IN THE MATTER OF AN INTEREST ARBITRATION

BETWEEN:

The Participating Nursing Homes

and

ONA

Before:	William Kaplan, Chair
	Irv Kleiner, Employers' Nominee
	Phil Abbink, Association Nominee

Appearances

For the Participating Nursing Homes:	Bob Bass
	Dan McPherson
	Mary Claire Bass
	Kyle McPherson
	Bass Associates
	Laura Cox, Extendicare
	Meghan Scherer, Extendicare
	Sandra Fougere, Sienna
	Holly Moser, Southbridge
	Linda Calabrese, Kindera
	Harrison Jarlette, Jarlette
	Courtney Dunlop, Jarlette
	Mike Putt, Schlegel

Ivana McIntosh, Schlegel

Shawn Riel, OMNI

Fil Falbo, AgeCare

Lindsay Bousfeild, AgeCare

John Scotland, Steeves & Rozema

Andrew Hall, Hall Labour Relations Services PC

Dwight Anderson, Shepherd Village

For the Association:

Wassim Garzouzi

Julia Williams

Adam Gregory

Raven Law

Barristers & Solicitors

Erin Ariss, Provincial President

Andrea Kay, Chief Executive Officer

Matthew Stout, Chief Operating Officer

Patricia Carr, Manager, Negotiations/Organizing

Marilynn Dee, Manager, Negotiations

David Cheslock, Regional Manager, Contract Administration/Negotiations Lead

Monique Storozuk, Vice President Region 1

Amanda Locking, Region 1 Full-Time Representative

Christopher Bolestridge, Region 1 Representative

Ashley Dombroskie, Region 2 Full-Time Representative

Isabelle Brunet, Region 2 Part-Time Representative

Genevieve Tiri, Region 3 Full-Time Representative

Kala Ramesh, Region 3 Part-Time Representative

Chinyere Worenwu, Region 4 Full-Time Representative

JoAnn Carey, Region 4 Part-Time Representative

Irene Aguiar, Region 5 Full-Time Representative

Patricia Daltrey, Region 5 Part-Time Representative

Dave Campanella, Economist

Marie Haase, Negotiations, Labour Relations Officer

Joshua Henley, Negotiations, Labour Relations Officer

Jaclyn Hayes, Labour Relations Assistant

The matters in dispute proceeded to a hearing held in Markham on June 15 & 16, 2026. The Board met in Executive Session on July 31, 2026.

Introduction

This interest arbitration was consensually convened pursuant to a *Memorandum of Conditions for Joint Bargaining* to resolve the issues in dispute between the Participating Nursing Homes (PNHs) and the Ontario Nurses' Association (Association). Notice to bargain was given on April 1, 2026. The Association represents RNs and other healthcare staff – more than 4,000 in total – employed at 210 Ontario nursing homes. The parties met in collective bargaining between April 20 & 24, 2026, followed by conciliation on April 27, 2026, and then mediation on April 28 & 29, 2026. The outstanding issues in dispute – there are no agreed upon items – proceeded to a hearing in Markham on June 15 & 16, 2026. The Board met in Executive Session on July 31, 2026. The collective agreements settled by this award shall be composed of their previous unamended provisions together with the terms of this award. Any Association or PNHs proposal not specifically addressed in this award is deemed dismissed.

The Criteria

The Statutory Criteria

The criteria are set out in the *Hospital Labour Disputes Arbitration Ac*t (HLDAA)*:*

9 (1.1) In making a decision or award, the board of arbitration shall take into consideration all factors it considers relevant, including the following criteria:

1. The employer's ability to pay in light of its fiscal situation.
2. The extent to which services may have to be reduced, in light of the decision or award, if current funding and taxation levels are not increased.
3. The economic situation in Ontario and in the municipality where the hospital is located.
4. A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of the work performed.
5. The employer's ability to attract and retain qualified employees.

The Normative Criteria

In addition to the statutory criteria, also important for the adjudication of this interest dispute are the normative criteria of which replication is the most important: Boards of interest arbitration seek to replicate free collective bargaining. The mandate of an interest arbitration board is to replicate, to the greatest extent possible, the result that the parties would have reached through free collective bargaining. The replication principle is informed by several factors; especially important in our view, in a very mature relationship like this one – marked by both settlements and awarded outcomes – is what these parties have historically negotiated/been awarded (over 16 rounds of joint bargaining (discussed further below). Other normative criteria include recruitment and retention, demonstrated need, gradualism, and total compensation.

Association Submissions

This was, the Association began by observing, a critical bargaining round. While progress had been made in the past – attention was focused on the last interest arbitration award between these parties – in moving PNHs RNs and other healthcare staff toward parity with municipal nursing homes – the gap remained and required redress. The fact of the matter was that RNs and other healthcare staff represented by the Association working at municipally funded long-term care facilities had the same qualifications and performed the same work under the same funding arrangements and legislative framework as those employed by the PNHs. This made the salary gap between the PNHs and this obvious compelling comparator offensive and unacceptable. In the words of the Association, "compensation parity across LTC can no longer wait."[1] The Association, accordingly, advanced two main interest arbitration priorities. First, parity with municipal long term care homes (effectively meaning matching wages provided in the OHA and ONA central hospital agreement, Hospital Parity), together with improvements to other terms and conditions of employment. And second, ending the practice of unpaid work.

The Appropriate Comparator

The Association argued that the Ontario Court of Appeal had identified municipal long term care homes as the appropriate comparator for the PNHs for pay equity purposes.[2] With the appropriate comparator identified – and applying a replication analysis together with the statutory and other normative criteria including most notably a system-wide RN shortage – the inevitable result was an outcome where compensation and terms and conditions were the same between the PNHs and municipal long term care facilities or, in other words, Hospital Parity. In the Association's submission, the Court of Appeal decision was dispositive: the PNHs were required to compare themselves with municipally funded long-term care to implement and maintain pay equity. As there was no meaningful difference between the approach to pay equity comparators, and the criteria for identifying comparators at interest arbitration, the result in one must be followed by the other meaning, to repeat, Hospital Parity.

There was, the Association pointed out, nothing novel about the comparison and its inevitable result. It was a long accepted arbitral standard that similar work in similar circumstances be paid the same, and that standard was more than met when the work of Association members was objectively compared with their identically qualified counterparts doing the exact same work in municipal long-term care. The previous interest arbitration award between the parties had – deliberately in the Association's view – narrowed the gap to just under 6%, and it was now time to complete the task and provide full Hospital Parity.

---

[1] Association Brief, p 8.

[2] Participating Nursing Homes v. Ontario, 2021 ONCA 149 (CanLII) and Participating Nursing Homes v. Ontario Nurses' Association, 2019 ONSC 2722 (CanLII).

Application of the Other Criteria

The PNHs were, the Association argued – because of increased government funding – in an excellent financial position to absorb the costs and were, moreover, reporting excellent, indeed, ballooning profits. There was clearly, in the Association's view, no inability to pay. Likewise, Ontario's economic situation was healthy; government revenues were growing. In any event, in the Association's submission, the healthcare sector operates independently from the broader economy and the immense social need for healthcare does not diminish during periods of economic downturns. Compensation must be assessed independently and certainly should not be influenced by a broadbrush approach when nuance was needed in assessing economic factors like GDP for example. The Association also submitted that that the recruitment and retention challenges were real: There were simply not enough RNs and other healthcare workers available to meet current and projected provincial demands. The limited layoffs of some registered staff at a handful of participating hospitals should not be conflated with the situation at the PNHs where there was no evidence of job loss. Indeed, in the Association's view, the number of job postings advanced as an example to demonstrate the absence of recruitment and retention challenges – vacancies the Association calculated as totalling 18% of the size of the existing bargaining unit – led to the opposite conclusion. The numbers illustrated an ongoing need to recruit healthcare workers especially RNs. Inflation continued while previous – large – inflationary increases were now baked into prices making life increasingly unaffordable and the cost of living more challenging than ever before further justifying the requested increases. The real value of wages had declined. Paradoxically, wages had flattened while productivity had demonstrably improved.

The important point was that the Association was not seeking a breakthrough – it was, it argued, seeking appropriate replication having identified the appropriate comparator which meant, in practical terms, the elimination of the 5.66% RN gap (and an even greater gap for RPNs, discussed below) and realization of long overdue Hospital Parity. The fact that Hospital Parity had not been previously achieved could not, and did not, mean it was unattainable. Catch-up was a recognized principle of interest arbitration. Whether all at once, or gradual, it was a part of the interest arbitration process. There was no legitimate basis for the PNHs assertion that just because it had not happened yet that it should never happen. The Association argued that it had made a compelling case: the evidence was uncontradicted that employees at the PNHs were doing the exact same work as the municipal nursing homes, had the same qualifications, and were governed by the same legislation. Municipal nursing homes may receive additional funding, but what mattered, the Association argued, was that "there is no ability to pay argument before the Board. To the contrary, the Homes are reporting record profits and issuing millions of dollars of dividends to their shareholders, over and above their earnings."[3] The Association also took issue with the PNHs misstatement of bargaining history. Arbitrated outcomes had distorted free collective bargaining and had set back Hospital Parity. Moreover, when the data was

[3] Union Reply Brief, p 12.

carefully analyzed, what the bargaining history demonstrated was a general trend towards Hospital Parity, which the Association argued, should be completed in this round (and, again to repeat, a major step toward that objective having been taken in the last round).

The Association was also seeking an end to unpaid work which was entirely without any justification as contrary to both law and public policy. Its other proposals were likewise justified and should also, the Association submitted, be awarded.

Wages

The Association sought the following:

1. Replication of the Participating Hospitals & ONA wage grid for the first year of the collective agreement for RNs followed by a 2% increase in year two (with a me-too clause should the Participating Hospitals & ONA obtain a higher increase in the corresponding year).
2. Replication of the Participating Hospitals & ONA wage grid for RPNs followed by a 2% increase in year two.
3. Maintain grid percentage differentials for all other classifications.

The existing differentials, illustrated by the Association in its brief, demonstrated the extent of the problem with percentage differences at each of the grid steps ranging from 5.66% to 11.59%. The gaps were even greater for the RPNs: between 25% and 29%. Hospital Parity has been a long-standing Association goal, and while not yet achieved there had been movement toward it giving effect to gradualism/incrementalism, one of the normative interest arbitration criteria (indeed, the gap had moved from 14.7% in 2000 to the current 5.66%). Moreover, the landscape had changed by the Ontario Court of Appeal's decision in 2021, identifying municipal long-term care as the appropriate comparator for pay equity purposes and, in 2023, by the elimination of the 25-year rate in the OHA & ONA Participating Hospitals grid.

Responsibility Pay

The status quo, the Association observed was unacceptable. The current Responsibility Pay provision limited payment to when the Director of Care or a supervisor was absent. The facts on the ground, however, established that ONA nurses, on each shift, perform critical work as charge nurses. The presence, or absence of the Director of Care or a supervisor had nothing to do with this work reality and assumption of responsibility on the floor. Nevertheless, Association members were only being compensated for work on select shifts even though charge nurse duties were now being performed as a matter of course (as was set out in several affidavits filed by the Association and reviewed at the hearing). Paying for this work was a healthcare sector norm (and was not tied to the presence or absence of a Director of Care or a supervisor).

Reporting Time

At the beginning and end of each RN shift, the Association explained, RNs were required to complete a Transfer of Accountability (TOA), also known as Reporting Time. The current collective agreement provided that employees required for reporting purposes shall remain at work for a period of up to fifteen minutes "which shall be unpaid." This was, the Association submitted, completely unacceptable (as was reflected in the recent authorities which were cited). The Association did not dispute the existence of the professional obligation but took issue with working for free. The PNHs neither tracked nor paid for this work. This work was inconsistent with the weight of the authorities, the Association argued, and not compensating it was also offside the *Employment Standards Act* and public policy more generally.

Other Association Proposals

While the Association clearly identified, and focused on Wages, Responsibility Pay and Reporting Time in their brief and at the hearing, it also made several other proposals including for an increase in Percentage in Lieu and Premiums, Removal of Waiver Language, introduction of Isolation/Quarantine Pay, increases to Pregnancy and Parental Leave Pay, participation by part-time and temporary employees in defined benefits on a cost share basis in exchange for foregoing Percentage in Lieu, payment of Percentage in Lieu during waiting period for defined benefits, transition of PNHs employees to HOPPP, improvements to defined benefits including unlimited mental health and substantial increases to paramedical benefits (as they had not improved in over twenty years), increases to sick pay and introduction of an LTD plan (and making both subject to the grievance and arbitration process), paid sick notes, modifications to the Equity, Workplace and Domestic Violence provision and to the Violence in the Workplace and Domestic, Sexual or Intimate Partner Violence Leave provisions, increases to time granted for an Association representative to meet with new employees as part of the orientation process (and formal notification to the Association in writing of all new hires), mandatory representation by an Association representative or designate during disciplinary meetings and improvements to union leave provisions.

The Association rejected the PNHs proposals as non-normative and concessionary. They did not reflect replication and would have never been agreed to in free collective bargaining. For example, the PNHs sought, without demonstrated need, or any credible explanation whatsoever, deletion of the long-standing work of the bargaining unit and minimum staffing provisions. Likewise, instead of engaging with the Association on improving sick pay and introducing a long overdue LTD plan, the PNHs had advanced a concessionary proposal eliminating LTD where it exists and reducing sick pay coverage. The Association urged that is proposals be granted in full or part, and that the PNH proposals be categorically rejected.

Submissions of the Participating Nursing Homes

Replication

The PNHs, like the Association, began their submissions with an observation: The Association's proposals represented the greatest deviation from the replication principle in the 16 rounds of this joint bargaining process that dated back to the early 1990s (and the two decades or so of joint bargaining that proceeded it). Put another way, over more than fifty years, these parties have, either through voluntary settlements or interest arbitration, resolved their differences. In three of the last four rounds, the parties reached a voluntary agreement (the most recent was a consent award).[4] In this long-storied history, the PNHs pointed out, most, if not all, of the economic proposals in dispute in this proceeding were advanced by the Association (and in many cases withdrawn, below). The Association's keynote proposal – Hospital Parity – had been repeatedly sought and never achieved, either through a voluntary settlement or an award, and should not, the PNHs argued, be the result here.[5] To do otherwise, the PNHs submitted, would be to turn the replication principle on its head.

Application of the Other Criteria

Other reasons, the PNHs argued, supported their approach to the resolution of the numerous issues in dispute. Settlements were trending lower. Inflation was abating. The Ontario economy was suffering and there was no relief in sight. For the first time, there were layoffs of registered personnel at several Ontario's hospitals (not to mention across the broad swath of the Ontario workforce). Unemployment was rising, the GDP was declining while other economic indicators, like rising mortgage defaults and delinquencies, indicated how dire the overall economic situation was (and could easily deteriorate further because of tariffs and ongoing CUSMA negotiations). Canada was in a technical recession; the economy was, at best, stalled.

The PNHs rejected the claim of any recruitment and retention challenges. The exact opposite was now true (as reflected in College of Nurses statistics and other data). For example, Sienna posted 258 external RN jobs in the past twelve months and received more than 10,000 applications. Southbridge posted 321 jobs and received almost two thousand applications. Jarlette posted 13 jobs and received almost eight hundred applications. Several of the PNHs employers had observed RNs applying to fill RPN/PSW jobs. Unlike the situation during the pandemic, there was virtually no agency use indicating no staffing issues whatsoever.

Association Proposals Disproportionate and Unjustified

In these circumstances, the Association's proposals costing 28.3% over a two-year term – where there were established patterns, and where all the issues brought forward in this proceeding had been advanced/argued/withdrawn in past rounds – should, the PNHs submitted, be soundly

[4] Participating Nursing Homes & ONA 2024 CanLII 44468 (ON LA).

[5] See History of ONA LTC Central Negotiations and Arbitration, Employer Brief, p 227ff.

rejected. Whether to support its court challenge of the constitutionality of the *Hospital Labour Disputes Arbitration Act*, (HLDAA), or for legitimate collective bargaining purposes, the fact was that the Association had brought forward a laundry list of breakthrough proposals that would have never been the result of free collective bargaining had it been allowed to run its course. In any event, this was a bargaining round – as illustrated in the larger collective bargaining landscape – where restraint was the order of the day, not introduction of truly unaffordable and breakthrough items, especially ones that had been regularly sought over decades and never achieved, voluntarily or otherwise.

Hospital Parity Not Reflective of Free Collective Bargaining

The evidence, which the PNHs reviewed, in their brief and at the hearing, established that over the last thirty-five years, ONA has never achieved its stated goal of Hospital Parity. In the three of the last four rounds, to repeat, the parties resolved their bargaining dispute and did not agree on Hospital Parity (including in the most recent consent award). Over decades of joint bargaining, again to repeat, the parties had never agreed on this outcome. Replication meant focusing on what the parties have done and have not done. They had, likewise, never agreed on economic increases totalling 28.3% in a two-year term. It was also important to point out, the PNHs argued, that the participating employers had no profit motivation for their compensation position as these bargaining units were funded through the Nursing and Personal Care Envelope (Nursing Envelope).

The PNHs agreed with the Association that identifying the appropriate comparator was important (and required by HLDAA albeit arguably not as important as replicating the parties' own bargaining history). By and large, arbitrators adjudicating these disputes, and the parties themselves in their voluntary settlements, had agreed, the PNHs pointed out, that the appropriate wage and benefit comparators were within sector; the most relevant comparator for a nursing home was other nursing homes. Reference was made to key cases including Arbitrator Stout's 2021 award:[6]

> [30] Turning to the matter before us, we begin by addressing ONA's submissions seeking parity with nurses employed in Hospitals and Homes for the Aged. These nurses have not had parity with nurses employed at either Hospitals or Homes for the Aged for the past 30 years, which covers 13 rounds of collective bargaining. Both in terms of mediated and arbitrated results, these nurses have not reached parity with compensation provided to nurses in Homes for the Aged and Hospitals. This is not because ONA never raised the issue of parity. Rather, when the issue was raised in interest arbitration, their proposals were denied on each occasion, including the most recent 2011 Stanley Award and 2015 Davie Award.
>
> [38] While we appreciate ONA's submissions and have great sympathy, particularly in the current COVID-19 environment, we do not see a compelling case for deviating from the well-established historical pattern. Therefore, like the Stanley and Davie boards before us, we dismiss ONA's arguments for parity.

[6] Participating Nursing Homes v Ontario Nurses' Association, 2021 CanLII 107099 (ON LA).

The Nursing Envelope, the PNHs continued, was a funding reality (and lower compensation results did not benefit the employers but residents because they permitted engagement of additional nursing staff who could provide more care). The PNHs were funded completely differently than Ontario's hospitals, and more importantly, the attempt at establishing municipal long-term care as a comparator was especially inapposite. For example, and this was detailed in the PNH brief and emphasized at the hearing, the City of Toronto's ten nursing homes receive substantial multi-million annual subsidies.

Wages

The PNHs proposed 1.75% as of July 1, 2026 and 1.5% as of July 1, 2027 for all employees. These numbers were, the PNHs argued, an appropriate disposition flowing directly from the statutory and normative interest arbitration criteria and reflected the emerging pattern of healthcare settlements (which the PNHs reviewed). The OHA & ONA Central Hospitals general wage increase for 2026 should not, the PNH argued be followed for the first year of the agreement because the economic situation had significantly deteriorated since it was issued and it had been, in any event, overtaken by the CUPE and SEIU Central Hospital outcomes (which were lower and there was currently justification for even a further decrease). The PNHs disputed the assertion that the most recent arbitration award between the parties – which was a consent award – represented a movement towards Hospital Parity. When carefully analyzed, all it did was set rates reflecting the normal and customary relationship to Hospital rates. The PNHs wage proposal, it submitted, was above Ontario core inflation. The PNHs noted that there has never been a special adjustment for RPNs, and now was not the time, and nor would it be justified, to introduce one.

Other Issues

The PNHs sought changes to the Work of the Bargaining Unit provision – aspects of it were too restrictive and not necessary for reasons set out in its brief and at the hearing – and resident care would be optimized by the changes it sought by allowing the individual nursing homes to best deploy resources especially as between RNs and RPNs. Also sought was the elimination of the Staffing Complement provision. Both parties had sick leave proposals, and the PNHs proposal sought the elimination of LTD where it exists and the introduction of an accumulating plan with a fourteen-day cap. To the extent that the Board was engaged by the Association's Transfer of Accountability proposal, it urged the Board, for administrative and other reasons, to come up with a flat rate reflecting normal time spent on the task (and a formula was proposed). All the other Association asks, the PNHs argued, should be dismissed.

Discussion

This is the 16th round of joint bargaining between these parties. In some cases, the parties resolve matters on their own; in others, they require a board of interest arbitration, and in the last case, a voluntary agreement was memorialized and issued in an award. One thing the long bargaining

history demonstrates is that there has never been an agreement on Hospital Parity (although it has been consistently sought by the Association).

As noted at the outset, the job of an interest arbitration board is to do its best in replicating free collective bargaining. What the parties have done – in their voluntary settlements – is the best evidence of replication. Successive interest arbitration boards have also considered, and rejected, the request for Hospital Parity.

In *Participating LTC & ONA* (February 4, 2016), Arbitrator Davie wrote: "We have referred to this history of voluntary settlements in some detail as we consider what the parties themselves have done in the past as highly relevant. This history shows that the parties themselves have not negotiated Hospital/Homes for the Aged and Nursing Home Parity." [7] This same conclusion was reached by other interest arbitrators reflected, for example, in the reasoning of Arbitrator Stout (above).

The Association's proposal on wages – to be given effect in a two-year term – is accordingly rejected. The fact of the matter is that the parties have never agreed on Hospital Parity (although they have agreed, obviously, on numerous monetary and non-monetary improvements over successive terms including the substantial increases in the last consent award). That award gave effect to a wage outcome agreed upon by the parties. It narrowed the gap between the PNHs and rates at Ontario's hospitals, but there is nothing in the award indicating that it reflected an agreement to move toward Hospital Parity (and given the PNH's long-standing opposition to that outcome it is not credible to conclude that this consent award provides any evidence of that). In fact, the award provides *no* reasons for the outcome as is often the case with consent awards. The overall bargaining history illustrates that in some rounds the gap between the PNHs and Ontario's hospitals grows; in others it lessens. Most important is what the parties have done – and not done – over many years of central bargaining. To put it bluntly, they have never agreed on Hospital Parity; nor has any interest arbitration board awarded it when asked.

The Association argued that the identification of municipal long-term care as a comparator for pay equity purposes was somehow dispositive, or at the very least compelling. We are not persuaded that a decision under the *Pay Equity Act* has anything to do with collective bargaining comparators. The proxy comparator under the *Pay Equity Act* has been known since 1994 when a regulation under that legislation was filed but, in its aftermath, the parties continued to bargain (but did not agree on Hospital Parity).[8]

Funding is a consideration meriting attention in determining relevant comparators. The Association never addressed the uncontradicted municipal subsidy information that – given its significance – makes comparing PNHs and municipal long-term care challenging even assuming for the sake of argument that a pay equity comparator was in any way dispositive of the

[7] See also ONA & Participating Nursing Homes, Stanley Award, October 31, 2011 and Participating Nursing Homes v ONA 2021 CanLII 107099 (ON LA).
[8] See observations in *Glen Hill Terrace Christian Homes Inc.*, Pay Equity Hearings Tribunal, Case No. 2001-18-PE, March 17, 2026.

consideration of appropriate comparators under HLDAA. This is not a case where there are two homes that are identically funded and one of them has somehow managed to provide higher wages than the other while the work, qualifications and classifications in both is the same. According to information filed with the Board, in 2025 the City of Toronto added $82,126,000 to its long-term care budget in addition to the funds received from the provincial Nursing Envelope (it was $101,857,000 in 2026). It would be derelict to ignore this (and not to consider other subsidies in other municipalities). These subsidies are the reason why these municipal homes are *sui generis*; not widely adopted comparators in the HLDAA sector. Experience in these matters indicates that when looking for comparators in HLDAA cases, municipal long term care homes are siloed. Obviously, we must appropriately consider the financial health of the various PNHs, but we do not draw a straight line between reported profit/dividends to shareholders and general wage increases. Assessing and applying the HLDAA and normative criteria is complicated and contextual, not reductive. Profitability is relevant but not standalone determinative.

The Reporting Pay provision is clearly an archaic relic of a bygone era and, as Arbitrator Price observed in her recent award between the *Participating Hospitals & ONA*, is a "patently unfair practice, which flies in the face of prevailing norms in society at large."[9] Nobody should be required to work for free or to "volunteer" for their job. We adopt the same reasoning and result as in *Participating Hospitals & ONA*: The Association's proposal "is granted, not on an overtime basis, nor on a straight time basis, but at the rate of pay applicable to the shift that has just been worked."[10]

Isolation Pay is now a sector norm for completely obvious and understandable reasons including arbitral awards concluding that employees required to isolate or quarantine were not covered by collective agreement sick leave provisions. An isolation/quarantine provision is in the interest of both healthcare employers and employees, and in the public interest. It is, increasingly, a predictable and inevitable result of free collective bargaining and interest arbitration. Any process that requires an employee to make use of their sick, vacation, accumulated overtime, etc., when required by law, or ordered by public health authorities, or their employer, to isolate or quarantine, is not, in our view, proportionate, satisfactory or fair. Isolation/Quarantine pay, where the qualifications are met, is, demonstrably, a best practice and widely acknowledged as such.

In terms of the Association's proposal for a point of care flagging system for residents presenting with aggressive and other challenging behaviours, we are far from indifferent to the interests at the stake, and the nature and complexity of the problem. At this point, however, we encourage the workplace parties to take advantage of current collective agreement language providing them with the jurisdiction to consider appropriate measures and procedures in consultation with the Joint Health and Safety Committee. This should, in our view, be a muscular and purpose-driven process with full exchange of relevant information with identification and implementation of

[9] Participating Hospitals v Ontario Nurses' Association, 2025 CanLII 89205 (ON LA), at para 67.
[10] Participating Hospitals v Ontario Nurses' Association, 2025 CanLII 89205 (ON LA), at para 64.

proactive measures followed by monitoring and assessment of tangible results. Approaching this issue in this manner, consistent with current collective agreement obligations, will provide the parties, and any future board of interest arbitration, with the data and information it needs should this issue be raised in a future round.

We have made normative and self-evidently overdue adjustments to premiums and benefits. Paramedical benefits have not been improved in over twenty years, and some adjustments are, accordingly, required (while acknowledging that unlike Hospital nurses for example, PNHs employees make no benefit payment contributions). There is no justification for any delta in benefit coverage between RNs and other employees, all of whom work side-by-side, and we direct that all benefits be set at the RN rate effective thirty days following date of the award. Likewise, pension eligibility should be harmonized across all the nursing homes. With one exception, we reject the PNHs proposals as unjustified. There is absolutely no basis to delete LTD plans where they exist and to impose "cost containment" on existing sick leave entitlements. We do not accept the PNHs proposal for transfer for accountability as we are of the view that the matter must be resolved in a straightforward fashion, one in which employees are paid for time worked. We are, however, persuaded that the PNHs have established a case for one of their proposed changes to the Casual Employees provision; namely, requiring a commitment of two days per month, one of which is to be on a weekend.

Award

Wages

July 1, 2026: 2.25%

July 1, 2027: 2.00%

RPN Adjustment

After the general wage increase on July 1, 2026, classification adjustment as follows.

Step One: Identify the current maximum rate in the SEIU Master - $35.07.

Step Two: Identify all PNHs where the maximum rate is below the SEIU Master Rate.

Step Three: Bring all RPNs currently at the maximum rate on their grid to the maximum rate in the SEIU Master (with corresponding increases to all non-maximum steps).

Paramedical Benefits

Effective thirty days following issue of award, increase mental health to fifteen hundred dollars per year ($1500) and all other paramedical benefits by one hundred dollars in year one and $100 dollars in year two. All benefits for all employees to be set at the RN rate.

Premiums

Effective date of award, increase all premiums by .30¢. Eliminate requirement to rotate for RPNs and PSWs where it exists.

Reporting Time

ONA proposal awarded with amendment, effective thirty days following issue of award.

Administrative/implementation remitted to the parties, but we remain seized.

Reporting time shall be considered time worked and will be paid at the same rate as the tour that has just been worked.

Pension Eligibility

Effective date of award, eligibility to be harmonized at 450 hours.

Isolation Pay

ONA proposal awarded, effective date of award.

Health & Safety

Employees who are absent from work due to a communicable disease and are required to quarantine or isolate due to:

i) The employer's policy, and/or
ii) Operation of law and/or
iii) Direction of public health officials

shall be entitled to salary continuation for the duration of the quarantine.

Casual Employees

Amend Article 2.02 to require casual employees, unless on an approved leave of absence, to provide monthly availability for at least two shifts per month, one of which must occur on a weekend (Saturday or Sunday).

Conclusion

At the request of the parties, we remain seized with respect to the implementation of our award.

DATED at Toronto this 18th day of August 2026.

"*William Kaplan"*

William Kaplan, Chair

I dissent. Dissent attached.

Irv Kleiner, Nominee of the Participating Nursing Homes

I dissent. Dissent attached.

Phil Abbink, Association Nominee

DISSENT OF EMPLOYER NOMINEE

This Board was constituted to determine an interest dispute between the parties under *the Hospital Labour Disputes Relations Act*. To be clear, this Board's mandate was to determine outstanding central collective bargaining issues with respect to the renewal of the central template provisions of the collective agreements between ONA and the Participating Homes.

The task of this Board was to replicate what the parties would most likely have achieved had they been able to resort to the economic sanctions of strike and lockout. The nurses' bargaining units are funded through the nursing envelope. The Participating Employers are motivated to optimize the care that they provide to long term care residents by maintaining compensation at fair and reasonable levels and at the same time, using the modest funding increases provided by government to improve staffing levels. Any replication process therefore would have to include a consideration of what these employers would have agreed to in a "free and unencumbered collective bargaining process" which would likely have included reasonable compensation improvements but not improvements that would in any way compromise the quality of care that these Employers must be able to deliver to residents.

The context for the negotiations of these parties as presented by counsel for the Employers indicated that major wage settlements in 2026 were trending in the 2% range and trending lower in future years which is in large part attributable to an Ontario economy that is struggling and becoming worse as time goes on. Ontario's unemployment rate was at 7.5% as of May 2026 while Ontario Hospitals have announced unprecedented recent layoffs which include registered nurses.

The Chairperson referred to recent healthcare settlements which confirm that health care settlements are trending downward. The CUPE and OHA freely negotiated settlement in September of 2026 was 2% which was .25% lower than the second year of the OHA and ONA Price Award (2.25%) for 2026 and this CUPE Hospital voluntary settlement was achieved about three months after the OHA Price Award. The SEIU and Hospital arbitration award of this Chairperson followed the settlement pattern established by the CUPE and Hospital settlement.

In my respectful submission, the outcomes that followed the Price Hospital and ONA award recognize a worsening economy which in turn warranted an adjustment to the rates of increase awarded by Arbitrator Price for 2026. This ought to been attributed considerable weight by this Chairperson in the course of establishing the rates of increase for July 1, 2026 and July 1, 2027.

I can understand the Chairperson's reasoning in awarding the 2.25% increase on July 1, 2026 for these nurses as it is the same rate of increase that Arbitrator Price awarded the hospital nurses effective April 1, 2026 (for a period of just three months earlier), although I don't agree with it.

The CUPE Hospitals wage settlement of 2% occurred on September 29, 2026 and applied to service workers. The SEIU Hospitals Award of 2% for wages which became effective on January 1, 2027 also applied to workers. Having said that, I would submit that the second year of the term of this Award ought to have most definitely reflected the emerging downward trend in wage settlements and ought to have been set at 1.5%.

I would respectfully submit therefore, that the wage improvements indicated in this Award over the two year term are excessive while having due regard to evidence of recent wage settlement and award trends which affirm that wage increases are indeed decreasing as a result of a worsening economy. It is clear that settlements and awards have been trending lower as time goes on and as the economic conditions, layoffs (including layoffs in the health care sector) have progressively worsened. The 2.25% increase that has been awarded on July 1, 2026 for the Participating Homes and ONA is less than 3 months earlier than the freely negotiated CUPE Hospital settlement of 2% on September 29, 2026. If this Chairperson had set the first wage increase at 2%, that would have been consistent with two major hospital outcomes that have obviously recognized a worsening economy.

I am also concerned about the total compensation impact of this Award in view of other monetary improvements that have been awarded by the Chairperson at a point in time during which restraint, and a more conservative approach to addressing monetary proposals ought to have been adopted. The awarded wage increases (especially the 2% in the second year of the term) in conjunction with other monetary improvements that have been awarded would not have been achieved by ONA in a right to strike/lockout environment. The parties own bargaining history affirms that moderation to "other" compensation areas of the collective agreement has been consistently applied.

The Employers in this case also urged this Board to delete a highly restrictive job protection provision in Article 2.04 of the expired agreement. In addition, the Employers urged this Board to delete Article 2.06 of the expired agreement which restricts the flexibility of the Homes to operate and staff their respective facilities as they deem necessary.

Both of these provisions constitute a significant encroachment on the Employers' ability to efficiently and effectively manage their enterprise while also creating obstacles for the Employers to properly manage their nursing envelope while providing top quality care to the

residents. The expired ONA Agreement actually sets out the maintenance of specific RN bargaining unit hours in each of the Homes.

The Chairperson has declined to award the Employer's proposals in relation to these two articles or to at the very least, amend the provisions to mitigate their impact on operations and the Employers' ability to manage and operate efficiently.

The modification of these articles was a high priority issue for these Employers and we heard that the Employers would have "endured a long strike to achieve changes in this area". The Employers quite rightfully submitted that employee job protection and union bargaining unit protection were important but not more important than ensuring that the quality of care provided to residents is not compromised.

I would submit that the Chairperson ought to have considered the Employers' concerns and the demonstrated need in relation to modifying these two limiting provisions especially given the fact that SEIU, UNIFOR, and CUPE represented employees in the nursing home bargaining units do not have the same kind of extensive job protection language that is currently enjoyed by ONA represented RN"s in these Homes. Those agreements do not contain minimum staffing provisions, Article 2.06 job protection language, nor professional responsibility provisions such as those found in Article 19 of the expired agreement. I would also note that the collective agreement between the ONA and the Hospitals do not contain the same kind of restrictive provisions as those found in the Participating Homes' agreement.

For all of the foregoing reasons, I would dissent from this Award in that it does not replicate an outcome that would have been achieved in free collective bargaining.

Dated this 6th day of August, 2026

"Irv Kleiner"

Employer Nominee

Dissent of Union Nominee:

I must respectfully dissent from the decision of the Board on three points: health and safety, wages, and TOA.

First and foremost, nurses continue to experience workplace violence and aggression that could be prevented or minimized. ONA submitted an affidavit from a Registered Nurse that detailed multiple instances of workplace violence that could have been prevented or mitigated had there been a point-of-care system flagging potential violence. There was evidence that point-of-care flagging is used for communicable diseases and residents with a risk of falls. The evidence demonstrated that the risk of violence remains inadequately addressed and would be mitigated with point-of-care flagging. In contrast, there was no persuasive evidence or legal argument from the Participating Nursing Homes as to why such a system could not be uniformly implemented.

Second, parity with Municipal Homes for the Aged has been the priority for ONA for decades. Interest arbitrators routinely rely on gradualism and require unions to maintain a proposal as a priority for multiple rounds before it is achieved. The wage increases in this round should have moved the Participating Nursing Homes closer to parity. As ONA continues to pursue this objective, future Boards should give effect to this unwavering bargaining priority.

The percentage increase awarded in the first year is the same as was awarded by the Price board in the most recent central hospitals award. However, changed economic circumstances supported a higher increase in both years. In 2025, inflation had cooled and that trend was anticipated to continue. In June of 2026, Canada's rate of inflation was 2.8%. Regardless of the more recent inflationary trends, the rate of wage increases continues to lag inflation historically.

I do not accept the Chair's analysis of the parties' bargaining history. Regardless of the lack of explanation for closing the gap with Municipal Homes for the Aged in the last round, that is precisely what the parties did. I accept ONA's analysis that since the early 1990s, the trend in arbitrated outcomes has been to increase the gap, while the trend in agreed outcomes has been to reduce the gap. Arbitrated awards have increased the gap by 5.8% during this period, while settlements have reduced the gap by 9.5% during this period (a prior award of the Chair of this Board was an exception in significantly reducing the gap). The pattern of freely negotiated settlements is more persuasive than arbitrated outcomes. The pattern of settlements is towards parity.

Lastly, neither of the parties proposed the language awarded in relation to time spent on transfer of accountability. Both parties identified significant concerns with awarding

payment for transfer of accountability at the same rate as the shift worked, and I accept those concerns.