



Grove Park Home 2025 Annual Programs Report



Commitment to care

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Incident reporting Program Summary – 2025

Critical Incidents and Complaints Review

Overview

In 2025, a total of **26 Critical Incidents (CIs)** were reported. **No written complaints** were received throughout the year, indicating positive family and resident satisfaction and effective issue resolution at the point of care.

The reported CIs primarily related to **falls with injury, infectious disease outbreaks, and system or process-related events**, with isolated incidents involving **reportable matters, environmental hazards, and medication handling**.

Key Trends Identified

1. Falls With Injury

- Falls with injury were the **most frequent type of CI** throughout the year.
- Injuries ranged from **lacerations** to **fractures** (hip, knee, shoulder, arm, wrist).
- Most residents returned to baseline or stabilized following hospital treatment.
- Fall prevention interventions were consistently reviewed and implemented following each incident.

Trend:

Falls occurred across multiple months and units, often unwitnessed, indicating an ongoing risk despite prevention measures.

2. Infectious Disease Outbreaks

- Multiple outbreaks were reported, including:
 - **COVID-19**

Trend:

Respiratory outbreaks occurred throughout the year, particularly in winter and spring months, reflecting seasonal vulnerability in congregate living settings.

3. Reportable Matters

- ▢ Incidents included:
 - Verbal abuse (staff to resident)
 - Resident-to-resident physical and sexual abuse
 - Misuse of resident money (external financial exploitation)
- ▢ All matters were reported, investigated, and addressed according to policy.
- ▢ Education and follow-up were completed where applicable.

Trend:

These incidents were infrequent but high-risk, requiring prompt reporting, staff education, and monitoring.

4. System and Environmental Issues

- ▢ **Failure of major system:** Call bell system disruption on Aspen unit.
- ▢ **Loss of essential services:** Power outage due to storm (generator functional but no heat).
- ▢ **Environmental hazard:** Chemical odor reported on Aspen unit.

Trend:

System and environmental incidents were isolated but highlighted the importance of emergency preparedness and infrastructure monitoring.

5. Medication Management

Trend:

Medication-related incidents were rare, suggesting overall strong medication management practices, with opportunity for reinforcement of counting procedures.

Gaps Identified**1. Falls Prevention**

- Continued occurrence of unwitnessed falls with injury suggests a need for enhanced individualized risk assessment and monitoring.

2. Outbreak Prevention

- Recurrent respiratory outbreaks indicate opportunities to strengthen infection prevention strategies, particularly during high-risk seasons.

3. Staff Education and Awareness

- Isolated incidents related to abuse, medication handling, and system errors highlight the need for ongoing education and competency reinforcement.

4. Emergency Preparedness

- Power and system disruptions revealed vulnerabilities in maintaining full essential services during emergencies.

Goals for Improvement (2026 and Beyond)**1. Reduce Falls With Injury**

- Falls huddle with units when see trends on the unit
- Increase use of targeted interventions for residents with repeated falls.
- Reinforce staff education on post-fall reviews and proactive prevention strategies.
- Continue with falls committee meetings and discussing high risks falls and review

- Review outbreak response timelines for continuous improvement.

3. **Improve Staff Training and Accountability**

- Ongoing education on abuse prevention, medication handling, and reporting requirements.
- Reinforce respectful workplace and resident-centered care practices.

4. **Enhance Emergency and System Preparedness**

- Review and test contingency plans for power outages and system failures.
- Ensure timely communication and escalation during infrastructure disruptions.

5. **Maintain Zero Written Complaints**

- Continue proactive communication with residents and families.
- Address concerns promptly to prevent escalation to formal complaints.

Conclusion

The 2025 program evaluation demonstrates effective reporting, follow-up, and resolution of critical incidents, with **zero written complaints** reflecting strong engagement and trust. Continued focus on fall prevention, outbreak management, staff education, and emergency preparedness will support ongoing quality improvement and resident safety.

Grove Park Home

Program Evaluation – Incident Reporting Program

(2025)

Program: Incident Reporting

Date of Review: __Jan 28/2026

Policy / Standard Reference

Long-Term Care Homes Act (LTCHA) and Regulations

Mandatory and Critical Incident Reporting Requirements

Abuse and Neglect Policy

Infection Prevention and Control Program

Medication Management Policy

Emergency Preparedness and Response Plan

Indicators / Methods Used to Monitor Program

Critical Incident (CI) reports

Complaints tracking log

RAI-MDS indicators (falls with injury)

Infection Prevention and Control outbreak reports

Participants and Positions

Shaz Mahdavi Director of Care

Goals of the Program From Previous Year

Goal | Date Achieved | Status

Timely reporting and investigation of all Critical Incidents | Ongoing | Achieved

Maintain zero written complaints | 2025 | Achieved

Improve follow-up and education post-incident | Ongoing | Achieved

Evaluation

1. Program Outcomes

Based on established program goals, analysis of Critical Incident data, RAI-MDS indicators, and Quality Improvement performance indicators, resident outcomes related to the Incident Reporting Program have:

Improved Not Changed Not Met

Supporting Data

In 2025, a total of 26 Critical Incidents were reported.

Zero written complaints were received throughout the year, indicating effective issue resolution at the point of care.

Incidents primarily related to falls with injury, infectious disease outbreaks, and

Are there new best practices related to this program (e.g., RNAO Best Practice Guidelines)?

Yes No

Trends and Analysis

Falls With Injury

Falls with injury were the most frequently reported Critical Incident. Injuries ranged from lacerations to fractures including hip, knee, shoulder, arm, and wrist. Most residents returned to baseline or stabilized following hospital treatment. Falls occurred across multiple units and months, often unwitnessed, indicating ongoing risk despite prevention measures.

Infectious Disease Outbreaks

Multiple outbreaks occurred throughout the year including COVID-19, Influenza A, and Acute Respiratory Illness. Several units were affected (Willow, Aspen, Maple, Pine, Spruce), impacting both residents and staff. Outbreaks were more prevalent during winter and spring months, reflecting seasonal vulnerability.

Reportable Matters

Isolated incidents included verbal abuse (staff to resident), resident-to-resident physical and sexual abuse, and misuse of resident money by an external party. All matters were reported, investigated, and addressed according to legislation and policy, with education and monitoring completed as required.

System and Environmental Issues

Incidents included a call bell system disruption, a power outage resulting in loss of

One incident involving missing controlled substances was identified as human error during counting. Root cause analysis was completed and staff education provided. Medication-related incidents remained rare, indicating strong overall medication management practices.

Comments Related to Program

The Incident Reporting Program demonstrates effective compliance with legislative requirements and timely follow-up of incidents. The absence of written complaints reflects positive communication and engagement with residents and families. While reporting and follow-up processes are effective, continued attention is required to address fall prevention, outbreak management, staff education, and emergency preparedness.

AIM for Upcoming Year

Change Ideas to be Reflected in the Home's QIP

Planned Improvement Initiative | Methods and Process Measures | Goals for Change Ideas | Comments

Reduce falls with injury | Falls huddles, Falls Committee review, targeted interventions | Decrease falls with injury | Focus on residents with repeated falls

Strengthen IPAC practices | Staff education, PPE audits, outbreak response review | Reduce outbreak frequency and duration | Seasonal focus

Improve staff training and accountability | Ongoing education on abuse prevention, medication handling, reporting | Zero substantiated abuse incidents | Competency reinforcement

Enhance emergency preparedness | Review and test contingency plans |

The 2025 Incident Reporting Program evaluation reflects effective incident reporting, investigation, and follow-up, with zero written complaints indicating strong trust and communication. Continued focus on fall prevention, infection control, staff education, and emergency preparedness will support ongoing quality improvement and resident safety.

Program Evaluation

Program: Medication Management Program – Grove Park Home

Date of Review: January 2026

Policy/Standard Reference:

Fixing Long-Term Care Act, 2021

Ontario Regulation 246/22

Grove Park Home Medication Management Policy

Professional Advisory Committee (PAC) Terms of Reference

Narcotic Control and Audit

Institute for Safe Medication Practices (ISMP) Guidelines

Indicators/Methods Used to Monitor Program

- ▯ Monthly medication incident reports submitted through **pharmacy portal**
- ▯ Monthly narcotic audits
- ▯ Quarterly Professional Advisory Committee (PAC) review
- ▯ Director of Care incident follow-up tracking

- ISMP safety assessments and annual improvement planning
- Monthly “Medication of the Month” education participation (read-and-sign compliance)
- Pharmacy consultation reports and communication logs
- Glucagon utilization tracking
- Quality Improvement Plan (QIP) medication safety indicators

Participants and Positions

Participan
ts

Position

Shaz
Mahdavi

Director of Care

Goals of the Program from Previous Year (2025)

Goal	Date Achieved
Maintain zero transcription errors throughout 2025	Achieved – December 2025
Ensure 100% monthly narcotic audits completed	Achieved – Ongoing
Provide monthly Medication of the Month education to 100% of registered staff	Achieved – Ongoing
Ensure 100% of medication incidents receive DOC follow-up	Achieved – Ongoing
Quarterly review of all medication incidents at PAC	Achieved – Quarterly 2025
Complete ISMP assessment and develop annual improvement plan	Achieved – November 2025

Evaluation

1. Based on established goals of the program, analysis of performance indicators and medication incident data, resident outcomes related to the program have:

- Improved
- Not Changed
- Not Met

Supporting Data:

- Total medication incidents in 2025: 51
- Highest months: February (9), September (9)
- Lowest month: June (0)
- Omissions: 24 (47% of total incidents)
- Dosage errors: 8
- Pharmacy errors: 7
- Wrong resident: 3
- Glucagon use: 4
- Transcription errors: 0

Strengths include sustained zero transcription errors and consistent reporting culture. Omission rates remain the primary contributor, indicating stable but ongoing risk.

2. There are new best practices relating to this program (e.g., Best Practice Guidelines from the RNAO)

Yes

No

Emerging best practices emphasize:

- Interruption-free medication passes
- High-alert medication safeguards
- Barcode verification systems
- Simulation-based education for medication safety

- Integration of ISMP recommendations into workflow and annual improvement planning

Trends and Analysis

The 2025 medication incident total was 51, with fluctuations across the year. February and September were identified as peak-risk months, potentially due to staffing transitions, seasonal acuity increases, or higher workload.

Omissions (24 incidents) were the most frequent category, suggesting workflow inefficiencies, interruptions, or workload pressures.

Wrong resident errors (3 incidents) remain low but represent high-risk events.

Glucagon use between September and November may reflect increased hypoglycemic events or improved escalation and documentation practices.

Pharmacy-related errors were intermittent and require continued collaboration to reduce recurrence.

Monthly narcotic audits showed compliance, with follow-up actions taken for any discrepancies identified.

ISMP assessments were completed annually, with findings reviewed by PAC and incorporated into the QIP and staff education planning.

Comments Related to Program

The Medication Management Program demonstrates strong leadership oversight and a positive safety culture. All incidents are reported through the **pharmacy portal**, reviewed by the Director of Care, and followed up with individualized staff coaching and education.

Barriers identified include:

- ▯ High workload during peak months
- ▯ Interruptions during medication pass
- ▯ Staffing variability

Monthly Medication of the Month education supports ongoing competency development; however, reliance on read-and-sign education may limit knowledge retention.

Zero transcription errors and timely reporting demonstrate strong documentation and order management. ISMP assessments provide structured guidance for identifying and addressing system-level risks.

AIM for Upcoming Year (2026)

To reduce overall medication incidents by 20%, with a specific focus on reducing omissions by 25% by December 2026.

Change Ideas (to be reflected in the Home's QIP)

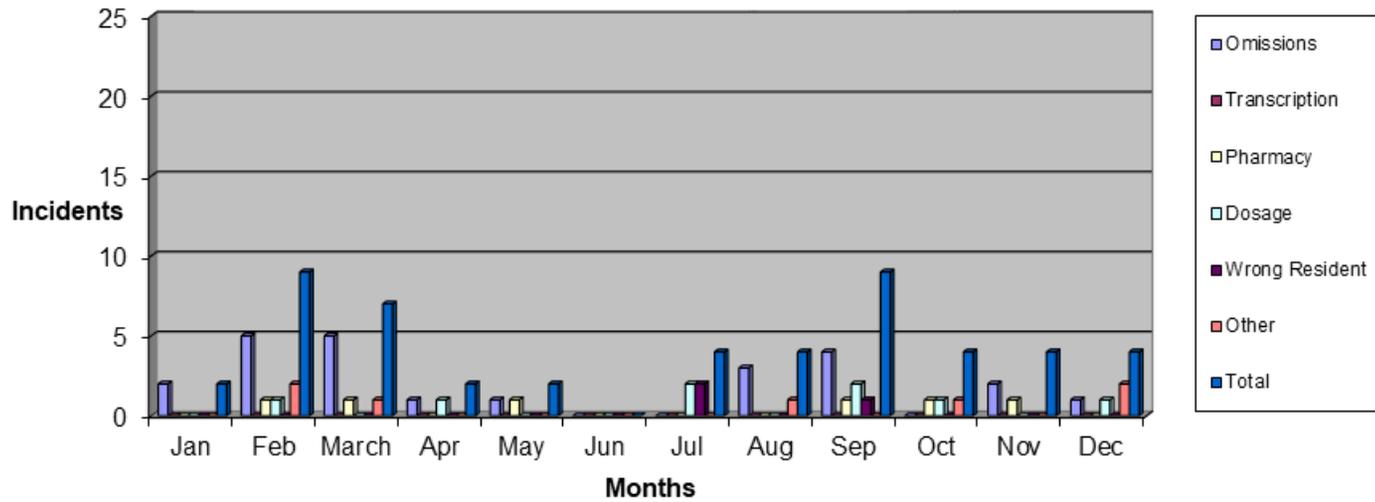
Planned Improvement Initiative (Change Idea)	Methods and Process Measures	Goals for Change Ideas	Comments
Review and update Medication Management education in Surge Learning	Audit completion rates; pre/post knowledge checks	100% registered staff complete updated module by Q3 2026	Align content with 2025 incident trends
Implement in-person pharmacy-led education sessions	Attendance tracking; post-session evaluation surveys	Minimum 2 sessions delivered in 2026; 90% staff attendance	Focus on omissions and high-alert medications
Implement interruption-reduction strategies during medication pass	Spot audits; staff feedback surveys	25% reduction in omissions by Dec 2026	Trial during high-risk months
Enhanced monitoring of omission trends monthly	Monthly dashboard reporting	Monthly omission rate trending downward by Q4 2026	Shared at PAC meetings
Joint review meetings with pharmacy for	Documented meeting minutes;	Reduce pharmacy-related	Strengthen system-level

recurring pharmacy-related incidents	action tracking	incidents by 20%	collaboration
Annual ISMP assessment and improvement plan	Review ISMP findings; track implemented recommendations	All identified system risks addressed by Q4 2026	Integrate into QIP and staff education

Note:

A complete program evaluation includes review of all related policies, procedures, audit tools, education materials, and documentation forms. Any changes implemented in 2026 will be reflected in the Medication Management Policy, education modules, audit tools, and QIP documentation.

Medication Incident Report 2025



	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Omissions	2	5	5	1	1	0	0	3	4	0	2	1	
Transcription	0	0	0	0	0	0	0	0	0	0	0	0	
Pharmacy	0	1	1	0	1	0	0	0	1	1	1	0	
Dosage	0	1	0	1	0	0	2	0	2	1	0	1	
Wrong Resident	0	0	0	0	0	0	2	0	1	0	0	0	
Glucagon used		0	0	0	0	0	0	0	1	1	1	0	
Other	0	2	1	0	0	0	0	1	0	1	0	2	
Total	2	9	7	2	2	0	4	4	9	4	4	4	51

Program Evaluation Template

Program: Falls Prevention

Date of Review: February 2026

Policy/Standard Reference : Falls Prevention Program – Policy # NUR-05-11

Indicators/Methods Used to Monitor Program:

- o CIHI Reports
- o number of falls /residents who fell / severity of falls / injury post fall
- o Staff documentation / education

Participants and Positions:

Participants and Position		
Cole Clark Clinical Nursing Coordinator	Brandan Horner - RN	Mary Ellen Miller – Nurse Practitioner
Shaz Mahdavi - Director of Care	Camille Sposito - PTA	Mitchell Hartman - Physiotherapist
Sara Pearson - ADOC	Edward Larsen – Support Lead	Candice Godin – Restorative care

Goals of the Program from Previous Year:

Goal	Date Achieved
Review and update policy	Policy reviewed in 2025
Decrease in falls rates	Falls rates stable throughout the year
Ensure accuracy of Care Plans	Care plans are updated quarterly and as

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved Not Changed Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports).

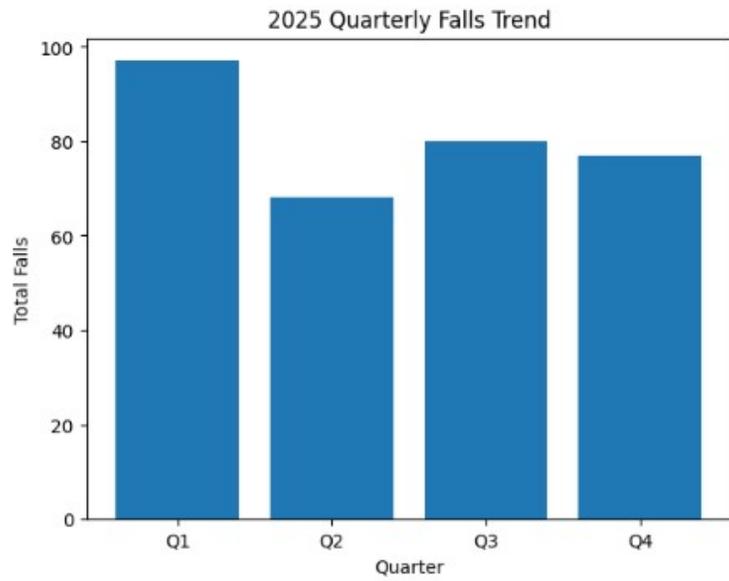
2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO): No

Trend analysis:

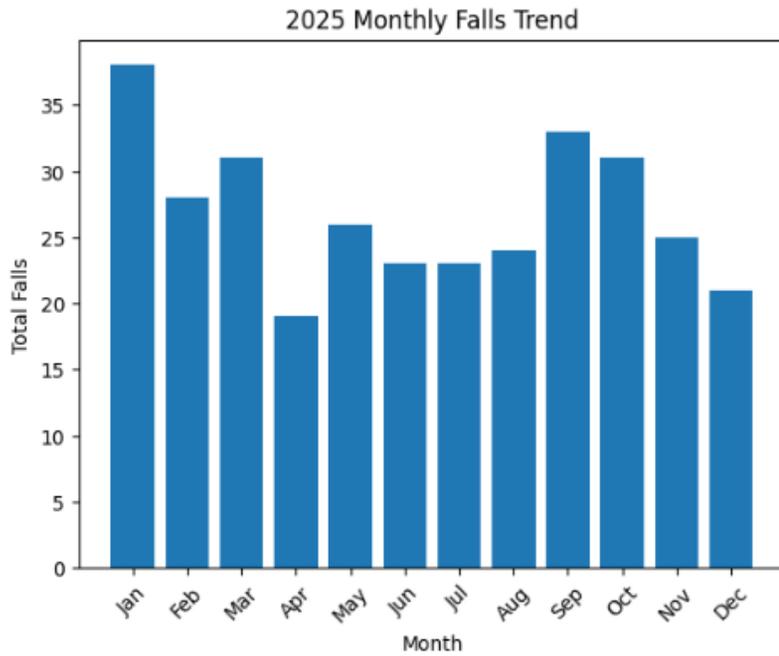
The 2025 monthly falls data demonstrates a fluctuating pattern in fall incidence throughout the year. The year began at its highest point in January (38 falls), coinciding with the highest resident population, followed by a notable reduction in February (28 falls). March increased slightly to 31 falls, indicating early instability in maintaining improvement. A significant drop occurred in April (19 falls), representing the lowest month of the year and approximately a 50% reduction compared to January, suggesting effective short-term stabilization during early Q2.

This improvement was not sustained. Falls increased again in May (26) and then remained relatively stable through June (23), July (23), and August (24), creating a mid-year plateau slightly below the annual monthly average of 26.8 falls. A pronounced spike occurred in September (33 falls), representing the second highest month of the year and indicating a resurgence of fall risk. October remained elevated (31 falls) before trending downward in November (25) and December (21), allowing the year to close below the annual average.

In total, the home experienced 322 falls in 2025, with an overall monthly average of 26.8 falls.



Quarterly Totals: Q1 = 97 | Q2 = 68 | Q3 = 80 | Q4 = 77
Total Falls for 2025: 322



AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Implement new falls interventions focused on harm reduction	Post-fall reviews and documentation monitored for injury severity. Implementation of new safety devices including alarms and furniture bumper pads.	Reduce severity of injuries related to falls.	New alarm devices and furniture bumper pads ordered at the start of 2026
Review and optimize use of alarm systems in the home	Monitor documentation for alarms not sounding or technical failures. Adjust placement of alarm devices closer to resident rooms and reassess workflow	Improve reliability and response to alarm systems.	New direction for alarm placement initiated in 2026.
Continue monthly falls reviews and interdisciplinary falls meetings	Track meeting minutes and attendance. Review falls data monthly and identify high-risk residents for targeted interventions.	Increase staff engagement and strengthen interdisciplinary review of falls incidents.	Ongoing initiative.
Purposeful rounding	Provide staff education on purposeful rounding practices and documentation.	Reduce unmet resident needs that may contribute to falls.	Education and reinforcement ongoing.

Program Evaluation

Program: Infection Prevention and Control

Date of Review: 2025

Policy/Standard Reference: IPAC P&P, FLTCA 2021.

Indicators/Methods Used to Monitor Program:

- IPAC audits including hand hygiene, donning and doffing PPE, and self-assessment audit tool.
 - Audits are completed on a monthly basis routinely then completed weekly when in outbreak.
- Symptom surveillance is completed by registered staff
 - Process was changed to an electronic version that is on sharepoint
 - Template taken from IPAC Canada
 - Able to review at any time
- Infection rates and spread through facility.
 - Outbreak report from SMDHU once outbreak has been declared over and they have reviewed outbreak outcomes.
- Vaccination rates- collected by IPAC Lead and reported to SMDHU and MOHLTC.
- Review of lab results, and antibiotic treatment
- Daily documentation review – helps identify changes in the moment.

Participants and Positions:

Participants and Position		
Sara Pearson	ADOC/IPAC Lead	January – December 2025

Goals of the Program from Previous Year: 2025

Goal	Date Achieved
Increase compliance of influenza rates of staff and residents.	Ongoing
Improve staff knowledge and compliance in placing resident on isolation.	Ongoing
Residents to be up to date on recommended vaccines; catch up residents in house, remain up to date as new admissions come	Completed; Ongoing
Update admission package vaccine consent form	Completed

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No

Trends and Analysis: COVID-19, respiratory, and enteric outbreaks continue to affect residents and staff at GPH however the severity is lessening. Vaccine burnout is evident with staff, residents, and families. 2024 had a total of 11 outbreaks 3 Gastro, and 8 respiratory ranging from Influenza A, COVID-19 and common colds. 2024 had one facility wide outbreak while 2025 had none. 2025 had a total of 8 outbreaks – all of which were respiratory in nature. 2024 had 4 outbreak related deaths while 2025 had 2. 2024 had suspect outbreaks that become confirmed outbreaks while 2025 had one suspect that did not develop into a confirmed outbreak.

Comments Related to Program:

- The program would benefit from have an IPAC committee that would consist of front line staff to meet routinely: identify gaps, and help with on the spot audits/education
- Barriers to the program: difficulties related to obtaining medical history related to immunizations for new admissions. Hesitancy with isolating residents, or isolating a resident for something that is a residents baseline.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP)			
"What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Continue to increase compliance with RSV immunization rates with residents.	Monitor staff vaccination statistics to assess if compliance percentage rates are increasing.	Continue to offer RSV vaccine in house. Provide education surrounding importance of vaccination.	

		vaccine.	
Continue to increase compliance with Influenza immunization rates with residents and staff.	Monitor staff vaccination statistics to assess if compliance percentage rates are increasing	<p>Continue to offer Influenza vaccine in house.</p> <p>Provide education surrounding importance of vaccination.</p> <p>Provide communication to staff and resident's families re: same.</p> <p>Provide influenza clinics at GPH in the fall.</p>	
Ensure all residents are up to date with recommended vaccines.	Review consents and Point Click Care to determine if/when residents receive recommended vaccines.	<p>Provide education to residents and families regarding vaccines.</p> <p>Provide the vaccines to residents who have consent</p>	
Implement an antimicrobial stewardship program	<p>Educating nursing staff about antimicrobial stewardship</p> <p>Understanding what is considered appropriate antibiotic use and misuse</p>	<p>Secure Leadership Support</p> <p>Form a Multidisciplinary Stewardship Team</p> <p>Assess Your Current State to identify a Baseline</p> <p>Develop or Update Policies & Tools</p>	

		Engage Residents & Families	
		Evaluate & Improve	

Program Evaluation Template

Program: Continence Program

Date of Review: February 2025

Policy/Standard Reference : Continence Care & Bowel Management NUR-05-02

Indicators/Methods Used to Monitor Program:

- o CIHI Reports
- o RAI data reports
- o Staff documentation / education

Participants and Positions:

Participants and Position		
Cole Clark – Clinical Nursing Coordinator.	Sarah Leng - PSW	
Amanda Phillips - PSW	Tracy Embury - PSW	
Brittany MacDuff - PSW	Victoria Helm kay - PSW	
Genefer Farmer - PSW	Cheryl Buckle- Administration	

Goals of the Program from Previous Year:

Goal	Date Achieved
Review and update policy, procedure and forms	Goal for 2026 (ongoing)
Decrease in worsened bladder continence by 1%	Goal for 2026 (ongoing)
Decrease in worsened bowel continence by 1%	Goal for 2026

- Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved Not Changed Not Met

- There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No

Trends and Analysis

Indicator	Q1 2025	Q2 2025	Q3 2025	Absolute Change (Q1→Q3)	Relative Change
Worsened bowel continence	37.3%	44.6%	33.33%	-3.97%	-10.6% decrease
Worsened bladder continence	32.6%	35.0%	28.57%	-4.03%	-12.4% decrease

Analysis

Across the first three quarters of 2025, continence indicators demonstrated an initial deterioration followed by improvement. Worsened bowel continence increased from 37.3% in Q1 to 44.6% in Q2, representing a 7.3 percentage point increase (19.6% relative increase). However, in Q3 the rate declined to 33.33%, indicating improvement and resulting in an overall 3.97 percentage point reduction from Q1 to Q3 (10.6% relative decrease).

Worsened bladder continence followed a similar pattern. Rates increased from 32.6% in Q1 to 35.0% in Q2, reflecting a 2.4 percentage point increase (7.4% relative increase). By Q3, the rate decreased to 28.57%, representing an overall 4.03 percentage point reduction from Q1 to Q3 (12.4% relative decrease).

Overall, the data suggest that while continence outcomes worsened between Q1 and Q2, there was measurable improvement in Q3, with both bowel and bladder indicators falling below Q1 levels by the end of the third quarter.

Note: Q4 data are currently unavailable due to the InterRAI system update, which has temporarily limited report generation. Full quarterly trend analysis will resume once reporting functionality is restored.

product use. The continence team continues to review and adjust resident-specific care plans and incontinence products based on individual needs.

Continence assessments are completed for each resident quarterly as part of the RAI-MDS assessment process, as well as on an as-needed basis when there are sudden or significant changes in a resident’s continence status. These assessments support timely care plan updates and appropriate product selection to maintain resident comfort and dignity.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home’s QIP) “What change can we make that will result in an improvement?”			
Planned Improvement Initiative (change idea)	Methods and Process Measures “How will we know that the change resulted in an improvement?”	Goals for Change Ideas	Comments
Continue use of paper tracking forms to monitor changes in continence status and product use	Paper continence tracking forms maintained in resident charts. Education provided to staff on proper completion and review of tracking sheets.	Improve identification of continence changes and ensure appropriate product use and care planning adjustments.	Allows early identification of continence decline and supports individualized interventions.
Routine audits of continence storage rooms	Distributor and program leads complete routine audits of storage rooms to ensure appropriate product stock and availability.	Monthly tracking.	Supports efficient inventory management and ensures correct products are available for residents.
Routine audits of bathroom wall continence cards	Review bathroom wall cards. Update cards when continence needs or products change.	Ensure bathroom wall cards accurately reflect resident continence needs and current product use.	Promotes staff awareness and consistency in continence care delivery.
	Monitor nighttime	Reduce unnecessary	Encourages

Program Evaluation for 2025

Program: Behaviour Management

Date of Review: February 18, 2025

Policy Reference: Behaviour Management NUR-05-04

Indicators/Methods Used to Monitor Program:

- Family & Staff Feedback
- Improved quality of life for the resident
- Behavioural Care Plans
- Biweekly “Risk Rounds”
- DOS tracking and behavioral progress notes in PCC
- Critical Incident Reports
- GPH Incident Reports
- Referrals to GMH Team & Geriatric Medicine
- Referrals to “Support Leads”
- InterRAI data
- Weekly GMH Team schedule including the residents which are being followed by the GMH Team

Participants and Positions:

Participants and Position		
Residents & Family	All residents & families who receive support	
Unit Staff	Unit Meetings with the Support Leads & GMH Team	The Support Teams meets with the staff to assist with identifying who they feel would benefit from additional support
Ingrid Montalban & Edward Larsen	GPH Support Leads	
Charmaine Andreasen	Behavioural Lead/ADOC	
Sarina Bagnarol	Social Worker	
Dr. P. M. T. ...	Medical Director	

	Medicine	

Goals of the Program from Previous Year:

Planned Improvement Initiative	Methods and Process Measures “How will we know that the change resulted in an improvement?”	Goals for Change Ideas	Comments
To reduce the number of residents who require 1:1	Review the number of hours accumulated to provide 1:1 staffing	Decrease the use of 1:1 by 2%	In 2024 the total number of hours for 1:1 was 5,527.5 & for 2025=2,737.5. This equals ___%
To continue to provide GPA to staff as per guidelines (q2 years & re-fresh annually)	Review the number of staff who have participated annually	Improve the number of staff who receive GPA by 2%	The total number of staff who received GPA training: <u>Year 2024</u> July 9/2024 - 9 participants July 23/2024 - 11 participants September 17/2024 - 16 participants September 25/2024 - 12

			<u>Year 2025</u> February 19/2025 - 12 participants Unfortunately, we are currently in the middle of a redevelopment which limited our parking & therefore was not able to offer GPA as frequently as the previous year.

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

X Improved
 Not Changed
 Not Met

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes X No

A continuing trend is the increasing number of admissions arriving with established community-based behavioural or mental health supports. The Support Leads play a key role in facilitating smooth transitions into long-term care by following residents closely from admission. This proactive approach reduces stress and anxiety associated with relocation and fosters early development of trusting relationships with residents and their families.

Another notable trend is the growing number of younger residents entering LTC with complex needs, including mental health diagnoses, substance use dependencies, and acquired brain injuries. In response, the home has strengthened collaboration with the Geriatric Mental Health Team (GMH) to provide staff education and guidance tailored to the needs of these residents. Support Leads also enhance communication by developing individualized “Tips” for residents requiring additional behavioural support. These strategies are organized in accessible “TIPS” binders on each unit, ensuring frontline staff have practical, resident-specific guidance readily available.

Comments Related to Program:

Over the past year, the Behavioural Support Program has been further strengthened through the formalization and integration of the in-house Support Lead model. This interdisciplinary approach — in collaboration with nursing, social work, and the GMH team — has improved behavioural management, reduced aggressive incidents, and decreased reliance on 1:1 staffing supports. The program has demonstrated effectiveness, sustainability, and strong team integration.

Structured processes, including formal referrals, family consent discussions, and bi-weekly interdisciplinary “Risk Rounds,” support collaboration and timely intervention. These forums promote shared understanding of resident risks, triggers, and individualized response strategies.

A key gap identified is the absence of a dedicated registered staff member responsible for consistently updating care plans with behavioural action plans and clearly defined escalation cues. This creates potential risk for inconsistent communication and intervention. Additionally, further staff education is required to strengthen recognition of early escalation signs and promote proactive, preventative approaches.

Continued education in Gentle Persuasive Approaches (GPA) remains a priority. The home is committed to ensuring staff maintain certification and receive regular refreshers to reinforce best practices in responsive behaviour management. We believe that strengthening our

Strong partnerships with community organizations, including Independent Order of Odd Fellows (IOOF), continue to support shared learning opportunities and program growth. Overall, the Behavioural Support Program reflects a proactive, interdisciplinary, and resident-centred approach, with clear strengths and defined areas for continued quality improvement.

AIM for 2026:

Change Ideas “What change can we make that will result in an improvement?”			
Planned Improvement Initiative	Methods and Process Measures “How will we know that the change resulted in an improvement?”	Goals for Change Ideas	Comments
Continue to improve on updating the Care Plans to reflect the current effective approaches to care to reduce personal expressions in a timely manner	Review the Care Plan as part of the bi-weekly “Risk Rounds” which will show care the current Care Plans and ensure they have been updated	The Care Plan will be updated in between each bi-weekly “Risk Rounds” to indicate any changes related to resident needs/approaches to care	Apply for Local Priority Funding to be able to have an additional registered staff member collaborate with the Support Leads to update the Care Plan
To continue to provide GPA to staff as per guidelines (q2 years & re-fresh annually)	Review the number of staff who have participated annually	Improve the number of staff who receive GPA by 2%	This is continuing on an ongoing basis. We have trained x2 GPH staff to be GPA Certified Coaches. In 2024 58 staff was trained and in 2025 12 staff was trained.
Reduce the number of binders which hold	The staff will know where the “TIPS” binder is located on	There will be a reduction in resident to staff injuries.	The Team will review the current information to

member to the Behavioral Team	support for personal expressions	support, reinforcing behavioural pathways, and reintroducing Dementiability training to further enhance staff capacity and resident outcomes.	completed.
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Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation for 2025

Program: Nursing Education -Grove Park Home

Date of Review: February 18, 2026

Policy/Standard Reference:

- Fixing Long Term Care Act 2021
- MOLTC

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for residents
- Best Practice Guidelines are followed
- Required education as per MOLTC are met annually

Participants and Positions:

Participants and Position		
GPH Staff	All Staff of Grove Park Home	
Charmaine Andreasen	ADOC-Nursing Educational Coordinator	
Suzanne Briggs	Director of Human Resources/Educational Director	
Shaz Mahdavi	Director of Care	
Sara Pearson	Assistant Director of Care/IPAC Nurse	
Tracy Lavigne	NSMHPCN Pain/Palliative/Symptom Management Consultant- RN	
Jacalyn Krzak	Pharmacy Liaison/RPN-Silver Fox Pharmacy	
Greg Fillier	Tena Representative	
Cole Clark	Grove Park Home-Clinical	

Goals of the Program from 2025:

SWIFT Program	Routine UDA audits	Improvement of wound management & documentation	Swift Program was implemented in 2025. Including training for all registered staff
PoET Program	Options of care will be discontinued and the PoET Approach will be introduced	Residents will feel more empowered in capacity & consent. SDM will be more aware of their role	Received a 1-year certification "Initiation Stream of the Provincial PoET Program- March 28/25
"Collaborative Project to sustain Palliative Care in LTC "	Review of the exit/palliative care summary which is completed by our families	Our residents & stakeholders will feel an improvement in all aspects of palliative care	Received a Certificate of Achievement of the Collaborative Project to Sustain a "Palliative Approach to Care" in LTC 2024-2025

Evaluation:

1. Based on established goals of the program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

X Improved Not Changed Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

further support real-time identification of knowledge gaps and emerging educational priorities, enabling Nursing Directors to respond proactively.

Education planning remains responsive to both resident-specific and unit-specific needs. In 2025, the Geriatric Mental Health Team provided diagnosis-specific education sessions for two units to enhance staff confidence and competence in caring for residents with complex mental health conditions.

A notable trend in long-term care is the increasing admission of younger residents with mental health diagnoses, substance use histories, and complex behavioural presentations. Many staff have had limited previous exposure to these populations, identifying a clear educational gap. Targeted mental health education remains a priority to ensure staff are equipped with the skills and confidence required to provide safe, person-centred care.

Comments Related to Program:

The Nursing Education Program focuses on strengthening best practices and ensuring alignment with professional standards, including guidelines set by the College of Nurses of Ontario. Strong partnerships with community organizations, including North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN) and North Simcoe Muskoka Specialized Geriatric Services Program, provide accessible education in palliative care, geriatric mental health, dementia care, and person-centred practice.

Internal education initiatives have also been strengthened. Monthly 30-minute “Palliative Mini” sessions are structured to accommodate staffing realities while maximizing participation. These flexible, needs-based sessions have supported consistent engagement across interdisciplinary roles.

A key challenge remains the cost of staff backfill for full-day educational sessions. Although many course fees are externally funded, the financial impact of replacing staff limits participation. As a non-profit organization, fiscal constraints continue to influence access to extended training opportunities.

To mitigate this barrier, GPH actively seeks external funding opportunities and collaborates with neighboring long-term care homes for shared planning and resource utilization. Incentive-based learning initiatives introduced in 2025 significantly improved staff engagement, increasing completion rates of mandatory Surge Learning modules from 34%

reinforcing consistent behavioural approaches remains a priority to ensure quality and safety in dementia care practices.

Looking ahead, GPH has applied for Local Priority Funding to expand educational initiatives in 2026, focusing on three key areas: wound care, personal expressions and mental health, and palliative care. These priority areas align with the needs of the home’s most vulnerable residents and emphasize prevention, early identification, and evidence-informed interventions.

Overall, the Education Program reflects a responsive, collaborative, and forward-thinking approach to workforce development, with continued focus on sustainability, staff engagement, and alignment with resident care needs.

AIM for 2026:

Change Ideas (will be reflected on the home’s QIP) “What change can we make that will result in an improvement?”			
Planned Improvement Initiative	Methods and Process Measures “How will we know that the change resulted in an improvement?”	Goals for Change Ideas	
Increasing access to full-day education through additional funding	We will see an increase in staff & resident satisfaction	We will be able to focus on our high-risk individuals- wound care, mental health/ behaviour management and palliative care	Applied for Local Priority Funding to be able to provide additional training /education
PoET Program	Options of care will be discontinued and the PoET Approach will be introduced	Residents will feel more empowered in capacity & consent. SDM will be more aware of their role	GPH will be making every effort to establish a 3-year certification prior

			76.5% in 2024. We would like to see an increase of 1% in 2026
Reinstating an Annual Education Day to support comprehensive staff development and policy review.	We will inquire on the Annual Staff Survey if staff participated in Education Day and if they topic ideas which they wish to learn more about	Education Day is booked for February 26 2026	We have 6 different topics for Annual Education Day. E have provided back fil for all Nursing staff who are working to be able to attend

Program Evaluation for 2025

Program: Pain

Date of Review: February 20, 2026

Policy Reference: Pain NUR-05-03

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improve quality of life for our residents
- Pain Assessments
- Feedback from Tracy Lavigne, Pain/Palliative/Symptom Management Consultant
- NSMHPCN-LTC Palliative Care Project-Data Collection Tool
- Referrals to North Simcoe Muskoka Hospice Palliative Care Network

Participants and Positions:

All residents & families who receive support	
Palliative Care /Pain Coordinator/ADOC	Charmaine Andreasen
Registered staff of the facility	
Staff of the facility	
Medical Director	Dr. Bruce McTurk
Nurse Practitioner	Mary Ellen Miller
NSMHPCN Pain/Palliative/Symptom Management Consultant/RN	Tracy Lavigne-Palliative/Pain Consultant-NSMHPCN

Goals of the Program from 2025:

Goal	Date Achieved
All registered staff to become familiar with the Pain Assessment	March 2025
Improve staff compliance with PRN pain medication administration	June 2025

Evaluation:

1. Based on established goals of the program, an analysis of the Inter-RAI indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

x Improved Not Changed Not Met

- ED Visits
- interRAI Data
- Pain Assessments

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

X Yes No

Trends and Analysis:

The PAINAD (Pain Assessment in Advanced Dementia) scale has been successfully integrated into practice for residents with cognitive impairment, supporting more accurate identification and management of pain in this population. Additionally, the general pain assessment tool has been revised for use with all residents to promote consistency, reliability, and accuracy in pain monitoring across varying levels of cognitive function.

Comprehensive staff education has accompanied these updates. All registered staff are now required to complete a pain assessment within seven days following any reported injury to ensure timely evaluation, intervention, and ongoing monitoring. Early and ongoing training initiatives have been implemented to strengthen staff competency in completing, interpreting, and documenting pain assessments appropriately.

While these enhancements have strengthened the overall pain management framework, opportunities for improvement remain. In particular, more consistent and timely administration of PRN (as-needed) analgesics is needed. Additionally, chart audits have identified instances where registered staff documented the presence of pain during assessment but did not clearly document corresponding interventions or follow-up evaluations. Ensuring that pain management includes both appropriate intervention and thorough documentation of reassessment remains an area of focus.

Continued quality improvement efforts will emphasize adherence to pain assessment protocols, timely administration of PRN medications, and comprehensive documentation practices to

An initial opportunity for improvement involved ensuring that pain assessment findings were consistently communicated and meaningfully incorporated into care planning. This gap was addressed through the implementation of weekly pain summary reports distributed to the Nursing, Falls, Rehabilitation, and Life Enrichment teams. These summaries have enhanced interdisciplinary awareness of resident pain levels, trends, and potential medication-related risks, supporting more informed and coordinated care planning.

A key gap identified within the program was the concurrent use of multiple pain assessment tools, which contributed to staff confusion and increased the risk of missed or inconsistent assessments. In response, the pain management policy was revised to streamline processes, standardize assessment practices, and reduce unnecessary workload.

Pain tracking procedures were formalized, and pain assessments are now required on admission and following return from hospital. Assessment tools were consolidated to a single standardized tool — the PAINAD (Pain Assessment in Advanced Dementia) — which has been integrated into PointClickCare (PCC) to improve accessibility, documentation accuracy, and compliance.

Targeted staff education delivered through team huddles supported the implementation of these changes. Feedback from staff has been positive, and there has been noted improvement in the identification and monitoring of unmanaged pain.

Ongoing evaluation will continue to focus on compliance, documentation quality, interdisciplinary communication, and sustained improvements in resident comfort outcomes.

AIM for 2026:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Adding a registered staff member through Local Priority Funding to enhance symptom management, update pain/palliative care plans & reduce unnecessary hospital transfers	Collection of data, meeting MOLTC directives without written notice, all care plans will be updated after palliative meetings	Utilize the additional staff member by compiling a list of current gaps in the pain & symptom management program	
Strengthen alignment	To improve the number of staff who attend	Continue to have	

Program Evaluation for 2025

Program: Palliative Care

Date of Review: February 20, 2026

Policy/Standard Reference: Palliative Program NUR-05-06

Indicators/Methods Used to Monitor Program:

- ▢ Residents, Family & staff feedback
- ▢ Improved quality of life for the resident
- ▢ Palliative Care Plans
- ▢ Palliative Assessments-PPS, Frailty Scale, ESAS
- ▢ Pain Assessments
- ▢ Palliative & pain progress notes from PCC
- ▢ Feedback from Tracy Lavigne-RN, CHPCN Pain/Palliative/Symptom Management Consultants
- ▢ NSMHPCN-LTC Palliative Care Project-Data Collection Tool
- ▢ Referrals to North Simcoe Muskoka Hospice Care Network
- ▢ Palliative Care Education
- ▢ Death at location of choice

Participants and Positions:

Participants and Position		
Residents & Family	All residents & families who receive support	
Unit Staff	Palliative Champions	
Charmaine Andreasen	Palliative Lead/ADOC	
RN/RPN	Facility/Unit Lead	
Dr. McTurk	Medical Director	
Mary Ellen Miller	Nurse Practitioner	
Tracy Lavigne	NSMHPCN Pain/Palliative/Symptom Management Consultant RN	

Goals of the Program from Previous Year:

Goal	Date Achieved
All registered staff to become familiar with the Pain Assessment	March 2025
Participate in the LTC Palliative Care Initiative Program	March 4 2025
Fundamentals of Palliative Care	Feb 24, March 4, March 25/25
Return to monthly Palliative Care Team meetings	April 17 2025

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved Not Changed Not Met

- Emergency Department Visits
 - NSMHPCN-LTC Palliative Care Project-Data Collection Tool- which collects monthly data- including number of residents, number of palliative residents, number of residents transferred to hospital, number of residents who died at GPH, and number of residents who died at hospital
 - Inter-RAI data collection
2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No

Trends and Analysis:

Our Medical Director prioritized enhanced symptom management, recognizing that not all medications included in the End-of-Life Order Set are required for every resident. Through collaborative discussions and review of our processes, we identified that hesitation in initiating a “Palliative Approach to Care” order was often related to concerns about prescribing standardized orders that may not be appropriate for all individuals.

By shifting to a resident-specific approach when writing “Palliative Approach to Care” orders, we reduced this hesitation. This individualized process has resulted in a measurable increase in the number of residents with an active “Palliative Approach to Care” order.

This initiative has been a collaborative effort among leadership, physicians, and frontline staff, and has strengthened interdisciplinary relationships while improving confidence in palliative care practices.

Comments Related to Program:

Re-establishing the Palliative Care Team was identified as a key goal for 2025. While this presented challenges, we successfully resumed monthly meetings in April 2025 following participation in the LTC Palliative Care Initiative Program.

The team adopted a revised meeting format focused on residents identified by staff as potentially benefiting from a palliative approach to care. This change empowered frontline staff to recognize and communicate meaningful changes in residents’ conditions.

When a resident is identified, a comprehensive palliative care assessment is completed. This assessment includes review of:

- Food and fluid intake
- Bowel patterns and related interventions

- Skin integrity and wound status
- Activities of daily living
- Current medications supporting comfort, bowel routine, mood, pain, and sleep

In addition, the team reviews residents who already have a “Palliative Approach to Care” order in place to ensure any changes in condition are promptly identified and addressed.

This structured and collaborative approach has strengthened clinical oversight, enhanced early identification of needs, and supported a more proactive, resident-centered model of palliative care delivery.

AIM for 2026:

Change Ideas (will be reflected on the home’s QIP) “What change can we make that will result in an improvement?”			
Planned Improvement Initiative	Methods and Process Measures “How will we know that the change resulted in an improvement?”	Goals for Change Ideas	Comments
Ensure all information pertaining to the Palliative Care Program is located in one file	Staff will become comfortable with accessing information pertaining to Palliative Care	Update the file on each of the desk tops at the Nursing Station to include changes to our current processes for Palliative Care	
To provide “post mortem care” education. We have identified this as a gap related to cultural diversity within our staff	We will include this as part of our orientation to new staff	Staff will feel more comfortable with providing post mortem care & if they are not, they will feel comfortable with sharing.	
Review what is required for a 3-year certification for the PoET Program	Participate in a review of our current 1-year certificate	Collaborate with the PoET Program facilitators to see if a 3-year commitment is visible in relation to other initiatives taking place with the facility	

Program Evaluation

Program: Restraints/ PASDs

Date of Review: February 26th, 2026

Policy/Standard Reference: Least Restraints/ PASD Policy

Indicators/Methods Used to Monitor Program: The number of Restraints/ PASDs used in the home, Quarterly/ PRN meetings, RAI/ RAPS, Provincial bench marking, QI team meetings, Bedrail Assessment Tool (PCC).

Participants and Positions:

Participants and Position		
Candice Godin	Restraint Team Lead	Restorative Care
Shaz Madhavi	Committee Member	Director of Care

Goals of the Program from Previous Year: **2025**

Goal	Date Achieved
Provide resident/ families with the necessary education when request for restraint is proposed.	On an as needed basis
Staff education through Surge Learning (Restraints/ PASDs)	Yearly
Ensure bed safety for all residents throughout the home.	Ongoing throughout 2025
Review of the current Restraint use.	Ongoing throughout 2025
Review of the current PASD use.	Ongoing throughout 2025
Assessment and Implementation use of Transfer Rails where appropriate	Ongoing throughout 2025
Incorporate new Transfer Rail assessment tool	Not completed – deferred to 2026.
Review of Restraint Policy	Completed

Evaluation:

- Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved
 Not Changed
 Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports).

- There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO, Fixing LTC Act)

Yes
 No

Trends and Analysis: Grove Park Home continues to work toward non-use/ minimal use of Restraints in order to reduce entrapment risks and comply with government standards, regulations and recommendations. All restraint implementation has been driven by family demand or clinical assessment prior to admission to GPH in an attempt to reduce risk for resident injury related to falls (despite all other fall prevention interventions/ measures being put into place).

Comments Related to Program: Grove Park Home continues to embrace government regulations and utilize minimalistic/ less invasive interventions that may pose entrapment risks to the residents of GPH.

AIM for Upcoming Year: 2026

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Use of Transfer Rails	Continue to assess the need for use – provide intervention when appropriate.	Continue to provide transfer rails to res' that require for transfer only to promote independence. Continue to assess for need during bed mobility/ care for those meeting a CPS score of 0-1 with impeding physical limitations.	Implemented upon assessment on an as needed basis.
Incorporate new bedrail assessment tool	Adopt a tool that measures the ability for a resident to use transfer rail.	Introduce a new tool to determine a res' need for a Transfer Rail with pre-generated guidelines/ approval for use.	Deferred - Goal to be completed by end of 2026.
Educate Staff and Family	Email, newsletters, surge learning, 1-1 education on admission.	Increased awareness	Ongoing
Review Restraint Policy	Consult RNAO Best Practice and referring to the guidelines set out in the Fixing LTC Act.	Ensure that the policy meets the necessary standards for use to maintain a least restrictive	Annually

		environment.	
Review PASD (Personal Assistance Service Devices) Policy	Consult RNAO Best Practice and referring to the guidelines set out in the Fixing LTC Act.	Ensure that the policy meets the necessary standards for use to maintain a least restrictive environment.	Annually

Program Evaluation Template

Program: Wound and Skin Program

Date of Review: February 2025

Policy/Standard Reference : Skin and Wound Care Policy NUR-05-05 (2025 update)

Enter the policy or standard relevant to the review (e.g. Inspection Protocol,
LTCHA/Regulations ...)

Indicators/Methods Used to Monitor Program:

- o CIHI Reports
 - o Decreased in number/severity/worsening of wounds
 - o Staff documentation/education
- What indicators/methods are being used to monitor the program's performance (e.g. CIHI report ...)

Participants and Positions:

Participants and Position		
Cole Clark – Clinical Nursing Coordinator	Sara Pearson -ADOC	Harleen Kaur – Float nurse
Shaz Mahdavi - DOC	Charmaine Andresen - ADOC	

Goals of the Program from Previous Year:

Goal	Date Achieved
Continue to track internally and externally acquired pressure ulcers	New wound App tracks this info
Achieve indicator below 4% for facility - Has a stage 2 to 4 pressure ulcer	Not met
Continued education for staff	Education provided throughout the year.
Assess completion rate of the Bates Jenson Wound Assessment Tool on the units	n/a no longer using bates
Introduce new Wound App/PCC wound tracking technology	Integrated throughout 2025
Ensure accuracy of Care Plans	Care plans are audited routinely
Standardize and consolidate wound products	Achieved in 2025

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved Not Changed Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports).

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No

Trends and Analysis:

The 2025 skin and wound data demonstrates a clear shift in overall wound burden across the year, primarily driven by a significant increase in Stage 2 pressure injuries. Stage 2 cases began the year at a low baseline in Q1, then rose sharply beginning in May, peaking in late summer and remaining elevated through Q4. This increase accounts for the majority of total wound volume in 2025. In contrast, Stage 3 injuries showed a steady and sustained decline after early-year peaks, and Stage 4 injuries remained relatively stable with only a slight increase toward year-end. Deep Tissue Injuries spiked briefly in Q2 but progressively declined to zero by year-end, while Unstageable injuries emerged mid-year and persisted at moderate levels through Q4.

It is important to note that the overall numbers are influenced by specific residents with multiple concurrent wounds. One or two high-acuity residents with several wounds each can significantly elevate monthly totals, particularly within Stage 2 counts. Therefore, the increased wound burden in the second half of the year reflects not only incidence trends but also clustering within individual residents. Overall, the data suggests improved control of advanced-stage injuries, but reduced effectiveness in preventing early-stage skin breakdown, with case concentration contributing meaningfully to total program metrics

Comments Related to Program:

A new skin and wound application was introduced in 2025 to improve documentation, tracking, and consistency of wound assessments. Coloplast skin tear protocol order sets were also implemented to standardize treatment approaches for skin tears across the home. In addition, a decision tree wound care protocol was developed to guide staff in selecting appropriate interventions based on wound type and clinical presentation.

“Wound Wednesday” was introduced as a standardized weekly wound assessment day to ensure routine reassessment, documentation updates, and interdisciplinary review. Education sessions were also provided to staff on the use of new wound care products to support appropriate product selection and application.

The home continues to utilize RVH NLOT Nurse Practitioners for collaborative multidisciplinary oversight of complex wound cases, supporting advanced clinical decision-making when required. There has also been an increase in referrals to the Registered Dietitian (RD) for residents with wounds to support nutritional optimization and promote wound healing.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Ongoing staff education on wound care products	Provide education sessions on wound care products (e.g., dressings, antimicrobial products, moisture management). Track attendance and completion of education	compliance with correct dressing/product use with new wounds initiated by registered staff upon occurrence of new wounds.	
Ongoing standardized weekly wound tracking day (e.g., Wound Wednesday)	Continue to use standardized weekly wound assessment day where all active wounds are reviewed, photographed, and documented in the wound tracking system as applicable. Monitor completion of weekly wound assessments and interdisciplinary review of complex wounds.	100% of active wounds reviewed and documented weekly and any missed wounds to be evaluated the following day.	Supports early identification of deterioration and consistent documentation practices.
Ongoing education for wound app upgrade (SWIFT App to ChartPIC App)	Provide staff training sessions on the new wound documentation platform including photo capture, measurement entry, and reporting features. Monitor staff completion of training and conduct documentation audits within the application.	Continue to train new staff onboarded to ensure all staff are trained and competent in assessment capabilities.	Supports improved wound monitoring, data tracking, and standardized documentation across the home.
	Provide education	adherence to	Reinforces evidence-

Ongoing education on wound care home protocols for standardized treatment options	sessions reviewing facility wound care protocols and decision trees (e.g., skin tear protocol, pressure injury treatment algorithms).	standardized wound protocols during quarterly wound chart audits.	based treatment selection and reduces variation in wound management practices.
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2025 Dietary Services Program Review



Travis Durham
Director of Dietary Services & Information Technology
February 2026

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Statement of Purpose

The Dietary Services Department at Grove Park Home is to improve and preserve the quality of life of the elderly. We accomplish this by providing a home-like atmosphere, high quality of service and food, and meeting everyone's nutritional needs.



The department is self-operated, and food is prepared in a conventional manner. Receiving, storing, preparing and serving food is carried out in a manner that is consistent with public health practices, applicable standards and institutional food production methods. There is an extensive Quality Assurance (HACCP) program in place to assure all sanitation standards are met throughout the food storage, preparation, cooking and serving of meals. Food preparation takes place according to standardized recipes and production worksheets. Food is prepared fresh every day, in quantities appropriate for consumption.

Grove Park Home encourages resident participation in menu planning. There is a 28-day cycle menu. This meets all nutritional criteria and provides appropriate choices for all diet variations. The menu is planned by the Director of Dietary Services & Information Technology and is approved in writing by the Consulting Registered Dietitian(s). The menu is presented to the Resident Council for consultation and approval prior to implementation.

Meals are a highlight of the resident's day, and as such comprise an important aspect of the resident's quality of life. This is especially true on holidays and special occasions. We work to provide special meals and celebrate special occasions with food because we believe that providing special acknowledgment of special occasions improves overall well-being, stimulates appetite, and increases resident satisfaction.

In this way, we take the utmost care in contributing to the implementation of the Vision of Grove Park Home to continuously provide the finest care for every resident. As well, the Mission statement for staff of Grove Park Home to provide continuous high-quality care in a secure environment with family and community support is realized within the parameters of nutritional care provided by the

Director of Dietary Services & Information Technology and the Consulting Dietitian(s).

Organizational Liaison:

The quality of service is enhanced through liaison with the Dietary Services Department in other Long-term care facilities, the Canadian Society of Nutrition Management, Advantage Ontario, Dietitians of Canada and the College of Dietitians.

Human Resources/Education:

The Dietary Services Department recognizes its staff as its most valuable resource and, as such is committed to providing opportunities for professional and personal growth. Attendance at educational programs offered within and outside the home is encouraged. In-servicing and departmental meetings are held regularly throughout the year for front-line staff.

Management Approach:

Staff are offered the opportunity to participate in the decisions that will directly affect their job and their work environment. Department Management integrates Quality Assurance, Risk Management, and Continuous Quality Improvement programs.



Nutrition & Hydration Program Audit Results

Clinicians of the Dietary Services team conducted an audit of the Nutrition & Hydration program in December 2026.

The areas requiring further development are as follows:

Major Asset Replacements

There was plans to replace the countertop in the Willow servery, due to non-compliance with SMDHU, severe cracking throughout. Unfortunately, that did not end up being completed, pushed into 2026.

Dining Room Chair Replacement

New dining room chairs were integrated in the four remaining dining rooms. These chairs are easy to clean and much gentler on the dining room floors.

Redevelopment Preparation

The Maple home area was closed in 2026, this included our dining room on that home area. A lot of work on ensuring assets are put into off-site and on-site storage for future use.

Soft Bite Size Texture Implementation

Grove Park Home has slowly introduced the IDDSI terminology for fluid consistencies. Plans for incorporating the soft-bite sized therapeutic texture to be implemented. This will allow safer texture for those who do not yet qualify to be minced texture.

Upgrading of Serveries/Dining Rooms

Continued improvement work being completed; Pine dining room/servery has plans for flooring replacement.

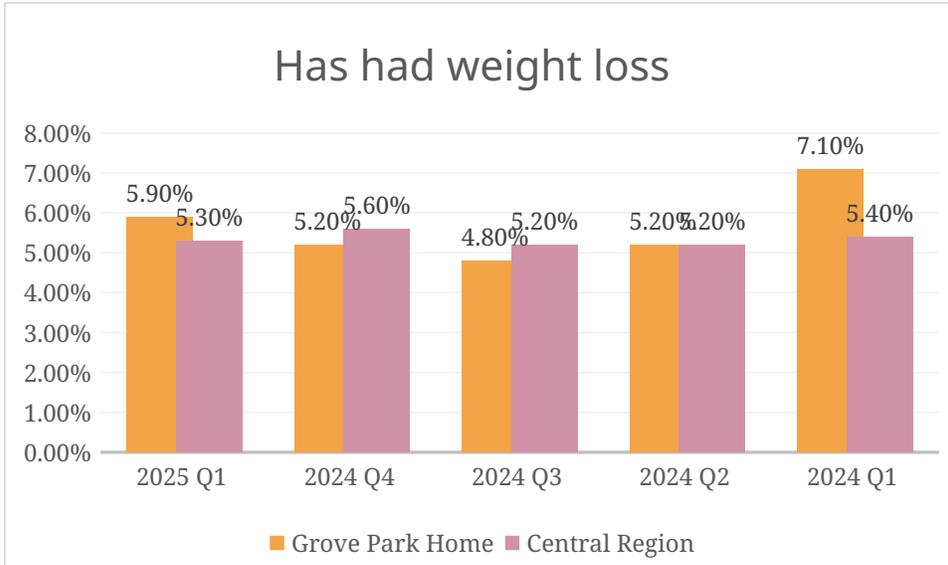
Dietary Services clinical team participating in the annual review: Travis Durham, CNM, Qurrat Babi, NM, Joanne Chantler, RD, and Allison Norman, RD.

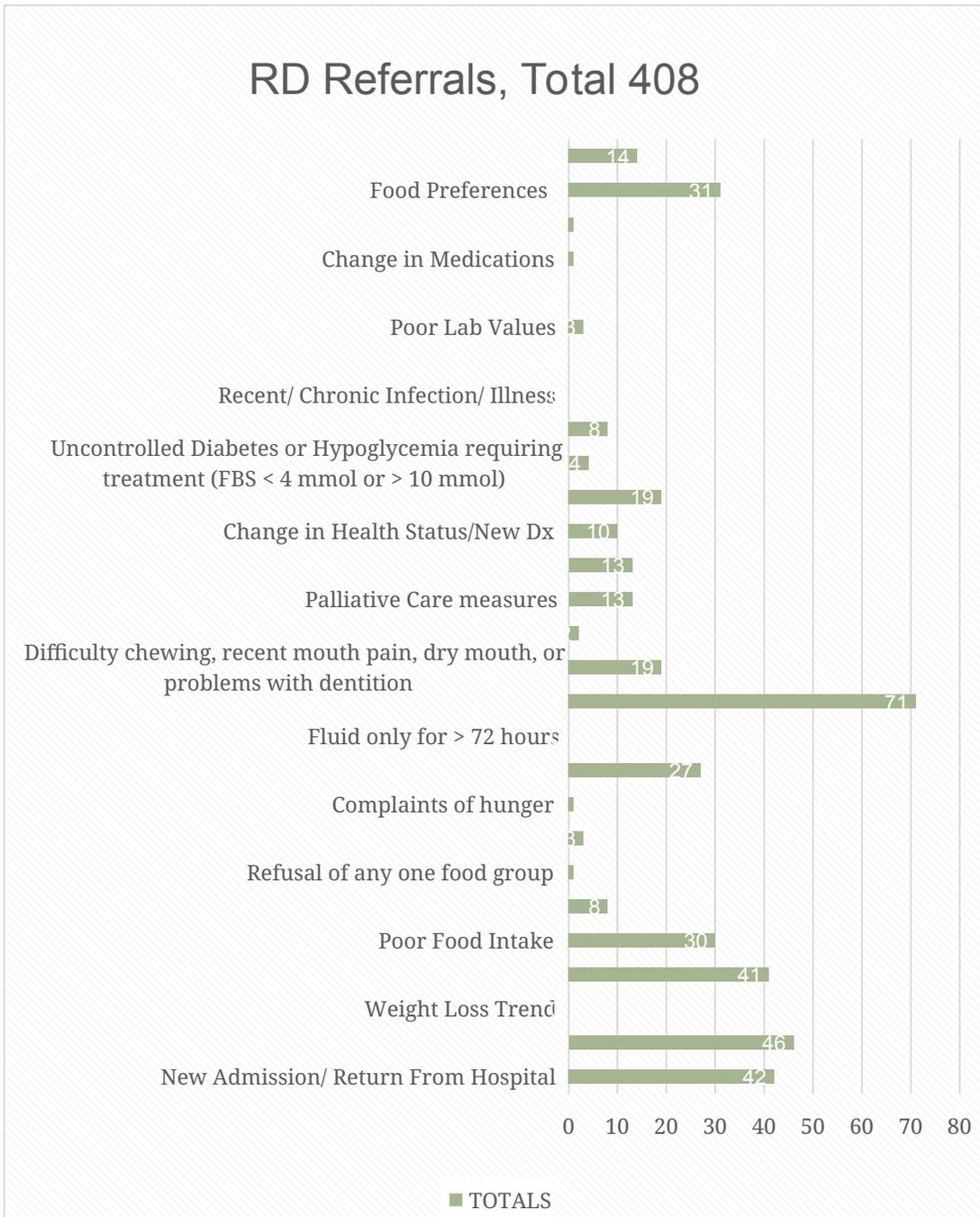
2026 Performance Indicator Review

The 2026 indicators are skewed due to a couple of factors. There are currently 30 beds in abeyance due to the redevelopment. Presented first will be a summary from January to December of the average, the minimum and the maximum of each indicator.

INDICATOR	AVG	MIN	MAX
# of Residents on Regular diet	64	56	72
# of Residents on Minced texture	20.5	17	24
# of Residents on Pureed texture	9.5	5	14
# of Residents on a Diabetic diet	17	14	20
# of Residents on Renal diet	0	0	0
# of Residents on Lactose Reduced diet	2.5	2	3
# of Residents on Gluten Restricted diet	0	0	0
# of Residents on Low Fat/Reducing diet	0	0	0
# of Residents on High Calories / High Protein diet	10	8	12
# of Residents on nutritional supplements	7	6	8
# of Residents on enteral feeding	0	0	0
# of Residents at HIGH nutritional risk	71.5	65	78
# of Residents at MODERATE nutritional risk	27	22	32
# of Residents at LOW nutritional risk	0	0	0
# of Residents on Anti-Reflux diet	0	0	0
# of Residents on Individual diet plans	0	0	0

Comparison of weight loss quality indicator in comparison to the Ontario average shows that Grove Park Home has maintained a weight loss level below the Ontario average.



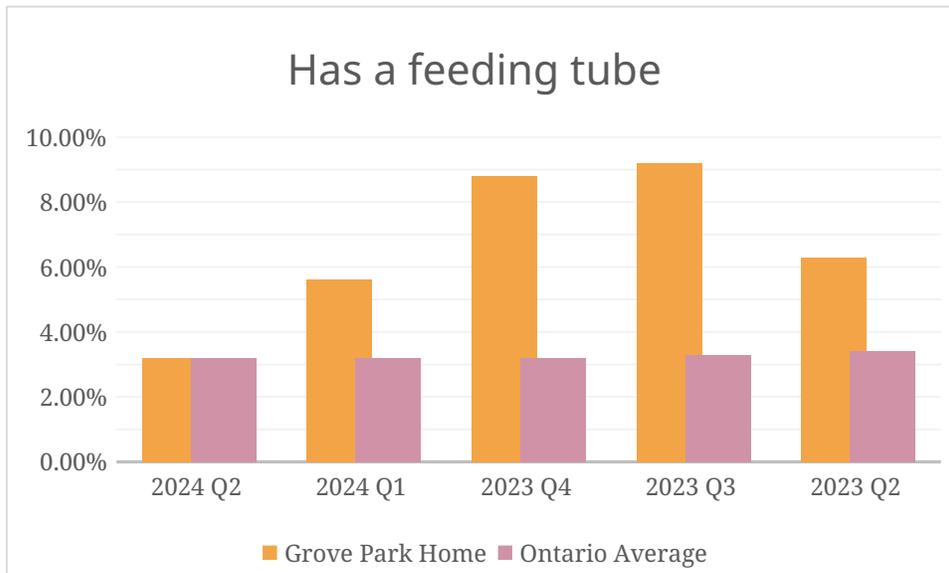


Jan - Mar ; other 1. r/a lactaid milk, 2 - stage 1 wound, 3 - skin tear, 4 - fracture, 5 - drink out of coloured cups, 6 - discontinue large portions, 7 - double handled cup, 8 - soup in nosey cup, 9 - wt gain interventions requested

Apr - Jun ; other 1 - straw, 2 - nosey cup, 3 - small portions x 2, 4 - d/c small portions, 5 - assess for adaptive devices, 6 - MD order for cranberry juice, 7 - staff wondering appropriate portion for peanuts, 8 - request for small portions of bread, 9 - request for lactose free milk, 10 - assess sodium intake, 11 - double handled cup, 12

- query if foods permitted with current texture. July - Sept ; referral x 2 re: syringe feeding, sitting in DR, request to consult POA, clarity re: diet.
 Oct - Dec; other 1 - fracture x4, 2 - clothing protector, 3 - full fluid diet, 4 - guidance re: portion restrictions, 5 - adaptive device x 6, 6 - request to upgrade texture/consistency x3, 7 - request for routine counselling, 8 - utensils , 9 - alternative at meals, 10 - small portions, 11 - POA requesting call, 12 - request for larger spoons x2

Comparison of feeding tube indicator in comparison to the Ontario average shows that Grove Park Home has maintained residents on feeding tubes below the Ontario average.





2025 Quality Improvement Initiatives

2025 was a unique year for the Dietary Services department. A number of construction projects in the department were necessary due to equipment malfunctions and flooding. Below is a sample of the work that was completed;



Equipment & Dining Room Enhancements

- replaced cupboard doors in the Pine and Spruce serveries that were failing
- switch coffee program from Nestle to Folgers due to major supply issues

Education

- mentored students from the Georgian College Food Nutrition Management program
- participate on the Ontario Seniors Nutrition & Advisory Committee (OSNAC) and the Food and Nutrition Advisory Team (FNAT) working group
- joined the CSNM Ontario Networking Group (ONG)
- regular safe food handling certification for all front-line staff
- hosted Barrie North and Eastview co-op students to complete their work terms in food production

Resident Meal Satisfaction

- introduce a new menu Winter/Spring 28-day menu in late October
- regular participation in the Resident Council meetings, as well as the Quality Improvement Committee and Professional Advisory Committee. This allows the Diet team to hear resident concerns with food quality and nutrition care, and act upon them
- managing the ongoing changes to nutritional supplement program, trialing different products based on resident needs

Food Improvements

- ongoing purchasing of fresh local foods to enhance the menu
- continuation of the Resident Council sponsored Country Fair meal in September,

held the popular steak BBQ in 2025

-created a Family and Resident Christmas Tea

Policy Changes

-made adjustments to the staffing policies as per new regulations under the Fixing Long Term Care Act.

Human Resources

-continued to seek new initiatives to keep staff engaged in the workplace

-ongoing recruitment of casual staff, typically Georgian Colleges FDNM students seeking employment.



Resident Satisfaction Survey Results

The 2026 Resident Satisfaction Survey resulted in a score of 87% satisfaction under the category 'Overall Satisfaction with Meals'. That is a 16% improvement from 2025. Some of the comments made by residents under this question were:

- too repetitive +++
- satisfied +++
- menu has improved+++
- too much fish
- it could be better +++

The Action Plan is as follows:

Dietary / Food	Creating a new menu with resident input, will review for follow up when in place	Director of Dietary Services and Information Technology	Q3 2026
	Continue to attend Resident Leadership Team meetings monthly to gather feedback from the resident representatives.	Director of Dietary Services and Information Technology	On-going
	Open new dining room on Maple, integrate a open concept dining experience	Director of Dietary Services and Information Technology	Q3 2026
	Dining room audits	Director of Dietary Services and Information Technology	On-going
	Development and implementation of a soft-bite size texture	Director of Dietary Services and Information	Q2 2026

		Technology	
	Beautification efforts – Pine replace dining room/serverly floor. Willow – replace countertop	Director of Dietary Services and Information Technology	TBD



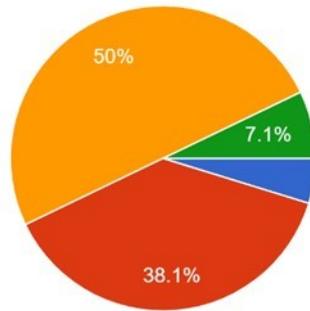
Family Satisfaction Survey Results

The 2025 Family Satisfaction Survey resulted in a score of 88.1% satisfaction under the category 'Meal Service (Pleasurable Dining)' and 92.9% satisfaction under the category 'Nutritional Content of Meals'. The areas requiring improvement and the action plan is as follows:

Identified areas for improvement	Action Plan	Date
<ul style="list-style-type: none"> ☐ Sometimes meals are cold and sometimes not enough. For the most part, they are good. ☐ The food often comes looking unattractive, and often only warm, not hot. My mother has always enjoyed her food and enjoys most flavours but she has most often complained about the meals. ☐ The food always smells delicious and from what I hear Rob enjoys it. Staff take time to feed him in the dining room or his room depending on his needs that day. 	☐ Purchases of local produce will be increased this year (at least \$10,000).	Seasonal
	☐ New resident menu has been developed with resident input	July 2026
	☐ Staff to be reminded of pleasurable dining policy, allowing residents a full hour to enjoy their meal and to not feel rushed	March 2026
	☐ Staff are to be reminded to pour drink preference for resident at time of seating (not beforehand causing coffee/tea to be cold)	On-going
	☐ Production meetings set for every other month. This will allow for cooks and managers to review areas of concern and determine best methods of improvement.	December 2026

Rate your satisfaction with meal service as a "pleasurable dining experience."

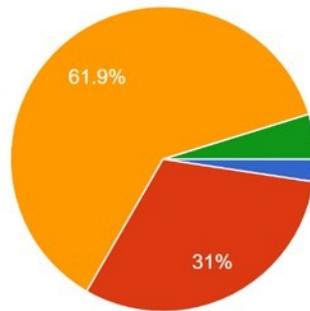
42 responses



- 1 = less than satisfied; barely tolerable
- 2 = satisfied; acceptable
- 3 = totally satisfied; more than I hoped for
- n/a = not applicable or no comment

How satisfied are you with the nutritional content of your love one's meals?

42 responses



- 1 = less than satisfied; barely tolerable
- 2 = satisfied; acceptable
- 3 = totally satisfied; more than I hoped for
- n/a = not applicable or no comment



2026 Improvement Initiatives

To build on the Resident focused initiatives of 2025, the following projects and enhancements are planned for 2026:

Equipment

- monitor and open the redeveloped Maple wing, dining room and servery
- shut down the Aspen dining room

Dining Room Enhancements

- replace flooring in the Pine dining room/server
- replace countertop in the Willow dining room

Education

- mentor students from the Georgian College Food Nutrition Management program
- regular testing of safe food handling for all front-line dietary staff
- host high school co-op students for food production roles



Resident Meal Satisfaction

- introduce a menu changeover around the halfway mark of 2026
- continue to build special event meals to coincide with popular holidays, in collaboration with the Diversity Committee
- continue to participate in the Quality Improvement Committee and work on increasing resident meal satisfaction



Food Improvements

- ongoing purchasing of fresh local foods to enhance the menu

Policy Changes

- implementation of IDDSI soft-bite size therapeutic texture
- Make adjustments to policies as per new regulations under the Fixing Long Term Care Act.
- add additional policies to meet current trends in food services

in LTC

Human Resources

- ongoing recruitment of staff to while navigating the health human resources crisis in long-term care
- managing operational changes as a result of closing Maple and Aspen home areas during redevelopment
- reintroduction of performance assessments of staff

Third-Party Interaction

In 2026 the Dietary Services department had numerous interactions with various regulatory and accrediting bodies.

Simcoe Muskoka District Health Unit had visited on four occasions in 2025 to conduct Food Premises Act inspection; March 20, June 26 and October 16 for routine inspections and on August 22 to follow up on a toaster fire. Findings from these visits were minimal to nil, with the most serious of those being:

- repair missing tiles in the main kitchen
- provide the Café with appropriate signage and resources for food prep
- replace Mulberry Lane fridge due to temperature fluctuations
- Willow's cracking countertop



Ministry of Long-Term Care compliance inspectors visited throughout 2025. No findings related to Dietary during the various inspections. 2025 did not have a Proactive Inspection

Canadian Food Inspection Agency inspectors did not visit the home in 2025. No areas of non-compliance.

Conferences and Continuing Education

Management and supervisors attended or spoke at the following events in 2026.

- Ontario Fruit and Vegetable Growers Convention, Niagara Fall, February 19th & 20th
- Sysco Healthcare Show, Mississauga. February 26th
- Together We Care Trade Show, Mississauga. April 9th
- CSNM Convention, Vancouver. June 17th to 20th
- CSNM ONG Conference, Mississauga. September 12th



Program Evaluation Template

Program: Laminar Flow Devices

Date of Review: _____

Policy/Standard Reference : Health and Safety Re: Water/Air

Enter the policy or standard relevant to the review (e.g. Inspection Protocol, LTCHA/Regulations ...)

Indicators/Methods Used to Monitor Program: _____

A _____ N/
 What indicators/methods are being used to monitor the program's performance (e.g. CIHI report ...)

Participants and Positions:

Participants and Position		
Moen	Moen Rep	
Maintenance/Contractor	Mnt. Staff / Plumber	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal	Date Achieved
To replace the existing aerators in the resident washrooms and replace with the laminar flow device. No previous year goal.	

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

- Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved
 Not Changed
 Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports).

- There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes
 No

Trends and Analysis: _____ Preventative Practices _____

Comments Related to Program: An improvement as to eliminating infectious bacteria from biofilms from piping when running water at faucet. To decrease the risk of spreading such infections to residents at high risk.

Tell a story about the program. Barriers, constraints, etc

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
To install laminar flow devices		To replace all resident faucet aerators	

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program.
If a change is implemented, this must be reflected in all relevant program materials.

2025

Programs Department Annual Review



Created by: Kerry Guy,

Director of Resident & Family Services

PROGRAM OVERVIEW

The primary purpose of the Programs Department is to assist the residents of Grove Park Home to lead meaningful lives by designing and promoting programs, with collaboration from Life Enrichment, Restorative Care, Physiotherapy, Chaplain/Spiritual Services, Social Services & Volunteers. Programs will stimulate mental and physical activity, maintain spiritual beliefs, and encourage the enjoyment of social and emotional relationships. In addition to overseeing all of the above responsibilities, the Director of Resident & Family Services ensures a smooth transition for residents during admission and continued placement. The Director provides comprehensive support to residents and their families before, during, and following the admission process, while consistently acting as a resident advocate.

In 2025, the Home welcomed a total of 43 new resident admissions, not including the re-admits from the “flood” on Pine and Spruce floors.

Life Enrichment/Activities

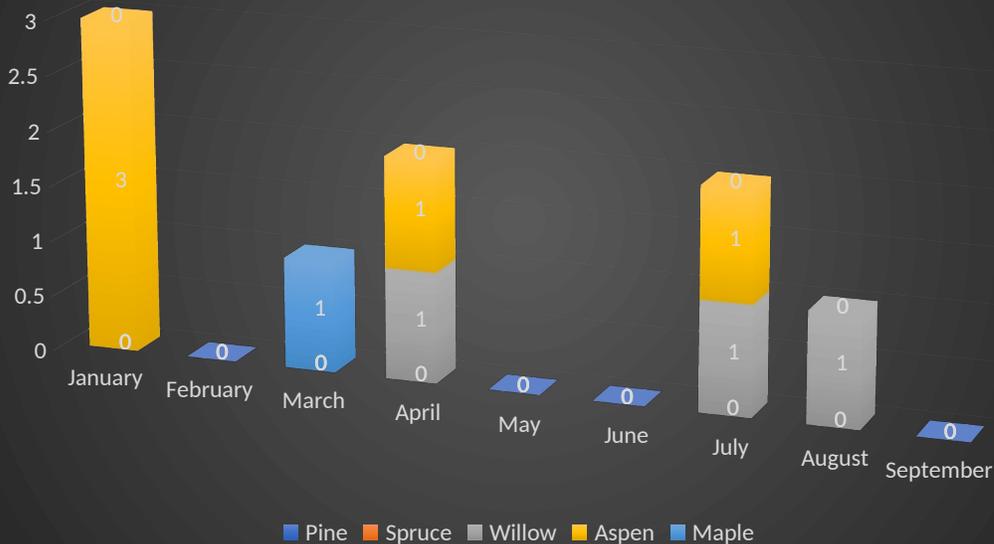
The Life Enrichment/Activity staff are accountable for the provision of a range of recreational, therapeutic, leisure programming. These programs must be of high quality, evidenced based, and provided in a manner that is consistent with Grove Park Home’s Vision and Mission Statements, the Long-Term Care Guidelines and other applicable regulations and guidelines. Karen Dixon is the Coordinator of Activities and works closely with the Director of Resident and Family Services.

2025 Life Enrichment Quality Initiatives:

- Applied for grants for new programming ideas. (approved for 2 grants in 2025)
- Continued communication with families. We now use the Grove Park Home channel for added communication.
- Increased special events on weekends and evenings.
- Continued collaboration with the Diversity Committee with special themed days and holidays that we celebrate/discuss as a Home.
- Continued to post regularly to Social media/Facebook
- Continued support of the link garden program
- Hosted a Summer student
- Ongoing collaboration with local schools in the area for placement learning opportunities.
- Continued increasing resident outings, introducing new ideas, when possible.
- Continued to revise policies, orientation process, etc... in the Department Manual
- Continued to introduce new and innovative programs for our residents.
- Apply for grants for new programming ideas.

- Purchased equipment for a new sensory room
- Three staff in the department became Drom (drumming) certified.
- Purchased new “Memorial frames for each floor.
- Purchased new Sensory Boards for each floor
- Increased our overall satisfaction from the Resident Survey to 90% or more.
- **2026 Goals for Quality Improvement**
- Score an overall satisfaction from the Resident Survey of 90% or more.
- New Horizons grant program (Java program is coming to an end and final reporting will be due early in 2026).
- Heart Radio grant program (program is nearing completion and final reporting will be due in the beginning of 2026).
- Host a Canada Summer jobs student program
- Spend the Dementia Care funding and Local Priority funding (by March 31)
- Ongoing collaboration with local schools in the area for placement learning opportunities.
- Grant approvals – from New Horizon Program
- Have our own means of transportation. Ie. Accessible bus
- Continue increasing resident outings, introducing new ideas, when possible. Ie. museums or galleries, etc...
- Continue to revise policies, orientation process, etc... in the Department Manual
- Strive to introduce new and innovative programs for our residents.
- Research what other homes are doing for their younger population. Incorporate more programming for our residents here living in their 40's-60's. – this is something that we continue to explore
- Purchase Active Living Program
- Dementia Care Program
- Possible to have a computer, printer, scanner, etc... for the department
- Continue to complete staff performance appraisals.

Little to No Programming 2025



As per RAI/MDS coding guidelines, residents may be coded as receiving “little to no” programming based on a 7-day observation period within the quarter. We did not collect for Maple after May as the floor closed due to the Redevelopment project. Data was not able to be collected for the last quarter of the month due to changes with Inter-RAI.

Each quarter, residents flagged as “little to no” programming are reviewed by the multidisciplinary Programs Team, including Life Enrichment, Restorative Care, and Physiotherapy. During this review, the team:

- Assesses the resident’s overall level of support and participation
- Identifies potential barriers to engagement
- Develops and implements individualized interventions to increase participation

Interventions may include:

- 1:1 programming
- Small or large group programming
- 1:1 restorative exercise
- 1:1 physiotherapy
- Individualized engagement strategies tailored to the resident’s preferences and abilities

Trend analysis indicates that some residents consistently code as “little to no” programming despite targeted interventions. In such cases, after documented attempts to increase participation have been made without success, the team respects and supports the resident’s right to choose their preferred level of daily involvement within the home.

When completing RAI/MDS coding during an outbreak, the following are considered valid forms of programming and engagement:

- 1:1 visits
- 1:1 restorative exercise
- 1:1 physiotherapy
- Virtual visits or phone calls with family
- In-person family visits (as permitted)

These individualized supports are included in the assessment of participation during the 7-day observation period.

Restorative Care

The Restorative Care department is accountable for the provision of a range of restorative, rehabilitative and activation programming. These programs must be of high quality, evidenced based, and provided in a manner that is consistent with Grove Park Home’s Vision and Mission Statements, the Long-Term Care Standards and other applicable regulations and guidelines. Candice Godin is the Restorative Care Coordinator and works closely with the Director of Resident & Family Services.

The Restorative Care Department works collaboratively with Physiotherapy and Nursing Rehabilitation as part of the interdisciplinary Rehab Team. Together, we ensure that residents receive the appropriate therapeutic support needed to maintain and promote their ongoing participation in activities of daily living (ADLs).

When residents are no longer receiving Physiotherapy services—whether due to discharge or any reason other than death—the Restorative Care team assumes responsibility for continuing their therapeutic programming. This ensures continuity of care and helps maintain the functional gains achieved during formal therapy.

Restorative Care programs include a variety of group and individualized interventions such as:

- Range of motion exercises
- Exercise classes
- Balance training
- Walking/ambulation programs
- Hand therapy
- Ex 'n Flex
- NuStep or physiotherapy bike
- Sit and Dance/Drumming
- Individualized 1:1 programs

In addition to therapeutic programming, the Restorative Care Department oversees the management of assistive devices throughout the building, including power wheelchairs, wheelchairs, walkers, dining assist equipment, and restraints/PASDs.

Our goal is to support residents in maintaining their highest possible level of independence, safety, and quality of life through consistent, individualized restorative interventions.

2025 Restorative Care Quality Initiatives:

- Continued to increase communication with the rehab team through quarterly meetings
- Continue with safety measures, ie. Infection Control, resident masking, put in place to allow residents to have opportunities to benefit their health mobility, well-being and physical abilities.
- Increased the number of residents that use the bike in the Rehab Centre.
- Nursing Rehab continues to work closely with the RC Coordinator to help target specific areas of residents needs, while working together to provide a cohesive environment to, in turn, give the best care for our residents.
- Shifted programming to accommodate for going down to 4 floors (due to redevelopment of Maple).
- Staff attended the Drumming Certification program and initiated the program on the floors, leading to a large group program in the Auditorium 1x/month.
- Continued to have approximately 85-90 people on program.

Goals for Restorative Care 2026:

- Implemented the “new portal” through ALIGN – mobility and aids services (deferred from 2025)
- Continue with safety measures, ie. Infection Control
- Implement Activity Pro for documentation
- Continue to introduce new and innovative programming ie. Drumming exercise (3 staff certified and will teach the department), new Rehab Gym program, the use of technology, etc...
- Continue to work closely with Physiotherapy to be sure all Residents are receiving therapy
- Continue to increase participation in Rehab Gym.
- Look into the prospect of adding a yoga or dance program.
- Continue the Tim Hortons' Walk and overall increase outdoor walking programs. (through Rehab Gym program 1x/month in the summer months).

Physiotherapy												
Active	47	39	40	37	41	42	46	49	51	51	51	51
Discharged	8	7	7	2	4	1	7	6	7	7	1	6
Added/Admission	0	8	4	7	5	5	10	8	7	7	1	5
Total # on Physio Program	39	40	37	41	42	46	49	51	51	51	51	50

In 2025 our Physiotherapy Department continued to work closely with the Restorative Care Department and continued to build up the program by increasing the amount of residents on PT program. The Physio Gym Program has been beneficial and a positive change for the department. The department continues to offer student placement opportunities.

2025 Physiotherapy Quality Initiatives:

- Increase our overall satisfaction from the Resident Survey
- Developed a “Physio Gym” program and then revised to the Rehab Gym program.
-

2026 Physiotherapy Goals

- Incorporate more walking into PT sessions
- Continue to offer the Tim Horton’s Walk (in the summer months).
- Continue to offer therapy sessions outdoors, whenever possible.
- Continue to increase participation in Rehab Gym.
- Look into the prospect of adding a yoga or dance program.

Spiritual Services

Grove Park Home does not have a Chaplain on staff. Our past Chaplain continues to volunteer 2-4x/month to do a Bible Study program for the Home. The programs provided by the Chaplain will be done in a manner that reflects Grove Park Home’s Vision and Mission statements, the Long-Term Homes Act and the legislated regulations. We are fortunate to have Claude Cox available for services, when needed. Claude remains the person available if a family request support to their loved ones at the end of their life. Claude also continues to be a part of our Remembrance Day Service.

Grove Park also continues to offer religious programs monthly from many different denominations.

2025 Spiritual Service Initiatives

- In 2025, four Celebration of Life Services were held to honor and remember residents who have passed, offering comfort and support to families, residents, and staff.

- Pastoral Care meetings were re-started with direct resident input. Feedback and suggestions were gathered through Residents' Council meetings to ensure services reflect the spiritual needs and preferences of the community.
- Religious and spiritual services continue to be offered for residents who request them, supporting diverse faith traditions and individual spiritual practices.

2026 Spiritual Service Goals

- Continue utilizing Resident Council meetings as an opportunity for residents to share concerns, provide feedback, and offer suggestions regarding spiritual and religious programming.
- Broaden spiritual programming by incorporating additional denominations into our monthly drop-in services, ensuring greater inclusivity and diversity in worship opportunities.
- Ongoing Faith-Based Programming:
 - Continue Bible Study programs held in the Auditorium, open to all residents.
 - Ensure Activity staff facilitate at least one spiritually based program each week.
 - Maintain the weekly Sunday Hymn Sing as a consistent opportunity for fellowship and worship.
- Continue hosting Celebration of Life services to honor residents who have passed. Life Enrichment (LE) staff will also continue to hold monthly remembrance gatherings on their respective floors.

Resident Council

The Director of Programs and Volunteer Services acts as the liaison with Residents' Council; answer questions, provide information on current concerns, typing and distribution of minutes. The staff do not have voting rights. This position must receive permission annually by Resident Council to attend meetings.

It is policy of the Home to welcome participation of Residents, families and/or representatives in the affairs of the Home by participating in a Resident Council.

2025 Resident Council and Projects that Council was involved in:

- Retirement gifts
- Honey – funded and fundraising for their council
- Donation to the BPSO for Welcome baskets for new admissions
- Christmas events including:
 - Staff Children's Christmas.
 - Gift Card fundraiser
 - Staff gifts – every staff member received a Christmas gift.
- Donation towards our "staff in need" baskets
- Grove Park celebrated Resident Council Week. We used this week to promote awareness for the Council. We had a special day all week long.
- Throughout 2025 we were able to continue with our routinely scheduled Resident Council Meetings. We continued to meet monthly.
- Developed a new fund, "Resident in-need fund" to support residents in need. The Council has agreed to help support the fund financially. (pending- not officially completed and ready for use)

-Develop a new Resident Council Information brochure to be delivered with new admissions welcome blanket. This will encourage residents to become a part of the Council. (completed- deferred from 2023)

2026 Resident Council Goals

- Continue to inform and collaborate with the Council on the overall goings on of the Home.
- Every resident in the Home will receive a brochure and a Resident Right booklet in upon admission to the Home.
- Develop a new fund, “Resident in-need fund” to support residents in need. The Council has agreed to help support the fund financially. (pending from 2025)
- Continue with our regular scheduled Resident Council Meetings, monthly.
- Collaborate with the Council on Ipac strategies, policies, codes or drills in the Home, incidents and any redevelopment news.
- Continue to have a hand in special projects/fundraising in the Home.
- Possible collaboration with Family Council to join together on special projects in the Home.

Family Council

The Director Resident & Family Services acts as the staff assist to the Family Council. Family Council meets monthly to discuss ways of improving the quality of life of their loved ones.

2025/2026 Family Council:

- Our hope is to have our Family Council back up and running in 2026. (this has been pending since the pandemic) Once we have an active Council again, we will collaborate with the Council on Ipac strategies, policies, codes or drills in the Home, incidents and any redevelopment news
- Information about the Family Council is posted on the Family Council Board with details on “what it is” and how to become involved. There has also been numerous “groupcast” emails sent to the families to remind them of the Council and to contact the Director of Resident & Family Services if they are interested.
- Survey results: The Family Survey and Resident Survey results are posted on the Family Council/Resident Council Board. This board is able to be seen by all visitors coming into the Home.

The goal for 2026: Recruitment is the number one priority and will remain the overall goal moving forward.

Social Service Worker

The Social Services role addition to the care team at Grove Park Home has been positive. Currently our Social Service Worker is Sarina Bagnarol. The services she provides are available to residents, families and staff on a referral basis.

Reasons for referral to social work include, but are not limited to, the following concerns with residents, family members or staff:

- Adjustment/transition challenges
- Bereavement/grief/loss

- Interpersonal issues (e.g. conflict, intimacy, role transitions, etc.)
- Crisis support
- Mental health concerns
- Substance use and addictions concerns
- Resource and community support referrals
- Resident legal or financial matters (POA, wills, etc.)
- End of life care concerns, coping and support
- Support around residents presenting with BPSD

Current caseload statistics 2025

New Referrals: 10

Active: 20 residents (PRN, weekly, or bi-weekly)

Goals for 2026:

- Collaboration with the Pine floor changes ie. Dementia- Care funding, Local Priority funding
- Continue advocating on behalf of residents on case load
- Supporting family members (grief support, system navigation support)
- Improvement in residents on case load who have triggered the "worsened mood and depression" report (RAI)

Health & Safety Policy



The Board of Directors and the Management Personnel of Grove Park Home are vitally interested in the health and safety of its employees. Protection of all from injury or occupational disease is a major continuing objective.

As an employer, Grove Park Home will make every reasonable effort to provide a safe, healthy work environment. Providing employees with the information, training, tools, procedures, and support required to do their job safely and without harming other employees' health. Legislative requirements will serve as minimum acceptable standards for Grove Park Home.

Managers and supervisors are accountable for the health and safety of employees under their supervision. Managers and supervisors are responsible to ensure that instruments, machinery, and equipment are safe and that employees work in compliance with established safe work practices and procedures. Employees must receive adequate training in their specific work tasks to protect their health and safety before commencement of their job.

Employees are accountable for maintaining or taking positive steps to achieve a state of health that is consistent with the demands of his/her occupation. They are also accountable for performing work safely and for identifying, communicating and where appropriate correcting workplace hazards in order to protect themselves and their co-workers from harm. Every employee, sub-contractor and worker of sub-contractor must protect his or her own health and safety by following the law, and Grove Park Home's safe work practices and procedures.

Employees will be involved in decisions, which will have an impact on their health and safety, both individually and through their employee representative groups.

Health and safety will be measured and evaluated in a meaningful way. With an objective of continuously improving performance.

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Health & Safety Audit Results



Committee Members conducted an audit on the Grove Park Home Health & Safety Program, scoring 93%, an increase from the 2025 score of 90% overall

The areas requiring further development or Committee Member competence are as follows:

Inspections:

-Does the department manager or supervisor ensure that each department does its own regular inspection on a monthly basis? ***Repeat item.**

Staff Development:

-Is Health and Safety regular a topic for employee in-service education sessions?

***Repeat item.**

-Is the department manager or supervisor directly involved in Health and Safety education within the department?

Visitor Safety:

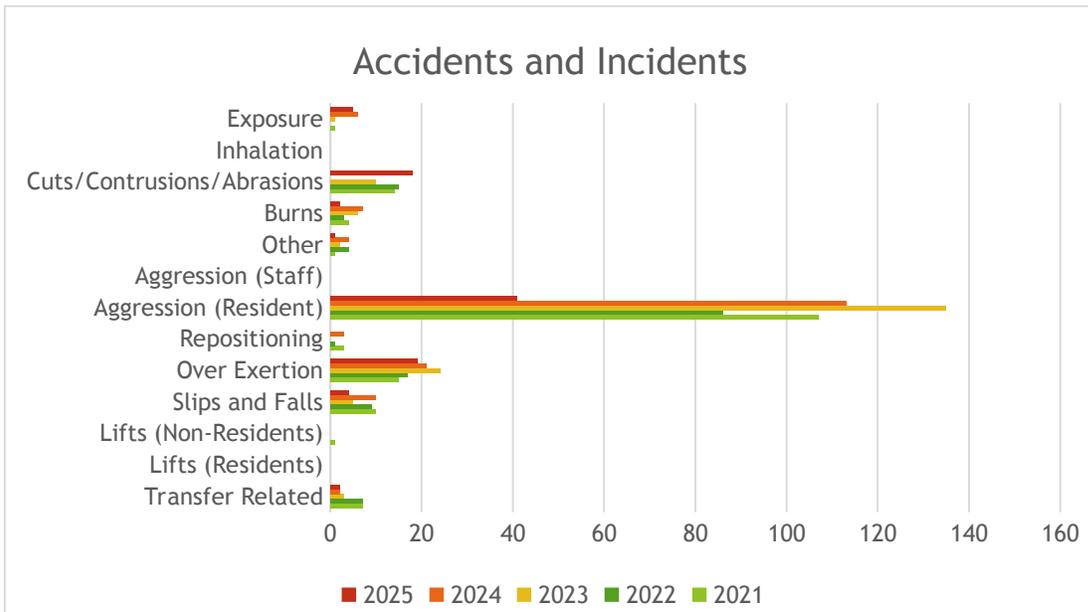
-Is visitor safety part of the orientation program for new staff as well as the continuing education of experienced staff? ***Repeat item.**

Management of Back Problems:

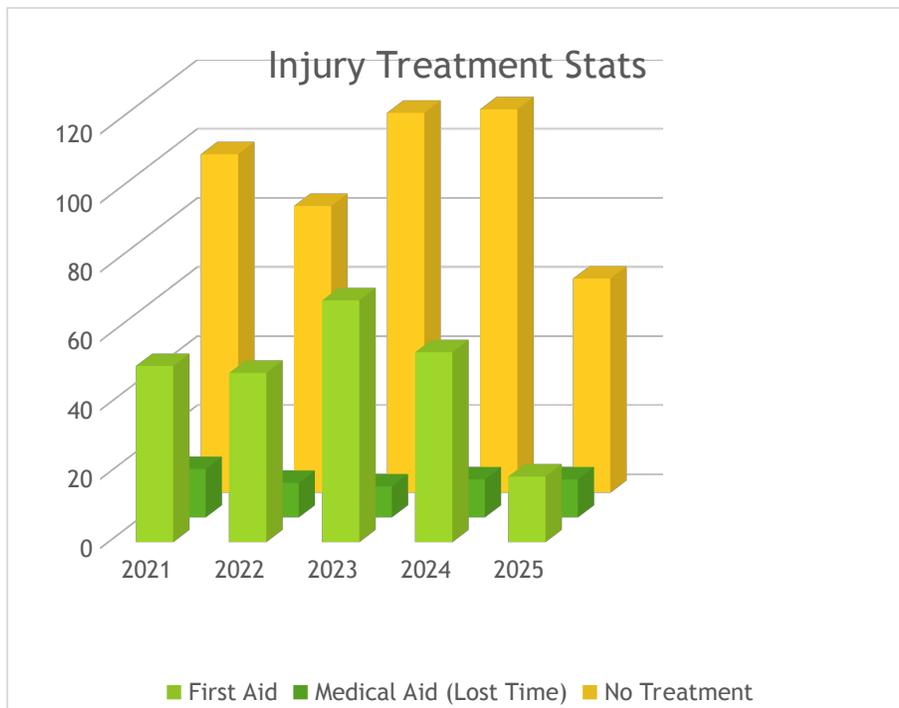
-Do staff follow policies and procedures on lifts and transfers? ***Repeat item.**

Committee Members participating in the annual review: Candice Godin, Edward Larsen, Amanda Phillips & Travis Durham

Review of 2025 Accident & Incident Statistics



In comparison, from 2024 to 2025; incidences have decreased from 177 to 92. The biggest contributor to the incidents continues to be Resident-to-Staff Aggression, and second to that is Overexertion.



A thorough review of the incident and accidents from 2025 is available on the H&S Board

2025 Committee Activity

In 2025 the Joint Health & Safety Committee (JHSC) continued to commit to ensuring staff were protected and prepared to respond to the infectious disease outbreaks, slip trips and falls and the various risks related to construction.



The Ministry of Labour, Immigration, Training and Skills Development (MLITSD) were on-site and remote for numerous follow-ups due outbreaks, complaints and the workplace violence campaign. There were numerous infectious disease outbreaks during the 2025 year.

Candice Godin was responsible for ensuring mask fit testing of disposable respirators was kept up-to-date for all staff. The Ministry of Health offered complementary fit testing for long-term care homes, we had OHSPS join us in April and Home Care Assistance join us for a session in November to get mask fit testing caught up.

Training and employee safety are the top priorities of the committee. There were also live training opportunities throughout the year as a refresher. The committee was influential in ensuring PPE stock was upheld and sourced regularly.

The Committee continued the work towards decreasing incidents resulting from Resident-to-Staff Aggression. This was done by expediting behavioural supports to address certain residents, as well as developing a 'cheat sheet' for all staff when approaching those residents with known aggression.

- Held two mask fit testing sessions for ongoing assurance of the entire workforce being mask fit tested
- Ongoing improvements to communicating known hazards and know aggressive residents to front line staff
- Regular disposable and reusable mask fit testing as PPE supply becomes available
- Maintaining reasonable supply of PPE for future pandemic and/or outbreak situations
- Planned power outage provided insight/ recommendations for such planned/ unplanned events.
- Cytotoxic safety training
- Working with the Behavioural Support Team to ensure Gentle Persuasive Approach training is available to all staff
- Ensuring safety during the redevelopment construction project
- Completion of the workplace violence risk assessment

2025 MLITSD Inspections

- January 15, 2025 - Field visit related to reviewing measures involving agency workers. No findings at time of inspection.
- February 5, 2025 - Field visit related to employee complaint regarding low building humidity. No findings noted at time of inspection.
- February 5, 2025 - Proactive inspection as per the slips, trips and falls blitz. The only finding was that a resident smoking area outdoor access had no means to collect snow and ice when entering. Resolved at time of inspection.
- February 20, 2025 - Follow up field visit related to the February 5 complaint inspection. Inspector brought hygienist in to review humidity concerns. No findings at time of inspection.
- May 22, 2025 - Proactive field visit of the Home and Mulberry Lane, numerous findings include; improper chemical labelling, some PPE missing in critical areas, eye wash station requiring repair, a floor drain with cracked tiles around it, missing caps on eye wash stations. All findings resolved at time of inspection or by July.
- July 2, 2025 - Field visit related to the workplace violence blitz, and Mulberry Lane proactive inspections. There were a couple of findings from this inspection; routine physical building inspections not being consistently completed, the workplace violence risk assessment not completed annually. Findings were all resolved by September.
- November 6, 2025 - Field visit due to self-reporting complaint of noxious scent in the resident home area from construction. Inspector requested hygienist for further investigation. No findings at time of inspection.



2026 Committee Planning



Following the results of the annual program audit and some of the trends in the sector, the JHSC plans the following key areas to focus on in 2026

- Any MLITSD driven trends or legislative changes - IRS internal responsibility system
- Ongoing improvements to communicating known hazards and know aggressive residents to front line staff
- Ongoing IPAC awareness, precautions and preparation during COVID-19, RSV and Influenza seasons.
- Regular disposable and reusable mask fit testing as PPE supply becomes available
- Maintaining reasonable supply of PPE for future pandemic and/or outbreak situations
- Ensure monthly inspections are completed as per inspection schedule
- Maintain a safe work environment during the construction project
- Start a more robust WSIB incident tracking system.
- Provide all nursing staff with Safe Resident Handling training.
- Flag frequently injured persons to their manager and investigate root cause.
- Revisit investigation procedures to tighten response timelines.
- Provide 'back care' training to staff to limit back injuries.
- Providing new members with the 'Worker Awareness' certification
- Work with ONA to determine the role of registered nurses on the committee and the selection process
- Finish development of the Workplace Violence and Harassment Incident Report
- Safe resident handling training

Occupational Health & Safety Committee

1. Dietary Services: Travis Durham, Management Co-Chair
2. Program Services: Candice Godin, Worker Co-Chair
3. Human Resources: Suzanne Briggs, Management Member
4. Environmental: Sandra Wolf, Management Member
5. CSS/Retirement: Christina Flynn, Worker Member
6. Dietary Services: Celeste Godin, Worker Member
7. Environmental: Clinton Simmons, Worker Member
8. Nursing: Edward Larsen, Worker Member
9. Nursing: Amanda Phillips, Worker Member
10. Nursing: Kari Abram, Worker Member
11. IPAC Lead: Sara Pearson, Ex-Officio Management Member
12. Executive Director: Paul Taylor, Ex-Officio Management Member

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POLICY STATEMENT

At Grove Park Home, we recognize the pivotal role Information Technology (IT) plays in supporting our mission to provide exceptional care and services to our residents. We are dedicated to upholding a secure, efficient, and reliable IT infrastructure that aligns with industry best practices and regulatory requirements. This policy statement articulates our guiding principles and expectations governing the management and use of IT resources within our organization, with a focused emphasis on the following key areas:

1. **Hardware and Software Procurement:**

- The IT department shall oversee the procurement process for hardware and software, ensuring alignment with organizational needs, budgetary considerations, and technical requirements.
- All acquisitions will undergo comprehensive assessment, including evaluations of compatibility, performance, reliability, and vendor reputation.
- Purchases must adhere to established procurement protocols, encompassing vendor selection, competitive bidding, and contractual negotiations.

2. **Security:**

- Security is paramount across all IT endeavors. The IT department will establish and maintain robust measures to safeguard our systems, data, and network from unauthorized access, breaches, and cyber threats.
- Regular risk assessments, access controls, encryption protocols, and employee training initiatives will be employed to foster a culture of cybersecurity awareness.
- Continuous monitoring and auditing of systems will be conducted to promptly address any identified security vulnerabilities or incidents.



3. **Communication and Life Safety Systems:**

- The IT department is entrusted with managing and maintaining communication and life safety systems, including voice communication, emergency notification, and surveillance systems.
- These systems shall be upheld to ensure operational efficacy, reliability, and compliance with relevant regulatory standards and emergency response protocols.
- Routine testing, maintenance, and upgrades will be executed to optimize the functionality and reliability of communication and life safety systems.

4. **Data Management:**

- Upholding the privacy and confidentiality of resident and employee information is of paramount importance. The IT department shall oversee the management of data assets, encompassing collection, storage, transmission, and disposal, in adherence to pertinent laws and regulations.
- Stringent data management policies and procedures will be implemented to ensure secure handling and access limited to authorized personnel based on necessity.
- Regular audits and assessments will be conducted to monitor compliance with data management protocols and identify areas for enhancement.

5. **User Training and Awareness:**

- Ongoing training programs will be developed and implemented by the IT department to educate employees on IT policies, procedures, and best practices.
- Training initiatives will cover topics such as cybersecurity awareness, data privacy, acceptable use of IT resources, and emergency response protocols.

- Regular communication and awareness campaigns will reinforce training messages, fostering a culture of IT security and compliance among all staff members.
- 6. Incident Response and Escalation:**
- Clear procedures for incident reporting, escalation, and response will be established by the IT department to address security breaches, system failures, and other IT-related incidents.
 - Employees will be provided with guidance on recognizing and promptly reporting security incidents, with designated points of contact and communication channels.
 - Documented incident response plans, delineating roles, responsibilities, and escalation procedures, will ensure a coordinated and effective response to IT incidents.
- 7. Vendor Management:**
- The IT department will maintain relationships with technology vendors and service providers to ensure timely delivery of products, services, and support.
 - Vendor contracts and service level agreements will be scrutinized and negotiated to align with organizational requirements, including performance expectations, support provisions, and data protection commitments.
 - Continuous monitoring of vendor performance and compliance will be conducted, addressing any discrepancies through established escalation procedures.
- 8. Continual Improvement:**
- Engaging in continual improvement initiatives will be a priority for the IT department to enhance the effectiveness, efficiency, and reliability of IT services and infrastructure.
 - Stakeholder feedback mechanisms will be instituted to identify areas for improvement and innovation, including input from residents, families, and staff.
 - Regular performance reviews, benchmarking exercises, and technology assessments will be conducted to evaluate the impact of IT investments and identify opportunities for optimization and enhancement.
- 9. Documentation and Knowledge Management:**
- The IT department shall maintain comprehensive documentation of IT systems, configurations, procedures, and troubleshooting guides to facilitate knowledge sharing and operational continuity.
 - Documentation will be regularly updated and accessible to authorized personnel to ensure accurate and up-to-date information is available for IT support and maintenance activities.
 - Knowledge transfer sessions will be conducted to disseminate critical information and expertise among IT staff members, fostering collaboration and skill development within the team.

By adhering to these principles and guidelines, we reaffirm our commitment to leveraging technology to enhance the quality of care and services provided to our residents, while safeguarding the security, privacy, and integrity of our IT infrastructure and data assets.

2025 ACTIVITY

January

- ▢ Provided the Nursing department with six laptops ‘computers on wheels’. New profiles for each device and security locked to the carts
- ▢ Installed a new time clock in the staff computer lab
- ▢ Completed a cybersecurity assessment to the website
- ▢ Continued with the implementation and security of the Office 365 transition
- ▢ Completed and submitted the annual ITS report for the MLTC
- ▢ Built a utility tracking form to manage and observe natural gas and water consumption
- ▢ Added a surveillance camera to be monitored by Maintenance in the Receiving area

February

- ▢ Renewed HP Fixed Support Services until February 2027
- ▢ PCC Skin/Wound or ‘Swift’ program implementation
- ▢ Purchased and set up six iPads strictly for use as per the Skin/Wound program
- ▢ Purchased and installed new versions of Office (2016-2024) for use on computers that require standalone versions

March

- ▢ Replaced the UPS battery backup for our basement tech equipment
- ▢ Updated firewall to restrict social media access on our business network
- ▢ Upgraded the Rogers hardware for the Café area wireless
- ▢ Implementation of the StaffScheduleCare mobile app
- ▢ Renewed LifeLabs Launchpad security certificate on all computers
- ▢ Managed communications during ice storm which disrupted power for approximately three days
- ▢ Replacement laptop for Director of Dietary Services
- ▢ Set up tech relocation of the Director of Care and the Assistant Director of Care

April

- ▢ Repaired PCC EMAR back-up
- ▢ Implemented 18 temperature/humidity sensors through AlertLabs system
- ▢ Completed a nurse call verification on the Spruce home area post-construction
- ▢ Closed the Maple home area, removing all tech related components
- ▢ Changed the Mulberry swing from Maple to the Aspen home area for nurse call
- ▢ Finalized the implementation of Office 365

May

- ▢ Replaced the UPS battery backup for our server cage
- ▢ Renewed HPE Fixed Support contract

June

- Renewed Symantec antivirus protection for 50 devices for another year
- Negotiated new bulk cable TV agreement with Rogers cable.

July

- Started the major project of changing out network switches and upgrading the wireless network adapters.

August

- Repairs were made to the wanderguard sensors on Pine due to continuous ringing
- Adjustments made to all stairwell door alarms to ensure they are alarming when left open.

September

- Replaced a laptop for two managers; Director of Community Services/Retirement Living and Director of Families and Resident Services
- Renewed website hosting with Digital Giants

October

- Replaced five nursing station desktop computers
- Switched the old (@groveparkhome.on.ca) e-mail account from EasyonNet to Namespro
- Replaced two cameras on Pine that were damaged from the flood
- Maintained systems and contingencies during a day-long full facility power shut down

November

- Rogers upgraded Cable TV equipment in preparation for the new service
- All RPNs received a cell phone for day-to-day communication as the wireless phone system has failed

December

- Conducted a School Messenger emergency response exercise
- Start investigating alternative learning management systems
- Updated data server firmware
- Developed policies:
 - Computer/Internet/Email Usage
 - Artificial Intelligence
 - Social Media
 - Rules of Conduct Regarding Computer Use
- Fixed data server

Throughout the year

- Improving wireless access in underserved areas
- Maintain/troubleshoot resident connectivity issues.
- Act as a help desk and remote support for any issues arising related to user access
- Ongoing improvements to workstations, printers, telephone devices

- Repurpose assets as capable, otherwise data wipe old equipment and make available for staff to take home
- Involved in redevelopment work with nurse call, surveillance systems, communication, cable TV, wanderguard, door controls and public address system

2026 PLANNING

- Review strategic plan and update for 2025-2028.
- Participate on the construction committee for redevelopment project, future tech needs and storing assets
- Continue to work through the migration to Office 365, work towards full utilization of SharePoint and OneDrive
- Upgrade telephone system prior to/and as part of capital redevelopment
- Upgrade nurse call system prior to/and as part of capital redevelopment
- Upgrade door and access controls prior to/and as part of capital redevelopment
- Improve surveillance cameras outside as well as in newly constructed areas prior to/and as part of capital redevelopment
- Integrate Lab Integration into Point Click Care
- Integrate RNAO Best Practice into Point Click Care
- Complete a penetration test from external attack.
- Add additional laptops and desktop computers as existing devices reach end-of-life
- Implement staff e-learning on malware, phishing and password protection
- Work with Director of Human Resources to transition to another
- Update the timebank with Poweredge in January 2026 (last update was November 2024) Total of 14 months of Labour. Time Bank of \$11,000.00/14 months = \$785.50 average per month or \$39.29 per day on a 30-day month. This will be an increase from 2024 upload as a number of major projects were conducted using time bank hours in 2025.

REDEVELOPMENT PLANNING

In capital redevelopment planning, IT at Grove Park Home oversees the integration of essential technology systems, including nurse call, telephone, door control, elopement control, cable television, and internet access. Our responsibilities include ensuring seamless deployment, optimizing functionality, and prioritizing resident safety and operational efficiency.

Rogers Cable – auditing existing infrastructure, determining locations of coaxial outputs in the redeveloped home areas.

Chubb Security – removing existing cameras and infrastructure in the redeveloped home areas and then having them re-installed after construction.

Aatel Communications – upgrading telephone system, wireless phone system, door controls (in construction areas), elopement monitoring system, and nurse call system for entire facility.

Advanced Data & Network – responsible for all ethernet cable runs for the entire Maple and Aspen construction project

Poweredge Solutions – provider of networking, printing and workstation replacement upon completion of Maple and Aspen construction project.

CYBERSECURITY SUMMARY

CURRENT SECURITY MEASURES:

We use software that detects open ports on routers and copies executable encryption viruses on servers or PC's. opening attachments on e-mail.

Symantec Antivirus on servers and PC's. Datto backup that detects .exe files and alerts Poweredge.

Datto protects against ransomware by automatically scanning each new backup for signs of a ransomware infection. If an infection has occurred, administrators can use Datto's Rapid Rollback to quickly identify and restore only the affected data, without needing to reimage the entire machine. Datto products also offer unequivocal disaster recover options. Datto's solutions rely on AES 256, which is the gold-standard in data security. AES 256 offers a level of protection that is unmatched.

Internal threats such as human error or intentional damage will still be detected by Datto detection, Symantec Antivirus, SonicWall Security Suite.

CURRENT THREATS / AREAS OF CONCERN:

In 2026, we are investigating and hoping to undertake some systems penetration testing to ensure that outside parties cannot gain access to our systems and create havoc or lock our systems under ransom.

Rapid onboarding and requests for technology enhancements by departments and software providers, does put the operation at risk for security breaches.

Program Evaluation

Program: Diversity and Cultural Competency

Date of Review: 2025

Policy/Standard Reference: CARF accreditation standards

Indicators/Methods Used to Monitor Program:

- Monthly committee meetings
- Collaboration with management team
- Diversity board which houses education/awareness

Participants and Positions:

Participants and Position		
Sara Pearson ADOC- chair	Sarina Piscopo SW- Co Chair	Ingrid Montalban RSL
Shaz Mahdavi DOC	Edward Larsan RSL	Emily Medeiros DIETARY
Karen Dixon AC	Qurrat Babi FSS	
Anukram Bhati LE	Emily Montalban DIETARY	

Goals of the Program from Previous Year: 2025

Goal	Date Achieved
Continue to update the diversity and cultural competency plan as needed	Ongoing
Monthly meetings to plan for ways to provide insight to different days or awareness/recognition	Completed for 2025
Providing at least 1 event/education/awareness related to culture and diversity each month.	Completed for 2025

State the goals that were set the previous year. Must be SMART Goals

Evaluation:

1. Based on established goals of the program, an analysis of the InterRAI LTCF indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

Improved Not Changed Not Met

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No

Trends and Analysis: Initially in the earlier months of committee meetings it was quite difficult to obtain buy in from staff. With consistency we have been able to sustain a committee, meet monthly, and provide education and awareness related to Diversity and cultural competency.

Comments Related to Program: As a committee we have been working together to find out how we want this program run. We have learned through the year what is working, and how to work together as a team, honing in on each person's specialties.

Tell a story about the program. Barriers, constraints, etc

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Increase members on the diversity committee	Tracking staff who attend the meeting monthly in meeting minutes, provides for more feedback and involvement.	Increase awareness about the committee while attempting to scout staff	
Increase attendees to monthly diversity meetings	Tracking staff who attend the meeting monthly in meeting minutes, provides for more feedback and involvement.	Increase awareness about the committee while attempting to scout staff focusing in on the fact that it is a meeting and does not have to be an ongoing commitment.	
Improve awareness with staff and residents through Diversity Committee	<p>Staff Education & Training</p> <ul style="list-style-type: none"> -% of staff who attend diversity training sessions. -Pre- and post-training surveys to assess knowledge improvement. <p>Resident Engagement</p> <ul style="list-style-type: none"> -% of residents participating in diversity-related activities. -Feedback surveys from residents on feeling included and 	<p>Increase Staff Cultural Competency</p> <p>Enhance Resident Awareness and Engagement</p> <p>Improve Communication of Diversity Initiatives</p> <p>Policy and Practice Review</p> <p>Measure Awareness and Satisfaction</p> <p>Celebrate and</p>	

	<p>informed.</p> <p>Diversity Committee Actions</p> <ul style="list-style-type: none">-Number of diversity initiatives implemented per quarter.-Number of policies reviewed or updated to include inclusive practices.	Recognize Diversity	
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Program Evaluation for 2025

Program: Quality Improvement

Date of Review: February 18, 2026

Policy/Standard Reference: Fixing Long-term Care Act 2021, Section Reg 165-169, Regulations O.Reg 246/22

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for residents
- Best Practice Guidelines are followed
- Required education as per MOLTC are met annually
- MOLTC Inspections/Annual Reviews

Participants and Positions:

Participants and Position		
GPH Staff	All Staff of Grove Park Home	
Charmaine Andreasen	Grove Park Home-ADOC/Nursing Educational Coordinator/Behaviour & Palliative Care/Pain Lead	
Paul Taylor	Grove Park Home-Executive Director	
Shaz Mahdavi	Grove Park Home-Director of Care	
Dr. McTurk	Medical Director for Grove Park Home	
Mary Ellen Miller	Grove Park Home Nurse Practitioner	
Sara Pearson	Grove Park Home-Assistant Director of Care/IPAC Nurse	
Travis Durham	Grove Park Home-Director of Food & Nutrition & IT	
Sandy Wolf	Grove Park Home-Director of Environmental Services	

Suzanne Briggs	Director of Human Resources/Educational Director	
Kerry Guy	Grove Park Home-Director of Resident & Family Services/ Programs & Volunteers	
Karen Speed	Grove Park Home-InterRAI Coordinator	
Joanne Chandler	Grove Park Home-Registered Dietician	
Candice Godin	Grove Park Home Restorative Care Coordinator	
Jodie Sing	Grove Park Home RN	
Joanne Swales	Grove Park Home RN	
Stephanie Nelson	Grove Park Home RPN	
Debbie Brown	Administrative Assistant for Nursing	
Amanda Phillips	Grove Park Home PSW	
Sarah McColeman	Grove Park Home PSW	
Savita Dhaliwal	Consultant Pharmacist -Silver Fox Pharmacy	
Ashley Allan	Royal Victoria IPAC Consultant	
Claire Campbell	Family Member	
John James	Grove Park Home-Resident from Aspen Unit	

Goals of the Program from 2025:

Goal	Date Achieved
<u>Resident Satisfaction Survey indicates:</u> Overall score of 96% which is an increase of 6% from 2024. There were 49 residents who participated.	October 2025 Overall score=90%
<u>Staff Satisfaction Survey indicates:</u> Number of staff surveyed 77 in 2025 an increase from 69 in 2024.	October 2025 Overall score= 96% which is an increase of 6% from 2024
<u>Family Satisfaction Survey indicates:</u> This was the first year we electronically sent out the survey	October 2025 Overall score= %

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Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

X Improved Not Changed Not Met

- Family Survey
- Resident Survey
- Staff Survey
- Minutes from QI Meetings

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

Yes No X

Methods of Communication:

- Family Survey
- Resident Survey
- Staff Survey
- Sharing of Quality Improvement Minutes
- Town Hall Meetings
- Care Conferences
- Phone Blasts to family

Trends and Analysis:

The Quality Improvement (QI) Program remains focused on promoting excellence in resident care and ensuring ongoing compliance with the Fixing Long-Term Care Act (FLTCA). Governance and oversight continue to be supported through regular Professional Advisory Committee (PAC) meetings, where quality indicators, program updates, and work plans are reviewed and shared with the QI Team to promote accountability and transparency.

Annual satisfaction surveys for residents, families, and staff remain a key driver of quality priorities. Survey findings are communicated transparently to stakeholders and are used to inform targeted action plans, ensuring that feedback meaningfully influences program development and service improvement.

Several challenges were identified over the past year. The loss of two QI Team stakeholders created a temporary gap in interdisciplinary representation and highlighted the need for recruitment and succession planning. Additionally, time constraints and inconsistent access to meeting documentation were identified as barriers to full engagement and continuity of quality initiatives.

To address these gaps, the team implemented OneDrive as a centralized, collaborative platform to support real-time documentation, improve access to meeting materials, and enhance

continuity between meetings. This initiative has strengthened communication, accountability, and progress tracking across quality improvement activities.

In parallel, Nursing Directors have initiated a comprehensive review and update of all nursing policies and procedures to ensure alignment with current legislation, evidence-based practice, and organizational standards. Strategic planning has also commenced in preparation for CARF International accreditation in 2027, positioning the organization to meet enhanced quality and performance benchmarks.

Overall, the program demonstrates continued commitment to structured governance, responsive quality planning, and long-term strategic improvement.

AIM for 2026:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Regain designation as a Best Practice Spotlight Organization	Supported by the Best Practice Champion Training	Continue to collaborate with the IOOF-LTC Team and RNAO Lead-Jen Behun to support each LTC facility	
Completion of updating all nursing policies and procedures by the end of the year	All polices will be updated and the date of the update added to the policy review section	Each year review any changes and update policies in real time	
Improve knowledge of medication management policy	Add to surge learning Pharmacy to provide in person training	Re-evaluate the training modules each year Ensure all new hires receive education and training prior to administering medications on their own	