Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #9	**48.00**	**85**	**85.70**	**--**	**NA**
Percentage of Residents who would respond to the statement "I am satisfied with the quality of care from dietitians." on the annual satisfaction survey. (Fenelon Court)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Registered Dietician will be hired, or services contracted by April.

Process measure

- Weekly attention until hire is successful.

Target for process measure

- Response to the statement about will have an increase in a positive response by 40%

Lessons Learned

We hired an excellent candidate who is very responsive and has 12 years' experience as a Dietitian which has helped improve our results.

Change Idea #2 ☐ Implemented ☑ Not Implemented

While we are recruiting for a registered dietitian, we will utilize a remote resource for consultation and MDS coding.

Process measure

- Ensure RD availability remotely and weekly

Target for process measure

- Family's positive response to above statement will improve 40%

Lessons Learned

This was not needed as we were able to hire a Dietitian.

Change Idea #3 ☑ Implemented ☐ Not Implemented

RD attends IDCC when needed and resident and family conferences as needed. Hi

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

RD attended 6 family conferences arranged this year since hire. RD lets the Interdisciplinary team know the high lights of his assessments and any changes noted. His communication with the team and with families is excellent. Supplement use went down, referrals for skin tears were clarified with the team's policy review, collaboration with FSM was excellent. Collaboration with the front line improved with our RD writing SBAR notes directly into the Physician book in preparation for Medical Director rounds

Indicator #11

Percentage of residents who would positively respond to the statement" I am satisfied with the temperature of my food and beverages" on the annual family satisfaction survey. (Fenelon Court)

Last Year		This Year		
48.00	**85**	**54.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Dietary Manager will perform touch the table survey weekly for residents which will include one question about the temperature of the food. Results and action plan will be reviewed with ED at Am meeting, monthly Q Day and quarterly at PAC

Process measure

- The Dietary Manager will bring the results from the weekly survey to am meeting, a collation of suggestions and action plan to Q day and PAC

Target for process measure

- Positive response to above statement will improve. 20%

Lessons Learned

FSM was away due to personal issues and was not always able to perform the weekly touch the table but did at least once monthly. The results were shared at Professional Advisory Committee as well as Family Council

Change Idea #2 ☑ Implemented ☐ Not Implemented

Dietary Manager with ED will assist residents in completing a survey regarding food preference and quality of the food temperature, in addition to the touch the table 5 surveys a week.

Process measure

- Surveys will go out via email and paper copy at front desk for a week in June and September. Results will be reviewed at am meeting, Q day and PAC and at Resident's council

Target for process measure

- Positive response to the above statement will improve by 20%

Lessons Learned

FSM provided a small survey prior to the menu changing in June regarding input into preference and experience with food temperatures.

Comment

2023 there were 25 touch the table surveys performed. In 2024 there were 87 touch the table surveys completed. The results of the surveys in 2024 revealed there were no concerns with food temperature and some suggestions for preferences which were honored by FSM.

	Last Year		This Year		
Indicator #3	**78.80**	**85**	**56.50**	**--**	**NA**
Percentage of Families who would answer positively to the statement "I am satisfied with the quality of cleaning services within my room" on the annual resident and family satisfaction survey. (Fenelon Court)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Environmental Service Manager to review cleaning schedules, deep cleaning scheudles and audit schedules with ED

Process measure

- 100% of cleaning and deep cleaning and auditing schedules will be adhered to

Target for process measure

- Resident response to the statement above will improve by 20%

Lessons Learned

Weekly cleaning and deep cleaning schedules and audit schedules were shared with ED and shared with families at family council as well at weekly Newsletter to families.

Change Idea #2 ☑ Implemented ☐ Not Implemented

ED and/or delegate to perform weekly audits of rooms as well as EVS as part of focused MBWA and report into Q day monthly and PAC quarterly.

Process measure

- 6 rooms will be audited weekly for cleaning and deep cleaning by ED and/or delegate

Target for process measure

- Positive response to above statement will improve by 20%

Lessons Learned

6 rooms were audited weekly with the ED auditing with ESM once weekly with UV light. Audits were completed 98% of the time and areas above toilet roll in Bathrooms which were missed were addressed on the spot with one performance management given for one team members

Comment

98% of weekly deep cleaning audits were performed in 2024. 10/67 rooms were decluttered before deep cleaning with family input. Weekly cleaning of carpets occurred. The smell in the home was still noted as an issue in the Sturgeon Long hall which is scheduled to have the carpets removed in 2025 as a priority in phases.

Indicator #1

Percentage of families who respond positively to the statement "I am satisfied with the quality of cleaning within the residents' rooms" on the annual resident and family satisfaction survey. (Fenelon Court)

Last Year		This Year		
51.50	**85**	**56.50**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Resident rooms will be cleaned as per schedule and deep cleaning will occur as schedule. Cleaning audits will occur as scheduled.

Process measure

- 100% of adherence to the cleaning schedules will occur. 100% of the adherence to deep cleaning schedules will occur. 100% of the audits will occur.

Target for process measure

- 100% of cleaning schedules and audits will occur.

Lessons Learned

Resident rooms were de-cluttered and deep cleaned. EVS's schedule was reviewed by ED, Marquise Regional Resource and IPAC Lead. EVS met with Family council twice regarding the declutter and deep clean schedule. Results of weekly cleaning audits were reviewed at Professional Advisory Council and revealed that 98% of the audits were completed as scheduled.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Executive Director will perform cleaning audits once per week in addition to EVS's audits.

Process measure

- ED will audit one home area a week as part of MBWA 100%

Target for process measure

- 100% of audits will be performed by ED

Lessons Learned

ED reviewed weekly audits and audited using UV lights with the ESM. Results of the audits were shared at family council and at Professional Advisory Council. Results revealed that 95% of UV audits showed complete cleaning with areas above the toilet roll not always wiped completely. Spot education was given and one performance management given to one team member. We invited a family member to join us for one UV audit monthly.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Heavy Duty Cleaning will be performed monthly

Process measure

- Develop tracking sheet for deep cleaning schedule and audits.

Target for process measure

- Response on the annual resident and family satisfaction survey will improve by 40%

Lessons Learned

Heavy duty cleaning was performed regularly once weekly particularly in the dining rooms where floors were cleaned in detail. All common areas carpets were cleaned regularly once weekly.

Comment

In 2024 98% of the weekly deep cleaning audits were completed. The ED reviewed 100% of all UV audits performed weekly which revealed the area above the toilet roll was not always cleaned resulting in spot education and one performance management. Family council noted an improvement in the decluttering of rooms and cleanliness of the carpets specifically. There were still some concerns about smell of carpets and the capital plan for 2025 was revealed to remove the carpets in phases. The families and team members were very happy about the plan.

Indicator #10

Percentage of Residents who would positively respond to the statement "I would recommend this home" on the Annual Family Satisfaction Survey (Fenelon Court)

Last Year		This Year		
80.00	**85**	**85.70**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Program Manager will complete a survey for families regarding suggestions for programs-calendars will reflect many of the suggestions.

Process measure

- Program Manager with the team will review activity pro and attendance at programs and review with families at monthly family council meetings.

Target for process measure

- 50% of the suggestions will appear on the calendars by end of April.

Lessons Learned

Program Manager executed a small survey to families and residents regarding activities they would like to see in the home which was very successful.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Program Manager will provide education regarding how programs are chosen for the home based on research and best practice. (as well as preference and attendance).

Process measure

- Results shared, Education provided, survey completed, and results shared and activities adjusted to suggestions on the calendars.

Target for process measure

- 50% of the suggestions will be executed

Lessons Learned

Education was also provided to family and resident's council regarding how programs and activities are chosen based on the 5 domains of human potential

Change Idea #3 ☑ Implemented ☐ Not Implemented

Share with families our admission Initial Recreation Assessment " all about me" and how we use it to enhance person centered care and programming.

Process measure

- Create a tracking tool to ensure al families receive a quarterly family forum invite and minutes.

Target for process measure

- Increase response by 40%

Lessons Learned

There was no tracking tool developed but all families received the invitation and attendance improved from 2 persons to 10 persons which was a huge improvement for this home.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Percentage of residents positively responding to the statement "I would recommend this home" on the annual Family Satisfaction survey will increase by 5 %.

Process measure

- Annual Resident and Family satisfaction survey

Target for process measure

- Improvement by 5% will be achieved as evidenced by a 5% increase in the percentage of residents who positively responding to the statement "I would recommend this home" on the annual Family Satisfaction survey

Lessons Learned

We met our goal and improved by 5%

Comment

We were able to meet our goal of improving by 5% in the area of families recommending our home. We were able to forge good relationships with families who were more highly engaged as well as create a Leadership presence at family forum.

Indicator #2

Percentage of families who respond positively to the statement "I have an opportunity to provide input on food and beverage options" on the annual resident and family satisfaction survey. (Fenelon Court)

Last Year		This Year		
51.70	**85**	**78.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

ED to review resident council and food council concerns and recommendations monthly with Dietary Manager and Team at am meeting.

Process measure

- Touch the Table results will be reviewed monthly by the team at am meeting as presented by Dietary Manager.

Target for process measure

- 50% of all resident suggestions and preferences will be honored.

Lessons Learned

ED reviewed resident council and food council concerns and FSM and ED attended 2 family council meetings. Results of the touch the table audits were shared at team town hall meetings as well. Food temperature was not identified as a concern, but some preferences were noted which were honored by Dietary.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Families will be engaged in Touch the Table Weekly Surveys where they are asked their opinions about the quality of the food and temperature.

Process measure

- Every week at least 1 family member will be surveyed using touch the table. Monthly the responses will be reported to the ED at am meeting and at monthly Q day and quarterly at PAC

Target for process measure

- Positive Response on the survey regarding input on food and beverages will improve by 20%

Lessons Learned

FSM was away for personal reasons for some days in the week so touch the table was not done as much as planned. There were several weeks these were not done. For the weeks they were done we collated the results and reviewed at PAC (not monthly at Q day) Residents and families liked the touch the table check ins very much.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Smaller Surveys for families will be put out in June and again in September specifically for suggestions for food and beverages for residents.

Process measure

- All families will be emailed and paper copies available at front desk for a period of 1 week before collation

Target for process measure

- Families response to the statement above will improve 20%

Lessons Learned

At Family Council in June, FSM provided a small survey regarding ideas for the new menu. It was very well received and feedback about the new menu was very positive in July and August "roast beef was amazing- the place smells wonderful at meal time". There were no logged complaints regarding food except for one resident whose concerns about the texture of the meat were resolved.

Comment

The number of Touch the table surveys improved by 80% from 2023 to 2024. Residents were not concerned about food temperature and provided feedback about preferences which were added to the new menu. 2 Family Council meetings included our Food Service Manager who reviewed resident preference and menu planning on the agenda.

Indicator #4

Percentage of Family who would positively respond to the statement "I would recommend this home" on the Annual Family Satisfaction Survey (Fenelon Court)

Last Year		This Year		
60.00	**75**	**84.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

PLEASE FILL IN THIS SECTION

Process measure

- PLEASE FILL IN THIS SECTION

Target for process measure

- PLEASE FILL IN THIS SECTION

Lessons Learned

Leadership was present with families and responded to concerns and questions immediately (within 24 hours). Family concerns decreased significantly in 2024 as a result.

Change Idea #2 ☑ Implemented ☐ Not Implemented

We will carry out the actions identified in our action plan for improvement including improving cleaning in the rooms and common areas, input into recreational activities, input into food and beverages.

Process measure

- mini-survey response will be 20 % and annual resident and family survey results will improve. 10%

Target for process measure

- annual resident and family survey results will improve 10%

Lessons Learned

In June Recreation and FSM provided a small survey to families and they were very appreciative of the input.

Comment

Identification of high-risk families decreased significantly in 2024. From Q1 to Q4 the number of high-risk families decreased from 11 to 1. In Q1 high risk family concerns were addressed with weekly meetings then monthly and relationships were built based on resident and family personhood and teams were positively engaged with the high risk families. Feedback was solicited in every monthly newsletter and activities and audit results conveyed in the newsletters and at family forums.

Safety | Safe | Optional Indicator

Indicator #6

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Fenelon Court)

Last Year		This Year		
15.90	**13**	**11.24**	**29.31%**	**10.10**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

PSW to perform purposeful rounds every hour on all residents during their shifts ensuring residents are toileted or checked for toileting/brief changes, observed for pain, checked for positioning, checked for the need for personal items within reach since falls generally occur with residents trying to toilet, are uncomfortable, and /or reach for items they want.

Process measure

- Monthly Q-day will evaluate the effectiveness of the measure

Target for process measure

- Falls will decrease by 10% this year

Lessons Learned

Rounds were implemented and not always performed as per audit and review of camera footage. Daily am meetings and weekly huddles review 4 Ps in preventing falls. Am meeting now includes a review of residents who are falls risks for each home area. Nurse In Charge report includes a high risk line list which includes all residents who are at risk for falls. Monthly Quality Labs with our region were held to review best practice, speak to our CIHI indicators and how we plan to improve for the next month.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Weekly IDCC rounds to assess falls risks related to medications and changes in condition.

Process measure

- Falls risk documentation will be reviewed at the round weekly as well as post fall huddle documentation.

Target for process measure

- 100% of post fall huddle documentation will be completed weekly when reviewed at the round. Residents at risk to fall will be reviewed and falls will decrease by 10% by end of April.

Lessons Learned

Weekly IDCC rounds were implemented and held each week. Residents at risk for falls were reviewed with Physio and the Nursing Team. Falls risks were also identified each day on our high-risk line list reviewed at am meeting with Nurse In Charge. New admissions were reviewed for falls risks (utilizing their Home and Community Health information as well as interviews with residents and families and care givers) and a falls plan created before they arrived.

Comment

CIHI data for falls revealed we were at or below the provincial benchmark except for 2 months in Q3 related to 2 residents who were very high risk for frequent falling. Our average for the year was 15.9 0.9 above the benchmark of 15. We continue to review frequent fall risks with Nurse In Charge report sheet daily utilizing our high risk line list which is also used at each shift report.

Indicator #8

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Fenelon Court)

Last Year		This Year		
14.47	**18**	**9.35**	**35.38%**	**9**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Antipsychotic reduction quarterly meetings will continue to be held and will not include RAI as well as DOC, Medical Director, BSO Lead and Pharmacist. Weekly BSO rounds will also review Antipsychotic changes, DOS and effectiveness and will be documented by BSO Lead

Process measure

- Weekly meetings and Quarterly meetings will occur 100% of the time and Antipsychotic use will be reduced even further by 2%

Target for process measure

- Antipsychotic use without diagnosis will be reduced by 2%

Lessons Learned

Responsive behaviors, 1:1s and medication requirements are reviewed daily with Nurse In Charge at am meetings. Weekly BSO rounds resident's medications are reviewed and our Pharmacist is available by email daily if needed. Pharmacist, BSO Lead and Nursing Leadership meet quarterly for med reviews with the Medical Director. Residents with 1:1s have their own binders with information related to personhood, preferences, triggers and actions to prevent and avoid behaviours. Registered staff and regular PSWs review the care for each resident with the 1:1 on each shift. BSO lead puts together the binders with the team's input and weekly BSO reviewed needs for changes to the plan of care for each resident with behaviors. Each day the Nurse In Charge's report includes a high-risk line list which also includes all residents with Behaviors, all resident who have 1:1s and any changes to the plan of care which may preclude the use of antipsychotics.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Fenelon will utilize more 1-1s to address residents with responsive behaviours using non pharmacolgical methods eg. understanding of personhood, DOS review with triggers, life story and BSO individual binders.

Process measure

- 100% of 1-1s will receive orientation to the BSO binders each shift by Nurse and BSO Lead will spot check and meet with 1-1s at least once weekly.

Target for process measure

- Antipsychotic use will be reduced by 2%

Lessons Learned

Our BSO program was implemented and our Lead flourished with support from Nursing Leadership with daily review of 1-1s at am meeting and weekly BSO rounds. BSO Lead attended education. The 1-1s utilized binders with DOS, life story, care plan and triggers as well as toileting records. Residents with 1:1s have their own binders with information related to personhood, preferences, triggers and actions to prevent and avoid behaviours. Registered staff and regular PSWs review the care for each resident with the 1:1 on each shift. BSO lead puts together the binders with the team's input and weekly BSO reviewed needs for changes to the plan of care for each resident with behaviors. Each day the Nurse In Charge's report includes a high-risk line list which also includes all residents with Behaviors, all resident who have 1:1s and any changes to the plan of care which may preclude the use of antipsychotics.

Comment

Our CIHI data revealed that we are at or below the provincial benchmark for Antipsychotic use. Our average for the year was 14 with a benchmark of 17. Our BSO program was revitalized this year with a new BSO lead who received all education, implemented weekly BSO Rounds, attended weekly IDCC rounds, participated in all Community of Practice initiatives, participated in monthly Quality Labs for the region where best practices are shared, and accountability and plans for improvement are reviewed for the subsequent month.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5	**0.00**	**4**	**0.00**	**#Error**	**NA**
Percentage of long-term care home residents in daily physical restrains over the last 7 days (Fenelon Court)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

We will continue to sustain our good practices of zero restraint

Process measure

- Weekly restraint numbers will be reviewed by ADOC and RAI

Target for process measure

- We will continue to have 0 restraints.

Lessons Learned

We reviewed restraints and PASD daily at am meeting after implementing our new am report template as well as the new Nurse In Charge report sheet which included a high risk line list.

Comment

We will continue utilizing our high risk line list with our report daily. RN in charge brings the Nursing report which includes the high risk line list to daily morning Interdisciplinary report after receiving report from all registered staff. In addition, upon admission we review PASD and restraint and inform families of our process and policy. We review PASD needs daily at am meeting, at shift report, weekly at IDCC specifically falls prevention and maximizing independence including physio reports, and also weekly at BSO as needed for residents with behaviors. We continue to have 0 restraints in the home.

	Last Year		This Year		
Indicator #7	**3.80**	**2**	**2.00**	**--**	**NA**
Percentage of LTC residents with worsened ulcers stages 2-4 (Fenelon Court)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Wound Care Nurse will be identified and complete wound care course

Process measure

- Wound Care Nurse to attend wound care training

Target for process measure

- Wound Care Nurse will be in place by end of March

Lessons Learned

We were able to mentor a Wound Care Lead who also completed the wound care course. The Wound Care lead reviews all wounds one day weekly, utilizes the NP stat resource when needed and our Corporate resource regularly to review completion of assessments, wound protocols, and education that is required. We held Clinical day for all registered staff with a focus on assessment, documentation and reporting of wounds.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Weekly Wound care rounds will be implemented. Wound assessments will be completed.

Process measure

- 100% of weekly Rounds will be completed and 100% of monthly education sessions will occur.

Target for process measure

- Wound numbers will decrease by 5%

Lessons Learned

Wound Care Nurse attended to Wound Lead duties once weekly which included review of wounds, orders, assessments and education required. Once weekly rounds occurred 95% of the time.

Comment

Our CIHI data reveals we were above the benchmark for worsening wounds at an average for the year of 3.3% where the benchmark was 2. In 2024 we re educated all registered staff on wound care, assessments, reporting and documentation. Our Wound lead reviews all wounds, assessments and performs education on a weekly basis with the assistance of our Corporate Wound clinical lead. We have also engaged our NP stat wound specialist with complicated wounds. We have had some resident turnover and have some improvement in our pressure injury rates. Our numbers should improve this year as a result.