

Equity | Equitable | Optional Indicator

| Indicator #8 | Last Year | | This Year | | |
|---|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |
| Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Extendicare Laurier Manor) | CB | 100 | CB | -- | NA |

Change Idea #1 Implemented Not Implemented In Progress

Empathy Training Video for all staff

Process measure

- # of staff who have watched the video

Target for process measure

- 100 percent of all staff, students, and newly onboarded staff and volunteers will watch the Surge Video on Empathy by June 30, 2025

Lessons Learned

All staff registered in Surge were required to watch the empathy video, and may have attended in house training provided by leadership. Staff who participated in the training voiced a better understanding of residents feeling on entering the home and coping with the decline of their abilities.

Comment

We will continue to offer Empathy training via Surge and through inhouse training as it was beneficial, and we will also be doing training on therapeutic communication and body language in 2026.

Experience | Patient-centred | **Custom Indicator**

| | Last Year | | This Year | | |
|--|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| Indicator #4 | 47.10 | 75 | 40.90 | -- | NA |
| In my care conference we discuss what is going well, what could be better, and how we can improve things | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |
| (Extendicare Laurier Manor) | | | | | |

Change Idea #1 Implemented Not Implemented In Progress

All residents will be asked if they would like to attend their care conference, and if they would like to have a representative attend their care conference with them

Process measure

- 1) # of annual care conferences where residents attend (/236) 2) # of care conferences where plan of care was discussed with resident (/236)

Target for process measure

- 100% of residents will have documentation of a invitation to participate in their IDTC 2019 and 50% by Dec 31, 2025

Lessons Learned

All residents "first" were informed of their ITDCC in person or via personal email, if capable, or SDM/POA for care was notified via phone or email. Initially, the option to do the interview on teams was offered, however it was noted that the nursing staff did not have the knowledge to set up the video conferencing option, or the MD was not at available. Also of note, the increased response of residents

Comment

We will continue to address the indicator in 2026/2027 with the goal of meeting or exceeding the meeting or exceeding the LTC Division Overall target of 71.4%

| Indicator #2 | Last Year | | This Year | | |
|--------------|--|--|----------------------------------|--|---|
| | I am satisfied with quality of care from my doctors (Extendicare Laurier Manor) | 50.80 Performance (2025/26) | 65 Target (2025/26) | 51.70 Performance (2026/27) | -- Percentage Improvement (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

1) Communicate role of Medical Director and Physicians and give opportunity for feedback

Process measure

- 1) # of times Medical Director meets Family and Resident councils annually 2) # of Feedback on services and areas for improvement received and discussed 3) # of updates provided at CQI meeting on action plan

Target for process measure

- 1) Medical Director will attend Family Council by March 13, 2025, and Quarterly 2) Medical Director will attend Resident Council by March 31 3) Action items and plan will be discussed at CQI committee with Medical Director by April 2025.

Lessons Learned

Slight improvement of 0.9% but did not meet the corporate target. Demographic for this response would have been from the upper floors, as Families responded with 67.5%

Comment

We will continue to address this QIP in 2026 and it declined and was lower than the LTC Division target.

| Indicator #3 | Last Year | | This Year | | |
|-----------------------------|--|------------------|-----------------------|----------------------------------|------------------|
| | If I need help right away I can get it | 51.60 | 65 | 59.60 | -- |
| (Extencicare Laurier Manor) | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

1) Increase staff awareness of call bell response times

Process measure

- 1) # of call bell response time reviews completed 2) # of times results communicated to staff and to leadership team 3) # of staff follow ups required.

Target for process measure

- 1) Call bell response review process will be in place by June 30, 2025 2) Communication of call bell responses to staff and to leadership will be in place by April 2025

Lessons Learned

The residents scored this element at 59.6% which was an improvement from 2024, however this indicator did not meet the corporate target. However, we have increased staffing on all units (PSWS to 8-9) and this may improve outcomes for this year.

Comment

Increase in staffing in 2026 will improve outcomes for 2026.

| Indicator #1 | Last Year | | This Year | | |
|--------------|---|--|----------------------------------|--|---|
| | Communication from home leadership is clear and timely (Extendicare Laurier Manor) | 58.70 Performance (2025/26) | 75 Target (2025/26) | 50.80 Performance (2026/27) | -- Percentage Improvement (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

1) Implement Town hall newsletter to inform and engage residents and family members on a regular basis

Process measure

- 1) # of newsletter sent out quarterly 2) Feedback from residents and families about information for newsletters. 3) # of times newsletter was posted on board 4) # of Hand deliver Newsletters to residents expressing interest

Target for process measure

- 1) Newsletter will be sent quarterly (March, June, Sept, Dec) 2) Feedback from residents and families about newsletter will begin May 2025 3) Post newsletter on bulletin board in home beginning May 2025

Lessons Learned

1/4ly newsletters were released, with approximately 80 residents in house receiving room delivery. However, families reported 71%

Comment

We will continue to address the indicator in 2026/2027 with the goal of meeting or exceeding the meeting or exceeding the LTC Division Overall target of 69.6.

Safety | Safe | Custom Indicator

| Indicator #5 Percentage of LTC care patients who developed a stage 2 to 4 pressure ulcer that worsened (Extendicare Laurier Manor) | Last Year | | This Year | | |
|---|---|--|---|--|--|
| | <p>0.93</p> <p>Performance (2025/26)</p> | <p>0.50</p> <p>Target (2025/26)</p> | <p>1.41</p> <p>Performance (2026/27)</p> | <p>--</p> <p>Percentage Improvement (2026/27)</p> | <p>NA</p> <p>Target (2026/27)</p> |

Change Idea #1 Implemented Not Implemented In Progress

All residents who present with a Stage 2+ pressure ulcer will be referred to Wound Care Management.

Process measure

- # wound referrals sent, # of UDA assessments completed, # of follow up to wound referrals completed, tracking with TPT pressure ulcer tool (corporate)

Target for process measure

- 50% of all newly acquired or inherited pressures will improve in the first three months and heal within 6 months

Lessons Learned

WCC assisted with front line training on the new wound care assessment and provided guidance and support to new staff - challenge was different levels of expertise with new hires, extra mentoring was required

Change Idea #2 Implemented Not Implemented In Progress

Monthly Wound and Treatment Care Summary will be prepared and managed by the SWAN to ensure timely wound care push assessments are completed

Process measure

- # of weekly skin reviews completed # of weekly skin review completed with no gaps # of weekly assessments accurately signed off by unit # of follow ups required

Target for process measure

- Process for monthly wound and treatment care summary will be in place by June 2025 There will be a 50% improvement in completion of Weekly PUSH assessments by July 2025 and 75% improvement by September 2025

Lessons Learned

Wound Care Champion was actively involved in assessment and treatment of all developing wounds - offered support to unit staff on treatment options and managed complex wounds. WCC also managed the Skin and Wound Tracker developed by corporate and was an advocate for staff at the planning level when it came to the development of the assessment tool

Comment

We will continue to offer in-house education on wound care product selection and will be sending PSWs for wound care training in 2026

Safety | Safe | Optional Indicator

| | Last Year | | This Year | | |
|---|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| Indicator #6 | 15.56 | 10 | 13.27 | 14.72% | 12 |
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Laurier Manor) | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

Physiotherapy will review all residents who have fallen to ensure appropriate fall interventions are in place after every fall which will include reassessment of transfer status and inventory of fall interventions.

Process measure

- # of post fall reviews completed within 7 days of the fall

Target for process measure

- 100% of falls will be thoroughly analyzed by the fall reduction committee to prevent future falls from occurring by June 2025.

Lessons Learned

New Policy implementation in 2025 - Referral to PT to assess Lift and Transfer Status on admission, Falling stars identified on the Fall Prediction and Prevention Tool - Falls lead would initiate a Falls review by PT and determine best and appropriate fall interventions - Will continue to develop an inventory tracking tool in 2026

Change Idea #2 Implemented Not Implemented In Progress

Falls Tracking Tool

Process measure

- # of residents identify high risk of falls with completed Comprehensive FALL Review based on the FTTP Tool assessment

Target for process measure

- 100% of the residents who have fallen in the previous month will have their care plan reviewed for accuracy and integrity consistently by June 2025

Lessons Learned

Implemented by corporate, FPPT identified fallers captured in the previous assessment based on risk management and on coding elements from MDS-Rai assessments that would put residents at high risk of falls. Falls lead would review the care plan for accuracy

Comment

We will continue to develop an inventory tracking tool in 2026

| Indicator #7 | Last Year | | This Year | | |
|---|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Laurier Manor) | 9.34 | 8 | 11.58 | -23.98% | 8 |

Change Idea #1 Implemented Not Implemented In Progress

Review all new admissions for antipsychotic use and where there is no diagnosis of psychosis, educate families on the risks of APS, and deprescribe safely

Process measure

- # of MCMR reviews, # of reviews of E-clinical portal information, # of reviews of mental health history. # of referrals by admission nurse # of education provided to families # of medications deprescribed monthly # of antipsychotic prn medications deprescribed monthly

Target for process measure

- 50% of all new admissions will have antipsychotics deprescribed by September 2025.

Lessons Learned

Antipsychotic medications were reviewed on admission and discussed with the attending physician and the pharmacy consultant if there was no diagnosis of psychosis evident. Many residents transferred from the hospital setting were started on antipsychotics during their stay in hospital to manage behaviours and were successfully deprescribed. New admissions coming from the community with dementia were also on antipsychotics to help them sleep only. Our attending physicians were hesitant to discontinue medications prescribed by other doctors until they were more settled into the long term care facility.

Comment

Our antipsychotic reduction plan will continue in 2026 - with the additional "exclusion" added of bipolar disorder (announced March 2026) , this will bring our performance indicator down further. We will continue to monitor new admissions and flag those using antipsychotics without a diagnosis. We will also be working with our attending physicians to have discussions with families during their interdisciplinary care conferences about prognosis of life-limiting illnesses and to document these conversations clearly in order to use the J6c exclusion in the LTCF assessment.