

IMPACT REPORT 2025 - 2026

NUCLEUS REIMAGINED

One Team. Digital Forward. Growing Stronger





“The healthcare system of tomorrow must be different from the healthcare system of today. We have a rapidly ageing population. We cannot afford to operate the healthcare system the way we are operating it today. You have to change the size and shape of the healthcare system and put extraordinary investments into home and community care.”

~ Dr. Karima Velji, Assistant Deputy Minister of Health and Chief of Nursing and Professional Practice, Ontario

Nucleus Reimagined Open House, November 19, 2025

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IMPACT REPORT
2025 - 2026





ABOUT NUCLEUS

We champion independent living by helping clients live well at home and within their communities.



Through personal care support, we aim to maintain the autonomy our clients want with the assistance they need. We partner with our clients and their families in the delivery of safe, quality care that incorporates their preferences and choice. We believe that when people are empowered to make choices, they can contribute more fully to their well-being and independence.



LAND ACKNOWLEDGEMENT

Nucleus Independent Living's head office is located on sacred land. This land is the traditional territory of the Haudenosaunee and Anishinaabe. This territory is covered by the Upper Canada Treaties and is within the lands protected by the "Dish With One Spoon" wampum agreement. We acknowledge these Nations (and any other recorded or unrecorded First Peoples who cared for the land) as the past, present and future caretakers of this land.

As settlers, we entered into an agreement to share this land equitably. This recognition of the contributions and historic importance of Indigenous Peoples must be overtly connected to our collective commitment to make the promise of Truth and Reconciliation real in our communities.

We wish to acknowledge those who have lived on and cared for this land and express gratitude to those who reside here, and to honour the Indigenous people who have lived and worked on and cared for this land historically and presently.

We are grateful for the opportunity to work with communities, and on this territory.

TRUTH AND RECONCILIATION: OUR CONTINUING COMMITMENT

This year, Nucleus advanced our Truth and Reconciliation journey through organization-wide education and strengthened understanding of culturally safer care. Building on the foundational work outlined in the Grandmother's Voice Survey, we launched a four-part culturally safer care education series for the entire organization.

This training creates an organization-wide foundation of awareness aligned with the Truth and Reconciliation Commission's Calls to Action 23 (cultural competency) and 57 (education for public servants). The series introduced staff to Indigenous history, culturally safe care, and the social determinants of health that contribute to inequitable outcomes.

Through participation in Ontario Health's Circle of Action: Turning Commitments Into Change, we learned alongside Ontario Health Team partners about the importance of relationship-first approaches, consistent presence at Indigenous-led events and community-guided co-design supported by ongoing cultural safety learning. These insights align closely with our internal Truth and Reconciliation work, and we are now reflecting on how they can inform and strengthen the next phase of our action plan.

The coming year will focus on building on these foundations, gathering staff feedback to refine our Truth and Reconciliation workplan, deepening sector collaboration and continuing to align our internal practices with the broader Calls to Action.

EQUITY, DIVERSITY & INCLUSION

At Nucleus, we view our diversity as our strength. We know that the unique perspectives of our clients, caregivers and staff contribute to a better environment for all.

We are committed to listening, learning and amplifying the voices that will help make us more inclusive and better informed to serve our communities.

We embrace diversity, choose equity and action inclusion.

A MESSAGE FROM OUR LEADERS



This was a year of reimagining at Nucleus – room by room, role by role, relationship by relationship.

On November 3, 2025, we reopened our head office after a four-month renovation, giving physical form to a culture we have been quietly building for years: one where strategy, operations and front-line wisdom share the same room, the same conversation, the same purpose. Two weeks later, we threw open those doors for our Nucleus Reimagined Open House, welcoming staff, clients, partners, dignitaries and friends to walk through what we had built together. It was a day to honour the people – inside Nucleus and far beyond it – who carried us here, and to look ahead, shoulder to shoulder, at what comes next.

The year asked us to reimagine in other ways, too, and we answered every time. We invested in our people in ways we have long believed they deserved: launching the Healthcare of Ontario Pension Plan (HOOPP), enhancing benefits, sustaining OPSWA professional membership for every Nucleus PSW, and hosting our first-ever standalone Staff Recognition Celebration. We earned Great Place to Work® Canada certification – a result that simply tells the truth about what our team already knew. We earned our fifth consecutive three-year CARF International accreditation – proof that quality at Nucleus is not an event but a discipline, lived in every shift. We deepened partnerships with primary care, with the Ministry of Health, and with organizations across the sector. And in every one of those conversations, we kept the work grounded where it has always mattered most: in our clients' homes, in their stories, in their lives.

None of this happened on its own.

To the staff who deliver extraordinary care every day – in homes, in hospitals, on the phone, on the road – thank you. You are Nucleus. To the clients and families who trust us with the most personal moments of their lives, thank you; your trust is the work. To our funders, our government partners, our sector colleagues and our Board of Directors – thank you for walking with us. And to one another, across every team at Nucleus, thank you for the year we shared.

Reimagining is not a finish line. It is a way of working – a quiet, daily insistence that the next version of ourselves is worth building. As we step into 2026-2027, we do so with gratitude for everything this year asked of us, and with real, earned confidence in what comes next.

Laura Salisbury
Chief Executive Officer

Jaspreet Hansra-Kulasingam
Board Chair

“ Together, we are reimagining community and care.



OUR 2025 – 2029 STRATEGY

Reimagining community and care, together.

2025 → 2026 → 2027 → 2028 → 2029

In 2025, the Nucleus Board of Directors approved a new three-year strategic plan that will carry the organization through to 2029. It builds directly on the foundation laid by the 2021-2024 plan – which prioritized stabilization, sustainability and digital readiness, and turns the organization outward toward financial resilience, workforce excellence and provincial digital leadership.

THREE STRATEGIC PRIORITIES

With the client, their families and loved ones at the centre of every strategic step the organization takes.

FINANCIAL RESILIENCE & SUSTAINABLE GROWTH

Strengthen financial resilience by optimizing resource use, diversifying revenue sources and building sufficient liquidity so that Nucleus can sustain service levels in a restricted funding environment and continue to invest in the workforce, digital infrastructure and innovation needed to remain relevant in a changing healthcare system.

WORKPLACE OF CHOICE & CULTURE OF EXCELLENCE

Build and sustain a high-performing workplace that attracts, develops and retains the talent who deliver exceptional care. A skilled, supported and committed workforce is the primary enabler of quality service delivery, growth and innovation.

SCALABLE DIGITAL HEALTH ECOSYSTEM

Build a scalable, interoperable digital ecosystem that enables high-quality care delivery while positioning Nucleus as a trusted system leader in digital health across community and partner networks.



VISION FOR 2029

Nucleus will be recognized in Ontario as a community support services leader in digital health, with a track record of agile implementation, supported by diversified and sustainable revenue streams.



OUR GUIDING PRINCIPLES

Every decision under this plan is anchored in five guiding principles: **client-centred, equity-focused, financially sustainable, digitally enabled and system-oriented.**

This Impact Report – the first under the new strategic plan – shows the strategy in motion. Many of the stories that follow are early Year 1 wins against these three priorities: a total compensation package that includes HOOPP-anchored employee value proposition, deeper sector influence, a maturing digital infrastructure and the first revenue-diversifying partnerships taking shape.



BY THE NUMBERS

2025 - 2026



241

Staff Members

162 Attendants | 75 Corporate Staff | 4 RPNs



130,330

Service Hours Delivered



210,528

Service Visits Delivered



2,965

Individuals Served



14,877

Support Visits & Calls



7,489

Support Hours Delivered



14,458

Meals Provided



3,868

New Referrals Received



2,380

Individuals Trained

Regional Learning Centre



644

Caregivers Supported

Central Intake for Community



244

Caregivers Equipped

Regional Learning Centre



117,910

New Funding Secured



351

**Self-Directed Living
Clients Activated**

From Waitlist to Service



359

**Adult Day Service
Clients Activated**

From Waitlist to Service



168

**Respite Clients
Activated**

From Waitlist to Service

FINANCIAL HIGHLIGHTS

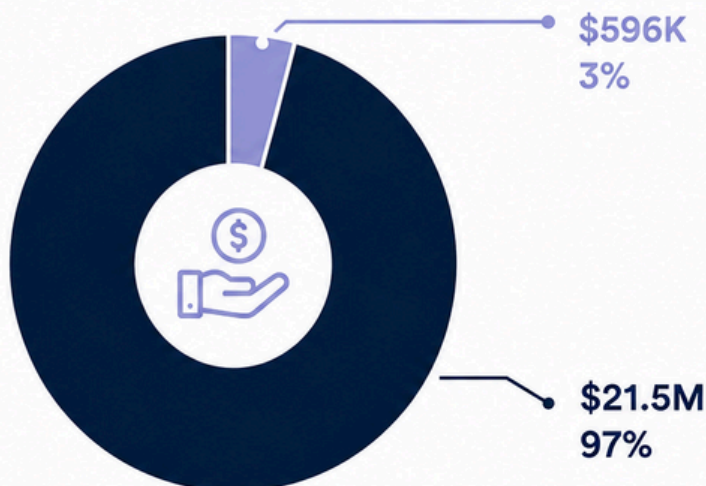
2025 – 2026



Total Revenue
\$22.1 million

REVENUES

- Ontario Health
\$21.5 million | 97%
- Other
\$596K | 3%



\$2.1M
9%

\$19.8M
91%



EXPENSES

- Wages, Benefits, Purchased Services and Travel
\$19.8 million | 91%
- Other Operating Expenses
\$2.1 million | 9%

*Nucleus Independent Living's audited financial statements from April 1, 2025 – March 31, 2026 are available upon request.

HOSPITAL TO HOME (H2H): CLOSING THE GAP

14 days → 2.3 days

Reducing the wait from hospital discharge to home support from 14 days to 2.3 days **in just four months.**

Every year, thousands of Ontarians are discharged from hospital still needing significant support at home. The window between discharge and the first home visit is one of the most fragile in the system – a moment when families scramble, hospital beds back up and clients can lose ground physically and emotionally. Closing that window safely is what the Hospital to Home (H2H) work this year was about – building trust with clients is what we do best.

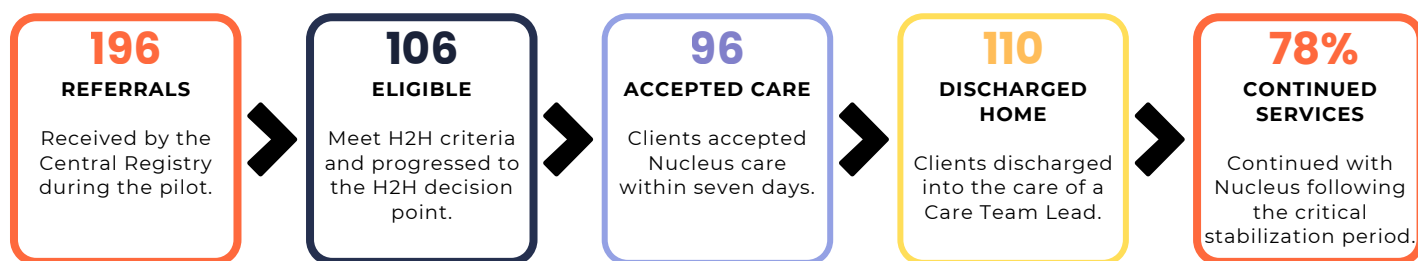
In 2024, the time it took for a Nucleus client newly discharged from hospital to receive their first home visit averaged more than 14 days. For clients, that gap was an anxious stretch in unfamiliar circumstances. For families, it was a logistical scramble. For hospitals, it was a backed-up bed in the emergency department or on the discharge ward, and a barrier to flow.

On Monday, April 21, 2025, Nucleus launched the Hospital to Home (H2H) Pilot to close that gap.

The objective was specific: reduce the time from hospital referral to a client's first contact with Nucleus services in the home. The team was deliberately cross-functional, comprised of leaders from Central Registry, Client Services and the 'MITO' digital team. Senior leader sponsors across Client Services and the Central Registry shepherded the pilot through 15 weeks of test-of-change cycles, huddles, process mapping and digital tool refinement.

By August 8, 2025, just under four months later – the team had accomplished a new number: 2.3 days.

THE H2H JOURNEY: BY THE NUMBERS



DID YOU KNOW?

Every nucleus needs a powerhouse and ours is called MITO. The name is a nod to the mitochondria, the energy-generating engine inside every cell. Fitting, really: just as mitochondria fuel everything a cell does, the MITO team is the energy behind the work that keeps Nucleus running.

The nickname was coined by our very first cohort of Master's co-op students from the McMaster eHealth program – and like all the best nicknames, it stuck.



"Hospital to Home isn't a program – it's a promise," says Trish Maxwell, Strategic Partnerships & Client Services. "That no client crosses that threshold alone. That the first day home is as carefully planned as the day of discharge (from hospital). And that home, again, becomes the safest place to be."

Inside the model is a workflow redesign described internally as a move "toward equitable, coordinated transitions rooted in continuity rather than handoffs." Decision-making authority now redirected with frontline teams. Care coordinators meet clients in hospital and stay with them through the early post-discharge period, connecting them not only to home care services but to other integral wrap around services, caregiver respite, meal programs, education through the Regional Learning Centre and culturally appropriate supports. Once stabilized, the client transitions to a long-term Care Team Lead. The 0–14-day period now has a clearly identified Most Responsible Person within AlayaCare, our electronic medical record. A new H2H dashboard refreshes every two hours to provide team-wide visibility into transitions.

Staff satisfaction tells one half of the story. With 95% participation, the staff survey confirmed a pilot that was demanding but profoundly believed in. Client satisfaction tells the other: 83% of clients expressed satisfaction with the care and support they received, 75% felt well supported at home after discharge, and 66% found the transition home manageable.

By July 2025, the pilot was no longer a pilot. H2H is embedded in day-to-day practice. The Care Team Leads continue to refine handoffs. The MITO digital team continues to enhance the digital scaffolding. And the central insight that came out of the pilot – that the right number of days is not 14, not 7, but as close to two as the system can be made to allow, is now informing Nucleus' broader thinking on every person in transition the organization touches.



THE FLORENCE NIGHTINGALE INITIATIVE

**66% Improvement in
helping people age at
home**

Nursing around the clock in the community



In May 2025, Nucleus launched a new model of community-based nursing.

Why – enhancing care for clients who are accomplishing what we strive to achieve every day, supporting and understanding what it means to “age in place”, longer lifespans, wellness and healthier, with dignity in their homes.

The choice of timing was deliberate – during national Nurses Week.

The choice of name was too.

Florence Nightingale was the pioneering nurse who walked the halls of military hospitals at night during the Crimean War, lamp in hand – and who has been called “the Lady with the Lamp” for nearly two centuries. The image gestures at something Nucleus wanted to make literal: that the path to safer, more responsive community care runs through nursing leadership at the right moments, in the right places, often in the dark hours when emergency departments would otherwise be the only option.

Nucleus' pioneer nurse joined the team in May. By July, with a broader team in place, they - went live with overnight coverage – 10 p.m. to 9 a.m., seven days a week. In the months that followed, weekday day coverage was added and overnight coverage extended.

Even before the formal overnight launch, the model proved its value in a way no data point could fully capture.

Not an unfamiliar story - a Nucleus Care Team Lead received a call from a client's daughter-in-law. Her father-in-law was no longer answering his phone.

The question was the same question that confronts community care teams every day: was this a 911 call, or was there a path that did not begin with paramedics?

In Nucleus' ONE Team approach, the nursing team was engaged, which resulted in a visit to the client's home. The RPN performed a head-to-toe assessment. They located the client's blood pressure machine, confirmed it was calibrated and took a reading. It was elevated, but not acute. The RPN reviewed his medications and offered hydration and electrolyte guidance to the family. By later that day, the client reported feeling significantly better.

A 911 call had been the obvious default. The RPN's presence made it the wrong default.

“The RPN's role today provided previously unavailable insight, and was valuable in mitigating a potential 911 call and preventing unnecessary use of emergency department resources”.

Stories like this are now routine, not exceptional. The Florence Nightingale Initiative is about bringing 24/7 community nursing support into the ONE Team model – building expertise that lives alongside Central Registry, Client Services and Supportive Housing rather than parallel to them. The model is maturing, with a planned 2026-2027 evolution to include a Physician Advisor and further integration with primary care.

What we did see – a 66% improvement in helping people age at home, rather than being transferred to long term care institutions.

SETTING THE BAR, AT SCALE



Ontario's First PSW Best Practice Guidelines

In April 2025, Nucleus formalized a three-year strategic partnership with the Ontario Personal Support Workers Association (OPSWA). The partnership had three focus areas: tiered membership and micro-credentialing, joint upskilling and public advocacy to raise the profile of PSWs as essential healthcare professionals.

In the eight months that followed, the partnership produced something Ontario had not previously had.

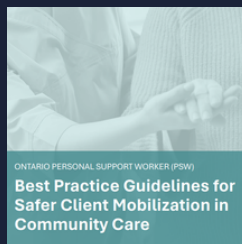
In late 2025, the Regional Learning Centre, in partnership with OPSWA, released Ontario's first-ever [PSW Best Practice Guidelines \(BPGs\) for Safer Client Mobilization in Community Care](#).

The guidelines provide practical, evidence-based recommendations to help Personal Support Workers deliver safe, high-quality care while minimizing risk for both clients and staff. The release was publicized through OPSWA's channels and Nucleus' platforms. And it laid the groundwork for the next set – a BPG focused on medication management coming later in 2026.

The implications go beyond a single document. As the BPGs spread to PSW colleges and across Ontario's home and community care sector, Nucleus and OPSWA are co-developing a path toward provincial standardization of competencies and care approaches. The goal: greater predictability, safety, reliability and quality for the public, and a clearer professional identity for the PSWs themselves.

By March 2026, Nucleus had also sustained up to 95% completion on PSW registration with OPSWA, maintaining its position as a Premier Partner and a national role model for home and community care organizations.

"Together, with Nucleus, we are laying the groundwork for the first-ever provincial Best Practices for community care PSWs – a standard that will outlast any single organization or any single year," says Miranda Romanowicz, CEO, OPSWA.



THE TIPPING POINT STRATEGY

Preventing Hospitalization, Upstream



In Fall 2025, Nucleus was selected from more than twenty submissions across Central Ontario Health as one of four Central Region partners – and the Mississauga Halton system lead – for Ontario Health's Tipping Point Strategy.

The strategy's premise is intuitive but operationally complex. Most clients who eventually become Alternate Level of Care (ALC) designations in hospitals have signals long before that moment – caregiver distress, mobility decline, mental health concerns, social isolation, housing risk. If those signals can be identified and addressed upstream, in the home and in the community, many hospitalizations and ALC stays can be prevented entirely.

Nucleus' role is to strengthen regional capacity in four areas: early identification, comprehensive assessment, care planning and intervention. The work draws on the assets Nucleus has been building for years – over a decade of standardized assessment data through Central Registry, the Caregiver Recharge program, the Regional Learning Centre's caregiver support, and the integrated Hospital to Home work. It also draws on a new research partnership with the Institute for Better Health at Trillium Health Partners, where researchers are co-developing client "personas" through engagement with providers, older adults and caregivers across the region. By December 2025, more than 85 individuals had participated in those conversations, alongside emerging partnerships with Dr. John Hirdes at the University of Waterloo and SE Health Research Institute.



"The biggest value is early identification of clients and caregivers at risk of hospital admission upstream – based on assessments and screening – to provide proactive solutions across the Central region," says Trish Maxwell, VP Strategic Partnerships & Client Services

What makes the work possible is that the upstream machinery is already in motion at Nucleus.

The Hospital to Home pilot cut the time from hospital referral to a client's first home visit from 14 days to 2.3 – turning the most fragile window in the discharge journey into one of the system's fastest. The Florence Nightingale Initiative put nursing leadership on the line for clients overnight, seven days a week, where 911 had been the only available answer. In ten days last December, Central Registry filled 39 of 43 Caregiver Recharge vacancies, releasing caregivers who had been waiting up to 18 months. And the Nucleus-Dorval Primary Care Integrated Team Model began closing the gap between primary care and community support for more than 600 unattached patients across the region. Each of these is, in its own way, a tipping point intercepted.

The Tipping Point Strategy is directly linked to Central Ontario Health's Access and Flow Table within the 2025-2026 system strategy, where Nucleus is actively represented.

Recommendations flow back to that table, and to the Health System Recovery Table – which is to say, back into how Ontario plans capacity, flow and prevention for everyone who needs care, not just the clients Nucleus serves. The work being done in homes today is the evidence base Ontario will use tomorrow to decide how the system shifts upstream. Nucleus is helping write it.

NUCLEUS REIMAGINED: THE WALLS CAME DOWN.



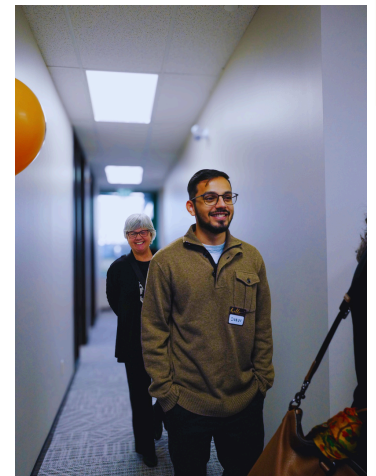
On November 3, 2025, Nucleus reopened its head office at 2030 Bristol Circle after a four-month rebuild, bringing to life a vision that had been years in the making. What emerged was more than a renovated office. It was a physical reflection of how Nucleus has evolved as an organization.

The redesigned space eliminated many of the physical barriers that once separated teams. Where corporate and operational functions had traditionally worked in different areas, staff now share an open, collaborative environment that supports connection, communication and a stronger understanding of how every role contributes to client care.

The new office also reflects Nucleus's commitment to innovation. Designed as a fully digital, technology-enabled workspace, the environment supports more efficient collaboration, flexible ways of working and the organization's continued focus on modernizing community care.

Two weeks later, Nucleus formally hosted the Nucleus Reimagined Open House. CEO Laura Salisbury opened the day with a staff huddle reflecting on five years of transformation. Staff then participated in a guided experience that highlighted the work of teams across the organization, from Central Registry, where many client relationships begin, to Client Services, the Regional Learning Centre, Finance, People and Culture, and MITO. The experience reinforced how each team contributes to a shared mission and how success depends on working together.

In the afternoon, Nucleus opened its doors to sector partners and guests. Representatives from the Ministry of Health, the Ontario Community Support Association, the Ontario Personal Support Workers Association, AlayaCare and organizations across the community care sector gathered to celebrate the milestone. They came not only to see a new space, but to recognize an organization that continues to lead, innovate and help shape the future of community care.



The walls came down. The work continues.

EXCEEDING EXCELLENCE, FIVE TIMES OVER



CARF International Accreditation 2025

5th

consecutive CARF accreditation

100%

compliance, 12 of 13 categories

1,550

standards reviewed

For three days in June 2025, CARF International surveyors walked through every program, policy, procedure and care practice at Nucleus. They sat with the Board. They interviewed staff. They reviewed 1,550 standards.

When they finished, Nucleus had earned its fifth consecutive three-year accreditation (the highest possible standing) with 100% compliance in 12 of 13 categories and only three recommendations for further improvement.

“The achievement reflects the dedication of our teams and a shared culture focused on striving for excellence in the services we provide,” says Natalia Sokolova, Manager, Quality & Risk.

In a sector where reaching standards is hard and sustaining them is harder, the fifth consecutive accreditation tells one story: Nucleus’ quality is not an event. It is a discipline.

The exit conference highlighted what the surveyors had observed: a high-achieving, data-driven organization grounded in person-centred care and collaboration; a cohesive Senior Leadership Team; preparedness and forward-thinking in digital strategy. The Nucleus team welcomed the feedback for three recommendations – a way to level up again, in an ever-evolving environment, and are already integrated into Nucleus’ Quality Improvement Plan.

Two further outcomes are worth naming. Our CEO, Laura Salisbury, along with Natalia Sokolova have completed CARF surveyor training – as an Administrative Surveyor and a Program Surveyor, respectively. Internal expertise in accreditation and quality standards is now embedded in Nucleus’ leadership in a way that did not exist before.

“This is an incredible opportunity to contribute to quality improvement across the sector while bringing back valuable insights that continue to strengthen care, accountability and client experience at Nucleus,” says Salisbury.

ASSISTED LIVING SERVICES TOOLKIT

Building a Common Language Across Ontario

Developed with The Ontario Association of Independent Living Service Providers (OAILSP) members, the ALS Toolkit creates standardized reporting definitions that improve data quality, strengthen advocacy, and support better decision-making across the Assisted Living sector.



A foundation for stronger data quality, better decision-making, more consistent sector advocacy and a fuller picture of Assisted Living Services work across Ontario.



STANDARDIZED REPORTING

Clear, consistent definitions for key reporting categories



SECTOR ALIGNMENT

A shared approach across OAILSP members



BETTER DECISION MAKING

More accurate data to inform funding and service planning



STRONGER ADVOCACY

A clearer, unified voice for the ALS sector across Ontario

WHAT IS IT?

The OAILSP ALS Toolkit is a sector-facing resource that helps Assisted Living Services organizations classify, collect and report service hours in a consistent, meaningful way. It establishes a shared approach to Direct Care/Service Hours, Indirect Hours, and Care Coordination so members no longer interpret or report these categories differently.

WHY IT MATTERS

Member organizations across Ontario deliver similar Assisted Living Services, yet often capture, define, and categorize that work differently. Those inconsistencies make it harder to compare data, identify operational pressures, and demonstrate the full scope of ALS work to funders and decision-makers. The toolkit creates a common language and structure for reporting work that organizations are already doing without changing how care is delivered.

BUILT WITH THE SECTOR, FOR THE SECTOR

The OAILSP ALS Toolkit is a sector-facing resource that helps Assisted Living Services organizations classify, collect and report service hours in a consistent, meaningful way. It establishes a shared approach to Direct Care/Service Hours, Indirect Hours, and Care Coordination so members no longer interpret or report these categories differently.

STRATEGIC IMPACT

- ✓ Standardization and stronger sector alignment across OAILSP members.
- ✓ A clearer foundation for future reporting to Ontario Health.
- ✓ A stronger evidence base for sector advocacy and decision-making.
- ✓ A shared way to demonstrate the full scope of ALS work in Ontario.

Learn more about the ALS Toolkit at:

https://irp.cdn-website.com/0eaec666/files/uploaded/OAILSP_ALS_Toolkit_OnePager+June+2026.pdf



INVESTING IN OUR PEOPLE



A GREAT PLACE TO WORK

T

his year, Nucleus received Great Place to Work® Canada certification – an honour we are proud and pleased to have earned.

What gives the recognition its weight, for us, is that it is awarded on the strength of survey results from our own staff, measured by a process the organization does not control.

Great Place to Work® Canada certification is not a logo, and it is not an award an organization applies its way into. It is an externally administered, independently verified survey of an organization's own employees, measuring trust, fairness, pride, camaraderie and the everyday experience of working somewhere. To earn it, an organization has to meet meaningful benchmarks across all of those dimensions, in a survey that leadership does not write, edit or curate.

The people behind our inaugural results are the ones who would know best – the PSWs, nurses, schedulers, coordinators, educators

and managers who experience Nucleus every day – and what they described, in aggregate, was a workplace they were willing to stand behind.

That result reflects a long arc of work. Years of decisions about pay, professional development, recognition, scheduling, technology and culture quietly compound into the moment a staff member answers a survey question about whether they feel respected, heard or supported. None of those decisions were made for the sake of a certification, which is part of why the certification, when it came, meant so much to us.

In a sector under significant workforce pressure, Nucleus is now part of a small but growing community of Canadian organizations whose employer experience has been independently verified by the people who live it. That signal matters – to our staff considering their next role, to partners deciding who in the sector can be trusted to deliver, and to a system that needs to know which organizations can be relied on to deliver care year after year.



 **nucleus**



DEVELOPMENT

**Learning Without
Limits**



PEOPLE

**Growing
Future Talent**



CULTURE

**Partnerships
That Matter**



HOOPP + OPSWA: A NEW STANDARD FOR COMMUNITY CARE

Nucleus' staff are the organization's greatest asset. That is not a slogan. It is the working assumption behind every investment described in this section.

Personal Support Workers, in particular, are the heart of Nucleus – and the heart of the community care sector itself. They are the people who walk into homes early in the morning and late at night, who build relationships over years, and who notice the small changes that others might miss. Investing in them is not a benefit calculation. It is a recognition that the people who care for others deserve to be supported themselves – with fair compensation, meaningful benefits, professional recognition and opportunities to grow.

This year, two significant investments brought that commitment to life.

On January 5, 2026, the Healthcare of Ontario Pension Plan (HOOPP) came into effect at Nucleus. HOOPP is one of Canada's most respected defined-benefit pension plans, providing secure, lifetime retirement income and portability across participating healthcare employers.

While pension plans of this calibre are common in hospitals and other parts of the healthcare system, they remain rare in community care. By introducing HOOPP, Nucleus joined a small group of organizations providing this level of long-term financial security to frontline staff.

The introduction of HOOPP reflects years of planning and operational improvement led by Chief Operating Officer Oliver Blunn and teams across the organization. It represents a deliberate investment in the workforce that will be needed to meet growing demand for community-based care. As more Canadians choose to age in place and healthcare shifts increasingly into the community, attracting and retaining talented staff has never been more important.

HOOPP was complemented by another important milestone: organization-wide membership and professional verification through the Ontario Personal Support Workers Association (OPSWA).

Beyond the practical benefits, OPSWA membership sends a clear message. Personal Support Workers are skilled professionals whose contributions deserve recognition, support and a strong professional identity. It also reinforces Nucleus' commitment to quality, accountability and public safety.

"Nucleus was the first employer in Ontario to mandate OPSWA professional verification – a bold commitment that raised the bar for excellence across the entire home and community sector. Their belief in professionalism, safety and high standards has made a meaningful difference in the lives of both PSWs and the clients they support," says Miranda Romanowicz, CEO, Ontario Personal Support Workers Association.

Together, HOOPP and OPSWA represent more than workforce initiatives. They are investments in the people who make community care possible every day. By strengthening financial security, professional recognition and workplace culture, Nucleus continues to build an environment where staff can thrive, and where clients ultimately benefit from a stable, skilled and supported workforce.

QUALITY IMPROVEMENT SPOTLIGHT

STABILITY BY DESIGN:

FROM AGENCY TO EMPLOYEES

Scheduling stability is one of the hardest challenges in community care. The pandemic deepened it. Demand surged, staff burnt out, agencies stepped in to fill the gaps and continuity of care became harder to deliver. Most home and community care organizations across the sector are still living with the consequences: high agency reliance, unpredictable schedules and clients who see a different face week to week.

“Impact on client services is evident.”

~ Allison Shand, Manager, Client Services

Clients and staff want predictability. Nothing about the work – the route a PSW drives, the body language a client expects, the rhythm of a trusted morning, thrives on rotation. And the underlying scheduling challenge is genuinely complex: new clients onboarding quickly, care needs changing in real time, appointments shifting, staff availability moving and a small team of schedulers holding the whole picture together.

Nucleus has been working to address this complexity. This year, the organization decided to focus and finish: to pull the team together, name the root causes and solve them. The single most visible act of that focus was the June 2025 Hiring Blitz to combat scheduling stability.

Within 6 weeks, the numbers describe an internal shift more than they describe a single hiring event. The Hiring Blitz reduced Nucleus’ agency use to near-zero across the community-based Attendant Outreach and Supports for Daily Living programs.



“The Hiring Blitz strengthened our ability to provide continuous and consistent care to clients. It not only helped fill staffing gaps, but also improved scheduling stability, strengthened client relationships, and enhanced continuity and quality of care across our programs,” says Neha Jose, Scheduling and Client Services Manager.

The shift toward our own in-house staff did several things at once. It improved continuity for clients, who increasingly see the same attendant. It improved scheduling consistency for the team. It made Nucleus’ workforce more directly trainable and accountable, and it created the conditions in which the broader investments, such as HOOPP, OPSWA and the PSW Best Practice Guidelines, could be redirected into our workforce.

Impact on client services is evident – in our 2025/26 clients’ experience and satisfaction survey – results are at an all-time high, says Allison Shand, Manager, Client Services. Let’s keep striving for more.



LEADING WITH HEART:

PORCHIA'S JOURNEY FROM PSW TO CLIENT CARE LEAD



Porchia Tjimbara joined Nucleus as a Personal Support Worker in 2017. Today, she is a Client Care Lead (CCL) – a role created by Nucleus to provide experienced PSWs with opportunities to grow into leadership positions while remaining connected to the work and people they care about most.

Client Care Leads support scheduling, care coordination, service quality and frontline mentorship. The role recognizes the leadership, judgement and practical expertise PSWs develop through years of direct client care and creates a pathway for that knowledge to influence the broader organization.

"When I look back at my first day joining Nucleus as a PSW compared to today as a Client Care Lead, the biggest shift is how much broader my impact has become," says Porchia. "As a Client Care Lead, I still carry that same passion for frontline care, but now I also have the opportunity to support and mentor fellow PSWs using my own lived experience in the field."

In 2025, Porchia represented Nucleus at Community Connect 2025, the Ontario Community Support Association's flagship conference, where she presented Leading with Heart: A PSW Journey from Frontline Care to Client Care Lead. The session highlighted the importance of creating meaningful growth opportunities for frontline professionals and sparked conversations with peers from across the province.

Nucleus staff also contributed their expertise beyond the organization. PSW Nilmini Senewiratne represented Nucleus at the Canadian Safety Association Public Policy Centre's webinar on recruitment and retention in the profession, sharing the importance of supportive leadership, recognition and workplace culture.

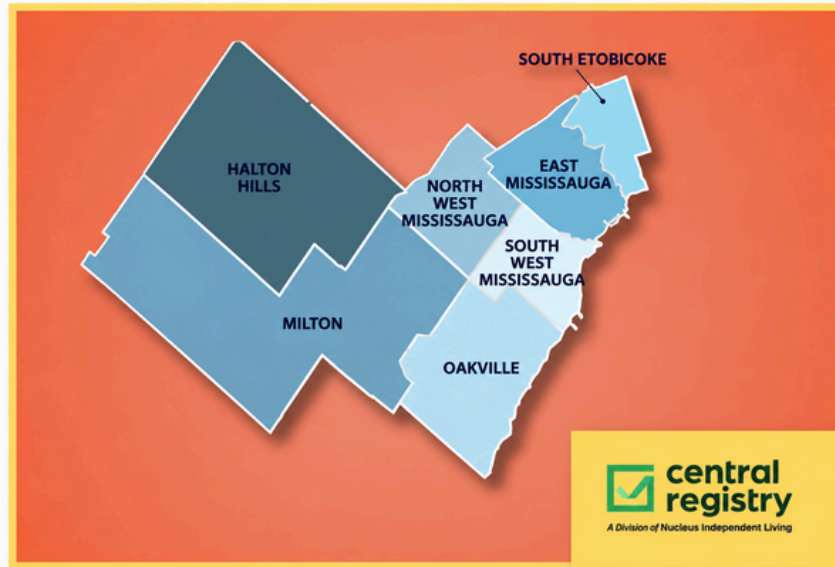
"PSWs have valuable knowledge because we work so closely with clients every day," says Porchia. "There are opportunities to grow, lead and advocate within the profession while still staying connected to compassionate care."

“

"Many of our frontline team members are racialized professionals whose talents, leadership potential and ambitions deserve to be recognized and supported," says Laura Salisbury, CEO. "At Nucleus, we are committed to creating pathways for growth through education, mentorship and opportunity. Whether that means advancing into leadership roles such as Client Care Lead or supporting staff who want to pursue nursing or other healthcare professions, our goal is to help people build meaningful careers while continuing to strengthen the future of community care."

CENTRAL REGISTRY:

Where Connection Begins



Central Registry is a division of Nucleus that supports the broader community care sector across the Mississauga Halton region. As a coordinated access point for community support services, it connects clients and caregivers to programs including Supports for Daily Living, Short Stay Respite, Caregiver Recharge, Adult Day Programs and Food Support Programs, while also facilitating referrals to a wide range of community partners.

Central Registry brings together clients, caregivers, hospitals, primary care providers and community organizations through a centralized intake, assessment, navigation and referral process designed to connect people with the right support at the right time.

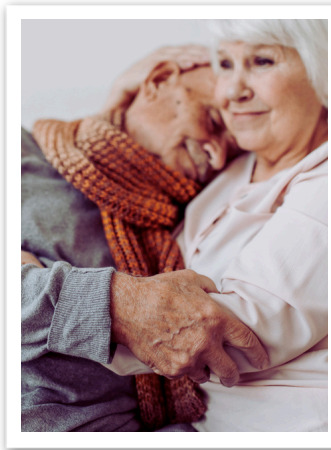
Beyond intake, the team serves as a system navigator and connector, helping people move more easily between services and reducing the complexity often associated with accessing care. Whether supporting a hospital discharge, helping a caregiver find respite, or connecting someone to services that allow them to remain safely at home, Central Registry ensures individuals and families are not left to navigate Ontario's healthcare system alone.

"Central Registry serves as the coordinated front door to community support services across the region," says Kimberly Martinez, Manager, Central Registry. "Our role is to connect clients, caregivers, hospitals, primary care and community providers through a centralized intake, assessment, navigation and referral process that helps people access the right support at the right time."

The team's expertise, compassion and deep understanding of available services help ensure people are connected to appropriate supports the first time. **In 2025–2026, 95% of clients referred through Central Registry were successfully matched to services,** demonstrating the impact of a coordinated, client-centred approach to access and navigation.

The team also provides operational oversight, data insights, waitlist management, provider coordination and quality monitoring that help strengthen service planning and responsiveness across the region. By connecting people to the supports they need and helping organizations work together more effectively, Central Registry plays a vital role in building a more coordinated community care system.

Caregiver Recharge: 39 of 43 in Ten Days



As the holiday season approaches, caregiver burnout soars.

In early December 2025, 43 Caregiver Recharge vacancies became available. By December 10, Central Registry had filled 39 of them. The caregivers who moved into those spaces had, in many cases, been waiting up to 18 months. They were caring for spouses with chronic and debilitating illnesses, such as Parkinson's and dementia, for parents with progressing illness, for partners with significant cognitive change.

The Central Registry team's proactive waitlist management process, including preparing the next group of potential clients in advance, to the point of transfer readiness, meant that when the vacancies appeared, the team could move within days.

"Because referrals are already organized, identifiable and prepared for transition, the team can move quickly when vacancies arise, reducing delays and helping caregivers access support faster," says Martinez.

One caregiver of a spouse with Parkinson's and dementia, shared: "I feel like I have got my life back" after coordinated supports were arranged through Central Registry. She returned to swimming, gardening and genealogy. Her physical and emotional well-being improved. The caregiving continued, but it was no longer consuming her.

Bridging Healthcare, Housing and Community Support

A 69-year-old Vietnamese-speaking gentleman was living in the community with increasing vulnerability – cognitive impairment, shortness of breath, high fall risk, daily cueing needs. In March 2026, a missed visit due to memory impairment led to a welfare check by the care team.

The Central Registry Care Coordinator recognized that daily supports alone would not be enough. She advocated and managed his Peel Housing application. She worked directly with Peel Senior Living to ensure his medical, cultural and language needs would be fully understood in his new environment. He secured a unit. The transition gave him safety, stability, dignity – and a setting that respected his linguistic and cultural background.

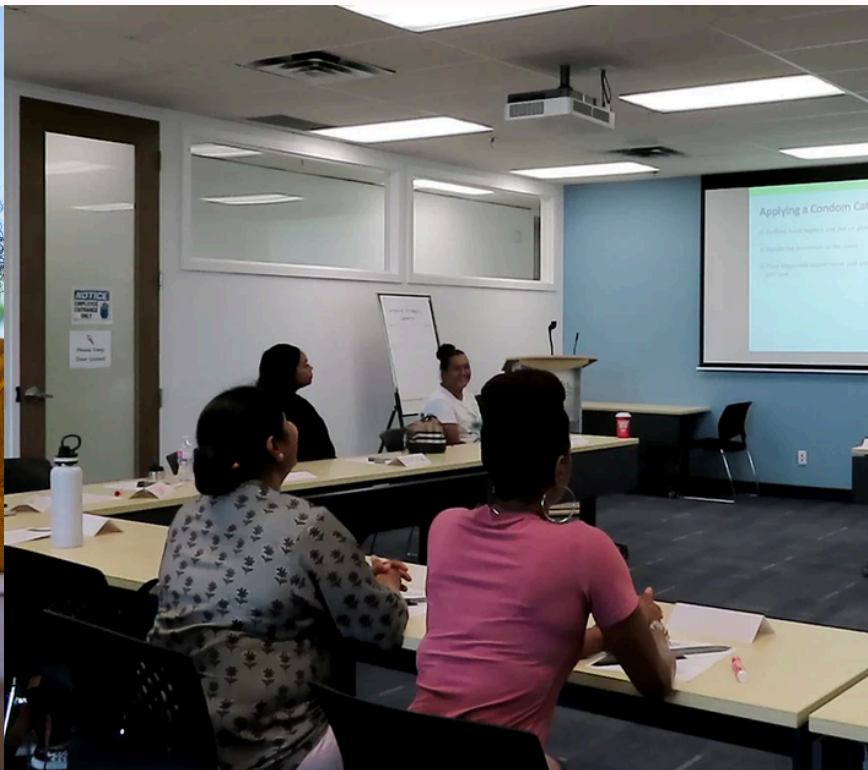
Heard, Supported, Held

An 84-year-old man was admitted to Trillium Health Partners–Mississauga with general weakness and poor intake. His dementia had progressed. His daughter was overwhelmed trying to keep him safe at home alone. The Care Coordinator listened, recommended Adult Day Program access for social engagement and nutritional support, suggested caregiver education through the Regional Learning Centre and walked through home safety monitoring strategies. By the end of the call, the daughter said she felt heard.

These three stories represent thousands. Central Registry's coordinated intake, paired with the team's resilience, accountability and creativity, is what makes navigation through Ontario's community care system feel – for the people who need it most, like there is a hand to hold.

Learn more at www.centralregistry.ca

Building Knowledge Across the Community Sector



Regional Learning Centre *A Division of Nucleus Independent Living*

Learn more at www.regionalllearningcentre.ca

REGIONAL LEARNING CENTRE



Since 2014, the Regional Learning Centre (RLC) has been the dedicated education and knowledge-sharing resource for community healthcare organizations in the Mississauga Halton region. Its focus is staff providing home support and personal care, regulated professionals and family caregivers. Its team of educators share a single passion: improving safety and outcomes for both clients and the staff providing care.

The RLC's model is built around the recognition that community-based personal care has historically been under-resourced for formal education compared to long-term care or hospital settings. Hospital training does not always answer the questions a PSW driving between homes needs to ask. The RLC creates education that does.

Through partnership with eligible community organizations, the RLC enables long-term training plans, evidence-based content tailored to the unique challenges of the Community Support Services sector, and consistent best-practice messaging across organizations.



FISCAL YEAR 2025 - 2026: BY THE NUMBERS

2,933

**INDIVIDUALS
TRAINED**
across the year
(2,573 staff and 360
family caregivers).

230+

**SESSIONS
DELIVERED**
against a target of
230.

87.3%

Q4 UTILIZATION
of available staff
education seats,
well above the 70%
target.



**STRONG
SATISFACTION***

*across topics from Applied Suicide Intervention Skills Training (ASIST) to Crisis Prevention Intervention (CPI), Bowel and Bladder Care, Safer Lifts and Transfers, Documentation and Reporting, and culturally responsive practice

2025 -2026 RLC HIGHLIGHTS

- The first-ever provincial **PSW Best Practice Guidelines for Safer Client Mobilization in Community Care**, developed jointly with OPSWA, originated at the RLC. (See "Setting the Bar Provincially" earlier in this report.)
- A research collaboration with March of Dimes, VHA Home HealthCare and the Centre of Research Expertise for the Prevention of Musculoskeletal Disorders at the University of Waterloo culminated in 2025 with research on preventing barriers and facilitating safe patient handling through slide sheet use. A national webinar based on the research will run in May 2026.
- The RLC continued to lead the Human Library initiative for Ontario Health Central Region – a diversity-learning approach that uses lived-experience "books" to address stigma and stereotypes. Six months after participating in a session, one reader wrote:

"I found that this experience had a significant impact on my personal and professional life. Learning and asking very vulnerable questions to a person that has the lived experience was hard. I found myself feeling unsettled or at times embarrassed to ask questions that I normally would never ask. This was a really powerful tool for me to learn so much."
- The RLC also continued to coordinate Ontario Health Central Region's Infection Prevention and Control (IPAC) Community Resources – a frequently-updated regional resource page, RLC YouTube channel webinar recordings, administrative oversight for mailing lists and event registration, and quarterly newsletters featuring curated resources and updates.
- Family Caregiver Programming:** This year, the RLC's caregiver-facing programming included a December 2025 Caregiver Paint Night in partnership with Seniors Life Enhancement Centres.

A

SCALABLE DIGITAL HEALTH ECOSYSTEM

Over the past four years, Nucleus has moved from using digital systems mainly as administrative tools to using them as part of daily decision-making, service oversight, communication and organizational planning. The shift is not about the tools themselves. It is about how the tools are embedded into operations.

“Nucleus has been investing in staff digital literacy, process redesign and change management, recognizing that digital transformation is as much about people and culture as it is about technology. This thoughtful, practical approach positions Nucleus not just to adapt to system changes, but to help shape them,” shared Lori Holloway, CEO, Ontario Community Support Association.

“The fundamental change is that Nucleus has shifted from reactive, manual and system-dependent work toward a more proactive, data-informed, digitally enabled operating model. Teams can now monitor and respond to issues – double-booked shifts, scheduling gaps, service-code exceptions, before they become larger problems.”

– Shiva Vosoughi,
Lead of Digital Health & Privacy



A few examples from this year tell the story.



The Integrated Decision Support (IDS) platform – administered by the Ontario Hospital Association, gives Nucleus the ability to link internal records with regional data, including hospital admissions and emergency department visits. The result is a sharper picture of clients' health system journeys and an ability to identify risk earlier.



Department-specific dashboards – give frontline managers real-time access to operational and quality indicators. Care Team Leads, Care Coordinators and managers now use data to support attendant performance review, Hospital to Home journey monitoring, scheduling oversight and operational issue identification, moving from reactive problem-solving to proactive operational management.



Service code data entry accuracy was sustained at less than 1% error throughout fiscal year 2025–2026, with an average error rate of approximately 0.17%. It reflects data quality monitoring, staff accountability and operational checkpoints working in concert.



The Family Portal – Nucleus' client and family-facing AlayaCare interface, added a major feature on February 23, 2026: clients and families can now access their personalized care plans through the portal app. The launch followed a careful cross-functional planning effort. The feature represents the next phase of Family Portal evolution: clients move from viewing schedules to seeing their own care goals and care planning information directly.



Dial My Calls, a new mass communication system, allows Nucleus to deliver pre-recorded, standardized voice messages to clients and staff in inclement weather and other emergencies. Expanded use cases are being explored.



Custom applications and integrated data – Nucleus has built its own applications and linked previously siloed systems – incident reporting, finance, human resources, scheduling and hospital data – into a single picture spanning client assessments, service utilization and acute-care use. The result is a clear line of sight from frontline service to system-level outcomes like avoidable hospital visits and alternate-level-of-care days, and the ability to map a client's journey before and after Nucleus to advocate for funding and inform regional service planning.



Sandbox Initiative: In partnership with the University of Toronto's Sandbox program – a model that brings real organizational challenges into academic-applied research – Nucleus continued its food-insecurity geo-mapping and Adult Day Service business case work, and went further this year by sharing de-identified data on roughly 4,000 clients with student research teams in statistics and human biology. Their independent analyses found that clients rely on the hospital system less after starting with Nucleus, with the strongest effects among the highest-need clients: unscheduled admissions for clients with mental health conditions fell by roughly 40%, and clients with cardiovascular conditions saw inpatient admissions, readmissions and costs drop by 35–55%. These are exploratory analyses that describe patterns rather than prove causation, but they offer external, data-grounded support for what Nucleus sees in practice – that home- and community-based care keeps people healthier at home and eases pressure on acute care.

ONE TEAM IN ACTION

2025

APR

- Sandbox initiative launched
- Staff Wellness Committee launched

MAY

- PSW Week Celebrations
- Wellness committee assembled UWHH Wellness Kits

JUN

- On June 5, 2025, the Toronto District School Board recognized Nucleus' Supportive Housing program with a formal appreciation plaque. The recognition acknowledged a partnership that has now grown for two years.
- Through the Burnhamthorpe Adult Learning Centre, Nucleus welcomes Personal Support Worker students each year for four-week supervised placements across our supportive housing sites. The placements provide students with hands-on learning. They also provide Nucleus with a pipeline of pre-trained, mentored future staff. Two former students have already joined Nucleus as part-time Supportive Housing staff, contributing the skills and passion they developed during their placements to the clients they now serve.

AUG

- On August 23, 2025, Nucleus joined the Civitan Farmers' Market in Oakville for the third consecutive year as a community partner. With more than 4,500 visitors, the event was the largest yet. The team engaged families through games and conversations about the importance of home and community care.
- Nucleus earned its fifth consecutive CARF Accreditation
- Partnership with OPSWA Announced - becoming the first organization in Canada to ensure that all Personal Support Workers (PSWs) are active members in good standing of their professional association.

SEPT

- On September 13, 2025, #TeamNucleus participated in the United Way Halton & Hamilton Plane Pull at Hamilton Airport. The team — "Team Nucleus_goteamgo" — physically pulled an airplane to raise \$1,770 for United Way programs, exceeding the \$1,500 fundraising goal.

OCT

- CEO Laura Salisbury elected Chair of the Ontario Association of Independent Living Service Providers (January 2026, three-year term)
- AlayaCare Early Adopter Award nomination (BetterOutcomes 2025)
- At AlayaCare BetterOutcomes 2025 in Toronto, Porchia Tjimbara and Nilmini Senewiratne represented Nucleus on the panel "In Their Shoes: A Day in the Life of Frontline Care." Nucleus was also nominated for AlayaCare's Early Adopter Award.
- On October 21, 2025, Nucleus hosted the second annual AC X CSS Training Day at the Hilton Toronto/Markham Suites Conference Centre & Spa. More than 70 participants from over 20 organizations across Ontario participated. The day covered privacy and security in EMR use, smarter scheduling, data-driven insights and the role of AI in improving client care. The Ontario Community Support Association officially endorsed the event and was present to open the day. The advocacy sessions in the afternoon were translated into a 12-month work plan, supported by AlayaCare, with accountability for action.

NOV

- Nucleus was awarded 1 of 60 grants across Canada by Healthcare Excellence Canada for its Cohort 2 Enhancing Integrated Care initiative. The project — the Primary Care Integrated Team Model (PCITM) — is a 1.5-year collaboration with Dorval Medical Associates Family Health Team to integrate primary and community care.
- Nucleus' Service Provider Organization application was approved at Level A, making Nucleus eligible to compete for Ontario Health at Home contracts over \$10 million across the province. A second application, submitted in partnership with Ultima, was also approved.

DEC

2026

- At the Staff Holiday Party in December 2025, the team raised an additional \$855 for United Way Golden Horseshoe - large in spirit.
- The annual Holiday Gift Bag program continued. Nucleus shared bags filled with essentials and small festive items with clients, recognizing that for many of the older adults and persons with disabilities Nucleus serves, the holiday season can be lonely. The gift bags are a small thing. The relationships they reinforce are not.

JAN

- Nucleus' MITO team supported the development of the Data Standards for Assisted Living implementation for the Ontario Association of Independent Living Service Providers (OAILSP). Ontario Health has confirmed they will use these standards to validate and spread to the rest of Ontario's health service providers. The collaboration was remunerated through a successful business case valued at \$65,000.
- Learn more about OAILSP at www.oailsp.ca

FEB

- Care plans went live in Family Portal.
- We received GPTW status

MAR

- On March 19, 2026, at ON26, Digital Health Canada's annual Ontario Conference, Oliver Blunn joined a panel with home care leaders from ParaMed Home Health Care and VHA Home HealthCare, moderated by Aleem Bhanji of AlayaCare. The panel — "Beyond hours and visits: Reimagining digital infrastructure for outcomes-driven home and community care" — explored how provinces across Canada are modernizing home care digital infrastructure beyond legacy systems toward AI-driven platforms that support new models of care.
- 86% of clients rated their overall experience with Nucleus as "Good", "Great", or "Excellent", reflecting a high level of trust in the care delivered in the annual client experience survey.



Letters from *OUR CLIENTS* & their families



“

“The scheduling staff were always responsive, helpful and listened attentively. Managers and the Senior Manager were accessible, supportive and clearly invested in our father’s well-being. The entire organization worked as a team to advocate for our father’s needs, not just deliver tasks.

Nucleus felt like a team that truly cared.”

— **Daughter of a long-standing Nucleus client**, on transitioning to a Hub and Spoke partner provider

“

“He passed at home exactly the way he wanted. It was beautiful. **Having Nucleus involved made the world of difference.**

The system really came through for us. He could have had a very different ending and would not have survived as long without Nucleus.”

— **Wife of a Nucleus client** supported for nine years through the Supports for Daily Living program

“

“We could not have done it without Nucleus. Our father remained **safely in his home far longer** than we ever thought possible.”

— **Family of a client** supported by Nucleus for 8.5 years

Celebrating the people who bring our mission to life.



VIP AWARD

Allison Shand

Values Inspired Person Award

"This recognition is not just about me. It reflects all the amazing people I have had the privilege to work alongside over the years. I am proud to be part of a team that continues to grow, adapt and lead with compassion and heart."

The VIP Award recognizes the employee who most actively brings Nucleus' corporate culture to life, measured against all six values: Integrity, Compassion, Collaboration, Accountability, Respect and Excellence.

This year's recipient is Allison Shand, RPN, Client Services Manager (AO/SDL).

Allison brings the discipline of a clinician and the instincts of a nurse to a role that, on paper, is operational and, in practice, is about people – managing them, advocating for them, and refusing to let them disappear inside the workload.

Allison, characteristically, sees the recognition through a wider lens than herself.

Allison joined Nucleus seven years ago as a Care Team Lead at Supportive Housing. In 2025, she took on the role of manager for both Attendant Outreach and Supports for Daily Living, where she leads a team of Care Team Leads and Personal Support Workers.

"I have worked in different environments throughout my career," she says, "and what makes Nucleus special to me is that the values here are real. They are not just words on paper. You see them in the work we do every day, in the support we give our clients, families, attendants, and one another as One Team. Even during difficult times, being able to support someone, advocate for them or simply make their day a little easier can leave a lasting impact. That is something I never take for granted."



FOUNDERS' AWARD
BEVERLEY BROWN
Attendant, Supportive Housing



Beverley is a shift monitor whose mornings are spent making sure every client has been attended to: breakfast served, hair done, phones charged, keys accounted for. She carries a painkiller in case a colleague needs one. Years ago, when a co-worker pulled a muscle and couldn't walk, Beverley wheeled her to the elevator on an office chair and called her daughter to come pick her up. When the floor is short-staffed, she rallies the rest of the team so every consumer always gets their care. In short, she takes care of everyone.



COMPASSION IN ACTION

Beverley is known for ensuring every client receives exceptional care and every colleague receives support when they need it the most.



THE INDEPENDENT LIVING PHILOSOPHY

Her work reflects the founding principles that have guided Nucleus for more than four decades.



2025 RECIPIENT

Nominated by four co-workers, Beverley exemplifies the compassion, integrity and human connection that define exceptional attendant care.

Long Service Recognition

This year, **33 individuals, representing an extraordinary 585 combined years of service, were recognized for Long Service.**

5 YEARS

- Oliver Blunn
- Yalini Gunarajan
- Laura Salisbury
- Helen Zhang

10 YEARS

- Griselia Alfaro De Quinteros
- Sally Lambert
- Grace Osarenkhoe

15 YEARS

- Natalie Balgobin
- Juliet Bude
- Patricia Darien
- Gurbax Dhaddy
- Mandeep Kaur Grewal
- Rita Kumari
- Kamesha Lalor
- Vinnette Miller
- Luche Ponce
- Cindy Ramkissoon
- Gornatie Seesankar
- Anna Skorupinska
- Caron Spence

20 YEARS

- Dean Stewart
- Lesa Waite
- Marta Wiatr
- Shirgater Wong
- Beverley Brown

25 YEARS

- Yonette Benn
- Janet Barrett-Morgan
- Derick Morgan
- Agnes Abrokwaa Yeboah

35 YEARS

- Larry Boateng
- Kenute Cornwall
- Concepcion Manalang
- Hyacinth Pinkney

Thank you for your dedicated service to Nucleus. The culture, the teams, the quality of care delivered are built by the people whose names appear on this list and the many more whose work this report cannot fully capture, but who shape it.



our FUNDERS, VALUED PARTNERS, SENIOR LEADERSHIP and BOARD



Our Funders

- Ontario Health
- United Way Golden Horseshoe

Our Valued Partners

- Ableliving
- AlayaCare
- CUPE Local 5071
- Unifor Local 40
- Caredove
- CARF
- CILT
- Acclaim Health
- Alzheimer Society of Peel
- Alzheimer Society of York Region
- CANES Community Care
- CARF International
- City of Mississauga - Next Step to Active Living Program
- Connecting Care Halton OHT
- Dixie Bloor Neighborhood Drop-In Centre
- Dorothy Ley Hospice Inc.
- Dorval Medical Associates Family Health Team
- Etobicoke Services for Seniors
- Food for Life
- Great Place to Work
- HIROC
- Halton Healthcare
- Halton Healthcare - Supportive Housing
- Healthcare Excellence Canada
- Heart House Hospice Inc.
- Home Care Ontario
- Home Instead
- HOOPP
- Ian Anderson House
- Indus Community Services (formerly India Rainbow Community Services of Peel)
- Institute for Better Health (Trillium Health Partners)
- Ivan Franko Home
- Joyce Scott Non-Profit Homes Inc.
- Links2Care
- McMaster University - eHealth MSc Program
- M.I.C.B.A. Forum Italia Community Services
- Milton Meals on Wheels
- Mississauga Ontario Health Team
- Oakville Senior Citizens Residence
- Ontario Association of Independent Living Service Providers
- Ontario Community Support Association
- Ontario Health - Central Region
- Ontario Health at Home
- Ontario Hospital Association
- Ontario Hospital Association
- Ontario March of Dimes (Etobicoke)
- Ontario Personal Support Workers Association
- ParaMed Home Health Care
- Peel Cheshire Homes Inc.
- Peel Halton Dufferin Acquired Brain Injury Services (PHD ABIS)
- Peel Senior Living
- Peel Senior Link
- Region of Halton
- Region Municipality of Halton - Supportive Housing
- SE Health Research Institute
- Seniors Life Enhancement Centre
- Sheridan Villa - Adult Day Program
- Summerville Family Health Team
- The Arthritis Society
- The Canadian Hearing Society
- The Corporation of the Town of Halton Hills
- Toronto District School Board (Burnhamthorpe Adult Learning Centre)
- Trillium Health Partners
- United Way Golden Horseshoe
- University of Toronto (Sandbox Program)
- University of Waterloo
- VHA Home HealthCare
- Victorian Order of Nurses - Peel
- Vision Loss Rehabilitation Canada
- Wesburn Manor - City of Toronto
- Yee Hong Centre for Geriatric Care

SENIOR LEADERSHIP TEAM

2025 -2026



Chief Executive Officer

Laura Salisbury



Director of Information Management & Technology

Michael Cox



Chief Operating Officer

Oliver Blunn



Director, People, Talent & Culture

Inna Hoover



Vice President Strategic Partnerships & Client Services

Trish Maxwell



Corporate Services Manager

Jill Youngberg



Controller

Angela Wu



Executive Director, Regional Learning Centre

Taryn Bolt

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2025 -2026



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***“Reimagining is not a finish line. The walls
have come down. The work continues.”***



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