Both councils jointly decided in favor of creating a combined Action Plan and formed a temporary Action Plan Working Group including residents, family and staff.

Grace Manor has 120 residents. 32 residents were deemed capable of participating in the survey. Of those, 30 residents who completed the survey (5 completed the online survey with volunteer assistance). 114 families were eligible to complete the survey (based on a 6-month residency requirement). Of those, 43 families participated in the 2024 survey. Family responses were submitted via Survey Monkey.

Below is the Action Plan created by the Working Group in response to the 2024 Resident Satisfaction and Family Experience survey results.

In 2023, 88% of residents responded affirmatively to the statement "I would recommend this home to others". In the 2024 Action Plan, the target for responses to this question was set at 90%. 100% of residents responded affirmatively to this statement in the 2024 survey. The target for 2025 will remain at 100%.

In 2023, 80% of families responded affirmatively to the same statement. The target established in the 2024 Action Plan for responses to this statement was 85%. 92% of families responded affirmatively to this statement in the 2024 survey. The target for 2025 will be 100%.

Areas to Improve	Action Plan (to be carried out in 2025)	Person Responsible	Date Completed	Outcomes of Actions
Personal Care and Services • **Daily decisions** • **Personal relationships** • **Privacy** • **Trust** • **Comfort and Facilities**	Educate all Care Partners, that residents and family can access the first available care partner and not just those assigned to the resident. This education will be provided through in-person huddles and learning circles and annual mandatory training by November 1, 2025.	Training and Development Coordinator, DRC, ADRC	November 1, 2025	Care partners will take more time during care routines to engage positively with residents - will improve resident satisfaction resulting in less concerns; improve relationships and confidence in care delivery.
	Re-educate and perform the Hourly Rounding protocol and ensure that all 4 P's are completed for each resident (pain, position, personal needs, personal belongings) audited daily to ensure completion. This will be tracked on the registered staff audit tool check list starting May 1, 2025.	DRC, ADRC, Team Leads	May 1, 2025	Ensure hourly rounding is completed and that staff are engaging positively with residents and meeting unmet needs.
	Care partnering with residents and honoring resident's daily rhythm of life by empowering choice and dependence, autonomy, and providing dignity, respect and care measured by the Warmth Survey by October 31, 2025.	Dementia Care and Services Lead	October 31, 2025	Following Eden philosophy helps resident's well-being through honoring resident's daily rhythm of life by empowering choice and dependence, autonomy, and providing dignity and respect.
	All care partners will respect resident choices. This will be achieved by re-educating care partners on the Resident Bill of Rights during the annual training by October 31, 2025.	Training and Development Coordinator, DRC, ADRC	October 31, 2025	Honoring personal preferences makes residents feel valued and in control of their lives, supporting their dignity and well-being as per Eden philosophy.

	Reducing the institutional appearance of the environment by removing unnecessary PPE stored on walls and relocating them to designated storage areas while ensuring easy access to care partners by June 30, 2025.	IPAC Lead	May 31, 2025	Reducing visibility of PPE supplies creates a home-like environment.
	Care partners will be empowered to identify environmental factors (such as sound levels, lighting, clutter) during regular hourly rounding. Education will be provided to support this practice by October 31, 2025.	Training and Development Coordinator, DRC, ADRC	October 31, 2025	Incorporating environmental checks into existing routines helps maintain a calm, safe, and home setting.
Care Partners, Resident Bonding, & Relationships	Share results of the Eden Alternative Warmth Survey with Family and Resident Councils. The survey will also be provided to all residents, families and care partners to determine Grace Manor's culture baseline by June 30, 2025.	Dementia Care and Services Lead	June 30, 2025 and November 12, 2025	Care Partners, residents and families in all neighborhoods will be more aware of how Grace Manor will be working towards creating a caring, inclusive environment empowering resident's independence, choice and promoting well-being based on actin plan after survey results.
	Add a section within the Annual Mandatory training sign off to identify care partners that speak other languages to serve as internal interpreters to residents whose primary language is not English/French. Once 100% of care partners complete the training, create a list and provide to the leadership team by October 1, 2025.	Training and Development Coordinator	October 1, 2025	List of care partners who can serve as translators for residents whose first language is not English. Use of translation tools or services will improve communication between residents and care partners resulting in individualized, holistic resident care. Residents will have access to care partners who can understand their language, impowering communication.
	Provide enhanced communication training to ensure care partners communicate effectively	Training and Development	April 1, 2025	Resident and care partners will not feel they have been left out due to not understanding what is being

	and empathetically with residents, speaking only English when providing care for a resident unless the resident speaks another language for which the care partners also speaks. Training to be delivered during neighborhood huddles and through monthly onboarding education to start April 1, 2025.	Coordinator		said. Respectful communication.
	Utilize the Champions of Change, Certified Eden Associates and Leadership to create a Pilot Neighborhood Action Plan in response to the findings of the completed Eden Warmth Survey by June 1, 2025.	Dementia Care and Services Lead	September 10, 2025	There will be an action plan to drive Eden change and making Grace Manor a more person-centered home. We achieved this action items however, we were too ambitious with the time line and we extended as we started to grow and learn the process took us a bit longer.
	Educate and inform all care partners, residents and family care partners on the Eden journey. Education will include how we can all create a caring, inclusive environment empowering resident's independence, choice and promoting well-being. This will be accomplished through hosting huddles, posters, hand-outs, information boards, Tie that Binds article, Pulse newsletter, etc. by August 30, 2025.	Dementia Care and Services Lead	August 11, 2025	Providing education on the Eden journey helps shift the culture from task-based care to person-directed living. It builds a shared understanding among care partners, residents, and families about how to support independence, choice, and community.
Daily Decisions & Communication	All care partners will be educated to use resident-centered language, use active	Dementia Care and Services	October 31, 2025	Care partners will use person-center language.

	listening and compassionate communication with all interactions through “words make worlds” education. This education will be provided through in-person huddle and learning circles and annual mandatory training by October 31, 2025.	Lead and Training and Development Coordinator.		
	An email distribution list will be developed for general mass communication to families by October 1, 2025.	IT Support Team, RAI Coordinator, Administrator	October 1, 2025	Respectful, flexible communication helps build trust, keeps families well-informed, and supports a positive partnership in care.
Activities and Building Community	Install an Ambient ABBY board an interactive gaming device in each neighborhood. Train care partners on how to engage residents (or encourage residents with self-directed usage) with this board by October 30, 2025.	Resident Advocate and Program Manager	November 12, 2025	To reduce boredom and loneliness through providing meaningful activities residents can easily engage with. Delay due to installation training 3rd party, training was completed November 19, 2025.
	Enhance activity levels on weekends by exploring the possibly of reducing intervals between activities increasing by two activities and empowering care partners to create meaningful engagement during non-scheduled times on the weekend by July 30, 2025.	Resident Advocate and Program Manager	July 30, 2025	To reduce boredom and loneliness between activity downtimes through providing meaningful activities residents can easily engage with.
	Complete the Sensory door escape project by October 31, 2025.	Resident Advocate and Program Manager,	Installed August 29, 2025 and November	Each resident door will have its own personalized door. Fully completed by November 4, 2025 due to installation schedule 3rd party availability.

		Administrator	4, 2025	
	To foster community engagement of residents by following the Eden model of care and introducing a variety of plants, animals and local community connections by October 31, 2025.	Resident Advocate and Program Manager, Administrator, Dementia Care and Services Lead	October 31, 2025	Will provide opportunities to maximize social connections by pairing residents with similar interests during group activities; will foster social connections. Engagement with community connection, plants and animals will enhance resident interaction, sensory stimulation and reduce boredom, and loneliness.
Engagement in Care	Enhancing the person-directed care model using the Eden Alternative throughout our community. Identify a community neighborhood to pilot culture change creating home and create an action plan as an appendix by June 1, 2025.	Administrator, Dementia Care and Services Lead	June 1, 2025	Improve well-being to all residents and community care partners. Pilot neighborhood is chosen, projects, new ideas can be challenged and trialed before rolling out to entire community.
Visiting Experience	Provide knowledge to resident and families of designated spaces available for visiting enjoyment by June 1, 2025.	Behavior Support Lead	June 1, 2025	Residents, families and care partners to be more aware of designated spaces that family and friends can visit in private and enhance the visiting experience.
Volunteers	Foster deep meaningful connections with Volunteers to enhance resident experience and engagement by September 31, 2025	Volunteer Coordinator	September 31, 2025	Residents will have increase meaningful engagement through visits with volunteers.
	Re-engage 100% of end-of-life volunteers by ensuring they complete their training by April 30, 2025, through targeted outreach and providing necessary resources to support	Volunteer Coordinator, NP	April 30, 2025 and June 10, 2025	Educated volunteers will continue to be aware of the care expectations at End of Life.

	training completion.		training completed	
Spiritual Care	Offer more accessible religious activities for non-verbal or less mobile residents, by offering interactive prayer sessions or guided spiritual exercises or the audio bible devices (in different languages) by June 30, 2025.	Spiritual Care Coordinator	June 30, 2025	To increase participation in religious and spiritual programs.
Meal Service, Snacks, & Dietician	Organize a food show for residents, families and care partners to taste food samples for recommendations for new menu by July 31, 2025.	Dietary Manager	Due to vender schedule event took place August 7, 2025	Residents and families will have an enhanced opportunity in making food choices.
	Educate all care partners on future environment that is calm and welcoming to ensure resident well-being and encourage families to engage during meals by June 30, 2025.	Dietary Manager, DRC, Dementia Care and Services Lead	June 17, 2025	Residents and families will enjoy a dining experience together and families will feel welcome and encouraged to participate.
Accommodation • **Housekeeping** • **Laundry**	To reduce misplaced lost and mixed-up clothing, hold care partner huddles with re-training monthly on each neighborhood. First huddle to be held April 8, 2025 and ongoing after that.	Housekeeping and Laundry and PSW's care partners.	April 8, 2025	Reduce incidents of misplaced items, and decrease the number of concerns received due to lost clothing.
	Monthly audits will be done on resident	Housekeeping	April 1,	Eliminate concerns regarding lost and/or damage

	clothing delivery to ensure items have been correctly delivered to the right resident. 5 residents per unit each month will be audited starting April 1, 2025 and ongoing after that.	and Laundry Manager	2025	items. Increase attention to detail when handling laundry, including pre- washing checks for stains and proper washing procedures for delicate items and putting into right resident room to decrease incidents.
Resident Advocate, Palliative Care & End of Life	Implement the RNAO Palliative and End-of-Life clinical pathways at Grace Manor by November 31, 2025, by coordinating with key stakeholders, providing necessary resources, and ensuring care partners training and readiness for full integration.	Nurse Practitioner, Spiritual Care Coordinator, DRC	Decision made not to pursue this once we learned more	Care partners will ensure to capture appropriate information for End-of-Life care.
Environmental, Safe and Secure Maintenance	Families will be encouraged to inform registered care partners as the first point of contact on the neighborhood if any repair needs to be completed. Registered Care Partners will then place a request to repair in the “Click Maintenance” portal by April 1, 2025.	Director of Environmental Services, DRC	April 1, 2025	Maintenance and repairs are reported, fixed and/or replaced in a timely manner.
Medical Care MD/NP	Provide information to resident and family councils about communication process of the MD/NP by May 30, 2025.	Administrator, Nurse Practitioner	May 30, 2025	Enhance residents and family’s knowledge about MD/NP communication process.
Continence	Complete check-in audits with residents to review satisfaction with continence care and address any concerns by auditing 5 residents per month. First 5 residents to be audited by	Restorative Care Lead	April 30, 2025	Enhanced review of care products to ensure they are meeting individual resident care needs and satisfaction.

	April 30, 2025, then ongoing monthly.			
Contracted Services	Informed resident and family of contracted services to improve their understanding by May 30, 2025 with move in resource package and annual care conference huddles. Families are empowered to follow through with information given for their signed-up services.	Resident Advocate and Program Manager	May 30, 2025	Families and residents will better understand contracted services available.

Holland Christian Homes

Grace Manor
2026 Action Plan

Based on Results of 2025 Resident Satisfaction and Family Experience Survey

The Grace Manor 2025 Resident Satisfaction and Family Experience surveys launched on November 17, 2025, with a deadline of December 12, 2025. The CQI Specialist tabulated the results which were then shared with Residents and Family Councils on January 16, 2026. A temporary working group, with members of Residents Council, Family Council and the Grace Manor team was created to take the survey results and create an Action Plan for 2026.
Grace Manor has 120 residents. Of those, 41 residents were deemed capable of participating in the survey. With the help of volunteers, 30 residents completed the survey. From the families who were eligible to complete the survey (based on a resident's 6-month residency requirement), 52 family members completed the survey via Survey Monkey.

Below is an Action Plan created by the working group in response to the 2025 Resident Satisfaction and Family Experience survey results.

In the 2024 Action Plan, the target for responses by residents to the statement "I would recommend this home to others", was set at 90%. The result in 2024 was that 100% of residents responded positively to that statement. In 2025, the target was 100% and the result was 96%.

The same statement was asked in the family survey and in the 2024 Action Plan the target was set for 85% positive response. The result was that 92% of families responded positively. In 2025, the target was 100% and the result was 96%.

Person-Centred Language

Institutional Language	Person-Centred Language
Patient/Client	Elder/Resident
Loved One/Caregiver	Family Care Partner
Staff	Employee Care Partner
Administrator	Community Leader
DOC / ADRC	Community Guide
Registered Staff/ Charge Nurse	Neighborhood Mentors
Program Leads	Neighborhood Leads
Activities Manager	Life Enrichment Leader
Activities Staff	Life Enrichment Support Team
Departments	Support Team Care Partners
LTC Facility/Home for the Aged	LTC Community
Unit/Floors	Neighborhoods
Secured Unit/Dementia Unit	Neighborhood (Supporting residents living with Dementia)
Activity Room	Gathering Space/Studio/Creative Corner
Tub Room	Spa
Semi private Room	Share accommodations
Shift Report/ Information sharing	Daily Huddles
Team Meetings/Communication tool	Learning Circles
Fully staffed/Short Staffed	Full Compliment/ Under Complement
Behaviours	Personal Expressions
Triggers	Unmet Needs/ Contributing Factors
Exit seeking/wandering	Exploring/Searching
Allow/Delegate/ “get to”	Choice/Empower/Support
Diapers	Briefs/Underwear/Panties
Feeders	Assisted dining/assistance with meal
Bib	Apron/Clothing Protector
Call Bell	Assistance Alert/lifeline
Care Plan	Growth Plan
Admission	Moving In
Discharge	Moving out
Annual Performance Review	Personal Growth Plan

Areas to Improve	Action Items	Person Responsible	Date Completed	Expected Outcomes of the Actions
Personal Care and Services • Daily decisions • Personal relationships • Privacy • Trust • Comfort and Facilities	All Care Partners will respect resident choices, and we will reinforce this through re-educating all care partners on Resident Bill of Rights by November 30, 2026, through huddles and scenarios increase from 83% in 2025 to 90% in 2026 from the resident satisfaction survey response.	Support Team Care Partner (Training and Development Coordinator), Community Guides (DRC/ADRC)		Residents will feel valued and in control of their lives, supporting dignity and well-being.
	We will develop and implement an “EDEN EYES” checklist to use in the pilot neighbourhood by November 30, 2026.	Community Guides (DRC/ADRC)/Training and Development Coordinator		To help to ensure neighborhoods are in keeping with Eden implementations for consistency. Once trialed and successful can be utilized in other neighborhoods.

	Audit two wheelchairs per neighborhood per week to ensure compliance with the cleaning schedule by April 30, 2026.	Neighborhood Lead (Restorative Care Nurse)		Residents will enjoy wheelchair that is clean and free of smell.

	Inform residents and families that they can access the first available care partner for assistance. This information will be shared at Resident and Family Council, “Did You Know” fact sheet, handbook and we will enhance our welcome signage at the care center to include this information by May 30, 2026.	Community Guides (DRC/ADRC)		Enhance care results, communication, and the satisfaction of residents and their family care partners with the delivery of care. If the care partners (PSW) do not respond to a family request in a timely manner then the first point of contact is the Neighborhood Mentor (RN or RPN) on neighborhood. If they do not support with satisfaction, then this should be brought to Community Guide (DRC/ADRC) attention or concern form with date time of occurrence so it can be effectively addressed.

Care Partners, Resident Bonding & Relationships	Enhance our Purposeful Hourly Rounding by incorporating the seven domains of wellbeing through neighborhood huddles and changing to Point of Care electronic documentation tracking platform by June 30, 2026.	Community Guides (DRC/ADRC/RAI), Community *Builder and Mentor*		Create more opportunities for bonding, building relationship and enhanced well-being between resident and care partner.
	Develop Customer Service and Effective Communication Education slides and re-educate to care partners with this by October 30, 2026.	Support Team Care Partner (Training and Development Coordinator)		A solid understanding of customer service in caregiving will alleviate worries associated with care. Enhance care results, communication, and the satisfaction of residents and their family care partners with the delivery of care. This education will include real scenarios for more effective learning style.

	Educating care partners while role-playing -"a day in a resident's life" through providing 5 learning circles (in-services) by September 30,2026.	Support Team Care Partner (Training and Development Coordinator) *Community Builder and Mentor*		To provide care partners with the understanding of residents' feelings/concerns.
	All Care Partners will support purposeful television watching in each neighbourhood by **empowering** residents to choose programs and watching times as choice, having the TV support the current activity, turning tv off between use or screen such as seasonal theme fireplace, by February 28, 2026.	*Community Builder and Mentor* *Life Enrichment Leader (*Programs Manager/ Resident Advocate), Community Guides (DRC/ADRC)		Residents will feel more empowered and enjoy more meaningful television and increased opportunity for engagement in neighborhoods and create a cozy home atmosphere.
Daily Decisions &	Neighborhood Leads will be	Neighborhood Leads		Ensure that the Neighborhood

Communication	providing enhanced training on “Effective Communication” during the on- floor orientation shifts to all new registered care partners (Neighborhood Mentors) and re-education to current care partners by April 30, 2026.	(Program Leads), Community Guides (DRC/ADRC)		Mentors (registered care partners) have a better understanding of expectations and clear communication to increase satisfaction for resident and family when receiving updates from Care Partners.
	Ensure all Care Partners always make their name tag visible while working in the neighbourhoods by adding this to our Eden eyes audit check list that will be developed and implemented by November 30, 2026. The pilot neighborhood will trial high visibility name tags by November 30, 2026.	Support Team Care Partners (Department Heads), Community Guides (DRC/ARC)		Residents and families able to read names to increase better personal communication and bonding with care partners. Residents will enjoy easier to read name tags to increase better personal communication and bonding with care partners. We will trial high visibility name tags in pilot neighborhood then if successful and budget is approved can be implemented in other

				neighborhoods.
	Purchase and install new white boards and dry erase markers on each neighborhood for Care Partners to legibly print their names by April 30, 2026.	Community Guide (DRC/ADRC), Registered Staff (Neighborhood Mentors)		Resident and family will easily read who is providing care on the neighborhood.
	Create a 'Did You Know' fact sheet to be included in the Resident/Family Handbook and distributed at Annual Growth Learning Circles (Care Conferences) by April 12, 2026.	Life Enrichment Leader/ Resident Advocate		Increase knowledge about a variety of topics for resident and families.
	Implement a resource area by the Resident and Family Information board with 'Did you Know?', EOL Care Guide, how to access Growth Plan, Contact Lists etc. by May 20,	Life Enrichment Leader/ (Resident Advocate)		Increase knowledge about resources available for resident and families.

	2026.			
Activities & Building Community	Empower residents to create resident driven activity calendars for all neighbourhoods by May 20, 2026.	Life Enrichment Leader/ Resident Advocate		Residents will feel more empowered and satisfied with their activity choices.
	Life Enrichment Care Partners will be trained on formal use of the Abby Boards and explore options available and possible costs associated to personalize by July 30, 2026.	Life Enrichment Leader/ Resident Advocate		Resident and families will enjoy increase of self-directed activity through the engagement of Abby Boards. Training will be provided to Life Enrichment care partners to learn the capabilities and types of personalization options such as for neighborhoods favorite songs or themes “Jamaica” if residents in that neighborhood grew up and are familiar and specific resident personalization that would have

				additional cost associated. We are looking into cost of individual fobs and exploring options available from Abby directly for families to purchase if they wish.
	Tour residents through neighbourhoods to educate on self-directed possibilities including busy bins, self-engagement stations, new room concepts and Abby boards quarterly by June 30, 2026.	*Community Builder and Mentor,* Life Enrichment Leader (Resident Advocate/Activity Manager)		Residents will experience less boredom and loneliness through meaningful self-directed activity opportunities.
Visiting Experience	Enhance the home experience through the creation of a handout sheet "Did You Know" fact sheet that will be part of the handbook and include areas residents and	Life Enrichment Leader/ (Resident Advocate/Activity Manager)		Enhance and support resident and family visiting experience with a handout fact sheet resident and families can refer to as reference.

	families can enjoy during their visit throughout the broader HCH community by April 30, 2026.			
Volunteers	Increase the number of new on- boarded volunteers by 15% by December 31, 2026 by increasing contact with 3 additional external contacts.	Support Team Care Partner (Volunteer Coordinator)		Enhance and support resident experience.
Spiritual Care	Make a connection with two external religious affiliations within our local area community who can offer onsite support or resources for residents of other religious/faith in the Neighbourhoods by September 1, 2026.	Spiritual Care Coordinator, Support Team Care partner (Director of Programs and Services)		Onsite services that offer variety and support one's faith will offer/ enhance residents' spirituality and meeting their spiritual well-being.
	Provide 1:1 Spiritual Care visits to include those	Spiritual Care Coordinator and		Reduce feeling of loneliness for residents and feeling of isolation if

	residents who are feeling isolated wishing to have visit. To be tracked through referral by the Spiritual Care Coordinator on the Activity Pro electronic attendance tracking platform by March 30, 2026.	Support Team Care partner (Director of Programs and Services)		the resident wishes to have the 1:1 visit with Spiritual Care Coordinator.
Meal Service, Snacks & Dietician	Implement Pleasurable Dining Resident huddles in each neighborhood to determine wishes of the residents and utilize the “Eden Mealtime Pleasurable Dining Checklist” once a week by June 30, 2026.	Support Team Care Partner (Dietary Manager)		Increase residents' pleasure during dinning and enhance residents’ opportunity in making choices. Checklist will be shared once available.
Accommodation Housekeeping • Laundry	Monthly audits will be completed on resident clothing delivery to ensure items have been correctly delivered to the correct	Support Team Care Partner (Housekeeping Laundry Manager)		Reduce incidents of clothing being delivered to the incorrect room. We are offering choices to residents of what to wear whenever possible and participate as much care themselves.

	resident, 8 residents per neighborhood each month by April 1, 2026.			
	Create and implement a cleaning schedule for common area neighborhood furniture for steam cleaning by April 25, 2026.	Support Care Partner (Housekeeping Laundry Manager)		Residents and families will have increased enjoyment by having clean chairs in common spaces to sit more comfortably.
Resident Advocate, Palliative Care & End of Life	Implement a Resource area that will include resources such as End-of-Life Care by May 20, 2026.	Life Enrichment Leader (Resident Advocate), Nurse Practitioner		Increase knowledge about resources available for resident and families.
Environmental, Safe and Secure, Maintenance	Provide training to Neighborhood Mentors of how to find and interpret the auto email reply that is sent from “Click Maintenance” to the general neighborhood email that can contain a comment such as if waiting	Community Guides (DRC/ARC), Neighborhood Mentors, Support Team Care Partner (Director of Facilities)		Improved feedback /updates to residents/families of repairs that were reported. Email from click maintenance can be accesses by care partner who placed the request originally should families ask for an update this information will be available to look up if maintenance

	for parts or still in cue for repair that can be shared with resident/family. Training will be completed by May 30, 2026.			has added a comment or update within the ticket.
Medical Care, MD/NP	Inform resident and families about physician rounding schedule at move in time and during Annual Growth Plan Learning Circles (care conferences), handbook and on white- board by December 10, 2026.	Community Guide, (DRC/ADRC) and Nurse Practitioner		Resident and families report improved satisfaction and understanding of physician availability.
	Provide information at move in time Growth Plan Learning Circle (care conferences) and the handbook about communication process for Physician or Nurse Practitioner Care Partners by	Community Leader, Community Guides (DRC/ADRC) Nurse Practitioner		Enhance residents and family knowledge about how and when to contact physician and Nurse Practitioner.

	December 10, 2026.			
Continence care	Complete “check-in” audits with five residents per neighborhood per month by April 30, 2026.	Neighborhood Lead (Restorative Care Nurse), Community Guides (DRC/ADRC)		Review of care product and care schedule to ensure it is meeting resident individual needs and satisfaction. This involves being attendee at specific care time to ensure resident is wearing correct product and it is being applied properly.
	Provide continence application training to PSW care partners in to prevent continence concerns by 30% by December 31, 2026. This year the Incontinence section had 7 concerns, next year 5 or less.	Neighborhood Lead (Restorative Care Nurse) Community Guides (DRC/ADRC)		Resident will feel comfortable with the continence products if they are applied properly. Reduce concerns related to improper application that can contribute to leakage and changing frequency.
Engagement in Care	Empower daily	Community Guide		Communication and information

	communication huddles between PSW Care partners at shift change through five spot audits per month by June 30, 2026.	(DRC/ADRC)		sharing will be improved so that residents and families will feel being listened to. Participate in the care they receive by being empowered through information transmission among care partners.
	Implement “who am I" poster readings to gain resident familiarity quarterly along with Growth Plan (Care Plan) reviews during huddles by March 30, 2026.	Neighborhood Leads Community Guides (Program Leads, DRC/ADRC)		Care Partners will provide more person-centered care and meaningful engagement with residents. The “who am I” is a quick reference and available for care partners to see in the resident room as they are providing care creating meaningful/resident bonding interactions. Care information is in the Growth Plan and is practiced by care partners.
Contracted Services	Enhance family and resident knowledge on contracted	Resident Advocate/Activity		Residents and families will better understand contracted services and

	services offered in the home (e.g. vision, hearing, dental, spasticity, footcare etc.) through the creation of a ‘Did You Know’ fact sheet to better inform residents and families of their care delivery and options by April 12, 2026.	Manager, Community Guides (DRC/ADRC)		options offered in-house. Prevent external travels and provide choice to receive contracted services in this Community; in the comfort of their home.