

The Woodlands of Sunset Continuous Quality Improvement Initiative Report

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Introduction

Woodlands of Sunset is one of seven long-term care homes owned and operated by the Regional Municipality of Niagara. Located in the Welland community, it has 120 beds. Woodlands of Sunset is recognized as a best practice spotlight long-term care home and is accredited through Accreditation Canada.

We collaborate with various stakeholders, including team members, volunteers, students, physicians, and the Public Health and Social Services Committee, to ensure that resident care and services are consistently monitored, analyzed, and evaluated. Our approach aligns with resident preferences, best practices, leading standards, and the Fixing Long-Term Care Act 2021 (FLTCA) requirements, Ontario Regulation 246/22, and Accreditation Canada standards. When opportunities for improvement arise, we work together to develop, implement, and evaluate initiatives to enhance care.

Our Mission

Working together, we provide the highest quality of life for Seniors living in long-term care and in the community.

Our Vision

Exemplary care, Compassionate team, and Community Leader.

Our Values

- Respect
- Serve
- Choice
- Honesty
- Partnership

Legislative Alignment

This report supports the home's annual continuous quality improvement reporting and reflects actions taken to monitor, evaluate, and improve care, services, programs, goods, and accommodation in alignment with the Fixing Long-Term Care Act, 2021 and Ontario Regulation 246/22.

This report was reviewed by the home's leadership and informed by input from the Continuous Quality Improvement Committee, Resident Council, Family Council, and relevant internal oversight committees.

Our Approach to CQI

Niagara Region long-term care homes have a comprehensive quality program that guides our long-term care homes through continuous quality improvement activities.

The Seniors Services Operational plan includes improvement efforts and initiatives across the homes to optimize standardization and decrease variability. We identify the priority areas through in-home committees, audits, reports, resident and family feedback, legislative requirements, and guiding principles.

Our home will monitor progress on strategic priorities to align it with our home needs by focusing on providing the best quality to our residents and embracing our continuous quality improvement philosophy. Prioritizing improvement opportunities is a critical step in translating data into action.

How We Identify Priority Areas for Quality Improvement

Woodlands of Sunset is committed to fostering a collaborative and inclusive environment where the voices of our residents and their families are integral in shaping the care we provide. Woodlands of Sunset actively engages members of the Resident Councils, Family Connection Meetings and in quarterly Professional Advisory and Continuous Quality Improvement (PAC-CQI) Committee meetings. The insights and experiences of the Resident councils, Family Connection meetings, and the Quality Committee are invaluable in identifying areas for growth and implementing meaningful, actionable plans that are included for the next fiscal year based on the recommendations of the homes and their quality committees.

During these meetings, the management team provides updates on our quality and safety programs, sharing any activities that need discussion and input. We review various topics, including program performance, feedback from residents and families, important incidents, complaints, infection control, and other key focus areas. This collaborative approach ensures that we consistently work towards enhancing the quality of care we provide.

Quality Improvement Plans (QIPs)

Each year, Woodlands creates Quality Improvement Plans that correspond with provincial system priorities. The plan for 2026-2027 emphasizes Health Quality Ontario's systemic challenges: Access and Flow, Equity, Safety, and Experience. These priorities align with our organization's goal of enhancing care and improving service quality. The objectives and suggested changes from this plan will often continue as multi-year initiatives, while Woodlands works to sustain advancements in effective care, service delivery, and resident experience. Our team will follow the PDSA cycle (Plan, Do, Study, Act).

Identify/Diagnose the Problem

All identified problems that need attention are analyzed using the root cause framework.

- The Woodlands team will document the problem and identify opportunities for improvement.
- The Woodlands team will gather data to better understand the problem.
- The Woodlands team will review the problem statement and team composition needs.

- The Woodlands team will analyze the problem and data available using QI methodologies to identify opportunities for improvement.

Create a Plan

- Once teams understand underlining causes and align any resident needs, they would define an action plan in collaboration with residents and families.
- The team will be exploring and evaluating those opportunities.
- Woodlands of Sunset will identify how they plan to achieve desired results and document them under the PCC insights and Resident and Family/Caregiver Survey Action Plan and other Project planning tools available.
- The plan should include: (1) Where we are, (2) Where we want to be, (3) How we will do it and who (specific team members are identified to support the improvement activity).
- The team will determine if training is needed and include it as a task.

Set Improvement Aims

The aims set in our plan are developed using an interdisciplinary approach and feedback from family and residents. Data supporting the objective will be collected and used for analysis and benchmarking. Examples of data include scorecards, dashboards, and other facility reports such as employee and resident satisfaction results. Reports available from outside resources, including but not limited to Health Quality Ontario, CIHI, Nquire, and RNAO, are used to set clear paths for improvement. We use the SMART framework (Specific, Measurable, Attainable, Relevant, and Time-Bound) to set goals that will align with the desired improvement target and will help to focus on continuous improvement.

Test Improvement Ideas

Our quality improvement plan relies on teamwork among all staff to analyze problems and propose and implement resolutions. Ideas or interventions are established and monitored for the duration of the plan. The analysis identifies the effectiveness of the improvement activity and if any other approach should be considered.

The improvement indicator or activity progress is documented in the Point Click Care (PCC) Insights, Project planner, and Resident and Family/Caregiver Survey Action Plan, and meeting minutes are recorded immediately after each quality meeting.

Implement, Spread and Sustain

Implementation plans are reviewed and evaluated routinely and as often as needed. The interventions are tested and assessed to ensure that any practice changes are appropriately embedded into our workflow and that staff are aware of the changes. At

the end of the testing period, the team will evaluate if interventions or change ideas resulted in improvement. The team will present any opportunities that could result in standardized practices across our long-term care homes to the quality steering committee. The Quality Steering Committee will discuss sustainability and consistency approaches and support the long-term care homes with the resources needed to implement any adaptations.

How We Monitor Improvement and Identify & Communicate Outcomes

Monitoring & Measurement

Woodlands advances quality initiatives by leveraging our Continuous Quality Improvement Advisor to support and guide project planning, measurement strategies and accountability. Our quality and risk management program processes include monitoring and evaluating

- Performance indicators at the home and program level
- Priority indicators outlined in the annual quality improvement plans
- Professional and CQI committee
- Core programs meetings
- Municipal benchmarking and Resident and Family/Caregiver Experience survey results
- System-wide indicators

An Interdisciplinary team reviews metrics on PCC and other sources, and monitors progress in line with the core programs by proactively reviewing real-time data and progress across indicators. This allows the team to communicate effectively and adjust strategies to align with any issues identified.

Outcomes

Outcomes are conveyed through a range of resident and family council committees, in addition to PAC and quality committees within the divisional frameworks. The primary outcomes can be divided into the following categories:

- Resident Well-being Outcomes: includes metrics such as decreased hospitalizations and reduced medication errors.
- Resident and Family Engagement Outcomes: align with the goals specified in the Resident and Family Action Plan and involve improvements in care, services and programs.

- Core and Risk Management Outcomes: emphasizes the management and oversight of our clinical indicators, particularly targeting a reduction among different indicators falls, injuries, and pressure injuries.
- System and Organizational Outcomes: outcomes in accreditation and compliance, along with the encouragement of innovation in technologies and processes.

Communication

Strategies are developed following the senior's communication plan but are not limited to home-specific needs and preferences. Updates to the quality improvement plan are shared through several means, including:

- Postings on the quality board
- Computerized information blast emails using the Cliniconex app.
- Direct e-mails to staff and families
- Newsletters
- Website
- Informal presentations/huddles
- Presentations at staff meetings
- Presentation at Professional Advisory and Quality Committees
- Presentations at Residents' Council meetings
- Presentations at Family Connection meetings (on request)
- Presentations at Public Health and Social Services Committee
- Quarterly reports at the Quality Steering Committee

Quality Improvement Priorities and Progress

Niagara Region Overview

In 2025, Niagara Region advanced initiatives that strengthen innovation, relationships, and well-being across our homes. Guided by the Vibrant – Live Your Best Model of Care, Niagara Region continues to foster safe, inclusive, and supportive environments where residents, families, staff, and visitors feel valued and connected. This model of care brings together our strategic initiatives to support person-centered care, meaningful relationships, and quality of life.

Several initiatives have been implemented to support the Vibrant – Live Your Best approach. This include the PAWsitivity Program, which enhances residents' quality of

life through meaningful interactions with animals. To strengthen engagement, Seniors Services implemented Policy AD02-007 – On-Site Leadership Presence, supporting the Leading with HEART philosophy. This initiative fosters authentic connections between leaders and team members, enhancing morale, communication, and trust through regular HEART Walks—visible leadership rounds focused on recognition and meaningful dialogue.

Resident Satisfaction and Engagement

Residents, family members, and caregivers were invited to participate in the annual Experience Survey. Volunteers, students, recreation staff, support workers, and family members were available to assist residents who wished to share their experiences. The survey included eleven questions rated on a five-point scale. Responses were scored from 1 to 5 and averaged to summarize results for each home.

Three additional reportable questions were included, using a ten-point scale and a six-point scale, respectively. Open-text questions also allowed residents and families to provide further comments and insights.

The Work Routine Project officially launched in the Nursing Department of Woodlands of Sunset in September 2025. A key milestone was the standardization of nursing start and stop times to promote coordination and stronger communication by ensuring that registered staff and personal support workers (PSWs) begin and end their shifts consistently across all units and homes. Standardizing routines allows staff to find more meaningful time to spend with residents, strengthening therapeutic relationships and reinforcing our commitment to person-centered care.

By reducing inconsistencies and operational inefficiencies, the project enables caregivers to focus on what matters most connecting with residents and enhancing quality of life.

Diversity, Equity, and Inclusion

In 2025, Niagara Region implemented a Facilitation of Smudging and Indigenous Ceremonies Policy, supporting the practice of smudging, an Indigenous healing ceremony and providing guidance to ensure culturally respectful practices are available for Indigenous residents, staff, and visitors in our long-term care homes.

Hospital Transfer Reduction

In collaboration with LifeLabs, Point of Care Testing (POcT) was introduced to the home in 2025 to increase timely access to medical testing to improve resident care and health outcomes. The LIAT ROCHE - gives PCR results for COVID, RSV and FLU A&B, allowing the ability to initiate prompt antiviral treatment, if indicated. The iStat device runs the Chem 8 panel - (sodium, potassium, chloride, ionized calcium, total CO (2),

glucose, blood urea nitrogen (BUN) and creatinine), BNP and Troponin tests, while the CLINITEK completes Urinalysis in about 1 minute.

Woodlands Resident and Family/Caregiver Experience 2025 Survey Results & Associated 2026 Action Plan

Woodlands of Sunset made significant progress during 2025-2026 across key areas, particularly in enhancing the dining experience, improving food quality, and strengthening communication with residents and families. Regular Resident Council (RC) and Family Connection meetings throughout 2025 have been instrumental in sharing updates, gathering feedback, and implementing action plans. The 2024-25 Survey Action Plan achievements are noted in Table 2 at the end of this document. These initiatives, supported by quarterly PAC/CQI Committee meetings, reflect a resident-centered approach and a commitment to continuous improvement in care and quality of life. A full action plan is available upon request.

Resident & Family/Caregiver Experience Survey Results 2025

Woodlands of Sunset conducted its annual Resident and Family/Caregiver Experience Survey to gather feedback from residents and their families/caregivers about the services provided. The purpose of the survey is to facilitate improvements and ensure that care meets each resident's needs. In 2025, the survey was available from September 22nd to October 17th, 2025, and we received a total of 101 responses, including 52 from residents and 49 from families.

The Resident and Family/Caregiver Experience Survey results will show a variance between 2024 and 2025 due to a change in methodology. The 2024 survey used a 100-point rating scale, while the 2025 survey used a five-point Likert scale. Because these scales measure responses differently, year-over-year comparisons should be interpreted with caution and should not be treated as a direct, like-for-like change in performance or satisfaction at this time. Baseline data is being collected.

The feedback we receive is invaluable as it helps us identify our strengths and areas for improvement, while also reinforcing our commitment to enhancing the quality of life in our homes. Overall care was 4.25 out of 5, Services 4.08 out of 5, Programs 4.07 out of 5, and Products 4.07 out of 5, with 92.50% of families and 90.20% of residents rate this home as either Excellent or Good. The following are the results compiled for the family/caregiver and resident surveys. Please see survey results appendix A.

Three areas were identified as opportunities for improvement: staff listening, enjoyable mealtimes, and enjoyment of programs. On January 7, 2026, the survey results were shared with the residents' council. Survey results were shared at the Professional Advisory and Quality Improvement Committee (PAC) on January 22, 2026. Printed

copies of the results were also made available at the main entrance and posted on the Quality Board.

Resident and Family/Caregiver Survey Action Plan from the 2025 Survey

Residents engaged in action planning on February 4, 2026, at residents' council. Families were provided with survey results and engaged in action planning at the quarterly family connection meeting on February 15, 2026. Families and residents were also encouraged to provide suggestions and engage in action planning through an engagement board located in the front lobby from January 20-February 28, 2026. Following consultation with residents and families, the leadership team further developed the action plan on March 4, 2026. Residents approved the proposed action plan on March 11, 2026. Families were invited to review the proposed action plan and provide any feedback and adjustments they would like to see via email (March 10-March 16, 2026). The proposed action plan was shared on an engagement board from March 13-25, 2026, offering an additional opportunity for families/residents to provide feedback.

To address the areas with low satisfaction ratings from our 2025 survey, we have identified the following actions for improvement, to be completed in 2026:

1. **Feeling Heard:** Our aim is to receive a 52% or higher rating in this category (our current rating is 45.10%) in our next annual survey for 2026. We will achieve this goal by providing staff with education on different forms of communication and diseases seen in the home. A residential-led social group will commence, and we will enhance staff understanding of reporting channels through case studies at staff meetings.
2. **Enjoyable Mealtimes:** We aim to receive a 4 out of 5 or higher on our next annual survey (our current rating is 3.81 out of 5) for this category. We will achieve this goal by creating reference photos for kitchen staff to ensure enhanced plating of food, review 100% of menus to ensure balanced flavours/meals beyond Sysco recommendations, advertising special meals in the dining room, providing staff education on mealtime service, and lastly reviewing staff feedback logs weekly to proactively address concerns staff notice, ahead of resident meals.
3. **Enjoyable Programs:** Our aim is to maintain or increase our annual survey rating in this area (our current rating is 4.19 out of 5). We will achieve this goal by enhancing bus outings, implementing purposeful programs for residents at risk of social isolation, and creating 5 new programs based on unit-to-unit interests.

The Resident and Family Council and the Professional Advisory and Quality Committee receive the current report and are regularly informed of

progress regarding the action items during their meetings. Members can raise questions, provide input, and request changes as needed. An updated report and meeting minutes are posted in the Home, with copies available upon request.

The action plan will be reviewed and revised every quarter in collaboration with the residents and family council and the Quality Committee (refer to Appendix A). A comprehensive action plan is available in the home.

Other Quality, Service, and Operational Improvements at Woodlands for 2025

The 2025 HQO QIP & survey action plan outcomes can be found in table 2. Woodlands of Sunset also prioritized some other improvement initiatives that were not listed in our 2025 QIP or survey action plan in 2024. These initiatives are as follows:

1. **Improved Lighting:** New lighting was installed in the hallways and resident rooms across all four units of the home (Apr.12, 2025). External lighting in the parking lot was added.
2. **Wayfinding Letters:** As part of our “dementia friendly” home improvement projects, new wayfinding letters were added for all four units, as well as the front office and café (Oct.23, 2025).
3. **Café Improvements:** A new BUNN coffee machine and cookie oven was added to the café (initiated Apr.2, 2025). A new awning was installed, and the area was painted for a fresh new look (May 19, 2025).
4. **New Furniture & Decor:** The front area was enhanced with new furniture, décor and plants to create a cozy, home-like environment for everyone in the home (initiated Jan.8, 2025). On-unit hallways were also repainted and refreshed with new décor (initiated May 7, 2025).
5. **Carpet Removal:** Carpet removal continued to progress across the home in 2025, with full removal completed in early 2026 across all home areas.
6. **Outdoor Enhancements:** Outdoor patios were cleaned and landscaped (May 7, 2025). The gazebo was replaced (July 10, 2025), a new bench for the Pine’s courtyard was purchased, and the tree out front was removed (June 4, 2025), to be replaced in spring of 2026.
7. **New Vending Machine:** The vending machine was swapped from a debit/credit only machine to one that accepts cash, allowing for more residents, families and staff to purchase goods (Apr.30, 2025).
8. **Regional “Glow-Up” Contest:** The home participated in a regional LTC “glow-up contest” for Christmas involving decorations and engagement activities. Woodlands

also participated in the Welland Winter Lights contest and received third place (Dec.3, 2025).

9. **Reader's Choice Award:** The home received first place for the Welland Readers' Choice Award for "Best Nursing Homes/Long-term Care Centre" for 2025 (announced Dec. 2025).

Priority Areas 2026 - 2027

In 2026-2027, Woodlands of Sunset is aiming to implement the following initiatives:

Area of Focus	Performance	Change Ideas
Rate of ED visits for the modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	Current: 24.38% Target: 22.00%	- Share a handout on in-home medical resources with residents and families to enhance understanding of families/residents on what can be provided in-home. Provide brochures on core programs and other topics during associated referrals and place on units for quick access. - Create an educational training video and share associated resources for staff on the use of POCT machines, to enhance understanding and bolster in-home diagnostic testing. Ensure 100% of staff trained on POCT review training videos. - Consult frontline staff through feedback forms to determine gaps and opportunities for the use of POCT machines in-home and utilize an ED transfer tracking sheet to determine gaps and prevent unnecessary transfers, with feedback collected by June 30, 2026, and analyzed in Q3. Tracking to occur on an ongoing basis and reviewed quarterly. Additional actions based on feedback to occur in Q3/Q4. - Enhance goals of care conversations and provide at least four education sessions for day and afternoon shifts.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	Current: 100.00% Target: 100.00%	- Run at least one DEI-related activity/event opportunity per month for residents/families/staff. - Implement the RNAO DEI BPG. Utilize the CLRI assessment to determine gaps. - Conduct a policy review for cultural perspectives at EOL by December 31, 2026. - Enhance staff engagement in DEI by providing staff monthly quizzes on relevant DEI topics at daily clinical rounds and trialing a home potluck by the end of Q3. Initiative

Area of Focus	Performance	Change Ideas
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?".	Collecting baseline	- Collaborate with PRC to deliver 12 education sessions across the year to enhance staff knowledge on various topics. - Provide at least 4 GPA sessions to frontline staff. - Trial a resident-led social group to enhance the resident community in-home, driving greater connections between residents. - Enhance understanding of concern reporting channels by adding case studies as a standing agenda at staff meetings and sharing via council and newsletter at least four times a year.
Percentage of residents responded positively to the statement: "I can express my opinion without fear of consequences".	Collecting baseline	- Create a "roles of the home" pamphlet for families, residents and staff to enhance understanding of who to come to for concerns. - Utilize unit tv screens to share information about the resident's bill of rights to increase understanding. Quiz staff at daily clinical rounds on bill of rights quarterly and share video at council meetings quarterly. - Provide partners in care (PIC) training to residents/families/staff. - Trial a leadership and resident "meet & greet" at least twice in the year.
Percentage of long-term care residents in daily physical restraints.	Current: 0.00% Target: 0.00%	Continue to conduct family discussions with new admissions on the risks of restraint use in LTC. Ensure admission nurses discuss restraint use in LTC.
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened.	Current: 6.64% Target: 4.59%	- Provide an external educational opportunity for at least two staff members to support early detection of pressure wounds by December 31, 2026. - Deliver at least two education sessions on skin & wound best practices to strengthen staff knowledge and application by December 31, 2026.

Area of Focus	Performance	Change Ideas
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Current: 17.13% Target: 15.95%	• Deliver at least two education sessions on falls prevention best practices to strengthen staff knowledge and application by Q3. • Digitalize falls related audits to enhance process for timely follow-up of potential gaps in practice. • Evaluate the current use of the post-fall huddle tool and consult frontline staff on improvements to support consistent use and sustainability. Provide education based on changes or needs to reinforce efforts on the audit. • Implement the PREVENT falls prevention project to support the reduction of hip fractures.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	Current: 9.38% Target: 8.00%	• Provide nursing leadership education on risks/benefits of antipsychotic use and reduction approaches, at least twice in the year of 2026; ensure one education is delivered by June 30, 2026, 2026, and an additional education is offered by December 31, 2026. Provide staff education on non-pharmacological and pharmacological strategies utilizing NP and RBTA expertise to enhance trust. • Register at least one physician in home for the “MyPractice” report to enhance insight into prescribing patterns as it relates to antipsychotics. • Run bi-monthly committee; select 1–2 eligible residents per meeting for deprescribing review and planning (as appropriate) for the calendar year of 2026 and implement a new TOR by June 30, 2026. • Provide purposeful programming to support enhanced engagement of residents, offering a non-pharmacological alternative to antipsychotic use.

Quality Improvement Accomplishments (reflections since last report)

Table 2: Results of 2025/2026 Health Quality Ontario (HQO) QIP & 2024-25 Survey Action Plan

Residents, families, and staff are invited to review the full progress report for Health Quality Ontario projects, located in-home at the Quality Board and upon request from the Administrator or Continuous Quality Improvement Advisor.

*CB=Collecting Baseline

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Rate of ED visits for the modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	Target: 18.70% Actual: 24.38%	- Enhance family knowledge on different services provided by Long Term Care to minimize ED visits. - Enhance staff's knowledge and skills in completing physical assessments through staff education. - Optimize the Goals of Care conversation by utilizing Nurse Practitioners and Physicians when there is a significant health decline. - Early Identification of residents exhibiting signs of delirium or potential treatable infections.	- Monthly newsletters were implemented May, September, and December 2025. - Education occurred through August and October 2025. - Initiated May 5, 2025. - Initiated Jan. 1, 2025.	- Our team successfully implemented all four change ideas in 2025, which has strengthened staff, resident and family education on ED transfer process and available, in-home resources. These efforts help to alleviate health system pressures and limit unnecessary transfers, prioritizing resident experience and comfort. - We had a rate 5.68% above our target; this is influenced by increased resident acuity, resident choice in transfer, and the Outreach Nurse role being implemented later in the year.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism education.	Target: 100% Actual: 100%	• To provide deeper awareness of different cultures, traditions and values of people from different countries. • To increase residents' and staff's awareness with respect to 2SLGBTQ+ community. • To enhance staff's knowledge of DEI through education and training using different channels. • Enhance staff's knowledge on diversity equity, inclusion and anti-racism topics.	• Key activities occurred Mar. 17; May 5; July 15; Aug. 20; Sept. 20; Sept.27; Oct.20, 2025. • Activities occurred May 5; May 30; June 9; June 11; June 12; June 16,17,18, 19, 20, 2025. • Annual PD completed Mar. 31. Staff/resident education July 28, 2025. Activities Sept.29, 2025. • Speaker event Oct. 27, 2025.	• In 2025, we sustained a strong approach to DEI in the home by encouraging staff, residents, and families to participate in events, activities, and education throughout the year. • We were able to meet our target measure, noting that education on DEI is embedded in our annual PD.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	CB Most recent consecutive 12-month period survey in-house data,	- Enhance staff's knowledge of different diseases that can affect how residents communicate. - To create a resident spotlight that promotes meaningful conversations. - Implement and communicate tips and tricks for residents who require more support with respect to communication and understanding. - Engage residents in projects that are being implemented in the home.	- Jan. 16; Feb.27; Mar. 27; Apr.17; May 22; June 19; June 26; July 25; Aug. 21; Oct.15; Oct.23; Nov.20, 2025. - Project abandoned; Aug. 20, 2025. - Initiated Jan. 1, 2025. - Jan. 8; Feb. 5; Mar. 5; Mar.17; Apr.2; Apr. 15; May 19; May 7; June 4; June 7; June 26; July 2; July 10; Aug. 1; Oct. 8; Oct. 23, 2025.	- We completed three out of four projects in this priority area. We spotlight resident voice through a person-centred care approach and ongoing collaboration with the Residents' Council. We utilized the expertise of our external partners at Hospice Niagara to deliver education and support communication between residents and staff. - Note changes to our survey this year resulted in collection of baseline and more accurate comparisons for 2026-27.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of residents responded positively to the statement: "I can express my opinion without fear of consequences"	CB	- Addressing residents' concerns within 24hrs when possible. - Enhancing Awareness of Management Roles and Concern-Reporting Channels. - Enhancing Resident Awareness of Concern and Complaint Reporting. - Providing Quarterly Updates on Resident Action Plan Progress.	- Food Committee Apr. 2, May 7, 2025. Heart walks policy shared Aug.25 and implemented Sept. 2, 2025. - Management display abandoned. Physician display May 7, 2025. - SW attended resident council Apr. 2 & Oct.8, 2025. Admin reviewed at resident council June 4, 2025. - Shared at residents' council Feb. 5; Apr. 2; May 7; Oct.8, 2025. Shared at family meeting Apr.15 & Oct. 14, 2025. Newsletters shared in January, February, March, September 2025.	- We fully completed three projects and partially completed the remaining fourth project. These efforts enabled us to improve awareness of reporting channels, provide timely follow-up, and transparent action-plan updates. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison for 2026-27.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: 16.00% Actual: 17.13%	• Conducting a Comprehensive Audit to Identify and Analyze Fall Trends Among Residents. • Raise awareness of falls and educate residents and families on fall prevention strategies. • Increase resident and family's awareness of Environmental considerations with respect to fall prevention. • Engaging the Recreation Department in Fall Prevention Through Unit-Based Physical Programs.	• Interdisciplinary review: Feb.13; Mar. 6; Apr.10; May 12; June 13; July 18; Aug. 14; Sept. 11; Oct.15, Nov.10 & Dec. 12, 2025. • Audit implemented: July 2, 2025. Education: July 2; July 9-Sept. 30, 2025. • Newsletters shared April, June, November 20 25. • Project abandoned July 7, 2025. • Project initiated January 1, 2025.	• We completed three out of four projects in this priority area. Our greatest strength lies in our collaborative, interdisciplinary approach in reducing falls. We remain committed to making our home safer by exploring innovative solutions and preventative measures that reduce falls and associated injuries. • We had a rate of 1.13% higher than our goal; this is influenced by residents experiencing frequent falls, which contributed disproportionately to the overall rate.

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 4.00% Actual: 9.38%	- Enhance staff's knowledge on the utilization of non-pharmaceutical strategies through specific education. - Ongoing education on how to properly identify hallucinations and delusions to personal support workers. - To identify residents who are on antipsychotics and monitor for opportunities to decrease medications. - Establish a formal titration process within 3 months.	- Education occurred monthly throughout the year from January-November. For more information see education logs. - Education Apr.15; Apr. 16; Apr.24; Oct. 15, 2025. - Initiated June 20, 2025. - Initiated Oct.1, 2025.	- Our team has strengthened our interdisciplinary approach by establishing a dedicated committee to support the ongoing monitoring and review of resident medications, leveraging non-pharmacological and pharmacological interventions as appropriate. We continue to utilize internal and external resources to reinforce best practices. - We had a rate of 5.38% higher than our goal; this is related to current incomplete titrations, new residents with in-community prescriptions, and later initiations in projects for the year 2025.

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
Survey: Food & Snack Quality	Previous score: 83.9% 2025 score (recategorized as enjoyable mealtime): 3.91 / 5	- By November 30, 2025, implement a new supplier system for meals, launch a revised menu, and introduce a new digital platform that allows Cooks and FSWs to easily access recipes and menus. The system will also provide residents and families with the ability to view both general and personalized menus. - Chair Food Committee meetings every month for the next 12 months, ensuring that all meetings are scheduled in advance. - Address all requests for changes related to food service within 48 hours of receipt and one provide a status update or resolution at the following Food Committee meeting.	- Launched Sept. 29, 2025. - Committees occurred monthly January-December. For more information see food council minutes. - Initiated March 31, 2025.	- Operational and technological advancements helped to support more individualized food options. Timely follow-up of feedback also supported a better resident dining experience. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison for 2026-27.

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
Survey: Physician Services	Previous 73.0% 2025 score (recategorized as quality of care): 4.33 / 5	- By May 1, 2025, explain the role of physicians in the long-term care (LTC) home at the next Resident Council meeting. - At the initial post admissions/Care conferences explain role of Physicians and NPs to family/resident. - Have pictures of Attending physicians posted so residents can associate the photos the physicians that are in their care team.	- Reviewed at residents' council Apr. 2, 2025. - Initiated Apr. 1, 2025. - Completed May 7, 2025.	- Improved visibility and understanding of physician services helped residents and families feel more informed about who is involved in care and how medical support is provided within the home. This contributed to clearer communication, greater familiarity and trust, and increased confidence in participating in care discussions and decision-making. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison for 2026-27.
Survey: Resident & Family Support	Previous: 86.5% 2025 score (recategorized as emotional and social support): 4.11 / 5	- RFSW will attend Resident Council 2x per year and share her role, emphasizing that RFSW is the same as Social Worker. - RFSW will set up an initial visit with all new admissions and provide them with a business card, and share what the RFSW/ Social Worker does. - Develop a poster that describes the RFSW/ Social Worker Role and includes hours of work.	- RFSW attended residents' council Apr. 2 & Oct. 8, 2025. - Initiated May 7, 2025. - Posted and shared at the residents' council on Apr. 2, 2025.	- Resident and family support was strengthened through targeted actions led by our social worker. - Our home enhanced understanding of social work services in the home contributing to enhanced communication, increased access to support, and a more informed and responsive experience for residents and families. - Note changes to our survey this year resulted in the collection of baseline and a more accurate comparison for 2026-27.

Appendix A: Woodlands of Sunset Satisfaction Survey Results 2025

Question Category	Question Short	Resident	Family	Combined
Care	Quality of care provided by the care team	4.27	4.40	4.33
Care	How your choices and preferences are respected in your care	4.16	4.24	4.20
Care	Support provided for your activities of daily living and routines	4.17	4.11	4.14
Care	How safe you feel living in this home	4.33	4.38	4.35
Services	How enjoyable mealtimes are	3.73	3.91	3.81
Services	Cleanliness and maintenance of the home	4.29	4.37	4.33
Services	Emotional and social support provided	3.94	4.30	4.11
Programs	How well the activities and programs match what you enjoy	4.15	4.24	4.19
Programs	How accessible programs and activities are for you	4.11	4.23	4.16
Programs	Experience with the rehabilitation and physiotherapy services	3.83	3.91	3.86
Goods	Comfort and quality of the continence products provided	4.00	4.16	4.07
Reportable	Do residents feel they can speak up without fear of consequences?	N/A	N/A.	76.47%
Reportable	Do residents feel they have a voice and are listened to by staff?	N/A	N/A	45.10%
Overall	What is your overall rating of the home as a place to live?	90.20%	92.50%	91.21%