Omni
Quality Living

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Omni Quality Living Continuous Quality Improvement Initiative Report 2026/27

Prepared in accordance with: *Fixing Long-Term Care Act, 2021* O. Reg. 246/22 – Section 168 Continuous Quality Improvement Initiative Requirements

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Omni Quality Living – Wildwood Care Center

Continuous Quality Improvement Initiative Report

2026/27

OVERVIEW

At Omni Quality Living, people remain the driving force behind our mission. Since 1975, we have been committed to delivering compassionate, high-quality care, and as we move into our 51st year, we continue to shape the future of long-term care in Ontario with innovation, integrity, and a deep sense of purpose.

Quality is embedded in our culture. Our **Quality Matters** program guides our approach, ensuring that every resident receives care that is safe, timely, effective, and personalized. This framework supports continuous improvement and reinforces our commitment to evidence-based practices, routine evaluation, and industry-leading standards.

We recognize our role in supporting a health system that is sustainable, equitable, and focused on long-term wellness. Our work aligns with Ontario's vision for a value-based universal health care system—one that prioritizes prevention, improves outcomes, reduces hallway medicine, and strengthens access to high-quality care for all Ontarians.

Our **2026/27 Quality Improvement Plan** reflects provincial annual priorities as well as corporate priorities identified across Omni Quality Living. It aligns with regional and provincial strategies and fulfills the requirements of the **Continuous Quality Improvement Initiative Report (CQIIR)** under section 168 of O. Reg. 246/22 of the *Fixing Long-Term Care Act, 2021*.

This plan also supports broader provincial goals: enhancing the health care experience through an integrated, resident-centered continuum of care, and collaborating with partners to build an accountable, high-performing system that reduces disparities and improves outcomes across diverse populations.

Access and Flow

Improving access and flow across Ontario's health system continues to be a shared responsibility, and long-term care plays a vital role in ensuring residents receive the right care

in the right place. Omni Quality Living remains committed to strengthening system capacity and supporting smoother transitions for residents, families, and partners across the continuum of care.

- **Timely and Responsive Admissions**
  All applications for admission are reviewed promptly and responded to in accordance with the *Fixing Long-Term Care Act*. We remain committed to ensuring that individuals waiting for long-term care receive timely decisions and clear communication.
- **Efficient Bed Management**
  Available beds are reported to Ontario Health at Home without delay, and admissions are scheduled as soon as possible to support flow across hospitals, community settings, and long-term care.
- **Expanding Capacity Through Redevelopment**
  We continue to redevelop existing homes, often adding new beds and licenses—and to build new homes in communities across Ontario. These investments support provincial efforts to increase long-term care capacity and reduce pressure on hospitals.
- **Nurse Practitioner–Led Outreach**
  Nurse Practitioner outreach remains a key strategy in enhancing on-site clinical support, reducing avoidable transfers, and improving resident outcomes.
- **Reducing Unnecessary Emergency Department Transfers**
  We continue to strengthen in-home clinical capabilities, early intervention strategies, and staff education to minimize avoidable transfers to emergency departments.
- **Enhanced On-Site Diagnostics**
  Partnerships with local health agencies enable more facility-based services such as X-ray, ultrasound, and laboratory testing—improving access to timely diagnostics and reducing the need for off-site appointments.
- **Improving Transitions Through Technology**
  We continue to advance our use of digital tools to support safe, accurate, and efficient communication with external health partners.
- **Strengthening Medication Reconciliation**
  Many of our homes have adopted the pharmacist-led “Boomer Process” for first-time admissions, ensuring accurate medication reconciliation and safer transitions into long-term care.

Technology

Strengthening digital connectivity across the health system remains essential to improving access, flow, and resident safety. Omni Quality Living continues to expand the use of technology to support accurate, timely, and coordinated transitions of care.

- **Maximizing PointClickCare**

PointClickCare remains our core clinical information system. We continue to leverage its advanced capabilities, including analytics, dashboards, and real-time reporting—to support early identification of risk, improved care planning, and stronger communication across the continuum of care.

- **HealthConnex Integration**
  HealthConnex supports secure, streamlined information exchange between long-term care and acute care partners. Expanded use of this platform reduces delays, improves accuracy of shared information, and supports more efficient transitions.
- **Optimizing CHRIS**
  CHRIS remains essential for communication with Ontario Health at Home and community partners. Consistent use supports timely referrals, accurate documentation, and smoother transitions for residents entering or leaving long-term care.
- **Driving Compliance Through CHeCS**
  CHeCS transforms regulatory complexity into operational clarity. This mobile-first, AI-enabled platform standardizes compliance workflows, reduces incident logging time, manages staff training and certifications, and supports adherence to the *Fixing Long-Term Care Act*. By reducing administrative burden, CHeCS enables staff to focus more time on resident care.
- **Advancing Interoperability Through Amplify**
  All Omni homes continue to use Amplify to support safer transitions by connecting clinical data systems between long-term care and acute care. This integration reduces the risk of medication discrepancies, treatment errors, and information gaps during transfers.

Together, these digital tools strengthen our ability to deliver safe, coordinated, and efficient care while supporting broader provincial goals for a more connected and higher-performing health system.

Resident and Family Experience

A positive resident and family experience is central to high-quality long-term care. It reflects every interaction resident and family have within our homes—from daily care and communication to access to information and involvement in decision-making.

At Omni Quality Living, the voices of residents and families guide our quality improvement efforts. We are committed to creating an environment where each person's preferences, needs, and values shape the care they receive.

Resident Experience Survey

We partner with **Metrics at Work**, an independent organization that administers and analyzes our annual Resident Experience Survey. This survey focuses on two key indicators:

- How well residents feel staff listen to them.
- Whether residents feel they can express their opinions without fear of consequences

Survey results provide valuable insight into the lived experience of residents and families. Findings are used to identify opportunities for improvement, guide action planning, and celebrate strengths. Results are shared openly to promote transparency and accountability.

Our goal remains clear: to ensure every resident experiences compassionate, respectful, and individualized care, supported by strong partnerships with families and caregivers.

Provider Experience

A strong provider experience is essential to delivering exceptional resident care. At Omni Quality Living, we are committed to being a workplace where people feel respected, supported, and inspired—across all roles, generations, and career stages.

- **Recruitment, Retention, and Workforce Development**
  We actively recruit and retain qualified candidates while investing in the next generation of long-term care professionals. Our corporate education coordinator strengthens partnerships with colleges and universities, coordinates student placements, and supports preceptorship opportunities.
- **Success Through PREP LTC**
  The PREP LTC initiative has strengthened our ability to support students and new graduates by enhancing preceptor training, improving onboarding, and building confidence among staff who take on mentorship roles. This has contributed to stronger multigenerational teams and a more supportive learning environment.
- **Commitment to Learning and Growth**
  We offer bursaries for continuing education, certifications, and skills training, recognizing that investing in our people strengthens both care quality and job satisfaction.
- **Creating a Supportive Workplace**
  A positive provider experience includes moments of connection, recognition, and joy. Our homes regularly host appreciation events, celebrations, and team-building activities. Every employee also receives a holiday gift card as a gesture of gratitude for their dedication.

Safety

Safety is the foundation of high-quality care. At Omni Quality Living, we view safety as a whole-person commitment that includes physical, emotional, psychological, and social well-being.

Whole-Person Safety

Our approach is grounded in a biopsychosocial understanding of health. We focus on:

- **Physical safety:** Strong IPAC practices, fall prevention, medication safety, and safe clinical procedures.
- **Emotional and psychological safety:** Trauma-informed approaches, respectful communication, and environments free from fear or intimidation
- **Social safety:** Supporting meaningful relationships, reducing isolation, and fostering belonging.

A Culture of Staff Safety

A safe home depends on a safe workplace. We support staff through:

- Clear protocols and training
- Access to tools and technology that reduce risk.
- A culture of open reporting and psychological safety
- Respectful, inclusive environments that promote teamwork.

Learning and Continuous Improvement

We encourage open reporting of incidents and near misses and use this information to guide improvements. Digital tools support consistent documentation, timely communication, and effective follow-up.

Partnering With Residents and Families

Residents and families play an essential role in safety. Their insights help identify risks, improve communication, and strengthen care planning.

Palliative Care

Palliative care at Omni Quality Living is grounded in dignity, comfort, and whole-person support. Our approach enhances quality of life for residents living with progressive, life-limiting illnesses while providing meaningful guidance to families.

Resident-Centered and Culturally Responsive Care

Care plans reflect each resident's physical, emotional, social, psychological, and spiritual needs. From admission, we complete additional assessments to support culturally appropriate advance care planning.

Support for Families

Families are essential partners. We provide education, emotional support, and practical guidance to help them navigate the palliative journey.

Holistic Comfort and Well-Being

Our teams focus on:

- Pain and symptom management
- Emotional and psychological support
- Social connection and belonging
- Spiritual care aligned with personal beliefs

Care in Place

Whenever possible, we provide palliative care within the home to reduce unnecessary hospital transfers and support comfort in familiar surroundings.

A Compassionate, Coordinated Experience

Our approach ensures personalized care, continuity, comprehensive support, and a focus on comfort, dignity, and peace.

Population Health

Long-term care plays a vital and often underrecognized role in improving population health. Omni Quality Living contributes to healthier communities by supporting older adults with complex needs, preventing avoidable hospital use, and promoting well-being across the continuum of care.

- **Supporting Aging Populations with Complex Needs**
  We provide stable, comprehensive, 24-hour care for individuals with chronic conditions, cognitive impairment, mobility challenges, and social vulnerabilities—reducing strain on hospitals and community services.
- **Promoting Wellness and Prevention**
  Our teams focus on early identification of health changes, chronic disease management, fall prevention, nutrition and hydration, and social engagement.
- **Reducing Health System Pressures**
  By providing high-quality care in place, we help reduce avoidable ED visits, unnecessary hospital admissions, ALC pressures, and harmful transitions.
- **Equity and Inclusion**

We support residents from diverse cultural, linguistic, and socioeconomic backgrounds and ensure care is respectful, inclusive, and aligned with individual values.

- **Strong System Partnerships**
  We collaborate with hospitals, primary care, Ontario Health Teams, community agencies, and specialized services to support coordinated care and improved transitions.
- **Data-Informed Decision-Making**
  We use clinical data, quality indicators, and resident experience feedback to guide improvement and target interventions.
- **Enhancing Quality of Life**
  Population health is about living well. We prioritize meaningful engagement, purposeful activities, social connection, and emotional well-being.

Alignment With the Fixing Long-Term Care Act and CQIIR Requirements

Omni Quality Living's 2026/27 Quality Improvement Plan fully aligns with the *Fixing Long-Term Care Act, 2021* and the **Continuous Quality Improvement Initiative Report** requirements under O. Reg. 246/22.

1. Systematic Approach to Continuous Quality Improvement

Our plan uses a standardized, evidence-informed framework supported by:

- Clinical indicators
- Resident experience surveys
- Safety reports
- Staff feedback

2. Annual Priorities and Targets

- Aligns with provincial priorities
- Includes home-level and corporate-level indicators
- Uses data from PCC, HealthConnex, CHRIS, CHeCS, and surveys
- Sets realistic, evidence-based targets

3. Resident, Family, and Caregiver Engagement

- Use independent Resident Experience Surveys
- Incorporate Resident and Family Council feedback
- Share results and action plans publicly
- Embed resident voice in care planning and safety initiatives

4. Staff Engagement and Provider Experience

- Strengthen workforce development
- Support multigenerational teams
- Promote psychological safety and open reporting
- Encourage staff participation in QI activities

5. Monitoring, Reporting, and Evaluation

- Use real-time data systems
- Conduct audits and interdisciplinary reviews
- Track trends in safety and outcomes
- Report progress to leadership, residents, families, and the public

6. Integration With the Broader Health System

- Strengthen partnerships with hospitals, OHTs, and community agencies
- Use digital platforms to improve transitions
- Support system flow and reduce avoidable transfers
- Contribute to population health and equity

7. Commitment to Resident Safety

- Use a biopsychosocial approach
- Strengthen IPAC, emergency preparedness, and violence prevention
- Encourage open reporting
- Implement technology-enabled safety systems

8. Public Transparency

- Share QI priorities and results openly
- Maintain clear, accessible documentation
- Demonstrate accountability through visible action

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	18.18	13.00	We have seen a slight decline since last year and still implementing more interventions to assist with decreasing this number. We have also added a full time in house NP and more at the bedside equipment.	

Change Ideas

Change Idea #1 Decrease number of ED visits

Methods	Process measures	Target for process measure	Comments
Review stats with Registered Staff at Registered Staff Meetings	Review with on-call MD the residents current status and determine if any medications can be added to avoid transfer. Review findings with family as they may not want a transfer to the hospital at that time. Education to be provided to registered staff to help better understand when transfers are required.	Review the quarterly statistics from the SWLHIN. Target to have 13 or less avoidable ED visits	

Change Idea #2	Nurse Practitioner to review advance directives in the home to ensure families and residents have a good understanding of what each level of care entails and that the level meets their goals of care for the resident.		
Methods	Process measures	Target for process measure	Comments
NP to review current level of cares for all residents. NP will have discussion with POAs to ensure they have a good understanding of the current level of care they have selected.	NP to keep track of the number of residents with each level within the home. Staff to review at annual care conference each residents level of care.	Number of residents with each level of care within the home.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	86.36	90.00	If the home averaged 90%, we would be similar to the average of other OMNI homes	

Change Ideas

Change Idea #1 Engage the Residents and have them participate giving input into routines ie. likes and dislikes. Get them more involved with organizational practices and day to day activities.

Methods	Process measures	Target for process measure	Comments
Residents to participate in quarterly Quality Meetings with staff and will also be involved in the interview process for new hires. Time allocated during residents council for residents to express any concerns they may have. LEC to follow up with the appropriate actions to address concerns.	LEC coordinator to track number of concerns as well as Administrator tracks number of written complaints from residents and families.	90% response rate	Total Surveys Initiated: 153

Change Idea #2 Educate staff on approach and body language when caring for their residents			
Methods	Process measures	Target for process measure	Comments
Meetings with Staff monthly in general staff meetings to discuss QI plans, initiatives, outcomes and follow-ups. Utilize surge learning for meeting minutes to reach those staff members who are not able to attend meetings. Time allocated during Residents council for Residents' to raise any comments or concerns they may have, concerns documented and follow up from LEC.	LEC and Administrator track number of verbal as well as written complaints and what follow up has been completed.	90% response rate	

Change Idea #3 Encourage residents and their families to participate in Annual Care Conferences to share their opinions and questions openly.			
Methods	Process measures	Target for process measure	Comments
Residents and families invited and encouraged to attend annual care conferences.	Concerns and comments received by staff written and addressed by staff.	90% response rate on Resident Satisfaction Survey	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	85.32	90.00	If the home averaged 90%, we would be similar to the average of other OMNI homes	

Change Ideas

Change Idea #1	Engage the Residents and have them participate giving input into routines ie likes and dislikes. Get them involved with organizational practices and day to day operations		
Methods	Process measures	Target for process measure	Comments
Residents to participate in quarterly Quality meetings with staff.	LEC to follow up in Residents Council and relays any concerns to the rest of the management team	To have overall results at 90% or higher	Total Surveys Initiated: 218

Change Idea #2	Engage the Residents and have them participate giving input into routines ie likes and dislikes. Get them involved with organizational practices and day to day operations		
Methods	Process measures	Target for process measure	Comments
Encourage residents to attend committee meetings around the home such as; Food Committee Meetings as well as Residents Council Meetings.	LEC and FSS to follow up with residents suggestions or concerns in a timely manner. Council meeting minutes to be posted and discussed with Management Team.	There is an aum to have a response rate of 80% or higher on the satisfaction survey.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement "Rate the level of satisfaction to which your missing clothing or laundry concerns were addressed."	C	% / LTC home residents	In house data, interRAI survey / 2025	75.00	80.00	An average of 80% would make us more comparable to other OMNI homes.	

Change Ideas

Change Idea #1 Family to be educated on the labelling process; where to take the items, what happens to them once given to the home. As well as educating families on what to do during an admission

Methods	Process measures	Target for process measure	Comments
In collaboration with Family council, a brochure has been created to educate families of the labelling process.	Resident satisfaction survey	There is an aim to have a response rate of 80% on the satisfaction survey	

Change Idea #2 Labelling of closet doors and dresser drawers with resident names to assist with ensuring clothing items are placed in the proper location

Methods	Process measures	Target for process measure	Comments
Labels created and placed in the appropriate location with which bed (A or B) they belong to	Random audits to be completed to ensure that labels are still in the right locations and not missing	To have an overall result rating of 80% or higher	

Change Idea #3 Randomized focus audits to be completed to audit if the clothing cart, drawers and closets have the correct residents clothes

Methods	Process measures	Target for process measure	Comments
Focus audit created for staff to complete while doing audit	Review the focus audit results to see amount of residents whose clothing is in the incorrect location	To have overall results of 80% or higher	

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	17.96	10.00	We have chosen to have our target set at 10 as we feel that this is an obtainable goal going forward. We have had a significant increase in falls but can link these falls to a couple residents.	

Change Ideas

Change Idea #1 Falls team to meet monthly to review falls, any patterns that are noticed and any further interventions that can be added to prevent further falls.

Methods	Process measures	Target for process measure	Comments
PT, DOC and members of the falls team review each fall since last meeting and determine if any repeat fallers and what interventions are in place.	Continue to track number of falls each month, specifying how many for each resident, time of day, location	Compare percentage of falls within the home with Insights data. Goal is to have falls as 10% or less	

Change Idea #2	Falls reviewed at PSW meetings, Registered Staff meetings, Quality Improvement meetings as well as Professional Advisory meetings.		
Methods	Process measures	Target for process measure	Comments
Review of residents who have had multiple falls and gather any suggestions for further interventions from a multidisciplinary teams.	MDS data, fall reports from PCC as well as Physio	Compare percentage of falls within the home with Insights data. Goal is to have falls at 10% or less.	

Change Idea #3	Implementation of Restorative Nurse to complete audits post fall as well as random audits to ensure that the appropriate interventions are in place for residents who are at risk for falls, and that the falls prevention equipment is in working order.		
Methods	Process measures	Target for process measure	Comments
Nurse completes audits on a regular basis ensuring that all equipment is working correctly as well as review post fall that all interventions were correctly used during the time of a fall	Nurse reviews what she has discovered on the spot to correct the issue, documentation and ensures the care plan has been updates. Staff are notified on the report sheet as well as at departmental meetings.	Compare percentage of falls within the home with Insights data. Goal is to have falls at 10% or less	

Change Idea #4	Implementation of " Falls Prevention Medication Review" for residents who staff feel require a review from a Pharmacist due to frequent falls		
Methods	Process measures	Target for process measure	Comments
staff to utilize "Falls Prevention Medication Review" forms	At Falls Committee Meetings, residents who could benefit from a Medication Review will have form completed and sent to Pharmacist.	Compare percentage of falls within the home with Insights data. Goal is to have falls at 10% of less within the home.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	35.56	25.00	Continue to work at decrease the rate of antipsychotic use within the home. Lowering to 25% will make our home comparable to the provincial average.	

Change Ideas

Change Idea #1 Quarterly Medication review by Pharmacist and MD/NP

Methods	Process measures	Target for process measure	Comments
Quarterly medication reviews printed and reviewed by MD/NP. Pharmacist completes a medication review quarterly and recommendations given to MD/NP to review	Quarterlies reviewed and order changes made	To decrease use of antipsychotics for residents without a diagnosis to 25% annually.	

Change Idea #2 ADhoc Antipsychotic use team meetings to occur with the NP leading. Staff will discuss current residents on antipsychotic and if any changes/reductions can occur

Methods	Process measures	Target for process measure	Comments
Team will meet and review each resident and their current medication orders. Discussion held and any trial reductions implemented.	Review our current stats within the home and compare to provincial averages.	To decrease the use of antipsychotics for residents without a diagnosis to 25% annually.	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	2.53	2.30	Reaching a target of 2.3% would put Wildwood in line with the provincial average.	

Change Ideas

Change Idea #1 Ensure Skin and Wound assessments are being completed on admission as well as quarterly after admission.

Methods	Process measures	Target for process measure	Comments
RAI coordinator to ensure that assessments are completed within the time frame. Assessments reviewed and if any skin concerns noted interventions would be added at that time.	Percentage of change noted on the Insights tab that is gathered from the InterRAI	To maintain an average of 2.3% on the prevalence of worsened stage 2-4 pressure ulcers within the home.	

Change Idea #2 Ensure weekly Skin and Wound assessments are being completed on any active wound or skin concerns within the home.

Methods	Process measures	Target for process measure	Comments
Assessment schedules activated for skin and wound assessment and the UDA completed within the 7 day time period.	No overdue UDA schedules for Skin and Wound Assessments	To maintain an average of 2.3% on the prevalence of worsened stage 2-4 pressure ulcers within the home.	

Change Idea #3 Ensure that the interdisciplinary team is aware of any new or worsened pressure ulcer within the home.			
Methods	Process measures	Target for process measure	Comments
Referrals are being made to the dietician, PT, NP as well as the wound care specialist if required. Wounds are reviewed by the skin and wound committee on a monthly basis.	Ensure that when a Wound assessment is complete the appropriate interdisciplinary teams are made aware. During skin and wound committee meetings, ensure that all departments are aware of any new or worsening wounds.	To maintain an average of 2.3% on the prevalence of worsened stage 2-4 pressure ulcers within the home	

Change Idea #4 PSW's to monitor residents skin on a daily basis to help observe any changes, to be documented on POC qshift.			
Methods	Process measures	Target for process measure	Comments
PSW's to document qshift on POC of the residents current skin condition, as well as ensure that they are applying lotion to residents legs and arms daily.	Review of PSW's documentation and alerts that are created from documentation on POC regarding skin conditions.	To maintain an average of 2.3% on the prevalence of worsened stage 2-4 pressure ulcers within the home.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	1.20	0.00	Our target is 0 as currently we have no restraints within the home and the average over the 4 quarters is including only 1 restraint that has since been removed.	

Change Ideas

Change Idea #1 Monitoring residents who are at a high risk for falls and ensuring the appropriate fall prevention and safety interventions are in place.

Methods	Process measures	Target for process measure	Comments
Audits completed to ensure interventions(such as; fall matts, alarms, hip protectors etc) are in place and located in the care plan.	Monitoring the prevalence of restraints within the home using Insights data from InterRAI	Our target is to maintain 0 restraints within the home	

Change Idea #2 Alarms on bed and chair in place at the time of admission for a review period

Methods	Process measures	Target for process measure	Comments
Alarms to be in place at the time of admission to alert staff when residents are attempting to ambulate independently.	Staff to document the amount of times a residents attempts to ambulate independently to determine the risk they are for falls. Percentage of falls noted on the Insights tab from InterRAI	To maintain a percentage of physical restraint use in the home at 0%	

Access and Flow | Efficient | Optional Indicator

Indicator #8

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Wildwood Care Centre)

Last Year		This Year		
23.08	**13**	**18.18**	**21.23%**	**13**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Decrease number of ED visits

Process measure

- Review with on call MD the residents status and medication may be added to avoid a transfer. Review findings with family as they may not want a transfer to the hospital. Education of the registered staff and families in order to reduce transfers to ED

Target for process measure

- Review the quarterly statistics from the SWLHIN. Target to have 13 or less ED visits

Lessons Learned

We have seen a significant decrease in the numbers since last year. Continue to call MD and POA prior to transfer if appropriate.

Comment

Continue to work with MDs and POA to assess if the transfer is appropriate. NP to work alongside POAs to readdress/discuss current level of cares within the home and what family plans/goals are for the resident.

Equity | Equitable | Optional Indicator

Indicator #7

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Wildwood Care Centre)

Last Year		This Year		
100.00	**100**	**100.00**	**0.00%**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Development of DEI Policy from OMNI Head office

Process measure

- Completion rate on surge learning.

Target for process measure

- 100% Trained on Surge Learning

Lessons Learned

Completed, Policies reviewed by all management staff

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

Training of all Staff on Equity, Diversity, inclusion and anti-racisms

Process measure

- Monitor surge completion rate annually

Target for process measure

- 100% completion rate

Lessons Learned

Policies reviewed by all staff.

Comment

No further changes to this plan at this time as all staff have completed.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #4 Percentage of residents who responded positively to the statement "How often do you feel you have sufficient time with morning care?" (Wildwood Care Centre)	**79.80** Performance (2025/26)	**80** Target (2025/26)	**80.80** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

PSW meeting held to discuss possible morning routine changes that could free up more time for them to spend with each resident in the am.

Process measure

- Follow up each month at the PSW Meeting

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Meeting held and suggestions taken into consideration/implemented.

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

Audit created to track that specific morning care items are being completed, to be used sporadically and on a random resident/staff member.

Process measure

- Review of completed audit tools. If concerns f/u discussion with resident if able as well as staff member who performed the care.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Several audits completed, will ensure more are completed to have better control group.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Individualize surveys created for residents to establish if any improvements have occurred.

Process measure

- Number of concerning responses from surveys

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Survey still in the works

Comment

Overall, there has been a very slight increase in the results from the Satisfaction Survey. Management to implement more survey/audits to determine where staff/residents are feeling the missing care items are occurring.

Indicator #5

Percentage of residents who responded positively to the statement "Rate the level of satisfaction to which your missing clothing or laundry concerns were addressed." (Wildwood Care Centre)

Last Year		This Year		
65.90	**80**	**75.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Staff Education on admission process for labelling clothes

Process measure

- Surge Learning staff meetings to be reviewed by staff with 100% completion rate.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Education completed for all nursing staff

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

Family education on admission process with clothing and when new items are brought into the home.

Process measure

- Compliance by family members as new admission arrive as well as when new clothing items come into the home.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Family council created new brochure to provide to families upon admission

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Labelling of closet doors and dresser drawers with resident names to assist with ensuring clothing items are placed in the proper location.

Process measure

- Random clothing audits to be completed to ensure items are in the correct location.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Closets and dressers have been labelled as A or B bed, to create and perform a routine audit of this going forward.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Randomized focus audits to be completed to audit if the clothing cart, drawers and closets have the correct residents clothes

Process measure

- Review the focus audit results to see amount of residents whos clothing is in the incorrect location.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Audits have been done and findings positive, will continue to implement this audit spontaneously

Change Idea #5 ☑ Implemented ☐ Not Implemented ☐ In Progress

Dedicated staff approximately 2-3 times per week assigned to ensure proper labeling of personal items, tidy rooms/closets and drawers.

Process measure

- Checklists reviewed and staff notify DOC of any common concerns.

Target for process measure

- To have overall results at 80% or higher

Lessons Learned

Staff continue to be assigned to this task on a weekly basis to ensure these items are being completed.

Comment

Will continue to providing brochure to families upon admission, providing education to staff of the proper policies to labelling clothes as well as perform audits to ensure that items are labelled correctly and in the appropriate place.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Wildwood Care Centre)	**89.66** Performance (2025/26)	**90** Target (2025/26)	**86.36** Performance (2026/27)	**-3.68%** Percentage Improvement (2026/27)	**90** Target (2026/27)

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

Engage the Residents and have them participate giving input into routines ie likes and dislikes. Get them more involved with organizational practices and day to day operations

Process measure

- LEC coordinator to track number of concerns as well as Administrator tracks number of written complaints from residents and family

Target for process measure

- 93% response rate

Lessons Learned

Residents are encouraged and have been participating in family council, food committee as well as QI Quarterly Meetings.

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

Educate staff on approach and body language when caring for their residents

Process measure

- LEC and Administrator track number of verbal and written complaints and what follow up has been completed.

Target for process measure

- 93% response rate

Lessons Learned

Staff continue to complete Surge Learning

Comment

Staff have completed mandatory education on Surge Learning that specifically educates them on appropriate ways to approach residents. Residents are continually invited and encouraged to attend committees around the home and to feel safe with sharing their ideas and opinions.

	Last Year		This Year		
Indicator #6	**89.80**	**90**	**85.32**	**-4.99%**	**90**
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Wildwood Care Centre)	**Performance (2025/26)**	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

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

Engage the Residents and have them participate giving input into routines ie likes and dislikes. Get them more involved with organizational practices and day to day operations

Process measure

- LEC to follow up in Residents Council and relays any concerns to the rest of the management team

Target for process measure

- To have overall results at 93% or higher

Lessons Learned

Residents continue to participate in Residents council, food committee as well as QI Quarterly meetings.

Comment

Resident concerns and suggestions are taken seriously and dealt with in a timely manner. Residents will continue to be encouraged and invited to participate in making decisions and suggestions.

Safety | Safe | Optional Indicator

Indicator #1

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Wildwood Care Centre)

Last Year		This Year		
12.44	10	17.96	-44.37%	10
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Falls team to meet monthly to review falls, any patterns that are noticed and any further interventions that can be added to prevent further falls.

Process measure

- Continue to track number of falls each month, specifying how many for each resident, time of day, location

Target for process measure

- Compare percentage of falls within the home with Insights data. Goal to have falls as 10% or less

Lessons Learned

Meetings occur monthly with good interventions being suggested that are specific to individual residents.

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

Falls reviewed at PSW Meetings, Registered Staff Meetings, Quality Meetings as well as Profession Advisory Meeting.

Process measure

- MDS data, Falls reports from PCC as well as Physio

Target for process measure

- Compare percentage of falls within the home with Insights data. Goal to have falls at 10% or less

Lessons Learned

Falls continue to be reviewed at meetings and input from other departments on ways future falls may be prevented.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implementation of "Falls Prevention Medication Review" for Residents who staff feel require a review from a Pharmacist d/t frequent falls

Process measure

- At Falls Committee Meeting, residents who could benefit from a Medication Review will have form completed and sent to Pharmacist.

Target for process measure

- Compare percentage of falls within the home with Insights data. Goal to have falls at 10% or less.

Lessons Learned

This form continues to be used for residents who frequently fall and may be due to medications. New addition of NP in the home to help initiate and implement these changes.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Random audit by registered staff implemented to ensure that fall prevention strategies are in place and appropriate working order; such as fall mats, bed alarms etc.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This new audit/follow up seems to help lessen some falls that were occurring due to staff not being notified early enough to prevent a fall. Also, ensuring fall mats are appropriately used has helped prevent significant injury.

Comment

The home continues to monitor falls within the home, tracking trends in the data for time of day, location and resident who is falling. Implementing any new interventions that may benefit residents who fall frequently.

	Last Year		This Year		
Indicator #2	**32.18**	**25**	**35.56**	**-10.50%**	**25**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Wildwood Care Centre)	**Performance (2025/26)**	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

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

Quarterly Medication review of residents who are on antipsychotics and reason for use with possible reduction.

Process measure

- Review medications and MDS to ensure accuracy of coding. Review any current medications for possible reduction. Also, review of PRN medication to see if any not being used that could be D/C'd

Target for process measure

- To decrease use of antipsychotics for residents without a diagnosis to 25% annually.

Lessons Learned

The form the home was recently using to track antipsychotic is no longer available. NP has initiated a new team to review these AdHOC and attempt to make reductions within the home.

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

Quarterly Medication review by Pharmacist and MD

Process measure

- Quarterlies reviewed and orders changes made

Target for process measure

- To decrease use of antipsychotics for residents without a diagnosis to 25% annually

Lessons Learned

Ongoing, NP now completing Quarterly Medication Reviews.

Comment

NP to initiate Team Meetings going forward to monitor residents who currently receive an antipsychotic, ensure appropriate and determine if any reduction is possible at that current time.