Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : SEAFORTH LTC

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Lovepreet Kaur - Associate Director of Care	May 27 2026
Director of Care	Shanon McKellar - RN Director of Care	May 27 2026
Executive Directive	Ryan Yoanidis - ED	May 27 2026
Nutrition Manager	Shagun Parekh - FSM	May 27 2026
Programs Manager	Stacey Kamerman - PM	May 27 2026
Clinical Consultant	Cindy Britton - RN Clinical Consultant	May 27 2026
Resident Council Representative	Paul Ghram	May 27 2026
Family Council Representative	Toni Malone	May 27 2026
Medical Director	Dr. Ameet Karaul	May 27 2026
Other	Sidhant Hans - RN/RAI -C	May 27 2026
Other		

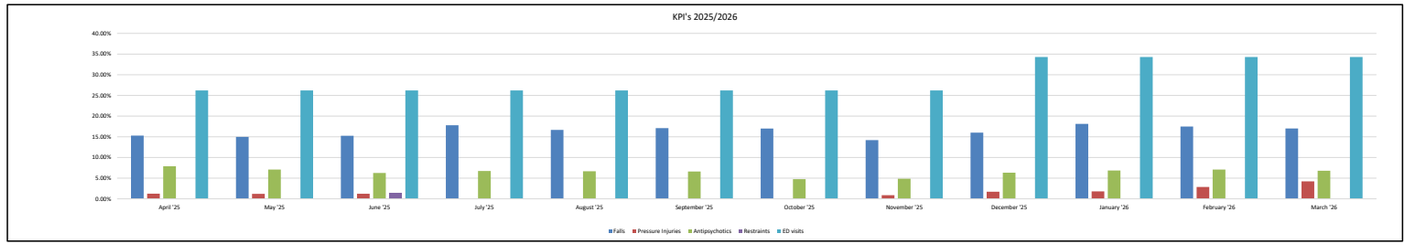
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Rate of ED visits for modified list of ambulatory Care sensitive condition /100 LTC residents to reduce by 4.69% by March 2026	**Change Ideas: Comprehensive Assessments:** Throughout the last four quarters, the home supported ongoing enhancement of nursing skills e through education, mentorship, and clinical practice initiatives. A Nurse Practitioner (NP) was available to the home until May 2025. Following the NP's departure, nursing staff continued to perform comprehensive resident assessments prior to contacting the Physician and transferring residents to hospital. This process ensured informed clinical decision-making and appropriate escalation of Care was considered. On April 17, 2025, the DOC provided education to six nurses on head-to-toe assessments, wound care, palliative care, end-of-life care, and advance Care planning. Throughout the year, a Corporate Education Consultant provided education and support on documentation standards and expectations, responsive behaviour management, preventive skin Care and assessments, falls prevention and management, pain management in long-term care, continence care, and critical incident reporting. On September 3, 2025, the DOC educated 10 nurses on medication rights, skin and wound management, continence care, falls prevention, and responsive behaviour management. On September 11, 2025, five staff members attended an in-home Medline Skin and Wound Care education session. Additionally, seven nurses completed Gentle Persuasive Approaches (GPA) training between September 22 and October 6, 2025. These initiatives strengthened staff competencies in assessment, clinical decision-making, documentation, wound care, responsive behaviour management, resident safety, and evidence-based practice, supporting the delivery of high-quality resident-centered care. Despite ongoing education and support provided to staff, the home's percentage of Emergency Department (ED) transfers remained higher than the Provincial Average. The home continues to review contributing factors, monitor trends, and implement strategies to reduce avoidable transfers while ensuring residents receive appropriate and timely care. **Change Ideas: Discussion with Residents and Families regarding Advanced Care Planning:** The Physician reviewed Code status and Goals of Care with residents and families upon admission and during annual Care conferences. In the past year, the Physician reviewed Goals of Care for 38 out of a possible 47 residents during Care conferences. the goal of the reduction of 4.69% was not achieved in the past year. The goal was not achieved due in part to the resident's inability to participate in Care planning and decision-making, as well as the absence of family or support persons to assist with the planned interventions. **Change Ideas: Review of ED Tracker:** Tracker was utilized for each transfer to hospital. ED transfers and related trends were reviewed and discussed monthly at Registered staff meetings and analyzed during Quality meetings, and presented at quarterly (CQI) Continuous Quality Improvement meetings. This monitoring and review process remains ongoing to support continuous quality improvement.	The provincial Average for 2025/2026 was 22.3%. The home's KPI for April 2025 was 29.69% with a goal of reducing the KPI by 4.69% by March 2026. Despite ongoing education and support provided to staff, the home's percentage of Emergency Department (ED) transfers remained higher than the Provincial Average. The escalation of transfers is recognized the increasing complexity, higher acuity levels, and multiple comorbidities within the home impacting clinical decision-making and transfer needs. The home continues to review contributing factors, monitor trends, and implement strategies to reduce avoidable transfers while ensuring residents receive appropriate and timely care. The current KPI for March 2026 is 34.3%. By December 31st, 2025 there was noticeable improvement in assessments by Registered staff and communication among clinician prior to transfers to hospital. Also, 80.85% residents and Families discussed there Advanced Care planning with Physician.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Change Ideas: Diversity training through Surge education or live events:** 100% of active staff completed Diversity training through Surge learning over the last four quarters. Live Events: These included Easter celebrations on April 18, 20 and 21, Victoria Holiday on May 19th, Canada Day-July 1st, Civic Holiday on August 4th , Labour Day September 1st, Oktoberfest on October 11th, Remembrance Day on November 11th and Christmas celebrations throughout December, and St. Patrick's day March 17th. Monthly Armchair Travel/Yum Box experiences further supported cultural learning and appreciation, featuring destinations such as Hawaii, Italy, Around the World, France and Brazil. During the period of May 1, 2025 to December 31, 2025, two CQI meetings were held. Cultural diversity and inclusion were discussed and incorporated into both meetings. **Change Ideas: CQI Meeting :** The past four quarters of CQI meeting minutes included discussions related to culture and diversity as evidenced by CQI meeting minutes. **Change Ideas: Admission package includes Cultural Diversity** All Admission (move in) packages included information on Workforce Diversity, Equity and Inclusion policy and Whistler Blower policy. All residents receive an admission package upon admission. The Workforce Diversity, Equity, and Inclusion Policy was added to the admission package in April 2025. Since April 2025, the home has had 34 admissions, and all 34 residents and Families received the admission package including the policies.	Current: 100% The home has proven successful in maintaining 100% compliance with the percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education. As of December 31, 2025 100% of staff completed education on culture and diversity topics through Surge Learning.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change Ideas: Whistleblower Policy:** 100% of active staff completed Whistleblower policy through Surge learning over the last four quarters. **Change Ideas: Admission and Care Conferences:** The Whistleblower Policy was discussed verbally with residents and families during Care conferences in last year; however, these discussions were not documented in Care Conference note. To support awareness of Resident Rights and available reporting mechanisms, 100% of new admissions received the Whistleblower Policy as part of the admission package over the past year. To promote visibility and awareness Whistler Blower poster was posted in the hallway near the dining room area. Additionally, a formal review of the policy during Care Conferences was initiated in May 2026 and has since been incorporated into the ongoing Care Conference process to promote continued awareness and understanding amongst residents and their families. **Change Ideas: Complaints and Concern Process:** The Concerns and Complaints process was discussed during all Care conferences; however, supporting documentation was not consistently in place. Documentation of the process was initiated in May 2026 and is ongoing. 100% of new admissions received the policy within the admission package. The Concern and Complaints process policy was also posted alongside the Whistle Blower Policy. As of December 31, 2025 100% of Residents' Council meetings reviewed the Residents' Bill of Rights as evidenced by Resident council meeting minutes. The Whistleblower Policy is scheduled to be shared with Residents' Council on June 3, 2026.	90.83% October 2025 . All Change ideas have been implemented. The home will continue with these interventions to contribute to the ongoing improvement of this initiative.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change Ideas: Restorative:** Between May 1, 2025, and December 31, 2025, there were 25 resident admissions. Of these, 13 residents received a restorative functional assessment, representing an achievement rate of 52%. While progress was made toward the target, the goal of 100% completion was not achieved. One contributing factor was that restorative Care program was not fully established during the first two quarters of the year and required re-establishment before assessments could be consistently completed. To strengthen the program, Restorative Care lead was appointed and obtained certification in November 2025. In addition, two Restorative Care Aides completed their certification in March 2026. These staffing enhancements have improved the home's capacity to conduct restorative assessments and support the ongoing development of the Restorative Care program. **Change Ideas: Post-fall assessments:** 100% of residents had post-fall assessments completed by Registered staff. In Keeping with the Fall management policy, residents are not transferred from the floor until they have been assessed by Registered staff. **Changes Ideas: Fall Huddles:** Falls huddles were completed for 16 weeks within the period between May 2025 and December 31, 2025. This represents 45.7% completion of the expected target of the 100%. This was due to competing priority and operational issues in the home. Weekly Falls Huddles during the period from May 2025 to March 31, 2026, represents a completion rate of 30.77% .	The current Key Performance Indicator (KPI) for March 2026 is 17.01%, compared to 15.29% in April 2025. This represents an increase of 1.72 % over the period. The upward trend indicates that the KPI has worsened relative to the baseline and requires ongoing monitoring and targeted interventions to support improvement. The target was not achieved due to inconsistencies in the implementation and sustainability of the weekly Falls Huddle process during the reporting period. To address this gap, weekly Falls Huddles were reimplemented in April 2026 and have since been incorporated as an ongoing quality improvement initiative within the home. Continued monitoring and reinforcement of the process will support regular interdisciplinary review of falls, identification of risk factors, and development of strategies to reduce future fall incidents.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Change Ideas: Antipsychotic Medication review :** The home utilizes the BOOMER process for admissions, which involves the Pharmacist, Physician, and Registered staff reviewing medications prior to admission. Between April 2025 and March 31, 2026, the BOOMER process was completed for 26 of 34 admissions. The remaining admissions did not meet the required 48-hour timeframe for completion of the BOOMER process. In these cases, medication reconciliation was completed upon admission to ensure safe and timely medication management. In addition, the physician reviews medications during the admission Care Conference. This was completed for all Care Conferences during the reporting period, with the exception of residents cognitive status and the presence of a Public Guardian and Trustee (PGT) for financial decision-making. **Change Ideas: Staff Education:** The home arranged GPA (Gentle Persuasive Approaches) education for staff to support learning alternative approaches to behaviour management. During the reporting period, 33 staff members completed GPA training, including Registered Nurses (RN), Registered Practical Nurses (RPN), dietary staff, and program staff. **Change Ideas : Review of Antipsychotic Medication use:** The home remains below the Corporate benchmark for antipsychotic use without a documented diagnosis. During this period, all but one resident received antipsychotic medications had a corresponding supporting diagnosis. There is supporting clearly documentation by the Physician outlining the clinical rationale for use.	The home remains below the Corporate benchmark for antipsychotic use without a documented diagnosis. The current Key Performance Indicator (KPI) for April 2025 was 7.87% and March 2026 is 6.78% and Corporate benchmark is 17.5 % of antipsychotic use without a documented diagnosis.

2024 Resident Satisfaction Survey : Top 5 Opportunities **1) Continence care products: Are comfortable = 72.73%** **2) I am satisfied with: The variety of spiritual care services =68.75%** **3) Overall, I am satisfied with the recreation and spiritual care services = 67.11%** **4) I am satisfied with the timing and schedule of spiritual care services =62.50%** **5) I am satisfied with the relevance of recreation programs =61.25%**	**Action Plan 2024 Resident Survey:** 1)The home continued to review Continence care at monthly Quality meetings. The home continued to implement and reevaluate the continence program in collaboration with Vendor and meet with Representative on quarterly basis. Education was arranged with residents regarding continence care product by the Vendor Representative. 2-5) The home continued to assess the recreation and spiritual care needs through the Recreation Admission Assessment and Spiritual and Religious Care Needs Admission Assessment which was completed with each resident within 14 days of admission, the monthly Resident Program Evaluations and the monthly home Program Evaluations was reviewed at Residents Council Meetings on monthly basis.	2025 Resident Satisfaction Result : 1) Continence care products: Are comfortable = 77.5% Improved 2) I am satisfied with: The variety of spiritual care services = 88.93% Improved 3) Overall, I am satisfied with the recreation and spiritual care services = 85% Improved 4) I am satisfied with the timing and schedule of spiritual care services =86.76% Improved 5) I am satisfied with the relevance of recreation programs = 77.08% Improved
2024 Family Satisfaction Survey : Top 5 Opportunities **1) I am updated regularly about any changes in the home =73.75%** **2) Overall, I am satisfied with communication from home leadership =72.50%** **3) Communication from home leadership is clear and timely =72.50%** **4) Overall, I am satisfied with the continence care products =63.89%** **5) There is a good choice of continence care products =61.11%**	**Action Plan 2024 Family Survey:** 1-3) Families were encouraged to attend the Quarterly Family Council Meetings and Those who were unable to attend were asked to review the posted Family Council Minutes on the board outside of the Activity Room. At Quarterly meetings Guest speaker were scheduled based on family requests with topic of interest IPAC, Corporate leadership team update, Food Service Manager and Alzheimer society Huron Perth. 4-5) The goal was not met as the Family Council did not request the Vendor representative to attend a Family Council Meeting as they preferred other guest speakers	2025 Family Satisfaction Result : 1) I am updated regularly about any changes in the home = 82.89% Improved 2) Overall, I am satisfied with communication from home leadership=80.36 % Improved 3) Communication from home leadership is clear and timely= 79.75 % Improved 4) Overall, I am satisfied with the continence care products =82.06% Improved 5) There is a good choice of continence care products=81.09 % Improved

Key Performance 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	15.29%	14.97%	15.24%	17.79%	16.67%	17.09%	16.99%	14.19%	16.00%	18.12%	17.48%	17.01%
Pressure Injuries	1.24%	1.20%	1.23%	0.00%	0.00%	0.00%	0.00%	0.88%	1.71%	1.79%	2.86%	4.23%
Antipsychotics	7.87%	7.07%	6.25%	6.73%	6.67%	6.60%	4.76%	4.85%	6.31%	6.84%	7.08%	6.78%
Restraints	0.00%	0.00%	1.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ED visits	26.20%	26.20%	26.20%	26.20%	26.20%	26.20%	26.20%	26.20%	34.30%	34.30%	34.30%	34.30%



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 incorporated 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:	The 2025 Resident and Family surveys, conducted between October 1 and October 31, show high overall satisfaction with the home.
Results of the Survey (*provide description of the results*):	A strong majority of Residents (90.83%) and Family Members (83.86%) would recommend the home to others. The Overall Satisfaction Resident Rate in 2025 is 86.81% which was an increase from 2024 of 85.36%. For Family Satisfaction Overall Survey in 2025 is 82.99%, which is slightly below the 2024 rate of 83.73%. To note, there was a significant increase in family participants for 2025 was 76.92% versus 65.96% in 2024 and the residents participation increased from 96.30% in 2024 to 100% in 2025.
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 survey results and action plan were shared with Family Council on February 23, 2026 and Residents Council on March 14, 2026 and were posted on Quality board in home for staff to review.

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%	96.30%	96.43%	100.00%	76.92%	65.96%	55.32%	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	92.00%	90.83%	77.15%	75.56%	85.00%	83.86%	80.00%	85.60%	To support improvement in the likelihood of residents and families recommending Seaforth Manor 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	90.00%	88.91%	82.50%	86.67%	83.00%	80.26%	83.06%	91.54%	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**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term Care residents.[1]	#1) Continue to implement regular health screening through IPAC assessments and preventive Care measures to help identify and prevent complications that may lead to hospitalization. Target: 100% compliance with health screening through IPAC assessments completed by Registered staff as indicated by June 30, 2026. #2) Implementation of the Nursing PLEDGE Initiative program to build capacity and improve overall clinical assessment skills of Registered Staff by supporting mentorship of nurses, enhancing quality of Care and workforce stability Target: 80% of ED visits were assessed appropriately based on resident outcome and transferred to the ED by December 31, 2026 #3) Nursing Leadership to review and analyze the monthly ED trackers for root cause of transfers and determine appropriateness of transfer based on resident outcome **Target:** 15% reduction in avoidable ED visits by December 31, 2026	January 2026: 34.29%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	#1) To continue to facilitate ongoing open door policy amongst the management team Target: 100% of reminders to staff re: open door policy by May 31 2026 #2) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace Target: 100% of cultural events to be celebrated monthly by December 31 2026 #3) To increase diversity training through Surge education or live events **Target:** 100% of active staff educated on topics of Culture and Diversity by December 31 2026	December 2025: 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	#1) To exceed our goal of 82% by engaging residents in meaningful conversations allowing residents to express their opinions Target: 100% of all Admission and Care Conferences will document the review of Resident Bill of Rights #29 by December 31 2026 #2) Continue reviewing Resident's Bill of Rights # 29 at Monthly resident council meetings Target: 100% of Resident council meetings have the Bill of Rights #29 reviewed by December 31 2026 #3) Continue to review Resident Bill of Rights #29 at Family Council quarterly meetings **Target:** 100% of all Family Council meeting minutes include Resident Bill of Rights #29 by December 31 2026	October 2025: 90%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	#1) To establish and facilitate an interdisciplinary approach to Weekly Fall Huddles **Target:** 100% interdisciplinary participation at Weekly Fall Huddles by June 30 2026 #2) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss **Target:** 100% of residents who experienced a fall in the month will have completed a comprehensive post fall assessment and reviewed at the Falls weekly Huddle by June 30 2026 #3) To Reduce the Number of Falls in the Home **Target:** 1) 100% of 24 hour report reviewed and identification of residents at high risk for falls/frequent falls by May 31 2026; 2) 100% of interdisciplinary staff participating in weekly fall huddle by June 30 2026; 3) 100% of Current (active) Registered staff educated on post fall analysis by June 30 2026; 4) 100% of referrals addressed by December 31 2026	November 2025: 14%
2025 Resident Satisfaction Survey Results: **Top 5 Opportunities:** 1) I have friends at the home 2) My goals and wishes are considered and incorporated into the plan of Care 3) I am satisfied with: Timing and schedule of recreation programs 4) Continence Care products: Are comfortable 5) I am satisfied with: The relevance of recreation programs	**The Top 5 areas of improvement that were identified with the Resident Satisfaction survey included:** 1) Implement a buddy system for residents where a resident volunteers to be the resident who welcomes new admissions and introduces them to peers. Introducing this program at resident council and ask for a couple volunteer's to be involved in this program. 2) Review 1:1 with each resident the plan of care and ask for feedback. Have a nurse and the social worker present. 3) Review Programs calendar with resident council for feedback. Bring feedback from Resident Council to the next Resident council with a draft April calendar and work with council to build the Final April calendar. 4) In March of 2026 the home will be changing from the currently offered continence products to new line of continence products . In this changeover process, all residents will be resized and refitted through the new algorithm. This process should ensure residents are in the most comfortable product. 5) Ask Resident Council to provide a list of recreation programs that they are interested in seeing at the home. Once the list is received, review and start to implement these activities to the calendar.	**2025 Resident Satisfaction Survey Results:** 1) 80.21% 2) 80% 3) 79.35% 4) 77.50% 5) 77.08%
2025 Family Satisfaction Survey Results: **Top 5 Opportunities:** **1) Overall, I am satisfied with the meal, beverage, and dining services** **2) The resident has access to foot Care when needed** **3)Continence Care products: Keep the resident dry** **4)Communication from home leadership is clear and timely** **5) Continence Care products: Are comfortable**	The Top 5 areas for improvement that were identified with the Family Satisfaction survey include: 1) Review the new cycle menu's (spring/summer and winter/fall) with family council for feedback. Including a meal sample. Start when the spring menu is implemented 2) Offer family council an information session on the footcare processes at home (what is offered from PSW staff vs. footcare paid service). Add foot care dates to new family newsletter. Bring the unfunded services form to all care conferences to provide family an opportunity annually to have the footcare process reviewed and sign up if interested 3) In March of 2026 the home will be changing from the currently offered continence products to new line of continence products . In this changeover process, all residents will be resized and refitted through the new algorithm. This process should ensure residents are in the most comfortable product. 4) Adjust the monthly newsletter to include leadership updates, menu changes, repairs/upgrades, new staff hires, etc. Review first draft with Family Council. 5) In March of 2026 the home will be changing from the currently offered continence products to new line of continence products . In this changeover process, all residents will be resized and refitted through the new algorithm. This process should ensure residents are in the most comfortable product.	**2025 Family Satisfaction Survey Results:** 1) 80.23% 2) 80% 3) 80% 4) 79.75% 5) 79.69%

Process for ensuring quality 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	Lovepreet Kaur, Associate Director of Care	**May 27 2026**
Director of Care	Shanon MacKellar	May 27 2026
Executive Directive	Ryan Yoanidis	May 27 2026
Nutrition Manager	Shagun Parakh	May 27 2026
Programs Manager	Stacey Kamerman	May 27 2026
Clinical Consultant	Cindy Britton	May 27 2026