SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : ORCHARD VILLA LTC

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Ryan Ranes - Quality Manager	01-Jun-26
Director of Care	Beverley Williams - DOC	29-May-26
Executive Directive	Nicole Simpson - ED	01-Jun-26
Nutrition Manager	Priya Gumbler - FSM	01-Jun-26
Programs Manager	Desiree Johnson-Fowler - PM	01-Jun-26
Clinical Consultant	Rebecca Macaalay - Senior Clinical Consultant	01-Jun-26
Resident Council Representative	Grant Harley	01-Jun-26
Family Council Representative	Diana Hamilton	01-Jun-26
Medical Director	Dr. Sina Sajed	01-Jun-26
Other	London Clarke - DCC; Sony Kurian - Social Worker Marva Griffiths - Regional Director; London Clark - Director of Clinical Services; Ryan Maracle - Office Manager; Jody Ann Johnson - IPAC Lead; Racquel King - BSO Lead; Priya Gumbler - Food Service Manager; Desiree Johnson-Fowler - Program Manager;	01-Jun-26
Other	Marva Griffiths - RD; Jodi Servant - RAI Coordinator; Kara Westlake - Scheduling Manager; Jasdeep Singh - Registered Dietitian; Kristina Marquis - Program Consultant Sivakumar , Niranjala - Dietary staff	01-Jun-26

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	**Policies, procedures and protocols used to achieve quality improvement**	**Outcomes of Actions, including dates**
Strengthening Clinical Communication and Transition Planning: Reduce unnecessary hospital transfers by improving staff communication, enhancing clinical decision-making and utilizing on site resources.	Building on the previous year's findings and interventions, the Home continued to strengthen strategies aimed at reducing unnecessary hospital transfers. The focus remained on maximizing available clinical resources, including the Nurse Practitioner, NP STAT program (where applicable), and Paramedicine/LTC+ support, to enhance in-home assessment, clinical decision-making, and management of residents whenever appropriate. Ongoing education remained a key priority, with continued emphasis on comprehensive resident assessment, early recognition of clinical changes, and appropriate SBAR communication when consulting Physicians and Nurse Practitioners prior to Emergency Department transfer decisions. In addition, further education sessions delivered through the NP STAT program supported continued development of registered staff clinical assessment skills, critical thinking, and clinical judgment. Hospital transfer data continued to be reviewed to identify trends including time of day, primary diagnoses, and contributing clinical factors. This supported ongoing quality improvement initiatives and the identification of opportunities for earlier intervention and enhanced in-house management.	Despite continued implementation and strengthening of existing interventions, the ED rate increased slightly to 40.70%, compared to 40.40% in the previous year. This increase is recognized in the context of increasing resident complexity, higher acuity levels, and multiple comorbidities within the Home, which continue to impact clinical decision-making and transfer needs. However, process indicators demonstrated sustained improvements, particularly in SBAR utilization, staff engagement in clinical education, and overall awareness of early deterioration and escalation processes.
	The Home continued to embed equity, diversity, inclusion, and anti-racism principles into daily practice and organizational culture. The existing initiatives were sustained and further reinforced to ensure consistency across all departments and levels of leadership.	

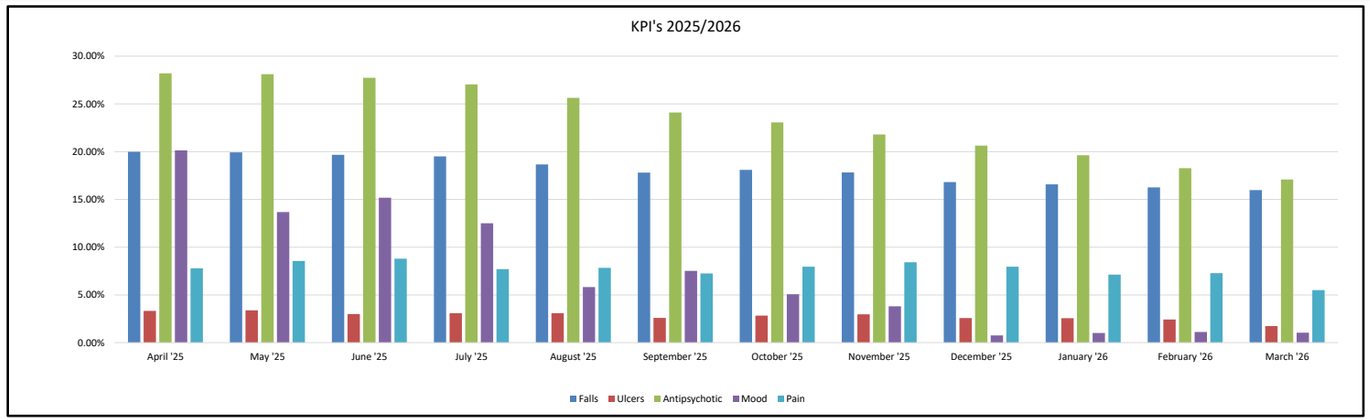
Service and Excellence: Promote equity, inclusion, and person centered service by fostering a culturally aware, engaged, and responsive care environment for residents, families, and staff.	Principles continued to be promoted through ongoing open communication between staff and management, supporting a safe environment for dialogue, feedback, and shared learning related to inclusion and workplace culture. The culture and diversity board remained active as a visible tool to reinforce awareness and encourage engagement among staff, residents, and visitors. In addition, equity, diversity, inclusion, and anti-racism education completion continued to be monitored and reinforced as part of organizational expectations, with continued emphasis on achieving full compliance across executive, management, and staff levels. These efforts supported the Home's commitment to embedding inclusion and anti-racism principles into both practice and organizational values	Outcome: Our resident satisfaction survery increased to 90.85%, compared to 87.60% in 2024. This improvement reflects our commitment to actively engage families and residents in providing feedback, addressing concerns, and implementing targeted interventions to improve their over all experience.
Reduce the incidence of falls and maintain the Falls Management quality indicator at or below the corporate benchmark.	**Enhanced Equipment Audits and Environmental Safety:** Weekly and monthly audits were conducted by the Program Lead and PSW Coordinator to ensure all fall prevention equipment (e.g., bed alarms, mats, hip protectors) were functional, available, and appropriate to resident needs. **Strengthened Leadership Oversight and Accountability:** Ongoing review of fall data by leadership, with follow-up on corrective actions and reinforcement of staff accountability in post-fall management and documentation. **Staff Education and Reinforcement of Best Practices**: Targeted education provided on high-risk residents, frequent fallers, and proper post-fall response, including consistent use of the Post-Fall Clinical Pathway. Implementation of the 4 P's (Pain, Positioning, Possessions, Prompted Toileting): Routine rounding practices reinforced to proactively address common fall risk factors. **Resident Monitoring and Interdisciplinary Follow-Up:** Use of fall risk assessment tools (e.g., Morse Fall Scale) to identify high-risk residents, with interdisciplinary care conferences conducted following recurrent falls to update care plans. **Post-Fall Huddles and Continuous Quality Review:** Immediate post-fall huddles conducted for root cause analysis, with ongoing documentation audits to ensure compliance and continuous improvement. Collaboration with Programs and Rehabilitation Services: Referrals to Physiotherapy and Restorative Care to support individualized mobility, balance, and strength interventions.	Falls Management quality indicator improved to 15.98% in Q1 2026, approaching the corporate benchmark of 15.50%, with a sustained downward trend over the past three quarters. Number of residents triggering the indicator decreased from 41 (Q1 2025) to 28 (Q1 2026). Improved management of high-risk residents, with reduced frequency and impact of falls. Consistent implementation of layered interventions contributed to sustained improvement and enhanced resident safety.
	The interdisciplinary team continued utilizing a collaborative approach to identify residents appropriate for dose reduction. Residents were carefully selected based on clinical judgment, including comprehensive review of diagnosis, responsive behaviors, overall health status, and risk-benefit assessment. Prior to initiation of dose reduction trials, residents underwent CMAI observation assessments to support clinical decision-making and confirm eligibility. Enhanced observation and documentation practices related to hallucinations and delusions were further strengthened throughout the year. Nursing staff were informed of residents within their look-back periods to ensure increased awareness of behaviors that may impact quality indicator triggering. Accurate and timely documentation supported appropriate clinical coding and proper exclusion of residents who met diagnostic criteria from the antipsychotic quality indicator list. Continuous auditing and monitoring of coding and documentation practices remained a key focus throughout the year to prevent errors and miscoding. Particular attention was given to ensuring medications such as antidepressants or anticonvulsants were not incorrectly classified as antipsychotics. Ongoing monthly reviews and double-check processes helped ensure both clinical appropriateness and documentation accuracy.	By April 2026, antipsychotic use without psychosis reached 17.03%, the lowest rate in over three years, successfully achieving below corporate benchmark. Six residents successfully discontinued antipsychotics through the dose reduction initiative. Ongoing auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement.

Reduce Antipsychotic use without a diagnosis of psychosis and maintain rate below the corporate benchmark.	Staff also continued to receive education on safe antipsychotic management, non-pharmacological interventions for responsive behaviors, clinical monitoring, and proper documentation practices. As a result of these combined interventions and sustained interdisciplinary efforts, the home's antipsychotic use rate significantly improved to 17.03% by April 2026, representing the lowest rate achieved in over three years and placing the home below the corporate benchmark.	
2024 Resident Satisfaction Survey: Top 5 Opportunities 1) If I have a concern: I feel comfortable raising it with the staff and leadership = 78.17% 2) I would recommend this Home to others = 77.37% 3) I am satisfied with the quality of care from: Dietitian = 76.86% 4) If I have a concern: My concerns are addressed in a timely manner = 76.80% 5) I have access to foot care when needed = 76.19%	The home continues to promote open communication and responsiveness to residents and families through promoting a culture of open, transparent communication to all parties involved. Encouring residents and families to voice concerns and provide feedback though multiple channels such as Resident and Family Council Committee, Satisfaction Surveys and direct conversation with the management team. The Management team continue to reinforce with the staff accountability to respond to concerns promptly, respectfully and professionally including adderssing any raised concerns in a timely manner. The Home continue to monitor foot care access to ensure residents receive timely and appropriate care through referrals and working with the service provider to optimize scheduling and availability based on resident needs. There is a continued collaboration with the dietary team and Registered dietitian to review and respond to resident feedback such as incorporating menu planning and individualized care plans including support with ongoing improvements in meal quality, nutritional care and resident/ family satisfaction. The Home continue to provide ongoing training for all staff on Mandatory Reporting requirements, Resident Bill of Rights, Zero Tolerance of Resident Abuse and Neglect, and Customer Service and Complaint Resolution. There is a reinforcement of expectations for resident-centered care, dignity, and respectful interaction for all staff. And the Home continue to conduct a regular refreshers and competency reviews to ensure compliance	The expected impact of the 2024 Resident Satisfaction Survey was to improved resident satisfaction survey and engagement, enhanced access to key services such as foot care and dietary support, stronger staff accountability and service culture and safer, more responsive care environment. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) If I have a concern: I feel comfortable raising it with the staff and leadership = 96.81% 2) I would recommend this Home to others = 81.87% 3) I am satisfied with the quality of care from: Dietitian = 90.72% 4) If I have a concern: My concerns are addressed in a timely manner = 95.92% 5) I have access to foot care when needed = 83.22%

2024 Family Satisfaction Survey: Top 5 Opportunities 1) I am satisfied with the quality of: Laundry services for linens = 79.91% 2) The resident has access to foot care when needed = 79.88% 3) I am satisfied with the timing and scheduling of spiritual care services = 79.61% 4) I am satisfied with the quality of care from: Dietitian = 78.31% 5) Continence care product fits properly = 77.74%	Imlementation of plans to improved services in the Home is always the priority for resident comfort, dignity and satisfaction. Family's inout is valuable to the Home to ensure essential services are completed in a timely manner and would better align for resident care preferences. This also ensure stronger staff accountability and quality in our service. The Home had implemented a linen inventory and ongoing tracking system to ensure adequate supply of linens at all times including increase par levels of linens to maintain and have backup of linens at all times. Education was completed to staff on proper linen handling and reporting shortages promptly. Timely access to foot care services was identified and prioritizeds including streamlining of regular on-site foot care clinics every 6 weeks and as needed. Collaboration with the Home, residents and its families was the key of this service to be a success. For Spiritual Care services, the Home continue to coordinate with community spiritual leaders/ volunteers to expand their availability and promote services as per resident spiritual preference. Ongoing communication with the Resident Council are enhanced to continue to engage in dialogue with spiritual services items that can continue to improve quality of resident life at the Home. Similar with the Resident Satisfaction Survey, there is a continued collaboration with the dietary team and Registered dietitian to review and respond to resident feedback such as incorporating menu planning and individualized care plans including support with ongoing improvements in meal quality, nutritional care and resident/ family satisfaction. The Home continue to complete a regular individualized continence assessment and re-assessment with any change in resident condition. There are adequate stock of all sizes and proper staff training on proper sizing, fitting and application techniques completed. The Home continue to monitor and document issues and adjust products accordingly to ensure resident comfort and dignity is followed.	Similar to the Resident Satisfaction Survey, the expected impact of the 2024 Family Satisfaction Survey was to also improved family satisfaction survey and engagement, enhanced access to key services such as laundry, foot care, spiritual support, dietary support and Continence program. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) I am satisfied with the quality of: Laundry services for linens = 95.97% 2) The resident has access to foot care when needed = 83.65% 3) I am satisfied with the timing and scheduling of spiritual care services = 80.22% 4) I am satisfied with the quality of care from: Dietitian = 83.65% 5) Continence care product fits properly = 88.63%

Key Perfomance Indicators

KPI	April '25	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Falls	19.98%	19.92%	19.67%	19.50%	18.66%	17.81%	18.10%	17.82%	16.82%	16.58%	16.26%	15.98%
Ulcers	3.33%	3.39%	2.99%	3.08%	3.09%	2.59%	2.83%	2.96%	2.58%	2.56%	2.42%	1.74%
Antipsychotic	28.20%	28.11%	27.73%	27.05%	25.63%	24.10%	23.06%	21.81%	20.63%	19.63%	18.27%	17.08%
Mood	20%	13.68%	15.18%	12.50%	5.82%	7.52%	5.07%	3.81%	0.76%	1.02%	1.12%	1%
Pain	7.79%	8.55%	8.80%	7.70%	7.83%	7.24%	7.95%	8.42%	7.96%	7.12%	7.27%	5.50%



How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and inccorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our

policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2024/25 year:	Oct-25
Results of the Survey (*provide description of the results*):	90.85% of the residents and 87.25% of family members would recommend this home to others; The Overall Satisfaction Resident Rate in 2025 is 86.08% over the 2024 of 85.36%. For Family Satisfaction Overall Survey in 2025 is 86%, also above the 2024 rate of 83.74%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025. The Family and Resident Council was in person meeting on February 25, 2026

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
Survey Participation	100.00%	100.00%	98.53%%	37.01%%	30.00%	78.00%	20.95%	11.24%	The Home will continue to promote participation in the Resident and Family Satisfaction Survey through multiple communication channels, including the Newsletter, Care Conferences, email communications, notice boards, and Resident/Family Council Meetings, to ensure broad engagement and awareness.
Would you recommend	80.00%	81.87%	73.37%%	80.87%	80.00%	61.11%	75.29%	60%	To support improvement in the likelihood of residents and families recommending Orchard Villa as a place to live, the Home will continue to focus on enhancing the quality of resident programs and services. Staff will be expected to consistently uphold the Home's Mission, Vision, and Values in daily practice and interactions with residents and families. Positive engagement and communication will be actively encouraged to strengthen relationships and overall satisfaction. The Home will also continue to highlight ongoing quality improvement initiatives and care outcomes through newsletters and Resident Council meetings, including updates and success on quality indicators, staffing levels, and care improvements. In addition, "Would you recommend this Home?" will remain a standing discussion item at Resident Council meetings, with follow-up completed on feedback and recommendations provided.

If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	96.81%	90.20%	79.13%	95.00%	92.41%	93.61%	74.74%	The Home remains committed to fostering an environment where residents and families feel safe and comfortable raising concerns. In alignment with the Home's HOO-OP improvement initiatives, the following strategies will continue: 1. Ongoing review and reinforcement of the Complaints and Concerns process upon admission, during annual care conferences, and through staff education and training sessions. 2. Continued engagement of residents in meaningful discussions during care conferences to encourage open expression of opinions, concerns, and suggestions. 3. Regular review of the Residents' Bill of Rights at Resident Council meetings, with emphasis on Resident Rights #29, which supports the right to raise concerns or recommend changes without fear of discrimination or reprisal. 4. Timely follow-up, discussion, and resolution of resident concerns raised through Resident Council Meetings related to home operations. These ongoing initiatives aim to strengthen resident voice, improve communication, and support continuous quality improvement within the Home.

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Target/Change Idea	Current Performance
Initiative #1 - Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents from 40.70% (as of January 2026 data) to 30%	To support the reduction of unnecessary hospital transfers, the Home will continue to utilize available on-site resources, including the Nurse Practitioner and NP STAT program (where applicable), as well as Paramedicine and LTC+ paramedic support, to enhance in-home assessment and management of residents whenever appropriate. Ongoing education for staff will remain a key strategy, with continued emphasis on comprehensive resident assessment, early recognition of clinical changes, and the appropriate use of SBAR communication when consulting the Physician or Nurse Practitioner prior to initiating an Emergency Department transfer. The Home will continue to review hospital transfer data to identify trends, including time of day, primary diagnoses, and contributing factors, to support early intervention strategies and explore opportunities for in-house treatment and enhanced clinical support. As part of continuous quality improvement, additional education sessions will be provided by the NP STAT program to strengthen registered staff clinical assessment skills, critical thinking, and clinical judgment, with the goal of supporting timely interventions and reducing avoidable hospital transfers.	As of April 2026 data: 40.70%
Initiative #2 - Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education - target is 100% from 96.23%	1)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; 2)To facilitate ongoing feedback/communication or open door policy with the management team regarding diversity and inclusion that may benefits the Home and its employees; 3)Re-creation of culture and diversity board representing and promoting relevant equity, diversity, inclusion and anti-racism for both resident and team members in the home.	December 2025 result is 98%
Initiative # 3 - Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" from 97.97% in October 2025 to 99% in October 2026	1)Review of Complaints and Concerns process in the home on admission, during annual care conference with resident and family as well as during staff training; 2)To continue to engage residents in meaningful conversations during care conferences and allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else"; 3)Timely discussion and response completion of resident concerns through Resident Council Meetings regarding the operations of the Homes	October 2025 Resident Satisfaction Survey Result: 97.97%

Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment - target is 13% from 15.98%	Strengthening use of fall risk assessments and post-fall clinical pathway. Regular equipment and environmental safety audits (e.g., alarms, mats). Staff education on fall prevention, high-risk residents, and post-fall response. Reinforcement of the 4 P's (Pain, Positioning, Possessions, Prompted Toileting). Interdisciplinary collaboration with Physiotherapy, Restorative Care, and Programs to support mobility and strength. Ongoing monitoring of high-risk residents and care plan updates following recurrent falls.	As of March 2026, the falls quality indicator is 15.98%, demonstrating sustained improvement and nearing the corporate benchmark.
Initiative #5 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment - Reduce rate to ≤20% (from a high of ~30%)	Gradual dose reduction program for eligible residents using an interdisciplinary approach. Enhanced observation and documentation of hallucinations and delusions during the look-back period. Ongoing auditing and monitoring of RAI/MDS coding to prevent misclassification of medications. Staff education on appropriate antipsychotic use, monitoring, and documentation practices. Improved communication and awareness among nursing staff regarding quality indicator triggers.	As of April 2026, the antipsychotic use without psychosis indicator is 17.09%, successfully below the corporate benchmark.
2025 Resident Satisfaction Survey: Top 5 Opportunities 1. I have access to foot care when needed 2. I am satisfied with: The variety of spiritual care services 3. I am satisfied with the quality of: Cleaning services throughout the home 4. I am satisfied with the temperature of my food and beverages. 5. I am satisfied with the quality of: Cleaning within the resident's room	1. I have access to foot care when needed Set up a schedule for footcare nurses Provide residents with notices/reminders for footcare services in their room. 2. I am satisfied with: The variety of spiritual care services Review Welbi insights on residents' religious/spiritual preferences, Expand the variety of spiritual and religious offerings, and Share clear updates at the next resident's council meeting 3. I am satisfied with the quality of: Cleaning services throughout the home Complete the QRMHL- Resident Room cleaning and QRMHL- Resident room Sanitation audit for the housekeeper weekly We will be increasing the number of on-the-spot housekeeping checks completed throughout the week. 4. I am satisfied with the temperature of my food and beverages. Root Cause Review: FSM/FSS will complete a kitchen production audit to assess production timing, holding practices, and workflow. Temperature Controls: During floor audits, FSM/FSS will ensure hot foods are kept in steamers (not pans) and cold foods are held using proper ice-bath methods at proper temperature and correct at the point of service Audit using QRM-DS- food production audit and Daily management Dietary audit. 5. I am satisfied with the quality of: Cleaning within the resident's room Real-time correction of cleaning or sanitation issues Clear, supportive coaching that reinforces expected procedures Consistent application of infection prevention and cleaning protocols Increased staff confidence through quick feedback and clarification	2025 Resident Satisfaction Survey Results: 1) Home score - 83.22% 2) Home score - 82.81% 3) Home score - 82.50% 4) Home score - 82.22% 5) Home score - 80.90%

2025 Family Satisfaction Survey: Top 5 Opportunities		
1) I am satisfied with the food and beverages served to residents 2) I am satisfied with: Tthe timing and schedule of recreation programs 3) I am satisfied with: The relevance of recreation programs 4) I am satisfied with: The variety of spiritual care services 5) I am satisfied with: The timing and schedule of spiritual care services	1) I am satisfied with the food and beverages served to residents Implement themed menus aligned with cultural and seasonal events (i.e valentines, Ester etc.). Residents receive special meals; families may purchase meal tickets to participate. Launch Spring/Summer menu at the end of May to increase variety and seasonal options. Audit using QRM-DS- food production audit and Daily management Dietary audit. FSM/FSS to attend monthly Family Council meetings to share upcoming themed events and gather input. 2) I am satisfied with: The timing and schedule of recreation programs The Council will review the current daily program schedule for resident activities and add more programs where needed. Council feedback is requested regarding the suitability of these times, resident participation levels, and any recommended adjustments to be made 3) I am satisfied with: The relevance of recreation programs An overview of the programs for Family Council, on information nights will be conducted including "Suggestion items" to be added to the Agenda The Five Domains for residents and families will be added to the Home's Newsletter 4) I am satisfied with: The variety of spiritual care services Review Welbi insights on residents' religious/spiritual preferences, Add to newsletter the religious programs in the home and the times Add to the activity board the religious services being provided Resource external churches Audit all residents Religion and spiritual care and provide input from Residents and family variety of services 5) I am satisfied with: The timing and schedule of spiritual care services Increased variety of spiritual and religious programs	2025 Family Satisfaction Survey Results: 1) Home score - 80.72% 2) Home score - 80.22% 3) Home score - 80.00% 4) Home score - 79.00% 5) Home score - 79.00%

Process for ensuring quailty initiatives are met
Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Ryan Ranes	**01-Jun-26**
Executive Director	Nicole Simpson	**01-Jun-26**
Director of Care	Beverley Williams	**29-May-26**
Nutrition Manager	Priya Gumbler - FSM	**01-Jun-26**
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