COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT,*

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF NNENNA EJELONU

DECISION OF THE HEARING TRIBUNAL
OF THE
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF NNENNA EJELONU, LPN #36319, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via teleconference using Zoom on March 19, 2024, with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Cindy McLeod, LPN
Terry Engen, Public Member
Kate Freeman, Public Member

Staff:
Caitlyn Field, Legal Counsel for the Complaints Officer, CLPNA
Stephanie Karkutly, Complaints Officer, CLPNA
Sanah Sidhu, Complaints Director, CLPNA

Investigated Member:
Nnenna Ejelonu, LPN ("Ms. Ejelonu" or "Investigated Member")
Lee Watson, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Ms. Ejelonu was an LPN within the meaning of the Act at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Ejelonu was initially licensed as an LPN in Alberta on September 23, 2013.

By letter dated June 22, 2022, the CLPNA received a complaint (the "Complaint") from Maggie Hwong, Unit Manager, Unit 1A, Villa Caritas, in Edmonton, Alberta pursuant to s. 57 of the *Health Professions Act* (the "Act"). The Complaint stated that Ms. Ejelonu, LPN, was terminated while under probation due to multiple medication administration and documentation errors as well as not communicating professionally and refusing to assist with patient care.

In accordance with s. 55(2)(d) and s. 20(1) of the Act, Ms. Sandy Davis, Complaints Director at the time for the CLPNA (the "Complaints Director") appointed Katie Emter (the "Investigator") to conduct an investigation into the Complaint.

Ms. Ejelonu received notice of the Complaint and the investigation by letter dated June 22, 2021.

On December 12, 2022, the Investigator concluded the investigation.

Following the conclusion of the Investigation, the Complaints Director determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Ejelonu received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated January 22, 2024.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are:

"It is alleged that **NNENNA EJELONU, LPN**, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. Failed to follow proper medication administration practices by doing one or more of the following:

    a. On or about May 26, 2022, failing to administer Admelog 6 units at 1715 hours as per client KM's Basal Bolus Insulin Therapy ("BBIT") order;
    b. On or about May 26, 2022, failing to administer a correction dose of Admelog 3 units at 1715 hours as per client KM's BBIT order;
    c. On or about May 26, 2022, administering Basaglar 19 units instead of Basaglar 25 units as per client KM's BBIT order;
    d. On or about May 30, 2022, preparing multiple clients' crushed medications at the same time and storing the prepared medications in Styrofoam cups prior to administration;
    e. On or about June 2, 2022, failing to use patient identifiers when administering medication;
    f. On or about June 13, 2022, failing to administer Potassium Chloride 30 ml to client BP at 0830 hours, as ordered;
    g. On or about June 13, 2022, failing to ensure client SD consumed polyethylene glycol powder 17g when administered at 0830 hours;

h. On or about June 13, 2022, failing to administer Acetaminophen 650 mg to client CM at 1230 hours, as ordered;
i. On or about June 13, 2022, documenting in the Patient Care Notes that client BP was compliant with scheduled medications despite not administering Potassium Chloride 30ml at 830 hours as scheduled;
j. On or about June 13, 2022, failing to use patient identifiers when administering medications.

2. Failed to follow medication documentation practices by doing one or more of the following:

    a. On or about May 21 – May 22, 2022, failing to document the time of administration of Lorazepam 1mg PRN on client RW's Medication Administration Record;
    b. On or about May 21 – May 22, 2022, failing to document the reason for administration of Lorazepam 1mg PRN in client RW's Patient Assessment Record;
    c. On or about May 21 – May 22, 2022, failing to document the effectiveness of the administered Lorazepam 1mg PRN in client RW's Patient Assessment Record.

3. Further and in addition to allegations #1 and #2, despite concerns being brought to her attention previously by her employer on a number of occasions with respect to medication administration and documentation, failed to adequately remediate the deficiencies identified.

4. On or about May 2022, failed to don Personal Protective Equipment ("PPE") as required by isolation precautions by doing one or more of the following:

    a. Failing to don required PPE prior to collect Methicillin-resistant Staphylococcus aureus ("MRSA") and/or COVID-19 swab samples from client JG, who was on isolation precautions;
    b. Failing to don required PPE prior to entering client RH's room, who was on isolation precautions.

5. On or about May – June, 2022, failed to foster a respectful or collaborative relationship with her co-workers by doing one or more of the following:

    a. On or about May 22, 2022, refusing to assist with client RW's care despite requests made by colleagues;
    b. Refusing to assist with client care when requested;
    c. Communicating with her co-workers in an unprofessional manner.

6. On or about May 27-28, 2022, failed to secure patient medical information by leaving clients' Medication Administration Records unattended and/or open on the medication cart.

7. On or about May - June 2022, failed to secure medication by doing one or more of the following:

    a. Leaving the medication cart unattended;
    b. Leaving the medication cart unsecured;
    c. Failing to lock the narcotic cupboard.

8. Failed to perform and/or document complete client assessments on the Patient Assessment Record, by doing one or more of the following:

    a. On or about June 8, 2022, failing to perform and/or document on the Patient Assessment Record a complete assessment of client DE;
    b. On or about June 13, 2022, failing to perform and/or document on the Patient Assessment Record a complete assessment of client JH.

9. On or about June 18, 2022, failed to document constant observation for client SH from 1315 hours-1500 hours on the Observation Rounds Mental Health record.

10. On or about June 18, 2022, slept, or in the alternative appeared to be sleeping, while on duty.

11. On or about June 19, 2022, failed to follow documentation of care practices by pre-documenting care before it was provided by doing one or more of the following:

    a. Pre-documenting care provided to client EL at or about 1845 hours, before it was provided at 1900 hours;
    b. Pre-documenting care provided to client KL before it was provided;
    c. Pre-documenting care provided to client CC before it was provided."

(5) **Admission of Unprofessional Conduct**

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Ms. Ejelonu acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Officer submitted, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2:	Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #1.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #1 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Ejelonu's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Ejelonu.

Allegation 1

Ms. Ejelonu admitted that she failed to follow proper medication administration practices by doing one or more of the following:

a. On or about May 26, 2022, failing to administer Admelog 6 units at 1715 hours as per client KM's Basal Bolus Insulin Therapy ("BBIT") order;

b. On or about May 26, 2022, failing to administer a correction dose of Admelog 3 units at 1715 hours as per client KM's BBIT order;
c. On or about May 26, 2022, administering Basaglar 19 units instead of Basaglar 25 units as per client KM's BBIT order;
d. On or about May 30, 2022, preparing multiple clients' crushed medications at the same time and storing the prepared medications in Styrofoam cups prior to administration;
e. On or about June 2, 2022, failing to use patient identifiers when administering medication;
f. On or about June 13, 2022, failing to administer Potassium Chloride 30 ml to client BP at 0830 hours, as ordered;
g. On or about June 13, 2022, failing to ensure client SD consumed polyethylene glycol powder 17g when administered at 0830 hours;
h. On or about June 13, 2022, failing to administer Acetaminophen 650 mg to client CM at 1230 hours, as ordered;
i. On or about June 13, 2022, documenting in the Patient Care Notes that client BP was compliant with scheduled medications despite not administering Potassium Chloride 30ml at 830 hours as scheduled;
j. On or about June 13, 2022, failing to use patient identifiers when administering medications.

On May 26, 2022, Ms. Ejelonu provided care to patient KM.

The Facility's Glycemic Management for Adult Patients policy indicates that elderly patients' blood glucose should be in the target range of 5-12 mmol/L. The policy at s. 2.6 further requires that insulin administration should be coordinated with meals and blood glucose testing.

The Facility's Hyperglycemia Procedure indicates that moderate hyperglycemia is defined as a blood glucose level between 14.1 to 18 mmol/L. Severe hyperglycemia is defined as a blood glucose level greater than 18 mmol/L. If a patient has a hyperglycemic event, all treatment provided, including interventions and medications administered, notification to other team members, and assessment/observation must be documented.

Patient KM was ordered to receive Ademlog insulin three times a day, and otherwise in accordance with his BBIT order.

At 1715 hours, Ms. Ejelonu recorded KM's Glucometer result of 16.0 mmol/L for his "dinner" blood glucose reading. According to KM's BBIT, KM required a "dinner" dose of Admelog 6 units and based on his elevated blood glucose reading, also required a further correction dose of Admelog 3 units.

Ms. Ejelonu failed to administer Admelog 6 units or the correct dose of Admelog 3 units at 1715 hours. When these missed doses were noticed by a colleague at 2030 hours, Ms. Ejelonu recorded KM's blood glucose level had increased to 20.7 mmol/L.

Patient KM was also ordered to receive a dose of Basaglar 25 units at bedtime. Ms. Ejelonu instead administered Basaglar 19 units to patient KM in error.

On May 30, 2022, Ms. Ejelonu worked at the Facility and provided care to multiple clients.

The Facility's Medication Administration and Preparation procedure requires that medications should be prepared for one patient at a time immediately prior to the administration. Medications may not be pre-poured, and if medications for a patient are removed from the original packaging a medication label shall be affixed to the medication at the time of preparation and administration.

On May 30, 2022, when preparing for medication administration, Ms. Ejelonu crushed medications for multiple clients directly into jam packets, mixed the jam and medications together, and then transferred the mixture into plastic medication cups. Ms. Ejelonu then stacked multiple medication cups within Styrofoam cups on which she wrote the patient's name. Ms. Ejelonu prepared multiple patients' medications at once, and at times stacked medication cups from different patients within one Styrofoam cup.

On June 2, 2022, Ms. Ejelonu worked at the Facility and provided care to clients.

The Facility's policies require that healthcare providers use two patient identifiers prior to administering medication. Such identifiers include the patient's full name, date of birth, wristband ID, recent patient photograph, and other identifiers.

On June 2, 2022, Ms. Ejelonu failed to use the required two patient identifiers, which involves checking the patient's wristband and picture to confirm their identity prior to administering medications.

On June 13, 2022, Ms. Ejelonu worked at the Facility and provided care to patients BP, SD, and CM.

With regard to patient BP, he was ordered to receive a dose of Potassium Chloride 30 ml at 0830 hours. Ms. Ejelonu failed to administer Potassium Chloride 30 ml to patient BP as ordered.

When Ms. Ejelonu documented the care she provided to patient BP; she inaccurately documented that patient BP was "compliant with scheduled medications" despite having not administered his scheduled medications.

The Facility's Medication Administration and Preparation procedure at s. 11.2 requires that healthcare professionals administering an oral medication remain with the patient until the medication has been consumed.

With regard to patient SD, he was ordered to receive a dose of polyethylene glycol powder 17g at 0830 hours and 1715 hours. Ms. Ejelonu administered patient SD's 0830 hours dose while SD was in the Facility's dining room. Ms. Ejelonu failed to ensure that patient SD in fact consumed this dose and instead walked away.

Regarding patient CM, she was ordered to receive a dose of Acetaminophen 650 mg at 1230 hours. Ms. Ejelonu failed to administer CM's 1230 hours dose of Acetaminophen of 650 mg.

On June 13, 2022, Ms. Ejelonu was observed by the Complainant, Ms. Hwong, to have failed to use the required two patient identifiers to confirm patient identity prior to administering medication.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice; and
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to administer medications to three patients, failed to ensure that patients were compliant with taking their medications, failed to use patient identifiers when administering medications, and then prepared multiple patients' medications at the same time by crushing them and then storing them in Styrofoam cups until she was able to administer these medications. Ms. Ejelonu also did not adhere to Facility policies when doing this. This is a core competency of an LPN regardless of their experience and should not have been done in this manner.

Ms. Ejelonu failed to follow the medication documentation practices of a healthcare professional. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu failed to administer correct doses of medications, failed to use patient unique identifiers when administering medications, failed to ensure that patients took their medications, and failed to adhere to proper medication documentation practices and documentation of blood glucose readings. The allegation deals with core competencies which an LPN is expected to know and adhere to, which are the rights of medication administration. By failing in this manner, Ms. Ejelonu undermined the integrity of the LPN profession.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics") and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice").

CLPNA Code of Ethics:

Ms. Ejelonu acknowledged that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

Principle 1: Responsibility to the Public – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate, and ethical care to members of the public. Principle 1 specifically provides that LPNs:

- 1.1 Maintain standards of practice, professional competence, and conduct.
- 1.5 Provide care directed toward the health and well-being of the person, family, and community.
- 1.6 Collaborate with clients, their families (to the extent appropriate to the client's right to confidentiality), and health care colleagues to promote the health and well-being of individuals, families, and the public.

Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.3.1 Safeguard health and personal information by collecting, storing, using, and disclosing it in compliance with relevant legislation and employer policies.
- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.
- 2.8 Use evidence and judgement to guide nursing decisions.
- 2.9 Identify and minimize risk to clients.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- 3.3 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.
- 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws, and regulations under which they are accountable.

Principle 4: Responsibility to Colleagues – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically provides that LPNs:

- 4.2 Collaborate with colleagues in a cooperative, constructive, and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families, and communities.

- 4.4 Acknowledge colleagues' roles and their unique contribution to the interprofessional team.

- 4.5 Respect the expertise of colleagues and share own expertise and knowledge.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

- 5.1 Demonstrate honesty, integrity, and trustworthiness in all interactions.

- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws, and regulations under which they are accountable.

- 5.8 Maintain the required mental and physical wellness to meet the responsibilities of their role.

Ms. Ejelonu acknowledged that her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA in 2020 which states as follows:

CLPNA Standards of Practice:

Standard 1: Professional Accountability and Responsibility – LPNs are accountable and responsible for their practice and conduct to meet the standards of the profession and legislative requirements.

- 1.1 Practice within applicable legislation, regulations, by-laws, and employer policies.

- 1.2 Self-assess their professional practice and competence and participate in continuous learning.

- 1.3 Share knowledge and expertise to meet client needs.

- 1.4 Practice within LPN scope of practice and individual level of competence and consult and collaborate when necessary.

- 1.6 Adhere to established client safety principles and quality assurance measures to anticipate, identify, evaluate, and promote continuous improvement of safety culture.

- 1.8 Are accountable and responsible for their own practice, conduct, and ethical decision making.

Standard 3: Protection of the public through self-regulation – Licensed Practical Nurses collaborate with clients and other members of the healthcare team to provide safe care and improve health outcomes.

- 3.3 Lead and contribute to a practice culture that promotes safe, inclusive, and ethical care.

- 3.4 Provide relevant, timely, and accurate information to clients and healthcare team.

- 3.5 Understand and accept the responsibility of self-regulation by following the standards of practice, the code of ethics, and other regulatory requirements.

- 3.7 Maintain their physical, mental, and emotional fitness to practice in order to provide safe, competent, and ethical nursing care.

Standard 4: Professional and Ethical Practice – Licensed Practical Nurses adhere to the ethical values and responsibilities described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics:

- 4.3 Advocate for the protection and promotion of clients' right to autonomy, confidentiality, dignity, privacy, respect, and access to care and personal health information.

- 4.5 Demonstrate effective, respectful, and collaborative interpersonal communication to promote and contribute to a positive practice culture.

- 4.6 Demonstrate practice that upholds the integrity of the profession.

Ms. Ejelonu failed to demonstrate professional accountability and responsibility in that Ms. Ejelonu did not practice within applicable legislation, regulations, and employer policies. Ms. Ejelonu did not adhere to various policies at the Facility, and this is an expectation of an LPN not only to be aware of the policy but to follow them as well. This is an expectation of the employer, CLPNA and the public. Failure to adhere to these policies would have an effect on the care that the patients would receive in that failure to document a patient's blood glucose reading and not administering insulin to the patient can result in serious harm to the patient.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 2

Ms. Ejelonu admitted that she failed to follow medication documentation practices by doing one or more of the following:

a. On or about May 21 – May 22, 2022, failing to document the time of administration of Lorazepam 1mg PRN on client RW's Medication Administration Record;
b. On or about May 21 – May 22, 2022, failing to document the reason for administration of Lorazepam 1mg PRN in client RW's Patient Assessment Record;
c. On or about May 21 – May 22, 2022, failing to document the effectiveness of the administered Lorazepam 1mg PRN in client RW's Patient Assessment Record.

On May 21 and May 22, 2022, Ms. Ejelonu worked at the Facility and provided care to patient RW.

The Facility's Medication Administration and Preparation procedure at s. 20 requires that medication administration documentation should be completed on the client's Medication Administration Record after administration. Documentation must include the date and exact time of administration and reasons for PRN medications. Regarding a PRN medication, the procedure requires at s. 9.2 that the patient must be assessed following administration including the therapeutic effectiveness of the medication.

RW was ordered to receive Lorazepam 1mg PRN, or as needed by the patient.

Ms. Ejelonu administered Lorazepam 1 mg to RW on two occasions over the period of May 21, 2022, and May 22, 2022. Ms. Ejelonu failed to document the time of administration for either of these doses.

Ms. Ejelonu did not document the reason for administering Lorazepam 1 mg, or its effectiveness in addressing the reason for administration. Ms. Ejelonu's documentation of her care of client RW merely indicated that he had remained calm throughout and had no abnormal behavior noted.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to document the time of the administration of Lorazepam as well as the reason for the administration, and the effectiveness of Lorazepam with

respect to patient RW. This is a core competency of an LPN regardless of their experience. Documentation of the reason for the administration and effectiveness of Lorazepam is important in that it allows the other health care professionals to know that patient RW had received the medication, the reason why RW received the medication, and what the outcome of RW receiving the medication was. By not documenting the administration of the Lorazepam no other health care professions were aware that RW received the dose, and this had the potential for RW to receive an extra dose of the medication or no medication.

Ms. Ejelonu was in contravention a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice. Ms. Ejelonu failed to demonstrate professional accountability and responsibility with respect to her medication administration practices as she failed to document the time of administration, the reason for the administration, and the effectiveness of the medication administration. Ms. Ejelonu also failed to maintain standards of practice, as well as responsibility to the LPN profession, and responsibility to colleagues. By failing to properly document, this prevented patient RW from potentially receiving the care that was required by other healthcare providers. It is an expectation of the public that when they are receiving care from an LPN that the proper protocols and documentation takes place. The public has an expectation of the type of care and communication that takes place among health care providers and documentation is a key component of this communication.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation. LPNs follow self-regulation and as a part of this LPNs need to follow direction from their employer. By not remediating the deficiencies that were brought to her attention by her employer this could cause a distrust in the LPN profession within the eyes of the public. This harms the integrity of the LPN profession in the eyes of the public.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 3

Ms. Ejelonu admitted that further and in addition to allegations #1 and #2, despite concerns being brought to her attention previously by her employer on a number of occasions with respect to medication administration and documentation, failed to adequately remediate the deficiencies identified.

During Ms. Ejelonu's buddy shifts, several colleagues raised concerns regarding Ms. Ejelonu's practice with Ms. Hwong. On May 18, 2022, Ms. Hwong relayed these practice concerns to Ms. Ejelonu, which included concerns regarding medication administration and documentation. At this time, Ms. Hwong planned to start monitoring Ms. Ejelonu's medication administration practice.

On May 25, 2022, Ms. Ejelonu met with Ms. Helen Pulido, Manager of Unit 2B at the Facility, to discuss several practice concerns that had been raised, including medication documentation and charting.

After receiving further concerns regarding Ms. Ejelonu's practice through the end of May 2022, Ms. Hwong determined that additional buddy shifts would benefit Ms. Ejelonu. Ms. Ejelonu was not open to further buddy shifts and believed she did not need assistance to improve her practice.

On May 30, 2022, and May 31, 2022, Peter Duncan, LPN was assigned to shadow Ms. Ejelonu on her shift. Ms. Ejelonu did not want to be shadowed and told Mr. Duncan to go away.

Following the completion of these shadow shifts, Mr. Duncan sent an email to Ms. Hwong detailing his observations of Ms. Ejelonu's practice. In this email, Mr. Duncan described that he observed Ms. Ejelonu did not follow appropriate medication administration and documentation practices.

On June 6, 2022, Ms. Hwong assigned Ms. Ejelonu to complete a buddy shift with John Pollet, RN. Ms. Ejelonu continued to be unreceptive to completing buddy shifts. On June 6, 2022, Ms. Hwong assigned Ms. Ejelonu to do a buddy shift with Mr. Duncan.

On June 7, 2022, Ms. Hwong informed Ms. Ejelonu that she was going to develop a learning plan to address multiple practice concerns and that Ms. Ejelonu would spend a day doing continuing nursing education to remediate the raised concerns.

On June 10, 2022, Ms. Ejelonu completed continuing nursing education which covered all the topics of concern. Ms. Ejelonu was provided with a performance improvement plan prepared by Ms. Hwong. The performance improvement plan identified several areas that required improvement, including a failure to document accurately and timely, failure to adhere to medication administration and preparation procedures and administration practices.

Ms. Hwong also provided Ms. Ejelonu with a letter that clearly identified the deficiencies in her practice and required areas of improvement.

Despite Ms. Ejelonu being made aware of concerns regarding her medication administration and documentation practices, Ms. Ejelonu did not adequately remedy the identified deficiencies.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed, despite several concerns being brought to her attention previously by her employer with respect to medication administration and documentation, to adequately remediate the deficiencies that were identified. LPNs are expected to adhere to continuous education as well as professional development and growth throughout their careers and Ms. Ejelonu was not open to this as Ms. Ejelonu did not adequately remedy the deficiencies that were identified by her employer. Ms. Ejelonu was assigned to have further buddy shifts; however, Ms. Ejelonu believed that she did not need assistance to improve her practice. This is concerning as Ms. Ejelonu's employer did bring to her attention on a number of occasions some areas of concern as listed in Allegation 3. Ms. Ejelonu in fact told Mr. Duncan when she was assigned buddy shifts with her to go away and that Ms. Ejelonu did not want to be shadowed. Ms. Ejelonu failed to recognize the limitations in her practice and to remedy the limitations.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. In respect to this allegation Ms. Ejelonu had concerns brought to her attention by her employer and was given a performance improvement plan which identified several areas of required improvement, including a failure to document accurately and timely, failure to adhere to medication administration and preparation procedures and administration practices. The allegation deals with core competencies which an LPN is expected to know and adhere to. Ms. Ejelonu failed to remediate deficiencies that were identified to her on more than one occasion by management. Ms. Ejelonu was supposed to complete additional buddy shifts; however, Ms. Ejelonu did not believe that she needed the assistance in order to improve her practice. When Ms. Ejelonu was offered buddy shifts, she refused additional assistance. Ms. Ejelonu did not adequately remedy the deficiencies that were identified to her by her employer.

Ms. Ejelonu's actions also harm the integrity of the LPN profession in that Ms. Ejelonu did not act in a manner that is expected of an LPN regardless of their experience. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 4

Ms. Ejelonu admitted that on or about May 2022, she failed to don Personal Protective Equipment ("PPE") as required by isolation precautions by doing one or more of the following:

a. Failing to don required PPE prior to collect Methicillin-resistant Staphylococcus aureus ("MRSA") and/or COVID-19 swab samples from client JG, who was on isolation precautions;
b. Failing to don required PPE prior to entering client RH's room, who was on isolation precautions.

In May 2022, Ms. Ejelonu worked at the Facility and provided care to patients JG and RH.

RH was on contact precautions which required staff to wear personal protective equipment (PPE) including a gown, gloves, mask, and eye-protection. A notice of the required Contact and Droplet Precautions was posted on RH's door for all staff and visitors.

Ms. Ejelonu entered RH's room along with two other staff, both of whom were wearing the required PPE. Ms. Ejelonu did not don Personal Protective Equipment as required prior to entering RH's room. Ms. Ejelonu assisted with RH's shower and admission assessment without wearing the required PPE.

Similarly, JG was on contact precautions which required staff to wear personal protective equipment (PPE) including a gown, gloves, mask, and eye-protection. While completing a swab collection on JG, Ms. Ejelonu only donned gloves and a mask. Ms. Ejelonu failed to don a gown and eye protection as required. JG later tested positive for COVID-19.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to adhere to the Facility's policies with respect to donning PPE prior to collecting both Methicillin-resistant Staphylococcus aureus (MRSA) and COVID-19 swabs despite the Facility policy as well as there being notice of Contact and Droplet Precautions posted on RH's door. This put the other health care providers as well as patients in the Facility at risk of contracting either MRSA and/or COVID-19 as Ms. Ejelonu did not follow standard infection policies.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged

by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. Ms. Ejelonu did not adhere to the Facility's Personal Protective Equipment isolation precautions despite a notice of required Contact and Droplet Precautions being posted on the patients' door. Ms. Ejelonu's lack of adherence to the Facility's Personal Protective Isolation Precautions exposed not only herself to MRSA/COVID, but also exposed the patients, staff, and family members of both the staff and the patients. This disregard had the potential to not only cause an outbreak within the facility but in the community. This also could have had adverse effects on both the patients and community.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 5</u>

Ms. Ejelonu admitted that on or about May to June 2022, she failed to foster a respectful or collaborative relationship with her co-workers by doing one or more of the following:

a. On or about May 22, 2022, refusing to assist with client RW's care despite requests made by colleagues;
b. Refusing to assist with client care when requested;
c. Communicating with her co-workers in an unprofessional manner.

In May 2022, Ms. Ejelonu worked at the Facility and provided care to RW.

Khukie Jambo, HCA approached Ms. Ejelonu to assist with providing care to RW. Ms. Jambo's HCA partner was on break and Ms. Jambo needed Ms. Ejelonu's help to complete a sit to stand lift with RW as it requires two staff members.

When asked to provide assistance by her co-workers, Ms. Ejelonu refused to help Ms. Jambo. Ms. Jambo then approached Mr. Pollet, RN, and asked for help. Ms. Ejelonu began to rudely accuse Ms. Jambo of having a poor attitude. Ms. Jambo, Mr. Pollet, and Kenny Pedrajas, RN, explained to Ms. Ejelonu that everyone was expected to assist with patient care.

Following this conversation, Ms. Ejelonu attended RW's room to assist with the two-person lift. However, when Ms. Ejelonu arrived, she did not help Ms. Jambo to prepare RW for the lift.

In addition to the events of May 22, 2022, over May to June 2022, Ms. Ejelonu regularly refused to assist with client care when requested, this included:

- When working a buddy shift with Mr. Pollet, refusing to assist with client care;
- Refusing to assist an HCA to take JG to the toilet, and assigned another HCA to the task;
- Not putting JG's hearing aids and dentures in after being asked to do so;
- Refusing to connect the attending psychiatrist;
- Refusing to reposition a restless patient when asked;
- Refusing to assist a physician with assessing a patient.

In addition to the events of May 22, 2022, over May to June 2022, Ms. Ejelonu communicated with her co-workers in an unprofessional manner, including:

- Openly referring to health care aides as "only HCAs" or "just HCAs" in a demeaning or derogatory manner;
- Telling colleagues to "forget it" when they attempted to provide coaching;
- Telling colleagues that certain tasks where "beneath her";
- Regularly communicating in a rude or disrespectful manner.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu refused to assist her co-workers as well as to communicate with them. This is a fundamental component of working within a health care setting as members of the health care team must assist each other as well as possess communication skills. Regarding the patient, this meant that patient RW was not able to receive the type of care that RW required in a timely manner. It is expected that LPNs will provide quality care to their patients and assist their coworkers when required. Ms. Ejelonu refused to assist with patient care, providing basic needs for the patients. Ms. Ejelonu refused to contact a psychiatrist when required as well as refused to aid a physician when requested. Ms. Ejelonu stated to her colleagues that certain tasks were "beneath her" and this is not acceptable from any Health Care provider let alone an LPN.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. Ms. Ejelonu failed to foster a respectful or collaborative relationship with her co-workers by refusing to help her co-workers when they asked for assistance when using a patient lift. Ms. Ejelonu refused to assist without any reason. Ms. Ejelonu also would not assist co-workers when they asked for assistance with patient care and these were basic needs of the patients, such as assisting to take a patient to the toilet, putting in a patient's hearing aids and dentures, refusing to contact an attending psychiatrist, refusing to assist a physician when assessing a patient and refusing to reposition a restless patient. These are basic daily activities that patients should be able to have assistance with within a timely manner. Ms. Ejelonu would also refer to the colleagues as if they were beneath her and would state that some of the tasks were beneath her as well. Ms. Ejelonu failed to adhere to the basic needs of patients and to foster a respectful relationship with her fellow Health Care Colleagues.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation. This harms the integrity of the LPN profession in that Ms. Ejelonu failed to maintain the standards of the LPN Profession and that she failed to foster the respect and trust of her patients, as well as health care colleagues, and the public. LPNs are expected to work within a multidisciplinary team and be respectful in their interactions.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 6

Ms. Ejelonu admitted that on or about May 27-28, 2022, Ms. Ejelonu failed to secure patient medical information by leaving clients' Medication Administration Records unattended and/or open on the medication cart.

On May 27-May 28, 2022, Ms. Ejelonu worked at the Facility. Kenny Pedraja, RN found Ms. Ejelonu's medication administration cart unattended in the Facility's dining room. On top of the medication administration cart, the Unit's Medication Administration Record was open and accessible to patients.

Ms. Ejelonu failed to secure patient medical information by leaving the Medication Administration Records open and unattended on the medication administration cart.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

ii. Contravention of the Act, a code of ethics or standards of practice;
iii. Contravention of another enactment that applies to the profession, and
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to secure personal health information with respect to the patients that were on the unit in which she was working by leaving the medication administration cart unattended. This type of behavior could have led to a privacy breach in respect to her patients. Ms. Ejelonu showed poor judgment by leaving the medication administration cart unattended in the Facility's dining room as well as leaving the Units Medication Administration Record open as this allowed for accessibility to both the Medication Cart as well as the Administration Records so that patients, other staff, or family members could have access to this information. The Medication Cart contains all medications for all the patients on the units and many of these patients had psychiatric conditions and would be able to access medications that were not prescribed to them. Depending on the type of medication if it was taken by a patient who it was not prescribed for there is the potential for adverse effects to that patient. There would be no record of what was taken by the patient which would hinder the staff to be able to assist that patient if a medical emergency took place. Regarding the Medication Administration Record this was allowing personal health information to be accessed by anyone on the unit as well and it is an expectation that personal health information be protected by Health Care Professionals; this is an expectation of both the CLPNA as well as members of the public.

Ms. Ejelonu was in contravention of the code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu was in contravention of the Health Information Act in that Ms. Ejelonu failed to properly secure patient information which allowed access for patients, visitors, and other Health Care Professionals to have access to all the medications and personal information for the patients who were in Ms. Ejelonu's care. This is a core competency of an LPN and a violation of trust.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. Ms. Ejelonu failed to secure patient medical information by leaving the unit Medication Administration Records unattended and open on the medication cart while the medication cart was in the Facility's dining room. This allowed for the potential of any of the patients or visitors to have access to private personal health care information. The allegation deals with core competencies which an LPN is expected to know and adhere to. LPNs are expected to secure and guard personal health information with respect to the patients that are in their care. LPNs should take all the precautions to protect this information and treat the information as if it was their own and not leave the information to be accessible by anyone else. It is an expectation of the public that when they are under care within a Health Care Facility that the staff will take all the precautions necessary to protect their personal health information.

In this way, Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation and medication administration are core competencies of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 7</u>

Ms. Ejelonu admitted that on or about May - June 2022, she failed to secure medication by doing one or more of the following:

a. Leaving the medication cart unattended;
b. Leaving the medication cart unsecured;
c. Failing to lock the narcotic cupboard.

The Facility's Medication Administration and Preparation procedure at s. 1.7 requires that medications are kept in a secure area at all times.

As described in Allegation 6 on May 27, 2022, Mr. Pedrajas, RN, found that Ms. Ejelonu had left her medication administration cart unattended and unsecured in the Facility's dining room. Mr. Pedrajas moved the cart to the medication administration room for safekeeping and advised Ms. Ejelonu that she left the cart unsecure.

Francis Wambui, RPN, observed Ms. Ejelonu repeatedly leaving the medication cart unsecured during medication administration and reminded her to lock it. Despite this reminder, Ms. Ejelonu continued to fail to secure the medication cart.

On June 12, 2022, Ms. Hwong entered the medication room at the Facility and found the narcotic cupboard unlocked, with the key still in the lock. Due to the storage of potential hazardous or controlled medications, the narcotic cupboard must always remain locked and the key to the cupboard must be kept on the LPN on duty. Ms. Hwong checked the medication documentation to determine who had last administered a narcotic and found that it was Ms. Ejelonu. Ms. Ejelonu failed to lock the narcotic cupboard, as required, to ensure that the medications were properly secured.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to secure the medication cart, leaving it unattended and unsecured, as well as failing to lock the narcotic cupboard. There was a potential for harm here as patients had access to the medications in the cart as well as to the medications that were stored in the narcotic cupboard. This was a clear violation of the Facility's policy in regard to medication management. This type of behavior is not acceptable of LPNs regardless of their experience.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. Ms. Ejelonu left a medication cart unattended, unsecured, and failed to lock the narcotic cupboard. Ms. Ejelonu was reminded to lock the medication cart as Ms. Ejelonu was observed doing repeatedly. All of these are expectations of an LPN in that there was the potential of harm to patients. The allegation deals with core competencies which an LPN is expected to know and adhere to. Ms. Ejelonu did not adhere to the Facility's Medication Administration and Preparation policy s 1.7 which stated that medications must always be secured. The Medication Cart contains all medications for all the patients on the units and many of these patients had psychiatric conditions and would be able to access medications that were not prescribed to them. Depending on the type of medication if it was taken by a patient who it was not prescribed for there is the potential for adverse effects to that patient. Ms. Ejelonu also failed to lock the narcotic cupboard and left the key in the lock. Narcotic medications are to be locked and they are counted at the beginning and end of nursing shifts for tracking purposes. They are controlled substances and are to always remain locked with the key not being kept in the lock.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Medication administration is a core competency of an LPN, and it is expected that LPNs will safeguard medications both in the medication cart as well as in the narcotic cupboard. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation. For these reasons, Ms. Ejelonu's actions also harm the integrity of the LPN profession.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 8

Ms. Ejelonu admitted that she failed to perform and/or document complete client assessments on the Patient Assessment Record, by doing one or more of the following:

a. On or about June 8, 2022, failing to perform and/or document on the Patient Assessment Record a complete assessment of client DE;
b. On or about June 13, 2022, failing to perform and/or document on the Patient Assessment Record a complete assessment of client JH.

On June 8, 2022, Ms. Ejelonu worked at the Facility and provided care to DE. At 1300 hours, Ms. Ejelonu performed an assessment of DE. However, when documenting the assessment, Ms. Ejelonu recorded information on only the first page of the required three-page assessment document.

Ms. Ejelonu failed to perform and/or document a complete assessment of client DE on the Patient Assessment Record.

On June 13, 2022, Ms. Ejelonu worked at the Facility and provided care to JH. At 1430 hours, Ms. Ejelonu performed an assessment of JH. However, when documenting the assessment, Ms. Ejelonu recorded information only on the first page of the required three-page document. Ms. Ejelonu failed to perform and/or document a complete assessment of JH on the Patient Assessment Record.

In addition to the typical patient assessment, JH required a functional assessment and Antibiotic Resistant Organism screening. There is no documentation to support the fact that Ms. Ejelonu completed these assessments of JH on June 13, 2022.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to perform and/or document completely on patient DE and JH's Patient Assessment Record. Ms. Ejelonu documented on page 1 of the Patient Assessment Record and failed to complete the rest of the documentation. Documentation is how Healthcare Practitioners communicate essential information to one another and is a core competency of an LPN regardless of their experience. The lack of documentation on the other pages of the document resulted in a failure of communication among the Health Care Team with respect to both patient DE and patient JH. If there were changes in the patient's condition, then no other member of the health care team would be aware of this as a result of the lack of documentation. Ms. Ejelonu did not adhere to the Facility's policy, which Ms. Ejelonu should have been aware of.

Ms. Ejelonu was in Contravention of the Act, a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice set out at Allegation #1. Ms. Ejelonu failed to perform and/document assessments on two patients in her care on June 8, 2022, and June 13, 2022. These assessments are a core competency of any LPN and should be recorded within the patients' charts. Ms. Ejelonu only recorded her assessment on page 1 of a three-page document. The allegation deals with core competencies which an LPN is expected to know and adhere to. By not properly documenting or performing the complete client assessment this shows to other health professionals that the assessment was not completed by Ms. Ejelonu. This is a failure to the public, responsibility to clients, responsibility to the profession and responsibility to colleagues. Documentation is key in communication among health professionals and by not completing the full assessment then other health care professionals are not aware of what is taking place with the patient. The public entrusts that LPNs will document all information that is appropriate with respect to the care that they are receiving, and Ms. Ejelonu failed to do this.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation is a core competency of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 9

Ms. Ejelonu admitted that on or about June 18, 2022, she failed to document constant observation for client SH from 1315 hours-1500 hours on the Observation Rounds Mental Health record.

On June 18, 2022, Ms. Ejelonu worked at the Facility and provided care to SH. SH had been diagnosed with mixed dementia and was on "constant" observation. The Facility's Observation Levels policy requires that patients under constant observation will have at least one health care provider present with the patient at all times, observing uninterrupted close visual contact and monitoring of the patient. Patients with "Q15" monitoring means they must observe the patient at least every 15 minutes for the duration of the order. Documentation verifying observation for a patient on Constant Observation must occur at least once per hour.

On June 18, 2022, SH required constant observation with a check to be completed and documented on an Observation Round record every 15 minutes.

While assigned to provide constant observation for SH, Ms. Ejelonu documented her observations on the Observation Rounds Mental Health Record. However, Ms. Ejelonu failed to document constant observation for the period of 1315 hours to 1500 hours. SH's Patient Assessment Records indicate that Ms. Ejelonu was assigned to constant observation until 1450 hours.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu failed to perform and/or document completely on patient SH with regards to the Observation Rounds Mental Health Record for the time period of 1315 - 1500 hours even though there was a physician's order for SH to be observed every 15 minutes. Ms. Ejelonu failed to follow a physician's order which is an expectation of LPNs. By not adhering to the physician order and given the diagnoses of patient SH there was a potential of harm for SH. Ms. Ejelonu documented on page 1 of the Patient Assessment Record and failed to complete the rest of the documentation. Documentation is how healthcare practitioners communicate essential information to one another and is a core competency of an LPN regardless of their experience. The lack of documentation on the other pages of the document resulted in a failure of communication among the Health Care Team as SH was under observation. If there were changes in SH's condition, then no other member of the health care team would be aware of this because of the lack of documentation. Ms. Ejelonu did not adhere to the Facility's policy, which Ms. Ejelonu should have been aware of.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out at Allegation #1. Ms. Ejelonu was assigned to work as a "constant" with patient SH who had been diagnosed with mixed dementia. Part of working with a patient who is under constant observation according to the Facility's Observation Levels Policy is that there must always be at least one health care provider with the patient and that the health care provider must observe the patient at least every 15 minutes for the duration of the constant order being in place. Ms. Ejelonu failed to document constant observation for the period of 1315 hours to 1500 hours. The allegation deals with core competencies such as documentation in which an LPN is expected to know and adhere to regardless of their experience. Professional Accountability and Responsibility states that LPNs are accountable and responsible for their practice and conduct. Ms. Ejelonu

appeared to be sleeping outside a patient's room. This showed a lack of accountability for her conduct as Ms. Ejelonu was to be working providing constant care for patient SH.

This harms the integrity of the LPN profession as LPNs are expected to adhere to physician's orders as well as policies and procedures of the Facilities in which they are employed. It is an expectation of the physician that when they give an order with respect to a patient that members of the health care team adhere to these orders. Members of the public also expect that LPNs who are to provide care follow and adhere to physicians' orders. Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation is a core competency of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 10

Ms. Ejelonu admitted that on or about June 18, 2022, she slept, or in the alternative appeared to be sleeping, while on duty.

As described above in Allegation 9, Ms. Ejelonu worked at the Facility on June 18, 2022, and was assigned to maintain constant observation over SH.

While assigned to constant observation, Ms. Batacan, LPN, and Ms. Aysegul Yildirim, HCA, observed Ms. Ejelonu sleeping in a chair outside SH's room. Ms. Yildirim took pictures of Ms. Ejelonu sleeping while on duty on June 18, 2022.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu was sleeping or appeared to be sleeping while on duty. This is not an expectation of a healthcare provider or an LPN with any experience as they are expected to take care of patients who are in their care and not appearing to sleep while on duty. Patient SH had a physician's order to be under constant observation and Ms. Ejelonu was assigned to do this task. If Ms. Ejelonu was so tired that she required to sleep, then she should not have been at work. If Ms. Ejelonu was so tired that she was not able to provide the care required, then it was her professional responsibility to not work as she may have not been fit to practice as there was the potential for risks to her patients under her care.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Ms. Ejelonu appeared to be sleeping while in a chair outside patient SH's room when Ms. Ejelonu was to be providing "constant" care to patient SH. Health care providers should not be sleeping when they are supposed to be providing care to patients. Ms. Ejelonu has a duty to be fit for work in her practice and if Ms. Ejelonu was so tired that she needed to sleep on her shift then she may not have been fit for work. LPNs practice under self-regulation and one component of this is recognizing they are fit for practice. There was a potential for harm not only to patient SH but also to Ms. Ejelonu as she may not be working to her full capacity and the potential for errors is greater when staff are tired.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 11

Ms. Ejelonu admitted that on or about June 19, 2022, she failed to follow documentation of care practices by pre-documenting care before it was provided by doing one or more of the following:

a. Pre-documenting care provided to client EL at or about 1845 hours, before it was provided at 1900 hours;
b. Pre-documenting care provided to client KL before it was provided;
c. Pre-documenting care provided to client CC before it was provided.

On June 19, 2022, Ms. Ejelonu worked at the Facility and provided care to patients EL, KL, and CC.

Mr. Pedrajas, RN, completed a review of client charting at or about 1845 hours. In Mr. Pedrajas' review of the patient charts, Mr. Pedrajas noticed that Ms. Ejelonu had pre-documented care to EL, KL, and CC before the care was provided.

Regarding EL, Ms. Ejelonu had documented that EL had care provided by Ms. Ejelonu and two staff members. However, when Mr. Pedrajas spoke to the Health Care Aides on duty, they confirmed that care had not yet been provided to EL.

Mr. Pedrajas spoke to Ms. Ejelonu regarding her pre-documentation of care to EL, KL, and CC. After this discussion, Ms. Ejelonu edited EL's Patient Assessment Record to indicate her entry was made in "error".

Regarding KL, Ms. Ejelonu pre-documented that care was provided along with two staff members and that KL was cooperative.

Regarding CC, Ms. Ejelonu pre-documented that CC was compliant with the care provided, and later crossed out this statement on CC's Patient Assessment Record.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Ms. Ejelonu displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Ejelonu wrote her documentation on patients EL, KL, and CC before care was provided to these patients. Ms. Ejelonu pre-documented patient outcomes as well as care that was yet to be provided. Documentation is a core competency of an LPN regardless of their experience and pre-documentation is not an acceptable practice. LPNs should never do pre-documentation with respect to the care of their patients. Ms. Ejelonu documented that care was provided when in fact it was not provided. This should not be done as there was a situation on the unit with another patient and Ms. Ejelonu was not able to provide the care which makes it false documentation. By doing the pre-documentation this indicates that care has been provided to the patients and then other health care providers will believe that the care was provided to the patient resulting in the patient not receiving the care that they require. This is not an acceptable practice of any health care provider let alone an LPN.

Ms. Ejelonu was in contravention of a code of ethics or standards of practice in that Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Ejelonu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Ms. Ejelonu did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out in Allegation #1.

Ms. Ejelonu harmed the integrity of the LPN profession by not performing in a manner which is expected that an LPN would perform in a similar situation. Documentation is a core competency of an LPN. Ms. Ejelonu did not meet the expectations or standards of what is expected of an LPN in this situation. LPNs should not be writing pre-documentation in a patient's medical record especially regarding care that has yet to be provided. Ms. Ejelonu documented how the patient was behaving as well as how the patient was interacting with her when in fact she did not interact with the patients. Ms. Ejelonu documented care that was provided to the patient that was not yet provided including vital signs. By pre-documenting patients' vital signs if those were in fact not the proper vital signs then if the patient requires care or medications then they will not receive the medications or any interventions if required. This was documented on three patients. The allegation deals with core competencies which an LPN is expected to know and adhere to. LPNs and health care professionals should never do pre-documentation of care that has yet to

be provided as it is false documentation. This could potentially cause a patient not to receive the care that they require as other health care professionals would check the documentation and if it is documented that care has been given then they would not provide the care an additional time.

The Hearing Tribunal finds the conduct breached displayed a lack of judgment, harmed the integrity of the profession, and breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Ejelonu jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

In light of the circumstances described in the Agreed Statement of Facts, and on the basis that on January 18, 2024, Ms. Ejelonu provided the Complaints Officer with a signed declaration that she has read and reflected on the following CLPNA documents:

a) Code of Ethics for Licensed Practical Nurses in Canada;

b) Standards of Practice for Licensed Practical Nurses in Canada;

c) CLPNA Standard: CCPNR Entry-Level Competencies for LPNs;

d) CLPNA Document: Collaborative Practice in Nursing;

e) CLPNA Policy: Professional Responsibility & Accountability;

f) CLPNA Policy: Medication Management.

Further on the basis that Ms. Ejelonu has completed the following remedial education and has provided the Complaints officer with certificates confirming successful completion of the following:

(a) CLPNA Learning Module: Medication Management, completed January 18, 2024;

(b) CLPNA Learning Module: LPN Code of Ethics, completed January 17, 2024;

(c) CLPNA Learning Module: Connecting Regulation to LPN Practice, completed January 17, 2024.

Ms. Ejelonu and the Complaints Officer jointly recommend that the Hearing Tribunal impose the following orders:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Ejelonu shall pay 25% of the costs of the investigation and hearing to a maximum of $3,100.00 to be paid in full within **36 months** of the date when Ms. Ejelonu is provided with a letter advising her of the total investigation and hearing costs.

3. Ms. Ejelonu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer. Ms. Ejelonu shall provide the Complaints Officer a signed declaration attesting she has read the documents within **4 months** of the Decision:

   (a) CLPNA Policy: Documentation.

4. Ms. Ejelonu shall complete, at her own cost, the following remedial education. If any of the required remedial education becomes unavailable, then Ms. Ejelonu shall request, in writing, to be assigned an alternative education **prior to the deadline**. The Complaints Officer shall, in her sole discretion, reassign the education. Ms. Ejelonu will be notified by the Complaints Officer, in writing, advising of the new education required. Ms. Ejelonu shall provide the Complaints Officer with certificates confirming successful completion of all required education within **8 months** after the date of the Decision:

   (a) CLPNA Course: Resilience in Nursing;

   (b) MacEwan University's Medication Management Course (NURS 0161); and

   (c) MacEwan University's Documentation in Nursing Course (NURS 0162).

5. The sanctions set out above at paragraphs 2 to 4 will appear as conditions on Ms. Ejelonu's practice permit and the Public Registry subject to the following:

   (a) The requirement to complete the remedial education and readings outlined at paragraphs 3 to 4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Ejelonu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

      i. Readings;

      ii. Resilience in Nursing Course;

iii. Medication Management Course;

iv. Documentation in Nursing Course; and

(b) The requirement to pay costs and fine will appear as "Conduct Cost/Fines" on Ms. Ejelonu's practice permit and the Public Registry until all costs have been paid in full as set out above at paragraph 2.

6. According to the CLPNA's Regulations and Bylaws, Ms. Ejelonu shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current email address and current employment information. Ms. Ejelonu will keep her contact information current with the CLPNA on an ongoing basis.

7. Should Ms. Ejelonu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.

8. Should Ms. Ejelonu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

   (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

   (b) Treat Ms. Ejelonu's non-compliance as information for a complaint under s. 56 of the Act; or

   (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Ejelonu's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

Legal Counsel for the Complaints Officer submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may

significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Ejelonu and the Complaints Officer.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Nnenna Ejelonu has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

- **The nature and gravity of the proven allegations:** This is a significant factor as there are eleven (11) allegations that occurred between May 2022 and June 2022. These allegations deal with monitoring, documentation, and assessments of clients which are core competencies of what are expected of an LPN. Ms. Ejelonu failed to adhere to Policies and Procedures in respect to Personal Protective Equipment which would prevent the spread of diseases not only to herself, her colleagues, but also to other patients that were in her care within the Facility. Ms. Ejelonu failed to foster respectful or collaborative relationships with her colleagues which is essential in a health care setting as patients rely

on that the Health Care professional who is taking care of them is going to communicate with other Health Care professionals regarding their care.

- **The age and experience of the investigated member**: Ms. Ejelonu was initially registered with the CLPNA on September 13, 2013. Ms. Ejelonu began working at the Facility in May 2022. At the time of the allegations Ms. Ejelonu was an LPN in Alberta for approximately 8 years.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Ms. Ejelonu has some previous complaints however they were not presented to the Hearing Tribunal and was a neutral factor.

- **The age and mental condition of the victim, if any:** The Hearing Tribunal was not made aware of the age and mental condition of any of the patients in this regard. However, the Facility is an inpatient care center that provides acute psychiatric care for seniors.

- **The number of times the offending conduct was proven to have occurred:** There were 11 allegations brought against Ms. Ejelonu which took place between May 2022 and June 2022.

- **The role of the investigated member in acknowledging what occurred:** Ms. Ejelonu has acknowledged her conduct and that this resulted in unprofessional conduct and has taken responsibility for her actions. Ms. Ejelonu cooperated with the CLPNA and her cooperation was a mitigating circumstance that the Hearing Tribunal did consider.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Ms. Ejelonu was terminated from her position while under probation at the Facility on June 22, 2022, as a result of multiple medication administration and documentation errors as well as not communicating professionally and refusing to assist with patient care.

- **The impact of the incident(s) on the victim:** The Hearing Tribunal was not made aware of any impact because of these allegations. There was a potential for harm to the patients because of Ms. Ejelonu's actions; however, the Hearing Tribunal was not made aware of any.

- **The presence or absence of any mitigating circumstances:** The Hearing Tribunal was not made aware of any mitigating circumstances.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** There is a need to impose a sanction that deters Ms. Ejelonu from repeating this conduct as well as a sanction that would deter other LPNs from engaging in similar conduct. The sanctions that are ordered should send a message

to both Ms. Ejelonu as well as other LPNs to state that this type of conduct will not be tolerated by the CLPNA. The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the CLPNA Code of Ethics and CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

- **The need to maintain the public's confidence in the integrity of the profession:** The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches of the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

- **The range of sentences in other similar cases:** The Hearing Tribunal was made aware of other CLPNA hearings which dealt with similar matters and those Hearings were Anayo Akabogu in 2019 and Heather Taylor in 2020. Akabogu dealt with medication errors and the failure to document. Taylor dealt with failure to document assessments of patients. These hearings were referred to in reference to the costs that were put forward in the Joint Submission on Sanction which are similar regarding Ms. Ejelonu.

It is important for the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Ejelonu shall pay 25% of the costs of the investigation and hearing to a maximum of $3,100.00 to be paid in full within **36 months** of the date when Ms. Ejelonu is provided with a letter advising her of the total investigation and hearing costs.

3. Ms. Ejelonu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer. Ms. Ejelonu shall provide the Complaints Officer a signed declaration attesting she has read the documents within **4 months** of the Decision:

    (a) CLPNA Policy: Documentation.

4. Ms. Ejelonu shall complete, at her own cost, the following remedial education. If any of the required remedial education becomes unavailable, then Ms. Ejelonu shall request, in writing, to be assigned an alternative education **prior to the deadline**. The Complaints Officer shall, in her sole discretion, reassign the education. Ms. Ejelonu will be notified by the Complaints Officer, in writing, advising of the new education required. Ms. Ejelonu shall provide the Complaints Officer with certificates confirming successful completion of all required education within **8 months** after the date of the Decision:

    (a) CLPNA Course: Resilience in Nursing;

    (b) MacEwan University's Medication Management Course (NURS 0161); and

    (c) MacEwan University's Documentation in Nursing Course (NURS 0162).

5. The sanctions set out above at paragraphs 2 to 4 will appear as conditions on Ms. Ejelonu's practice permit and the Public Registry subject to the following:

    (a) The requirement to complete the remedial education and readings outlined at paragraphs 3 to 4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Ejelonu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

        i. Readings;

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(b) The requirement to pay costs and fine will appear as "Conduct Cost/Fines" on Ms. Ejelonu's practice permit and the Public Registry until all costs have been paid in full as set out above at paragraph 2.

6. According to the CLPNA's Regulations and Bylaws, Nnenna Ejelonu shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current email address and current employment information. Nnenna Ejelonu will keep her contact information current with the CLPNA on an ongoing basis.

7. Should Nnenna Ejelonu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.

8. Should Nnenna Ejelonu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

   (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

   (b) Treat Ms. Ejelonu's non-compliance as information for a complaint under s. 56 of the Act; or

   (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Ejelonu's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

The Hearing Tribunal believes these orders adequately balance the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a),(b) and 87(2) of the Act, the Investigated Member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 1st DAY OF MAY 2024 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal