

**IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE  
CONDUCT OF CRISTINA DRAGHICI, LPN #28648, WHILE A MEMBER OF THE COLLEGE OF  
LICENSED PRACTICAL NURSES OF ALBERTA**

**DECISION OF THE HEARING TRIBUNAL**

**(1) Hearing**

The Hearing was conducted at St Albert Inn & Suites in St. Albert, Alberta on March 13 - 16, 2023 with the following individuals present:

**Hearing Tribunal:**

Kelly Annesty, Licensed Practical Nurse (“LPN”), Chairperson  
Michelle Stolz, LPN  
James Lees, Public Member  
Vincent Paniak, Public Member

**Independent Legal Counsel for the Hearing Tribunal:**

Heidi Besuijen

**Staff:**

Caitlyn Field, Legal Counsel for the Complaints Director, CLPNA  
Gregory Sim, Legal Counsel for the Complaints Director, CLPNA  
Susan Blatz, Complaints Officer, CLPNA

**Investigated Member:**

Cristina Draghici, (“Ms. Draghici” or “Investigated Member”) LPN  
Simon Renouf, Legal Counsel for the 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.

### **(3) Background**

Ms. Draghici was an LPN within the meaning of the *Health Professions Act* (“the Act”) at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Draghici was initially licensed as an LPN in Alberta on April 18, 2006.

The CLPNA received a complaint dated July 8, 2020 (the “Complaint”), from Ms. Leah Posteraro, Site Manager at Wedman House and Village of the Good Samaritan Society (the “Facility”) in Edmonton, Alberta pursuant to s. 57 of the Act. The Complaint stated that Ms. Christina Draghici, LPN, received a one-day paid suspension for unprofessional comments made to colleagues and arguing with a resident’s daughter.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, Complaints Director for the CLPNA (the “Complaints Director”) appointed Katie Emter, Investigator for CLPNA (the “Investigator”) to investigate the complaint. Ms. Draghici received notice of the complaint and the investigation by letter dated July 10, 2020.

On October 26, 2020, the Investigator concluded the investigation and submitted the investigation report to the Complaints Director.

After reviewing the Investigation Report, the Complaints Director determined there was sufficient evidence the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act.

Ms. Draghici received notice the matter was referred to a hearing, as well as a copy of the Investigation Report and Statement of Allegations under cover of letter dated March 10, 2021.

### **(4) Allegations**

At the start of the hearing, counsel for the Complaints Officer advised that certain of the allegations were being withdrawn. An Amended Statement of Allegations was submitted to the Hearing Tribunal.

The Allegations in the Amended Statement of Allegations are:

“It is alleged that CRISTINA DRAGHICI, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about 2020, while employed as an LPN at Wedman and Village, failed to foster a respectful or collaborative relationship with one or more of her co-workers: L.P., D.S., E.C., P.B., S.P., B.D., M.I., and/or M.S. particulars of which include:

- a) On or about April 22, 2020, spoke in a raised voice to her manager, L.P.;
  - b) On or about April 22, 2020, used inappropriate language by telling her manager L.P. that she was a “bad manager” and “let bullshit happen all the time”, or words to that effect;
  - c) On or about April 22, 2020, criticized the conduct of her colleagues B.D. and/or M.I. in front of a client;
  - d) On or about May 16, 2020, refused to provide assistance to her colleagues D.S. and E.C. when they asked her to provide assistance and complete a post-fall assessment of client L.P.;
  - e) On or about May 16, 2020, spoke in a raised voice to her colleague, D.S., in the presence of other staff;
  - f) On or about June 14, 2020, spoke in a raised voice and/or criticized her colleague S.P. while S.P. performed her duties;
  - g) On or about June 14, 2020, spoke to her colleague S.P. in a rude and disrespectful manner by saying words to the effect that S.P. was “unprofessional” and that “enough is enough” in a raised voice;
  - h) On or about June 14, 2020, interfered with the performance of her colleague S.P.’s duties by refusing to allow S.P. to sign the medication administration record (MAR) following the medication count and/or refusing to give S.P. keys to the medication administration room so that S.P. could obtain medication for a client;
  - i) Communicated with her co-workers on a routine basis in an inappropriate manner causing her co-workers’ distress.
2. On or about May 12, 2020, engaged in inappropriate behavior in relation to her interactions with client N.B. and N.B.’s daughter, particulars of which include:
    - a) Spoke in a raised voice to client N.B.’s daughter, D.C.;
    - b) refused to apologize to N.B. or D.C. for speaking in a raised voice;
    - c) closed a door to the facility in D.C.’s face;
    - d) told D.C. that she needed to leave the facility in a rude and aggressive manner.
  3. On or about May 16, 2020 failed to provide care to client L.P. by refusing to perform a post-fall assessment as required.
  4. On or about June 13, 2020 inappropriately instructed D.S., who was a Health Care Aide, to administer antibiotic eye drops and a tablet of hydromorphone to client J.C. which fell outside of D.S.’s scope of practice.
  5. On or about 2019 to 2020, breached confidentiality and privacy by engaging in one or more of the following:
    - a) accessing her manager L.P.’s immunization record;

- b) disclosing L.P.'s date of birth to her colleague M.S. without authorization or justification.”

**(5) Exhibits**

The following exhibits were entered at the hearing:

- Exhibit #1: Proposed Book of Exhibits – Complaints Officer  
Exhibit #2: Agreed Statement of Facts

**(6) Witnesses**

The following individuals were called as witnesses in the hearing:

Dolores Serofina  
Estrella Carreon  
Sabina Pokhrel  
Patricia Bagot  
Brandy Denny  
Leah Posteraro  
Diane Cabush  
Maureen Smith  
Cristina Draghici

The following is a summary of the evidence given by each witness:

**Dolores Serofina**

Dolores Serofina has been a Health Care Aide (HCA) since 2007. Ms. Serofina has worked at the Facility since 2007. Ms. Serofina typically worked the evening shift which was from 1500 hours to 2300 hours.

Ms. Serofina stated that she knew Ms. Draghici as they worked together at Wedman House. There are two buildings at the Facility, one of which was Wedman House and the other one is called Village.

The Village sometimes was also referred to as the Cottage by the staff. The Village is a locked and secured dementia unit and there is not always an LPN on shift there. Wedman House always has an LPN on shift.

Wedman House is the main building at the Facility and the residents who live there have greater cognitive function. The residents have their own suites. Wedman House is where staff would pick up supplies or pick up food. Residents could go there for recreation and to get their hair done.

Ms. Posteraro's office was located in Wedman House. The Facility houses 60 residents total between the two areas.

Ms. Draghici worked the day shift and Ms. Serofina worked the evening shift which was from 1500 - 2300 hours and Ms. Draghici typically worked from 0700 - 1900 hours and their shifts overlapped from 1500 hours to 1900 hours.

Ms. Serofina stated that on May 16, 2020, she started work at 1500 hours at Wedman House. Ms. Serofina stated that she provided care to resident LP around 1850 hours and that when she entered LP's room, she saw LP in the bathroom on the floor in a kneeling position and the bathroom was full of bowel movement. Ms. Serofina said that it was an extra-large bowel movement as LP had three doses of lactulose. Ms. Serofina stated that in response to finding LP like this, she was trying to assist in cleaning LP up but was not able to as LP was slipping in the bowel movement.

Ms. Serofina described that LP had lactulose as it was given if someone has not had a bowel movement in three or four days. Ms. Serofina stated that it was Ms. Draghici who gave the lactulose to LP.

Ms. Serofina stated that she called for help from the LPN to help clean up resident LP. Ms. Serofina called for help and then left the resident's room and saw that the med room was open, and that Ms. Draghici was inside the med room. Ms. Serofina told Ms. Draghici that she required help with LP. Ms. Serofina testified that she informed Ms. Draghici that LP was on the floor and that Ms. Draghici responded by saying, "No, my time is up. They don't pay my overtime so call your coworker." Ms. Serofina stated that Ms. Draghici was yelling when she responded to Ms. Serofina. Ms. Serofina did not respond to Ms. Draghici. At that time Ms. Serofina's coworker, Ms. Carreon, was passing by with a tray of snacks so Ms. Serofina motioned to Ms. Carreon to go see LP to which she did. Ms. Serofina stated that Ms. Carreon went into LP's room right away and that Ms. Carreon called Ms. Draghici at 1900 hours and that Ms. Draghici answered the phone and refused to go to LP's room. Ms. Carreon said there needed to be a fall assessment as LP was found on his knees. Ms. Carreon left LP's room and went to get a lift and a sling to help assist in getting LP off the floor. Ms. Carreon left LP's room and saw the night staff LPN, Patricia Bagot and asked her for help and that Ms. Bagot did go to LP's room to help and helped clean up LP and then performed an assessment on LP.

Ms. Serofina stated that she had an earlier conversation with Ms. Draghici about the lactulose medication and that Ms. Draghici mentioned giving lactulose to LP. Ms. Serofina stated she did not express any concern over this as it was not a part of the Health Care Aide's job. Ms. Serofina stated that Ms. Draghici said to keep an eye on LP.

When Ms. Serofina had asked for help, she said Ms. Draghici was in the med room with another LPN, Jasmine Kaur, who was present as Ms. Draghici was on modified duties. Ms. Serofina stated that she did not enter the medication room and that she was just outside of the medication room

by the laundry room and that was where she asked Ms. Carreon for help. Ms. Serofina stated that when she went to the medication room, Ms. Draghici stated that she would not help as her time was up and they would not pay her overtime. Ms. Serofina said that Ms. Bagot was not in the medication room at this time and that Ms. Bagot was in the LPN room as Ms. Bagot was receiving report.

Ms. Serofina stated that Ms. Draghici approached her two days later, which was their next scheduled shift regarding LP and Ms. Draghici told Ms. Serofina to be honest and to tell the truth about what happened. Ms. Draghici followed Ms. Serofina after report and Ms. Serofina stated that she felt that Ms. Draghici was trying to provoke her, so Ms. Serofina did not respond and that she reported Ms. Draghici to the manager.

Ms. Serofina was asked about the phone system within the Facility, called TeleCare. Ms. Serofina stated that the TeleCare system records when a call is made or when a resident calls. On May 16, 2020, there was no call made from LP and Ms. Serofina did not press the call button in LP's room. Ms. Serofina stated that she knew at that time Ms. Draghici was called; both her and Ms. Carreon looked up on the phone what time Ms. Carreon called Ms. Draghici. Ms. Serofina was not able to hear the conversation that took place between Ms. Carreon and Ms. Draghici and that the information that Ms. Serofina received was second hand.

Ms. Serofina testified that she did work on June 13, 2020, with Ms. Draghici and that Ms. Serofina provided care to resident JC. Ms. Serofina stated that JC receives regular eye drops every two hours and that Ms. Serofina went in to give JC their eye drops. Ms. Serofina said the regular eye drops were Systane and that JC received them once in the morning, at lunch, and then at 4:00, 8:00 and 21:00. When Ms. Serofina went to administer the eye drops to JC, JC informed Ms. Serofina that there were antibiotic eye drops and narcotics left on the side table. Ms. Serofina stated that Ms. Draghici left the medication in the room. Ms. Serofina stated that the narcotics that were left on the table were Hydromorphone. HCAs receive additional training to be able to administer eye drops for residents; however, they are not allowed to administer antibiotic eye drops or narcotic medications. Ms. Serofina stated that she did not administer the antibiotic eye drops to JC. Ms. Serofina stated that she did mention to Ms. Draghici about the medication that was left on JC's table and that Ms. Draghici's response was that Ms. Serofina could give the medication and that Ms. Serofina did not administer the medication.

Ms. Serofina was asked if resident JC was their own decision maker for the purpose of taking medications to which Ms. Serofina responded that Ms. Serofina was not sure if JC was one of those residents. Ms. Serofina did state that narcotics cannot be left for a resident to take on their own.

Ms. Serofina then testified that Ms. Draghici was not a good team worker in that Ms. Draghici was demanding and would not help the HCAs. Ms. Serofina stated that Ms. Draghici had spoken to her in a raised voice. Ms. Serofina stated that she was scared of Ms. Draghici in that Ms. Draghici made her feel nervous and not safe. Ms. Serofina stated that the working relationship

was that the HCAs have their own routine and so did the LPN. The HCA would call the LPN if there was something unusual with the resident or if something was wrong with the resident. The HCA would call the LPN if there was a fall or if it had to do with medications.

Ms. Serofina mentioned that she did not like Ms. Draghici and that Ms. Draghici made her feel scared and nervous. Ms. Serofina stated that she could not rely on Ms. Draghici. Ms. Serofina stated that she currently is no longer scared of Ms. Draghici as they are no longer working together. Ms. Serofina confirmed Ms. Draghici would occasionally bring baking in and share with the HCAs and that she had offered to drive Ms. Serofina to the airport and had driven her in the past.

Ms. Serofina was asked whether there had been a discussion about the lactulose administration earlier on the shift and whether she had expressed concern about that. She said all that happened was Ms. Draghici reported that the lactulose had been given but nothing more. She was firm on this point.

Ms. Serofina was directed to Tab 2 of Exhibit 1 on several occasions, which was Ms. Serofina's statement with respect to LP on May 16, 2020. Ms. Serofina stated that she gave this statement two days later to Ms. Posteraro and that Ms. Posteraro was the person who typed up the statement. Ms. Serofina did state that she read the statement once it was typed up but did not sign anything. Ms. Serofina also stated that she was interviewed by Katie Emter who was the investigator for the CLPNA via telephone.

### **Estrella Carreon**

Estrella Carreon was previously a midwife in the Philippines and has worked at the Facility since 1994 as an HCA. Ms. Carreon typically worked the evening shift which was from 1500 hours to 2300 hours. Ms. Carreon stated that she worked with Ms. Draghici as they worked together at Wedman House. Ms. Carreon worked from 1500 – 2315 hours and Ms. Draghici worked 0700 – 1900 hours and they regularly worked together.

Ms. Carreon stated that on May 16, 2020, she was coming out of the dining room, and she saw Ms. Serofina who said to her, "Come, I need help." Ms. Carreon went right away and when they entered the resident's room, Ms. Carreon saw that LP was kneeling on the floor and this was considered a fall. Ms. Carreon stated that she knew the time as she checked what time it was, and it was at 7:00 p.m. Ms. Carreon stated that Ms. Serofina entered LP's room first and Ms. Carreon followed her. Ms. Carreon stated that LP was kneeling between the sink and toilet in his washroom. Ms. Carreon saw that it was dirty and there was stool on the floor in the washroom. Ms. Carreon asked Ms. Serofina if she asked for help and Ms. Serofina told her that no one was coming. Then Ms. Carreon called the LPN to state that they needed help. If the resident is on the floor the HCA does not touch the resident as the LPN is required to do an assessment before they move the resident. Ms. Carreon informed Ms. Serofina that they were not moving LP and that they were going to wait for the LPN. It was at that point that Ms. Carreon went to get the lift and

she went to the laundry room where the sling was kept and that was when she saw Ms. Bagot. Ms. Bagot took the sling and went to LP's room and Ms. Carreon brought the lift. Ms. Bagot assessed the situation and then they placed LP in the sling and transferred LP to bed. Then Ms. Carreon left the room. Ms. Carreon was asked if there was an emergency bell in LP's washroom which she stated there is a TeleCare button and that she could not remember if LP was wearing an emergency button on a lanyard.

Ms. Carreon stated that when she called the LPN, she checked the phone, and it was 7:00 and that Ms. Draghici answered, and Ms. Draghici stated she was giving report.

Ms. Carreon was directed to Tab 4 of Exhibit 1 and stated that was her statement and that it was written by herself, and that Ms. Posteraro assisted her with writing the statement.

Ms. Carreon was also directed to Tab 5 of Exhibit 1 and stated that it was the email that Ms. Carreon sent to Katie Emter who was the investigator for CLPNA.

Ms. Carreon stated that she liked to work with Ms. Draghici, but that Ms. Draghici was not a team player. Ms. Carreon stated that when she asked Ms. Draghici for help that Ms. Draghici would state that she was busy.

Ms. Carreon stated that if it is believed that a resident has fallen that Good Samaritan has a protocol in place in that someone should stay with the resident and there were two HCAs with resident LP and that was why Ms. Carreon went out to get some equipment.

### **Sabina Pokhrel**

Sabina Pokhrel became an LPN in 2012, and it was at that time that she began working at Wedman House and Village. Ms. Pokhrel has an RN degree from Nepal and took the international LPN program at Norquest College in 2012. Ms. Pokhrel initially became registered with the CLPNA in 2012. Ms. Pokhrel's typical shift was from 1900 hours until 0700 hours and she would pick up a day shift from time to time.

Ms. Pokhrel stated that she knew Ms. Draghici as they both worked in the same Facility and that Ms. Pokhrel typically worked as a full-time night LPN, which meant that her shifts were from 7:00 p.m. to 7:00 a.m. Ms. Pokhrel stated that when they were short-staffed that she would pick up shifts in the morning or on her day off. Ms. Pokhrel stated that she was on WCB at one point and during that time she was working a day shift.

Ms. Pokhrel was asked about Tab 6 in Exhibit 1. Ms. Pokhrel stated that was her signature at the end of the document. The document was written on June 24, 2020, and it was emailed to Leah Posteraro.

Ms. Pokhrel stated that she worked at the Facility on June 24, 2020, and that she was working a day shift which started at 7:00 a.m. When Ms. Pokhrel arrived for her shift, she was informed by Ms. Draghici to help an HCA named Dolores, and that Dolores would be arriving at 12:15. Ms. Pokhrel took charge of the cottage while Ms. Draghici took charge of the house. At approximately 9:30 a.m., they both took a coffee break and during that break Ms. Draghici told Ms. Pokhrel that Ms. Draghici had to return for a night shift and that she had already worked 24 hours, so Ms. Draghici was going to leave at 10:00 a.m.

It was at this point that Ms. Pokhrel asked Ms. Draghici to go and do the narcotic count. After the narcotic count was done Ms. Pokhrel asked for the key and phone from Ms. Draghici and Ms. Pokhrel took the plastic cover off the phone to disinfect the phone. When Ms. Pokhrel took the cover off the phone Ms. Draghici hit Ms. Pokhrel on the hand and said, "Don't do that, you can damage the phone." Ms. Pokhrel told Ms. Draghici that with the cover on the phone she has issues hearing properly, and without the cover the phone fits properly into her pocket. Ms. Pokhrel stated that Ms. Draghici was not letting her sanitize the phone or remove the cover from it.

Ms. Pokhrel stated that Ms. Draghici did not like it when Ms. Pokhrel answered Ms. Draghici back and that Ms. Draghici would become angry and would say things like "Enough is enough, you are too much, you are not listening". Ms. Draghici told Ms. Pokhrel that she was not professional and that she was going to tell Ms. Posteraro. Ms. Pokhrel stated that she felt that Ms. Draghici was trying to make her feel low, stressing her out and was trying to point out that she was unprofessional. Ms. Pokhrel stated that Ms. Draghici was trying to break her and to break her confidence. Ms. Draghici was speaking in an angry tone to Ms. Pokhrel. This interaction made Ms. Pokhrel feel bad and humiliated.

When they were doing the count Ms. Pokhrel could tell that Ms. Draghici was really mad with her and that Ms. Draghici was flipping pages angrily. Ms. Pokhrel stated that the narcotic count is done at the beginning of each shift, as well as at the end of each shift or whenever one of the LPNs would be leaving the floor. Then, once the narcotic count is done, they put everything back in the locked narcotic cupboard. The narcotics were kept in the med room which has a lock on the door and then the narcotics were kept in a narcotic locker.

In the nursing room, Ms. Pokhrel was sitting in a wheel chair and she was close to the cupboard where binders are kept for the residents. Ms. Pokhrel was wheeling herself back after grabbing a resident's chart and Ms. Draghici was behind Ms. Pokhrel and Ms. Pokhrel accidentally banged Ms. Draghici with the chair. Ms. Pokhrel stated that it was not a hard hit and that she wasn't sure if she had contacted Ms. Draghici. Ms. Pokhrel also stated that if she did make contact with Ms. Draghici that it would have been in the leg area and nowhere else. Then suddenly Ms. Draghici was screaming, and Ms. Pokhrel told Ms. Draghici that she was sorry as she did not realize that Ms. Draghici was there. This made Ms. Draghici mad again. Ms. Draghici then started to yell at Ms. Pokhrel and told her not to be sitting in the chair and to get up from the chair to grab the chart. Ms. Pokhrel tried to explain what happened and Ms. Draghici started to yell and tell Ms.

Pokhrel that she is a fighter and enough is enough. Further, Ms. Draghici's tone was rude, and she was angrily looking at Ms. Pokhrel. Then Ms. Draghici grabbed her bag and stated that she was leaving. Ms. Pokhrel tried to remain professional and said that she would see Ms. Draghici in the evening. It was at this point that Ms. Draghici stated that she might not come.

On June 14, 2020, Ms. Pokhrel provided care to resident JC after Ms. Draghici's shift ended. Ms. Pokhrel testified that JC told her that Ms. Draghici asked an HCA to give JC, a narcotic and antibiotic eye drops.

Ms. Draghici did return for her shift that evening and arrived at 6:45 p.m. When Ms. Draghici arrived, an HCA came in at the same time and told Ms. Pokhrel that a resident wanted Baclofen and when she returned, Ms. Draghici was waiting for her in the nursing office for report. Ms. Pokhrel went to give the PRN medication and then when she returned, she gave report to Ms. Draghici and then they did the narcotic count. Then Ms. Pokhrel handed the keys and phone to Ms. Draghici and the door closed. It was at this point that Ms. Pokhrel realized that she did not write the PRN order on the MAR for the Baclofen that she gave. Ms. Pokhrel then asked Ms. Draghici for the key to open the room and Ms. Draghici said, "No, you are done, and you are not allowed to go in the med room anymore." Ms. Pokhrel informed Ms. Draghici that she had to write down the PRN order for Baclofen and the MAR was inside. Ms. Draghici refused to open the door or give Ms. Pokhrel the key. Then Ms. Pokhrel went to the nursing office and obtained the other key as in the daytime there are two LPNs so there are two sets of keys. Ms. Pokhrel then opened the door to the med room and left the key hanging in the door and filled out the MAR. Ms. Draghici chased Ms. Pokhrel from the med room and then in an angry tone said, "Remove that key from the door" and Ms. Draghici put the key in her pocket, stared at Ms. Pokhrel and left. Ms. Draghici was not allowing Ms. Pokhrel to stay in the building and that caused Ms. Pokhrel to be stressed so Ms. Pokhrel went home. When Ms. Pokhrel got home, she was not feeling well at all. Then the next day Ms. Pokhrel showed up for her shift and she made a late entry for her documentation of the medication.

When Ms. Draghici returned, Ms. Pokhrel did speak to Ms. Draghici about JC's medication, which was a high-alert medication, was signed for by Ms. Draghici, but the medication was not given. Ms. Pokhrel also informed Ms. Draghici that JC told Ms. Pokhrel that for JC's narcotic and eye drops to be given by the HCA, Ms. Draghici's response was, "Yes I did, I was busy, so I told her, and you can go tell Leah about that".

Ms. Pokhrel testified that it was stressful to work with Ms. Draghici and that Ms. Draghici was not a good listener and not a good team worker. Ms. Pokhrel stated that working with Ms. Draghici made her feel stressed.

Ms. Pokhrel also testified that in respect to the issue with resident JC that JC is a resident who likes to talk about the staff including Ms. Pokhrel and that she lied to cause trouble for the staff. JC would comment a lot about the staff and would report things to Ms. Posteraro about the staff.

JC would report accurate information about the staff, but she would pull everyone into her things.

Ms. Pokhrel did ask Ms. Draghici if JC had taken the hydromorphone on her own and Ms. Draghici told Ms. Pokhrel that she was busy, so Ms. Draghici told the HCA to do it.

### **Patricia Bagot**

Patricia Bagot attended Lethbridge College right after finishing Grade 12 and completed her LPN diploma in 2015. Ms. Bagot registered with the CLPNA in 2015. Ms. Bagot started working as an LPN with Good Samaritan in October 2015 part-time in one of the other locations in Mill Woods Care Centre and then got hired as a full-time night LPN at the Facility in December 2018 and is currently employed there.

Ms. Bagot knew Ms. Draghici as they initially worked together at Mill Woods Care Centre when Ms. Bagot had her first orientation shift there but did not see Ms. Draghici again after that. Then when Ms. Bagot applied at the Facility and Ms. Bagot went for an interview, she was happy to see the friendly face of Ms. Draghici, who gave Ms. Bagot some pointers for her interview. Then once Ms. Bagot was hired as the night LPN, Ms. Draghici was the day LPN. Ms. Bagot worked from 7:00 p.m. to 7:00 a.m. and Ms. Draghici worked from 7:00 a.m. to 7:00 p.m. and they both had the same schedule.

Ms. Bagot was asked to refer to Tab 10 in Exhibit 1, which was the email that Ms. Bagot sent to Ms. Posteraro regarding May 16, 2020.

Ms. Bagot testified that she did start work at 7:00 p.m. on May 16, 2020, and that she arrived a few minutes prior to 7:00 p.m. Ms. Bagot testified that when she arrived at the Facility, she went inside the nursing office and found Ms. Draghici and Ms. Kaur in the office. Ms. Bagot testified that she usually would bring her bag with her into the office so that way they could do report.

Ms. Bagot testified that Ms. Draghici stated that everybody was okay and then Ms. Draghici continued with saying that the girls were calling her just to help to clean up a bowel movement with a resident. Ms. Bagot stated that Ms. Draghici was referring to the two-evening staff of Ms. Serofina and Ms. Carreon. Ms. Bagot stated that Ms. Draghici was complaining about them needing help cleaning up the resident's bowel movement. Then they proceeded to go into the medication room, and they did the narcotic count. Ms. Bagot asked Ms. Draghici if the resident was okay, and Ms. Draghici stated to her, "I don't know why they need three people to clean up his BM". Ms. Bagot then stated that she would check up on it after they did the narcotic count.

Ms. Bagot testified that Ms. Draghici answered the phone at 1900 hours in a loud, stern tone. Ms. Bagot stated she knew the time of the call as she looked up the phone log within the TeleCare system. Ms. Draghici stated that she would not be paid overtime for this and that she would pass the information on to Ms. Bagot.

Ms. Bagot testified that it took no more than five minutes to do the narcotic count and when they were done that Ms. Bagot saw Ms. Carreon approaching and Ms. Carreon appeared to be in a panic. Ms. Carreon stated to Ms. Bagot, "Come, Patricia, you have to help me". Ms. Bagot stated that her first instinct was to run with Ms. Carreon. Ms. Carreon told Ms. Bagot that LP was on the floor and that they were waiting for Ms. Draghici to come but Ms. Draghici did not come. Ms. Bagot then grabbed the neurovital machine as they were both approaching LP's room. When Ms. Bagot entered LP's room, she found Ms. Serofina inside the washroom attending to LP while LP was kneeling on the washroom floor. Ms. Serofina then proceeded to tell Ms. Bagot that she was attending to LP around 10 minutes before 7 and that LP at the time looked like LP was going to fall and that was why Ms. Serofina called for help. Ms. Bagot stated that LP was in the washroom and that LP was kneeling on the floor in between the toilet and the sink. LP had their left hand onto the toilet seat and the right hand was holding onto the sink. LP was visibly shaking, and that Ms. Bagot tried to calm LP down. Ms. Bagot noticed that there were no visible injuries at that time. Ms. Bagot then informed LP that they were going to help LP, lower LP down to the floor and then they transferred LP using the mechanical lift.

Ms. Bagot stated that as she assessed LP, Ms. Carreon came with the mechanical lift and sling and that was when the three of them lowered LP to the floor and cleaned LP up a little more. Once LP was in the lift, they transferred LP to the bed. Ms. Bagot noted that there was redness on LP's right knee.

Ms. Bagot was then directed to Tab 11 of Exhibit 1, which was Ms. Bagot's progress note of the fall. Ms. Bagot stated that when she assessed LP, she wrote everything down on a piece of paper as she was not able to properly document her assessment until 2159 hours due to her other responsibilities. Ms. Bagot documented that the resident's extremities appeared swollen and, as per LP's daughter, bruising was there since a visit that afternoon and not new. Ms. Bagot did contact LP's family as well as LP's doctor, who she contacted via fax.

Ms. Bagot was then referred to Tab 12 of Exhibit 1, which was her progress entry for 6:00. Ms. Bagot stated that she monitored resident LP every 30 minutes throughout the night as before the fall LP was getting up often throughout the night. So, when Ms. Bagot worked nights, she felt like she had to check on them more often, just to ensure their safety. Also, because LP had fallen at the beginning of her shift Ms. Bagot wanted to monitor LP more often just in case there were any injuries that would pop up after the fall.

Ms. Bagot was then referred to Tab 10 of Exhibit 1. Ms. Bagot stated in this document that "I know Christina will be mad at me again for telling you about this incident, but what's new?". Ms. Bagot testified that ever since she started working at the Facility, Ms. Draghici had always told Ms. Bagot how incompetent she was and told Ms. Bagot that she was a little girl and a young kid. Ms. Draghici would tell Ms. Bagot how Ms. Posteraro was disappointed for hiring Ms. Bagot and how the doctor was mad at Ms. Bagot for calling the doctor in the middle of the night to clarify

an order. Ms. Draghici would also tell Ms. Bagot that Ms. Bagot would lose her license for doing these things and how she could lose her job for doing this and those types of things.

Ms. Bagot stated that she tried to take what Ms. Draghici would say as constructive criticism and that she could better herself. This made Ms. Bagot cautious of the things that she was doing at work. Ms. Bagot stated that when it comes to the residents' safety and compromising their safety and being neglected, that is where Ms. Bagot draws the line as it is not just Ms. Bagot who is affected, it is the residents' care as well.

Ms. Bagot stated that Ms. Draghici was very nice to Ms. Bagot when she first started at the Facility and mother-like. Ms. Bagot stated that Ms. Draghici would tell Ms. Bagot how to do certain things the way the Facility would do them rather than how they were done at Mill Woods. Ms. Bagot stated that once you got on Ms. Draghici's bad side or once if you notice something that Ms. Draghici did not do and you tried to correct her for it or if you tried to remind her of it then you would be on Ms. Draghici's bad side. One time Ms. Bagot noticed that Ms. Draghici did not give a high-alert medication to one of the residents and when Ms. Bagot saw Ms. Draghici, she asked Ms. Bagot why Ms. Bagot was trying to make Ms. Draghici look bad to other people. Ms. Draghici would then look through Ms. Bagot's documentation and point out what Ms. Bagot did not do or did incorrectly.

Ms. Bagot was then asked to go to Tab 13 in Exhibit 1 to where she was interviewed by Ms. Posteraro on June 11, 2020. Ms. Bagot stated that she did not write this document. The document was the result of an investigation meeting that was held. Ms. Bagot stated in the document, "She has told me many times I am incompetent. That I should not phone the Dr. for a refill. She said the resident should do it then the LPN should not do it 'cause they always want us to do it. Ms. Bagot stated that if a resident was independent and could make their decisions themselves, they could call their own doctor to ask for any prescription refills or for any medical needs that they have. One of the residents asked Ms. Bagot if Ms. Bagot would fax her doctor regarding a concern. So, Ms. Bagot faxed the doctor that night with the ask. Then when Ms. Bagot was giving report to Ms. Draghici the following morning, Ms. Draghici asked why Ms. Bagot did that because now the resident is going to ask all the LPNs to contact their doctor for them.

Ms. Bagot was then asked about when she stated in the investigation about her statement where Ms. Bagot stated, "Cristina's behavior towards me – it has taken a toll on my mental health since I started working at Wedman". Ms. Bagot stated that before she started working at the Facility, she was off of antidepressants and since Ms. Draghici started telling Ms. Bagot that she was incompetent that Ms. Bagot started to feel that she was incompetent, and that Ms. Bagot started second-guessing everything that she was doing. Ms. Bagot stated that she was to the point that she was not getting any sleep and then going to work. Ms. Bagot went to her doctor and was informed that her anxiety and depression was back and she was then placed back on her antidepressants.

Ms. Bagot was then asked to go to Tab 14 in Exhibit 1, which was the phone interview with Katie Emter. This was in regard to the May 16, 2020 allegation. Ms. Bagot stated that she informed Ms. Emter about the bullying that she endured from Ms. Draghici. Ms. Bagot stated that Ms. Draghici would tell her about all the mistakes that Ms. Bagot made, and that Ms. Bagot was going to lose her license for them. Ms. Draghici also would tell Ms. Bagot that Ms. Posteraro is disappointed with hiring Ms. Bagot. Ms. Bagot confirmed that Ms. Posteraro never expressed dissatisfaction with her practice as an LPN.

Ms. Bagot also stated that there were times when Ms. Draghici would take Ms. Bagot's lunch bag and that Ms. Draghici would go through Ms. Bagot's lunch bag and tell Ms. Bagot that everything in it was junk and that Ms. Bagot should be eating a salad. It got to the point that Ms. Bagot would leave her lunch bag in her vehicle. Then when Ms. Bagot knew that Ms. Draghici had left the building, Ms. Bagot would go and bring in her lunch to the building. Ms. Bagot stated in her statement that, "One time I came in and she did not look for the food in my lunch bag, but she hid it as I left the office to respond to an emergency". Ms. Bagot stated that on that shift she brought Subway, and she placed her lunch bag in the office and Ms. Bagot was surprised that Ms. Draghici did not look in her lunch bag that time and Ms. Bagot stated that she thought that Ms. Draghici was fine with Subway, instead of her regular rice as Ms. Draghici did not look in Ms. Bagot's lunch bag. Ms. Bagot then stated she got a telephone call from the Village, and she responded to the Village and when Ms. Bagot returned and went to get a drink, Ms. Bagot noticed that her food was gone from the table where she left it. Ms. Bagot looked for her food but was unable to find it. It was at this point that Ms. Bagot went to do the medication pass and when she returned, she looked in the office where she was not able to find her food, as Ms. Bagot searched, she found her food in a cabinet behind some binders. Then the following morning when Ms. Draghici came in for her shift, she asked Ms. Bagot if Ms. Bagot found her food. When Ms. Bagot asked Ms. Draghici why she hid her food Ms. Draghici responded because it was junk.

Ms. Bagot testified that Ms. Draghici's actions had an impact on Ms. Bagot in that Ms. Bagot was very anxious every time that she would go to work. Then sometimes when Ms. Bagot would go home, she would not be able to sleep. Ms. Bagot also stated that she was always sick due to anxiety.

Ms. Bagot said that she did report Ms. Draghici's conduct to Ms. Posteraro. Ms. Bagot also asked Ms. Posteraro if there was anything that Ms. Bagot could be doing better in her job or if she was causing any issues for Ms. Posteraro and Ms. Posteraro told Ms. Bagot that there were no issues.

Ms. Bagot also stated that prior to September 2019, she had a good relationship with Ms. Draghici and that Ms. Draghici did coach Ms. Bagot when she was interviewing for the full-time position. Ms. Bagot stated that she did value Ms. Draghici's input and the mentorship that she provided.

## **Brandy Denny**

Brandy Denny has been an HCA since she graduated from the Academy of Learning in Edmonton in 2010. Ms. Denny was hired at the Facility in 2011 when she was doing her work practicum there and is currently employed there.

Ms. Denny stated that she knew Ms. Draghici as she was an LPN at the Facility. Ms. Denny stated that she typically worked an 8:00 a.m. to 8:00 p.m. shift and that she typically worked in the Village and that she would go to Wedman house to pick up supplies which included to pick up food, drop off the food cart and sometimes drop off the residents for recreation. They were typically just in and out of Wedman house.

Ms. Denny stated that the manager's office is located at Wedman House on the left-hand side and that the front desk is located on the right-hand side.

Ms. Denny was directed to Tab 15 of Exhibit 1, and this is a document that Ms. Denny gave to Ms. Posteraro. This was in respect to what occurred on April 22, 2020. Ms. Denny stated that she arrived at 7:50 a.m. and when she arrived Ms. Draghici was at the front desk pointing at Minire, an HCA, talking loudly. Ms. Denny stated that Ms. Posteraro was walking in the area as well. Ms. Denny stated that Ms. Draghici's volume of her voice was much louder than it should have been in a health care setting. Ms. Denny stated that Ms. Draghici was telling Minire not to be talking about Ms. Draghici to other staff. Ms. Posteraro was asking Ms. Draghici to nicely stop. Once Ms. Posteraro asked Ms. Draghici to stop, then Ms. Draghici turned to Ms. Posteraro and began telling Ms. Posteraro that she was an awful manager and that everything that happened there was bullshit or something to that effect. Ms. Denny stated that there was a resident present when this occurred as well, and that the resident was close enough to hear what was happening as the resident was about two feet behind Ms. Draghici. Ms. Posteraro's response to Ms. Draghici was that she was asking Ms. Draghici to stop and to quiet down in a calm voice. Then Ms. Denny asked Ms. Draghici to stop as well. Then Ms. Denny heard Ms. Draghici say to Ms. Posteraro, "You're a horrible manager. You don't know what you're doing. It's all Bullshit". It was after this that Ms. Posteraro turned and walked towards the medication cart. Ms. Posteraro asked Ms. Draghici if she wanted to go home as Ms. Draghici was being insubordinate, to which Ms. Draghici stated that she did not want to go home. It was at this point that Ms. Denny left and went to finish her work.

Ms. Denny stated that her interactions with Ms. Draghici would be when Ms. Draghici would take over as the LPN in the Village on evenings and weekends as there was no other LPNs in the Village at those times. Ms. Denny stated that there was nothing bad between them other than one time they had an argument about not answering the telephone when Ms. Denny called Ms. Draghici when she had a resident who was choking; however, Ms. Draghici arrived quickly and saved the resident.

## Leah Posteraro

Leah Posteraro was trained as a system analyst, and she has a certificate in adult education from the University of Alberta. Later she became an LPN and graduated in May 2000 and was registered in December 2000. Ms. Posteraro was the manager at the Facility from 2017 until 2022; it was at this time that Ms. Posteraro left Facility.

Ms. Posteraro stated that there were a variety of residents at the Facility in that there were 30 residents Supported Living Level 4, which is one step under long-term care. Residents had varying needs and varying health conditions. There are also three dementia units separate from the House. There were 30 residents with dementia on these units.

Ms. Posteraro stated that she knew Ms. Draghici as she was an LPN at Wedman House.

Ms. Posteraro was directed to Exhibit 1 Tab 16. Ms. Posteraro stated that she wrote the document which was a complaint to the CLPNA submitted on July 8, 2020. Ms. Posteraro stated that there were a variety of investigations that were done and because of those investigations it was determined that Ms. Draghici was going against the residents' rights and responsibilities, Good Sam's mission, vision, values, and Code of Conduct. There is a handwritten note in the upper right-hand corner and that was the results and the outcome of the four investigations that were completed. As a result of the investigations, Ms. Draghici was given a one-day suspension.

Ms. Posteraro stated that one of the investigations was in respect to a gentleman who was in room 107 and had a fall. Another one of the investigations was that an LPN had submitted a memo or letter and it contained a concern about medication delivery. There was a confrontation with Ms. Sabina Pokhrel.

Ms. Posteraro then testified about how in the spring of 2020, Ms. Posteraro entered the staff room, and that Maureen Smith was sitting at the table on her break. Ms. Smith then mentioned to Ms. Posteraro that Ms. Smith knew Ms. Posteraro's birth date and how old Ms. Posteraro was. Ms. Posteraro then stated to Ms. Smith that it wasn't possible as no one knew her birth date. During this time Ms. Draghici entered the staff room as well. When Ms. Posteraro asked Ms. Smith how she knew her birthdate, Ms. Smith stated that Ms. Draghici told her. Ms. Draghici originally denied this and then once pressed by Ms. Smith, Ms. Draghici then said that she saw Ms. Posteraro's birth date on her AHS immunization form. She explained AHS would go to the Facility in the fall and do their immunizations for them. Ms. Posteraro stated that the immunization records were on her desk in a pile. Ms. Posteraro stated that once AHS completed the immunizations, they hand them over to her and that she would have the staff immunization records and the resident's immunization records would go to the LPNs so that way they could be documented in the health care record. It was suggested to Ms. Posteraro that the immunization records were kept in a binder in the nursing office, to which Ms. Posteraro denied this and stated they were kept in her office. Ms. Posteraro stated that they were kept on a desk along the back window of her office, and they were left there. The process was that once the manager received

the documents they would be scanned and sent to Human Resources then placed in a file folder. Then eventually they would be shredded. It was suggested to Ms. Posteraro that they were in a binder and that they were kept at the nurses' station at the Facility. Ms. Posteraro stated that only the residents' immunization records were kept in a binder.

Ms. Posteraro was asked if she had investigated this, which she stated that she did not, but she did notify her director as well as Human Resources. Ms. Posteraro also stated that she did not have their support and that she was not able to proceed with an investigation without their support and that her director and Human Resources were not interested in doing an investigation.

Ms. Posteraro stated that her birth date is a very private matter for her and that it always has been a very private matter and that she was not happy about it, which was why she reported it to her director and Human Resources.

Ms. Posteraro was then directed to Tab 17 of Exhibit 1, which is an Event Reporting System document for the Good Samaritan Society. This is in respect to the allegation dated April 22, 2020. Ms. Posteraro stated that she arrived for work at 7:45 a.m. and that it was the beginning of CMOH #6, which was when they were required to start checking everyone who was entering the building. Ms. Posteraro stated she entered the building and was putting everything down and then was going to screen the staff who were coming into work at 8:00 a.m. Before Ms. Posteraro finished collecting what she needed, Ms. Draghici was standing in the doorway of Ms. Posteraro's office and Minire was off to the left and Ms. Draghici motioned for Minire to come forward. It was at this point that Ms. Draghici was questioning Minire about why Minire was talking behind Ms. Draghici's back, which happened approximately two weeks prior. Minire appeared afraid and very upset. Ms. Posteraro then told Ms. Draghici that it wasn't the time to deal with this as Ms. Posteraro had to get ready to start screening the staff coming in. Ms. Draghici then left the doorway and Ms. Posteraro walked past her. Ms. Draghici then went behind the nursing station desk. Ms. Posteraro told Ms. Draghici to calm down and that it was not appropriate right there and then. There was a resident out by the desk at this point as well. There was also an HCA filling out her paperwork for COVID coming in for work at this time. It was at this point that Ms. Draghici shouted at Ms. Posteraro that she was a bad manager, and that Ms. Posteraro let a lot of bullshit happen in the place or something to that effect. At this point Ms. Posteraro then again told Ms. Draghici to calm down and that it was not the appropriate time to deal with the issue. Ms. Draghici appeared visibly upset. Then Ms. Posteraro said to Ms. Draghici that if she did not want to work there that Ms. Draghici could go and work somewhere else if she did not like working at the Facility. It was at this point that Ms. Draghici left.

Ms. Posteraro stated that the resident who was at the desk looked afraid.

Brandy Denny was the HCA who was coming into the building completing her screening.

Ms. Posteraro asked to describe her own tone of voice throughout the interaction. Ms. Posteraro said she did not raise her voice but maybe her tone had changed a little. Ms. Posteraro stated that Ms. Draghici initially was in a conversation mode and then Ms. Draghici became louder and louder and abrasive and that she has the type of voice that carries a distance.

Ms. Posteraro stated that an investigation was done because of this interaction and that Minire would not cooperate in the investigation, but that Ms. Draghici and Ms. Denny were interviewed. Ms. Posteraro stated that she did ask Ms. Denny to provide a written statement with respect to what had taken place.

Ms. Posteraro was then directed to Tab 19 of Exhibit 1, which is her documentation of an investigation meeting that took place. The interview took place on May 13, 2020. In the investigation, Ms. Posteraro stated that she told Ms. Draghici if you do not like to work here there are lots of jobs out there that you can apply to and that this was said to Ms. Draghici. Ms. Posteraro was asked what she meant by this comment in the investigation and responded that Ms. Draghici was not bound to the Facility.

Ms. Posteraro stated that she did receive an apology from Ms. Draghici much later after the date of the incident and that Ms. Draghici apologized in person in Ms. Posteraro's office.

Ms. Posteraro was then asked about May 12, 2020. Ms. Posteraro stated that dogs were welcomed within the Facility; they just could not run all over the building. Ms. Posteraro stated that she knew Diane Cabush and that Ms. Cabush would bring in her dog for visits. Prior to COVID-19, Ms. Cabush was more than welcome to bring her dog into the building and that it brought life into the Facility. It was a small dog about 3 pounds in size and that the dog fit in a purse. The dog looked like a little black bear cub and that the dog was very quiet and timid. Then during the COVID-19 pandemic the Facility's policy regarding dogs was suspended; towards the end of COVID-19 dogs were allowed back in.

Ms. Posteraro was asked to describe the entrance to the Facility and stated that there are two doors. The first door automatically opens and was unlocked. The second set of doors you had to gain entry through as that door was a secure door. During the COVID-19 pandemic, dogs were allowed in the area between the two sets of doors, but they were not allowed to go any further than that into the building. It was in this area where the masks, hand sanitizer and questionnaires for the family to fill out were kept. It was also the drop off spot and where things between the families and the staff were handed over. Residents' families would drop off items here as well as groceries, but they were not allowed in the Facility. Sometimes the families would drop items off in here or just inside the second secure door if it was open. This was the only area where supplies could be dropped off.

She related that during the pandemic the process of dropping items and groceries off was that if it was in a bag, the staff would wipe off the outside of the bag and if it was fruit or vegetables they would not be wiped down as they were expected to be washed. It would just be the outside

of the bag that would be wiped. Then if something was in a box an Oxivir wipe would have been used to wipe it down and then let to dry then brought into the Facility.

Ms. Posteraro explained that the process for gaining access to the secure door was that there was a doorbell on the outside and it would go to the TeleCare call system. The family would ring the doorbell and then the call would go through to either the LPN or HCA who could talk to the family through the phone.

She noted some of the families would visit with the resident while dropping off supplies by social distancing and they would remain six feet apart. This wasn't always successful, but it was attempted. There was also visiting through windows as it is a one-story building, and the families could be outside the window visiting the residents as the families were not allowed in the building.

Ms. Posteraro was then directed to Tab 22 of Exhibit 1, which was her interview with Diane Cabush that was conducted. Ms. Posteraro stated that she was the person who wrote this document, and that Ms. Posteraro had a phone conversation with Ms. Cabush.

Ms. Posteraro was directed to Tab 10 of Exhibit 1, being an email from Ms. Bagot dated May 17, 2020. This email brought Ms. Posteraro's attention to the incident relating to resident LP. Ms. Posteraro stated she did not ask Ms. Bagot to send this email to her. Ms. Posteraro stated Ms. Bagot brought forth some instances where she felt that Ms. Draghici was harsh to her, in that Ms. Draghici was pointing out a lot of better ways that Ms. Bagot could do things. Ms. Posteraro said that this is an expectation of her LPNs to help each other out. The LPNs had to be very strong to work in those buildings because they were in charge. Ms. Draghici could be harsh sometimes in pointing out things to Ms. Bagot.

When Ms. Posteraro said when she received the email, she forwarded it to the Human Resources Department who launched an investigation.

Ms. Posteraro explained it is an expectation at the Facility that when an LPN receives a request for help from an HCA that they would help them. HCAs are not able to assess in their scope of practice; however, an LPN can. So, if there was a fall, an LPN would have to be involved. Resident LP had a number of complicated conditions, was afraid of falling, and had a hard time walking.

Ms. Posteraro was directed to Tab 20 in Exhibit 1 which was an email Ms. Posteraro received from Ms. Draghici also on May 17, 2020. Ms. Posteraro stated she might have requested it but that when anything happens Ms. Posteraro expects that the LPNs will report it.

Ms. Posteraro was then directed to Tab 21 in Exhibit 1, which was another email from Ms. Draghici to Ms. Posteraro dated May 19, 2020.

Ms. Posteraro stated that in the investigation she was trying to determine a timeline of events as she was getting conflicting information. Ms. Draghici felt that Ms. Bagot arrived after 7:00 p.m. and this is what Ms. Posteraro was trying to figure out. Ms. Posteraro did go through the phone logs with the IT department. Ms. Posteraro stated the phone logs showed Ms. Bagot was present at 7:00 p.m., as the phone call that went to Ms. Bagot was at 7:00 p.m. and that was when Ms. Draghici was giving report.

Ms. Posteraro reviewed a June 24, 2020, statement provided by Ms. Pokhrel. She indicated no interviews followed from it as she said it had occurred in the past.

Ms. Posteraro was asked about restricted activities for HCAs at the Facility and Ms. Posteraro stated that there were very few restricted activities that were delegated to the HCAs, and this was permitted due to annual training certification and documentation. There is also some basis for HCAs to perform a restricted activity if supervised.

HCAs were able to administer regularly prescribed medications such as Tylenol, vitamins, simple eye drops. Medications that do not require an assessment piece. HCAs were not allowed to administer any type of PRN, insulin, narcotics, or warfarin. Any high alert medications, they are not permitted to administer. HCAs were also not able to administer antibiotics if they are a short-term antibiotic as there is an assessment piece that is involved. There were some residents who are on long-term low antibiotic doses that did not require an assessment which the HCAs could administer. These medications are packaged and would be regularly monitored by the LPN.

In order to be permitted to engage in these activities, HCAs were required to complete 3 to 4 hours of training and to write an exam at the end of the training with a passing rate of either 80 or 90 percent. Then when they go to the Facility, they are monitored giving the medication for a minimum of three times.

Ms. Posteraro stated Ms. Draghici has excellent assessment skills, and she has made a difference for some for the residents. Ms. Draghici knew policies and procedures and was a mentor to many of the younger staff. Ms. Draghici was very knowledgeable and had a lot of experience in many different areas of long-term care as well as in acute care. Ms. Posteraro stated that she knew that supervision was a challenge with Ms. Draghici, but they were working on that. Ms. Posteraro stated that Ms. Draghici has a loud voice and that Ms. Posteraro had asked Ms. Draghici if she ever had her hearing checked. Ms. Draghici was good working with the physicians when they were doing rounds. Ms. Draghici is a very detailed person and has some good qualities.

Ms. Posteraro did a performance assessment of Ms. Draghici in 2019 and asked for feedback from her co-workers at that time. Ms. Posteraro stated that she excluded anything that might have been confrontational at the time. She said the purpose of performance appraisals were not disciplinary but to allow the employee to grow.

Ms. Posteraro was asked about ever pressuring Ms. Draghici to return to work when she was on Workers' Compensation to which Ms. Posteraro stated that she did not personally, but she thought that someone accidentally called Ms. Draghici as they were expecting Ms. Draghici to return to work earlier than was the case in the summer of 2020. Ms. Posteraro stated that Human Resources never kept her up to date as Workers' Compensation was not within her role. Ms. Draghici stayed on the phone list but was removed some time later.

Ms. Posteraro was asked if she had concerns about Ms. Bagot's performance, to which Ms. Posteraro answered no, as she was expecting Ms. Draghici to mentor her. Ms. Bagot came from Mill Woods, which has the highest level of long-term care in Edmonton. They probably have the most challenging residents both medically and with behaviors and cognition. Ms. Bagot's reference from her previous manager was excellent.

Ms. Posteraro reviewed Tab 35 in Exhibit 1, which was Ms. Draghici's performance review and development plan for July 4, 2017, to September 20, 2019, when Ms. Posteraro completed it. Ms. Posteraro explained the rating system that was used. Ms. Posteraro stated that Ms. Draghici had an A overall rating on all the key success indicators and the employer's values.

In regard of the concerns Ms. Bagot expressed, Ms. Posteraro said they were not reflected in the performance review as it was between Ms. Bagot and Ms. Draghici. Ms. Posteraro's comment as a supervisor of Ms. Draghici stated, "Cristina is a positive role model and takes an active role as an LPN Supervisor. She has strong leadership abilities and effectively communicates expectations to staff. She has developed positive relationships with residents, families, Case Managers, Physicians, AHS Support Staff and GSS Employees. Cristina has the ability to effectively deal with family and staff concerns. Residents and their families trust Cristina with decisions made and actions taken. She responds well in emergencies and knows when to seek advice or clarification". Ms. Posteraro added to the performance review, "Cristina has the ability to mentor and instruct her peers and co-workers. Staff can rely on Cristina to share ideas and expertise – she supports a work environment that encourages learning. Cristina responds quickly to new instruction, situations, methods and procedures. She is very competent in her nursing skills". Ms. Posteraro also added a note stating, "Very compassionate. A Strong Leader, Excellent Nursing Skills and work ethic. Easily takes on additional responsibilities. Honest with strong moral principles/has integrity. Has ability to teach, coach and mentor, and recognizes accomplishments of others."

### **Diane Cabush**

Diane Cabush is the daughter of resident NB with respect to Allegation 2.

Ms. Cabush stated she was familiar with Ms. Draghici as her mother is a resident at the Facility and Ms. Draghici worked there.

Ms. Cabush was directed to Tab 22 in Exhibit 1, being her statement given to Ms. Posteraro.

Ms. Cabush stated that she was at the Facility on May 12, 2020, to drop off groceries for her mother and she knew the designated drop off place was right at the front door. Ms. Cabush described the process that the staff would open the door for the families. Ms. Cabush stated that sometimes the staff would click the button on the door and leave the door open and then you would put your groceries down and the staff would sanitize them and then give them to her mom.

Ms. Cabush described the entrance at the Facility. Ms. Cabush explained there is one set of doors and then a fairly large entrance and then another set of doors into what she would call the lobby. Ms. Cabush described the button on the top of the second door as a button that the staff would click to keep the door open while she would drop off groceries. If the staff didn't click the button to open the door, then the door would continue to slide back and forth as you were trying to drop off your groceries.

Ms. Cabush described the process of dropping off groceries during COVID. Ms. Cabush stated you would go to the door and then put down your groceries and then the staff would sanitize them.

She explained that on May 12, 2020, the staff opened the door and clicked the button so that the door stayed open. Her mother was further back waiting as her mother was aware that she was coming. Ms. Cabush stated her mother was very lonely at that time. Ms. Cabush said she put her groceries down and Ms. Cabush had her dog with her as always, usually in her purse or in a little bag. She explained her dog is a Pomeranian-Chihuahua mix who weighs between 3 to 4 pounds.

Once the door was open, Ms. Cabush put everything down along with the groceries and at this point that the dog jumped out of her bag as it was familiar with being at the Facility. Ms. Cabush stated that after the dog jumped out of the bag, Ms. Smith was there, and Ms. Smith picked up the dog and held onto the dog and then brought the dog back to her.

Ms. Cabush was asked about how far away her mother was at this time and Ms. Cabush stated that her mother was about 15 to 16 feet back and was inside the lobby. Ms. Cabush was standing at the door.

Ms. Cabush described how Ms. Smith was handing her the dog back when Ms. Draghici came around from the nurses' station and yelled at Ms. Cabush. Ms. Draghici told Ms. Cabush that she could not be there and that she had to leave and then Ms. Draghici shut the door. Ms. Cabush was asked to clarify what she meant by yelling and Ms. Cabush stated that Ms. Draghici raised her voice and pushed the door closed and that the door slid past Ms. Cabush's face. Ms. Cabush stated that Ms. Draghici yelled that Ms. Cabush had to leave and that she could not be there and slid the door and said it again when Ms. Cabush was leaving.

Ms. Cabush stated that she was wearing a mask on May 12, 2020, as she always wore a mask as she has an autoimmune disease, and she was scared of COVID and that she did not want to get sick or to make her mother sick.

Ms. Cabush then left the Facility. After she left Ms. Draghici called her but Ms. Cabush did not hear the phone, so Ms. Draghici left a message to apologize. Ms. Cabush did not feel that it was an actual apology.

Ms. Cabush stated before COVID she would visit her mother every week and that she would bring her dog with her half the time. During the pandemic the number of visits changed depending on if there was a lockdown or not. That was the first time she had brought her dog to the Facility since the COVID pandemic had started. She thought someone might have mentioned to her that a rule prohibiting dogs had been implemented at the Facility.

### **Maureen Smith**

Maureen Smith is an HCA who has worked at the Facility for 29 years and with Good Samaritan Society for 33 years. Ms. Smith typically worked from 0700 hours to 1515 hours and worked with Ms. Draghici on the same rotations. Ms. Smith stated that she knew Ms. Draghici as they worked together at the Facility.

Ms. Smith was asked about COVID-19 protocols at the Facility during the pandemic. Ms. Smith stated that families could come in as long as they wore masks and had to stay six feet away if the Facility was not in lockdown. If the Facility was on lockdown, then the families were not allowed to enter. Family members had to show their proof of vaccination, have their temperature checked, and fill out a form at the front door when they entered the Facility.

Ms. Smith stated the process for family members to drop off groceries and personal items for the residents was that the families would bring the bags of stuff and leave them inside the first door. Then the LPN or HCA, whoever was available, would wipe it down and take it to the resident's room. Ms. Smith described the entrance to the Facility as there was a door from the outside going in and then a little foyer and then another sliding door going into the main building. During the pandemic the inside door was locked with a code that the staff and families would use. Ms. Smith stated that this was the only area that families had to drop items off for the residents.

Ms. Smith said the Facility's policy on dogs prior to the pandemic was that they were allowed to visit as long as they were on a leash. Then during the pandemic, dogs were not allowed in the Facility. Ms. Smith stated that she was not sure if dogs were allowed in between the two doors. Ms. Smith stated that she knew Diane Cabush and that Ms. Cabush would bring her dog into the Facility quite often, which was at least once or twice a week.

Ms. Smith was asked about May 12, 2020, and that she saw Ms. Cabush who was bringing her mother some items. Ms. Smith stated that Ms. Cabush was wearing a mask and had her dog with her. Ms. Smith was excited when she saw the dog as Ms. Smith loves dogs. Ms. Smith opened the door and said hello to Ms. Cabush, and that Ms. Cabush handed Ms. Smith the dog and that Ms. Cabush was inside the door at this point. Ms. Smith then stated that she talked to Ms. Cabush for a little bit and before Ms. Draghici came out of the office and raised her voice at both Ms. Smith and Ms. Cabush. She said that no dogs were allowed in the Facility. Ms. Smith stated it was at this time that Ms. Cabush took the dog and whatever she had and left.

Ms. Smith was then asked to open Tab 23 of Exhibit 1, which was an email from Ms. Smith to Katie Emter, CLPNA Investigator, in respect to Ms. Smith knowing about Ms. Posteraro's date of birth. Ms. Smith said there was a breach of confidentiality on Ms. Draghici's part in telling Ms. Smith Ms. Posteraro's age. Ms. Smith was unable to remember how it came about that she found out Ms. Posteraro's age, whether they were talking about age or if it was just brought up. Ms. Draghici just told Ms. Smith that Ms. Posteraro was of a certain age and that Ms. Draghici got it from the immunization records for the flu shot. This conversation took place in the staff room. Ms. Smith told Ms. Posteraro that it was Ms. Draghici who told her this information and Ms. Posteraro got quite upset. Ms. Posteraro stated to Ms. Smith that nobody should be talking about her age and that it is something that they do not talk about unless someone wants to tell you. In the staff room Ms. Draghici denied that she did it and then eventually she admitted it. Ms. Smith said the conversation was heated and voices were raised. Ms. Smith stated she was upset because she knew what Ms. Draghici had told her. Ms. Draghici admitted that she knew Ms. Posteraro's date of birth from the immunization record.

Ms. Smith was asked what it was like to work with Ms. Draghici and stated that it was not fun, and that Ms. Draghici picked on her a lot. Ms. Draghici would tell Ms. Smith how to do her job, micromanage Ms. Smith, and yell at Ms. Smith in front of residents while using her authority. Ms. Smith stated that when the LPNs are there, they are the supervisors and that Ms. Smith felt that Ms. Draghici took her authority too far. Ms. Draghici told Ms. Smith that she was her supervisor and that Ms. Smith had to listen to Ms. Draghici and that Ms. Draghici spoke in an authoritative voice.

Ms. Smith stated there was a time when she and Ms. Draghici were in a resident's room, and they were giving him eye drops and puffers and then something came up. Ms. Smith was unable to recall what it was, but that Ms. Draghici entered the room and was telling Ms. Smith what to do, and in a raised voice yelled at Ms. Smith in front of the resident. Ms. Smith reported it to the manager.

Ms. Smith was asked if working with Ms. Draghici had any impact on her, to which Ms. Smith said that it caused Ms. Smith a lot of stress in that Ms. Smith did not want to go to work every day because she knew that Ms. Draghici was there.

Ms. Smith was asked if she ever discussed her concerns of being micromanaged by Ms. Draghici with Ms. Posteraro and Ms. Smith stated that she did many times, and this went back to shortly after Ms. Draghici started at the Facility. Ms. Smith stated nothing was done with these complaints until something happened between Ms. Posteraro and Ms. Draghici and that was when things started getting worked on.

### **Cristina Draghici**

Ms. Draghici had worked at the Facility as an LPN since December 2017. Ms. Draghici came to Canada when she was 27 years old from Romania. Ms. Draghici stated that she has a strong voice and talks fast and loudly. Ms. Draghici stated that before she worked in health care, she worked in the oil field in Romania.

Ms. Draghici stated that her working relationship with Ms. Posteraro was friendly, with nice teamwork and very good communication.

Ms. Draghici described a conversation with her co-worker Anne Marie Canalang (phonetic), who came to Ms. Draghici and said she knew Ms. Posteraro's age and that Ms. Posteraro was going to be 60. Ms. Draghici stated that Ms. Canalang brought the immunization binder and opened the binder and showed Ms. Draghici, Ms. Posteraro's age with Ms. Posteraro's immunization record. Ms. Draghici remembered she knew that Ms. Posteraro had allergies and that Ms. Posteraro would not take any vaccinations so she was surprised by that.

Both Ms. Draghici and Ms. Canalang discussed getting a cake and some flowers for Ms. Posteraro as they typically would have a potluck to celebrate birthdays. Ms. Draghici's recollection was that the conversation with Ms. Canalang took place in the spring of 2020 as it was just before both Ms. Canalang's and Ms. Posteraro's birthday as it was the same day. Ms. Draghici stated that both her and Ms. Canalang were in the dining room or lunchroom and Ms. Posteraro entered the room and Ms. Posteraro asked what they were talking about, and Ms. Draghici told her that they were talking about Ms. Posteraro's age. It was at this point that Ms. Posteraro was getting pale and Ms. Draghici stated she was sorry. Ms. Draghici stated that it was not her intention to upset Ms. Posteraro.

Ms. Draghici was asked if she had any need to access Ms. Posteraro's immunization record for her job and Ms. Draghici stated that a co-worker showed it to her and that she did not see any harm in looking at the immunization record. Ms. Draghici stated that it was her coworker who brought her into this. Ms. Draghici agreed that she did not have any justification to view Ms. Posteraro's immunization record. Ms. Draghici was asked if she had permission from Ms. Posteraro to view her immunization record and Ms. Draghici stated that they never talked about those things; they would talk about birthdays. They would have potlucks when someone's birthday was coming up and they would celebrate that person if they were working.

Ms. Draghici stated that the immunization records were kept in the nurses' station in a binder with the policies and procedures.

Ms. Draghici talked about April 22, 2020. Ms. Draghici started working at 7:00 a.m. that day. She was talking to Minire but was not able to recall what time, only that it was a few minutes prior to when Ms. Posteraro arrived. Ms. Draghici told Minire she wanted to speak with her and Ms. Posteraro. Ms. Draghici stated that she wanted to talk about complaints she had received that Minire was not following the policies and procedures, about how she was handling the residents or leaving them alone and that Minire was fighting with the staff. Ms. Draghici stated that she did not believe in punishing people but that she believes in helping, giving more orientation, and trying to communicate so Ms. Draghici wanted to talk with Ms. Posteraro as well as Minire about this.

Ms. Draghici stated Ms. Posteraro arrived around 7:45 a.m. and Ms. Draghici asked Ms. Posteraro if she had time to talk so Ms. Posteraro invited both Ms. Draghici and Minire into her office to talk. Ms. Draghici tried to talk with Ms. Posteraro and Minire about everything that was happening, but Ms. Posteraro got upset and threw her hands up in the air and left the office. She said that was when everything went wrong.

Ms. Draghici disagreed that she said Ms. Posteraro was a bad manager, instead she said that Ms. Posteraro was not a good manager for letting things happen. Ms. Draghici denied she told Ms. Posteraro she was allowing bullshit to happen. Ms. Draghici said English is her second language and that she was speaking and said something in Romanian. Ms. Draghici admitted that her voice was raised.

Ms. Draghici said Ms. Posteraro told her that if she did not like working there that Ms. Draghici could go to work elsewhere as there are a lot of jobs for LPNs. Ms. Draghici stated that it was at this point that she then went on with her duties. Minire left as well and returned to the Village.

Ms. Draghici was asked if she spoke to Ms. Posteraro after this incident and Ms. Draghici stated that she felt very remorseful and went to apologize to Ms. Posteraro later that same day around 9:00 a.m.

Ms. Draghici stated that she was not aware of whether any residents were present when the incident occurred.

In relation to May 12, 2020, Ms. Draghici stated that she was leaving the medication room which is in the entrance and Ms. Draghici saw the door open. She said the policy was that the door had to be locked and stay locked. Ms. Draghici could see Ms. Cabush inside the door and Ms. Smith had Ms. Cabush's dog in her arms.

Ms. Draghici said her expression was, "Oh my god! You cannot be here". Ms. Draghici said she tried to explain to Ms. Cabush that Ms. Cabush was supposed to make an appointment to see her mother. At this point Ms. Cabush turned and left.

Ms. Draghici then attempted to call Ms. Cabush and left a message to apologize for what occurred. She said Ms. Cabush took it personally. Ms. Draghici wanted to let Ms. Cabush know that it was not her intention but instead to remind Ms. Cabush that the families were not allowed inside the Facility. It was at this point that Alberta Health Services were saying that even pets were carrying the virus. Ms. Draghici left the first message on Ms. Cabush's cell phone and then left another message on Ms. Cabush's home phone.

Ms. Draghici stated that she knew at that time that the families and the residents were all suffering from being far from each other. Ms. Draghici then approached Ms. Cabush's mother and explained to her what happened and apologized for getting Ms. Cabush upset and reminded her that there was a policy and procedure in place that needed to be followed. This conversation took place in Ms. Cabush's mother's room. It was after this that Ms. Draghici reported what happened to Ms. Posteraro. Ms. Posteraro told her there was nothing to apologize for.

Ms. Draghici stated that she takes accountability for everything that she does and never refuses to do something. It was not brought up to her that she refused to apologize to Ms. Cabush but that Ms. Cabush did not want to talk to her and listen to her apologies.

Turning to the May 16, 2020, incident with resident LP. Before any of that had occurred, Ms. Carron and Ms. Serofia were having their supper in the dining room. Ms. Draghici approached their table; she had received a phone call from a resident's family member complaining that the HCAs refused to open the windows. The family came from B.C. and they wanted to do some singing with a guitar at the window. Ms. Posteraro was aware of this and gave Ms. Draghici instructions to open the window when the family arrived. Ms. Draghici asked Ms. Carreon and Ms. Serofia why they would not open the windows. They stated that they were really busy, and they did not have the time. Ms. Draghici then went and opened the windows.

Once Ms. Draghici returned from opening the windows, Ms. Serofia asked Ms. Draghici about changing a shift with another HCA. Ms. Serofia's regular shift was an evening from 3:00 p.m. to 11:00 p.m. but she wanted to come in for the 7:00 p.m. to 3:00 p.m. shift. Ms. Draghici said she could not do the exchange with the other HCA as that HCA did not drive and took the bus and she would not be able to get the bus to work at those times. This took place towards the end of Ms. Draghici's shift, around 1852 hours.

Ms. Jasmine Kaur, an LPN, was working with Ms. Draghici as Ms. Draghici was on WCB, on modified duty. Ms. Kaur was to help Ms. Draghici with any falls or any problems that required lifting of anything that was over 20 kilograms or 40 pounds. Ms. Kaur's phone began to ring, and she said that it was an alarm set for 1903 hours as her mother was taking medication at that time. Ms. Draghici and Ms. Kaur continued walking and went into the medication room and were doing

the count for narcotics. When Ms. Draghici and Ms. Kaur were leaving the medication room, they saw Ms. Bagot. They then proceeded to go into the nurses' station to give report.

While Ms. Draghici and Ms. Kaur were in the medication room, Ms. Serofia was by the laundry room, which was approximately 20-25 feet away and loudly asked Ms. Draghici to help Ms. Serofia to clean LP. Ms. Serofia described that there was bowel movement all over the room, the bathroom, the bed sheets, everywhere. Ms. Draghici stated that it was the end of her shift and for Ms. Serofia to call her co-worker to try to help her and to work as a team. Ms. Serofia then left.

Ms. Carreon called, and Ms. Draghici did not answer the phone as she expected Ms. Bagot to answer the phone. The phone was on Ms. Bagot's desk, as well as the keys. Ms. Bagot did not answer the phone so then Ms. Draghici answered the phone. Ms. Carreon stated that she needed help but did not say anything about the fall, about neuro vitals, all that Ms. Carreon said was that she needed help. Ms. Draghici then informed Ms. Bagot that Ms. Carreon needed help and Ms. Draghici and Ms. Kaur proceeded to go home.

Ms. Draghici stated that no one told her that LP had fallen. Ms. Draghici was told that LP had bowel movements all over the suite and at 1910 hours that Ms. Carreon required help. This was the second time that Ms. Carreon called. Ms. Draghici then informed Ms. Carreon that she was to speak with Ms. Bagot. Ms. Carreon asked for help; however, at no point did Ms. Carreon or Ms. Serofia inform Ms. Draghici that LP had fallen. Ms. Draghici saw Ms. Serofia with the mechanical lift and was bringing it into LP's room; Ms. Draghici stated that she thought that Ms. Serofia was using the lift to help clean LP.

Ms. Draghici said that earlier she had discussed with Ms. Serofia about a medication that was given to resident LP, which was prescription lactulose. The lactulose had to be given if needed in the evening if LP did not have a bowel movement. Ms. Draghici asked Ms. Serofia to follow up with this and Ms. Serofia stated that she was not happy and argued with Ms. Draghici that the lactulose should be given in the day and not in the evening. Ms. Draghici informed Ms. Serofia that she was following the doctor's orders. Lactulose is required to be given by an LPN as there needs to be a result documented on the patient's chart. Ms. Serofia stated that she had to clean LP up from the bowel movement and from that point on she was going to call Ms. Draghici to help clean it up. Ms. Draghici told Ms. Serofia that if she needed help then she should contact her co-worker as they should be working as a team.

Ms. Draghici was asked about her relationship with Ms. Bagot. Ms. Draghici stated Ms. Bagot was a relatively new LPN. Ms. Bagot used to refer to Ms. Draghici as a second mother and called her "Mamacita". Ms. Draghici allowed Ms. Bagot to call her at home when she was not working to ask questions. Ms. Bagot would ask Ms. Draghici about policies, procedures, anything she was allowed to ask, anything she wanted.

Ms. Draghici talked about her relationship with Ms. Pokhrel and an incident that occurred on June 14, 2020. Ms. Pokhrel had complained that on that date when Ms. Pokhrel arrived for her shift at 0700 hours that Ms. Draghici was angry, rude, and unprofessional.

Addressing the issue with the phone first, Ms. Draghici stated Ms. Pokhrel took a bottle of sanitizer and started spraying it over the phone. There were a few instances where the phone was broken, and this was the only way that they could communicate with families or anyone from outside the Facility. She was trying to tell Ms. Pokhrel to use wipes to wash the phone. In response to this Ms. Pokhrel became very angry.

In regard of the narcotic count, Ms. Draghici said the narcotic count is done at the change of shifts and when the count is done the oncoming LPN would take the keys because then it is their shift.

Ms. Pokhrel said that she forgot to sign something, and Ms. Draghici told her to wait a little because Ms. Draghici was doing something else. Ms. Pokhrel then got mad and got another set of keys and went inside the medication room. Ms. Pokhrel left the keys in the door while she was in the medication room. Ms. Pokhrel did not sign the narcotic count and Ms. Draghici informed Ms. Pokhrel that they both were supposed to sign the narcotic count in front of each other as it was policy and procedure. Ms. Pokhrel then became upset and informed Ms. Draghici that Ms. Pokhrel could sign the narcotic sheet later and not at that time and that there was nothing to the policies and procedures to do something like that.

Ms. Pokhrel bumped into Ms. Draghici while she was at the desk and Ms. Draghici stated that Ms. Pokhrel knew which shoulder was hurting and Ms. Pokhrel went into it with all her power.

Ms. Draghici was asked if Ms. Pokhrel bumped into Ms. Draghici accidentally at the desk and Ms. Draghici stated that Ms. Pokhrel was mad at her and purposefully forcefully hit her bad shoulder. Ms. Draghici said it was not an accident.

In regard of whether she threatened Ms. Pokhrel with not showing up for the next night shift. Ms. Draghici stated that she was supposed to leave the site at 7:00 a.m. and Ms. Pokhrel did not agree to do all the medications by herself and said she wanted help, and she asked Ms. Draghici to stay. Ms. Draghici stayed until 10:00 a.m. and then when Ms. Draghici was leaving, she stated that she was very, very tired. Ms. Draghici stated that she did not argue with Ms. Pokhrel. Ms. Draghici stated that since she stayed until 10:00 a.m. she was only going to have five hours to sleep before her next shift. Ms. Draghici was trying to give Ms. Pokhrel enough time to find someone to cover her shift. Ms. Draghici did work her shift that evening.

Ms. Draghici gave evidence about June 13, 2020, with respect to resident JC. Ms. Draghici stated that she went to see JC to give her a narcotic and eye drops around 9:00 p.m. JC is her own decision-maker and would tell staff to leave the medication with JC. Ms. Draghici stated that JC was in a chair watching TV and that Ms. Draghici left the medication with JC. Ms. Draghici left the eye drops on the counter and informed JC that Ms. Draghici would come back because Ms.

Draghici was also being called to the Village at this time. Ms. Draghici informed JC that she was going to leave the medication as well as the eye drops and give it to JC when she got back. When Ms. Draghici returned, she asked JC if JC received her medication. JC stated that Ms. Serofia gave JC the eye drops. She also said she had taken the hydromorphone Ms. Draghici then asked Ms. Serofia if Ms. Serofia gave her the eye drops because Ms. Draghici did not ask Ms. Serofia to.

Ms. Draghici reviewed Tab 26 Page 9 in Exhibit 1 where Ms. Draghici stated that she was sorry and remorseful. Ms. Draghici was asked to expand on this. Ms. Draghici stated that growing up her family wanted perfection and there was no room for mistakes. Ms. Draghici stated that she felt that at that time the more she was trying to be perfect, to be a good co-worker, to be a good LPN for the residents, to work with no mistakes. Ms. Draghici wanted to let people know that she was not that person, she was not a monster, she has a good heart for the residents, for the families, for everyone, her co-workers, her manager. Ms. Draghici then stated that she was sorry.

The Hearing Tribunal recognizes some of the evidence before it in this matter may be hearsay evidence. The Hearing Tribunal concludes that hearsay evidence can be admissible when it is determined the central issues have been established or where there is additional evidence to support the Allegations. All issues of guilt or innocence are considered on a balance of probabilities. The onus is on the CLPNA to establish on a balance of probabilities the facts as alleged in the Statement of Allegations occurred and that it rises to the level of unprofessional conduct as defined in the Act.

#### **(6) Hearing Tribunal Decisions and Reasons**

The onus is on the College's Complaints Director to establish that the facts as alleged in the Statement of Allegations did occur. The standard of proof in civil cases is the balance of probabilities.

The Hearing Tribunal is aware that 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 carefully considered the testimony of the witnesses and the exhibits. The Hearing Tribunal finds the particulars of Allegation 1a, 1g, 1h, and Allegation 5b are proven and that the conduct constitutes unprofessional conduct. The remaining Allegations are found not to be proven based on the testimony and evidence that the Hearing Tribunal had before it.

### Allegation 1

On or about 2020, while employed as an LPN at Wedman House and Village, failed to foster a respectful or collaborative relationship with one or more of her co-workers: L.P., D.S., E.C., P.B., S.P., B.D., M.I., and/or M.S., particulars of which include:

- a) On or about April 22, 2020, spoke in a raised voice to her manager, L.P.;
- b) On or about April 22, 2020, used inappropriate language by telling her manager L.P. that she was a “bad manager” and “let bullshit happen all the time”, or words to that effect;
- c) On or about April 22, 2020, criticized the conduct of her colleagues B.D. and/or M.I. in front of a client;
- d) On or about May 16, 2020, refused to provide assistance to her colleagues D.S. and E.C. when they asked her to provide assistance and complete a post-fall assessment of client L.P.;
- e) On or about May 16, 2020, spoke in a raised voice to her colleague, D.S., in the presence of other staff;
- f) On or about June 14, 2020, spoke in a raised voice and/or criticized her colleague S.P. while S.P. performed her duties;
- g) On or about June 14, 2020, spoke to her colleague S.P. in a rude and disrespectful manner by saying words to the effect that S.P. was “unprofessional” and that “enough is enough” in a raised voice;
- h) On or about June 14, 2020, interfered with the performance of her colleague S.P.’s duties by refusing to allow S.P. to sign the medication administration record following the medication count and/or refusing to give S.P. keys to the medication administration room so that S.P. could obtain medication for a client;
- i) Communicated with her co-workers on a routine basis in an inappropriate manner causing her co-workers’ distress.

The Hearing Tribunal finds that Allegations 1a, 1g, and 1h have been proven on a balance of probabilities. The Hearing Tribunal finds that Allegations 1b, 1c, 1d, 1e, 1f, and 1i, have not been proven on a balance of probabilities.

Ms. Draghici admitted that on April 22, 2020, she did in fact speak in a raised voice to her manager Ms. Posteraro as Ms. Draghici was quite upset at the time.

Ms. Draghici in respect to June 14, 2020, did admit to saying “enough is enough” to Ms. Pokhrel.

Ms. Draghici admitted that she refused to give Ms. Pokhrel the keys to the medication room and denied Ms. Pokhrel access to the medication room as the narcotic count was completed at the time and Ms. Pokhrel was no longer on shift. As a result, Ms. Pokhrel was not able to document the administration of Baclofen. Ms. Draghici stated that she asked Ms. Pokhrel to wait as Ms. Draghici was doing something, although she could not recall what it was and then informed Ms.

Pokhrel once Ms. Draghici was done, they could go in the medication room together and document the administration. Ms. Pokhrel then went and obtained another set of keys to the medication room and documented the administration. Ms. Draghici then became upset by the actions of Ms. Pokhrel.

#### Allegations Not Proven:

Regarding Allegations 1b and 1c, the Hearing Tribunal accepts that Ms. Draghici either said Ms. Posteraro was “not a good manager” as Ms. Draghici admitted she said or was “a bad manager”. In either event the language is qualitatively the same and should not have been said. Further, the Hearing Tribunal finds that she did say something to the effect that Ms. Posteraro was letting “bullshit happen all the time”.

The Hearing Tribunal was left in doubt regarding whether Ms. Draghici criticized her colleague, Minire, in front of a resident. There was no evidence she had criticized Ms. Denny. Ms. Denny was unable to speak to exactly what was said.

Further, it was unclear whether anything that was said was said close enough to be “in front of” a resident. The Hearing Tribunal did not hear testimony from the resident in question, so it had no evidence as to what that resident heard or not.

In regard to whether Ms. Draghici failed to provide assistance and perform a post-fall assessment for LP, the Hearing Tribunal accepts that Ms. Draghici was never made aware that LP had experienced a fall and therefore needed an LPN’s assessment. The Hearing Tribunal heard testimony that LP had a large amount of bowel movement in the bathroom. Both Ms. Serofina and Ms. Carreon testified that they called Ms. Draghici at 1900 hours on May 16, 2020, and asked for assistance. This was at the end of Ms. Draghici’s shift and Ms. Draghici informed both Ms. Serofina and Ms. Carreon that they needed to work as a team to clean up the bowel movement and Ms. Draghici was giving report to Ms. Bagot, as well as, doing a narcotic count with Ms. Kaur. Ms. Draghici was on modified duties at this time and was working with Ms. Kaur in order to assist Ms. Draghici with her modified duties. Ms. Draghici testified that she was on modified duties due to a shoulder injury and was restricted to what she could lift. Ms. Draghici did not perform a post fall assessment on LP as it was not made clear from either Ms. Serofina or Ms. Carreon that LP had fallen.

Ms. Draghici informed the Hearing Tribunal that she typically spoke in a loud voice when speaking with her co-workers, as well as her manager.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the *Health Professions Act* (“HPA”), in particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

- a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
- b) Contravention of the Act, a code of ethics or standards of practice;

c) Conduct that harms the integrity of the regulated profession.

Ms. Draghici displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Draghici spoke to her manager in a raised voice. Ms. Draghici also spoke to her colleague in a rude and disrespectful manner. Ms. Draghici also interfered with the performance of her colleague by not giving her colleague keys to the medication room. Ms. Draghici should not have spoken to her manager in a raised voice or been disrespectful to a colleague. It is an expectation that health care professionals will speak in a respectful manner and tone when working with each other and assist each other in their work as well.

Ms. Draghici did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. Draghici in her testimony. The Hearing Tribunal finds the conduct breached in the CLPNA Code of Ethics and the CLPNA Standards of Practice were sufficiently serious to constitute unprofessional conduct.

Ms. Draghici's conduct harmed the integrity of the regulated profession as she behaved in a manner that is not expected of an LPN in a similar situation. LPNs should be respectful when speaking to each other and support one another in the workplace.

Ms. Draghici's conduct also breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada.

CLPNA Code of Ethics:

Ms. Draghici breached the CLPNA Code of Ethics listed below by not behaving in a manner that is expected of an LPN. Ms. Draghici spoke in a raised voice to her manager and colleagues, criticized her colleagues, and interfered with another LPN's performance. By doing this, Ms. Draghici did not maintain standards of practice, professional competence and most importantly conduct. Ms. Draghici did not conduct herself in a manner that is expected of LPNs in health care settings. Ms. Draghici did not promote the health and well-being of individuals with respect to her colleagues in that the Hearing Tribunal heard from witnesses that stated working with Ms. Draghici caused them stress. Ms. Draghici did not maintain the standards of the profession, nor did she conduct herself in a manner that upholds the profession as speaking in a raised voice or tone is not expected in how an LPN will communicate with their co-workers and managers.

Ms. Draghici's conduct breached 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.

- 1.6 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 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 specially 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.

CLPNA Standards of Practice:

Ms. Draghici breached the CLPNA Standards of Practice listed below by not practicing in a manner consistent with ethical values and obligations of an LPN in that Ms. Draghici was speaking in a raised voice to both her colleagues and her manager. This is not a behavior that is expected of an LPN when it comes to communicating. Ms. Draghici also criticized her colleagues while they were performing their duties.

Ms. Draghici’s conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

**Standard 4:** Ethical Practice – LPNs uphold, promote, and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.
- 4.7 Communicate in a respectful, timely, open, and honest manner.

### Allegation 2

On or about May 12, 2020, engaged in inappropriate behavior in relation to her interactions with client N.B. and N.B.’s daughter, particulars of which include:

- a) spoke in a raised voice to client N.B.’s daughter, D.C.;
- b) refused to apologize to N.B. or D.C. for speaking in a raised voice;
- c) closed a door to the facility in D.C.’s face;
- d) told D.C. that she needed to leave the facility in a rude and aggressive manner.

The Hearing Tribunal heard testimony in regard to this allegation and found that Ms. Draghici typically speaks in a loud voice as was stated by various witnesses throughout both the investigation and testimony that was given. Further, Ms. Draghici admitted she spoke in a raised voice but this was understandable in the circumstances as she was concerned about the COVID protocols and reacted in surprise rather than in anger towards Ms. Cabush.

The Hearing Tribunal accepts that Ms. Draghici did in fact call Ms. Cabush in order to apologize as soon as Ms. Cabush left the Facility as she wanted to explain the concerns she had. Ms. Draghici called both Ms. Cabush's cell phone, as well as her home phone and left a message explaining what the policy and procedure was, as well as, asking Ms. Cabush to phone Ms. Draghici back. Further, Ms. Draghici did inform NB of what occurred and apologized to NB as well.

The Hearing Tribunal accepts Ms. Draghici took steps for the door to be able to close but does not accept the door was closed in Ms. Cabush's face. Instead, Ms. Cabush turned and left the Facility on her own. Accordingly, it was not established that Ms. Draghici closed the door in D.C.'s face.

The Hearing Tribunal was not presented with any evidence which could establish that Ms. Draghici interacted with client N.B. in an inappropriate manner. Nor did the Hearing Tribunal consider Ms. Draghici explaining to D.C. the policy and expectations relating to COVID at the time in question to be inappropriate.

The Hearing Tribunal finds that the conduct alleged in Allegation 2 was not proven on a balance of probabilities. As such, there is no need to consider the issue of unprofessional conduct and the application of s. 1(1)(pp) of the HPA in regard of this allegation.

### Allegation 3

On or about May 16, 2020, failed to provide care to client L.P. by refusing to perform a post-fall assessment as required.

The Hearing Tribunal finds that this allegation was not proven. The Hearing Tribunal heard testimony with respect to this allegation and accepts Ms. Draghici was never informed that LP had a fall. Ms. Draghici was informed that LP had a large amount of bowel movement in the bathroom and was required to be cleaned up. This occurred at approximately 1850 hours as Ms. Draghici was preparing to give report to the on-coming LPN, who was Ms. Bagot, as well as, performing a narcotic count with Ms. Kaur. Both Ms. Carreon and Ms. Serofina did testify that they required assistance with resident LP, however they did not inform Ms. Draghici that LP had fallen; they were asking for help. Ms. Serofina in her testimony stated that Ms. Carreon identified that given LP's position it was considered to be a fall. As such, Ms. Serofina did not communicate the fall to Ms. Draghici. Notably, in her prior statement given about the events, Ms. Serofina did not reference the fact of a fall. Further, Ms. Carreon communicated with Ms. Bagot, not with Ms. Draghici. Ms. Draghici could not have known that LP had a fall and needed assessment.

The Hearing Tribunal finds that the conduct alleged in Allegation 3 was not proven on a balance of probabilities on clear and cogent evidence. As such, there is no need to consider the application of s. 1(1)(pp) of the HPA in regard of this allegation.

#### Allegation 4

On or about June 13, 2020, inappropriately instructed D.S., who was a Health Care Aide, to administer antibiotic eye drops and a tablet of hydromorphone to client J.C. which fell outside of D.S.'s scope of practice.

Ms. Serofina did testify that she did not administer the eye drops to JC. The Hearing Tribunal did not receive any evidence that Ms. Draghici had instructed Ms. Serofina to administer the eye drops or hydromorphone. The only evidence was that JC had advised this was the case. JC was not a witness and the Hearing Tribunal is not prepared to accept this evidence as reliable. As neither Ms. Serofina nor Ms. Draghici gave evidence that Ms. Draghici had instructed Ms. Serofina to administer either medication, the Hearing Tribunal finds this was not established.

The Hearing Tribunal finds that the conduct alleged in Allegation 4 was not proven on a balance of probabilities on clear and cogent evidence. Again, there is no need to consider the question of unprofessional conduct.

#### Allegation 5

On or about 2019 to 2020, breached confidentiality and privacy by engaging in one or more of the following:

- a) accessing her manager L.P.'s immunization record.

The Hearing Tribunal heard contradictory evidence with respect to this allegation. Ms. Draghici testified that the immunization record was shown to her by A.C. and that Ms. Draghici did not access the information as she did not seek it out.

- b) disclosing L.P.'s date of birth to her colleague M.S. without authorization or justification.

In her testimony, Ms. Draghici admitted to disclosing L.P.'s date of birth to her colleague M.S. There was a discrepancy as to where the immunization records were kept in that the Hearing Tribunal heard from L.P. that they were in a file folder on a back table in her office and Ms. Draghici stated that they were in a binder that was kept in the nurses' work room. The Hearing Tribunal does not find it necessary to make a determination on this point as it is not necessary to know where these records were maintained for the purpose of assessing whether this allegation is proven.

The Hearing Tribunal was not able to conclude Ms. Draghici accessed the information in question as it was shown to her. In these circumstances the Hearing Tribunal does not accept that being shown something is the same as accessing it. The first is passive whereas the second is active. Ms. Draghici gave the only evidence as to how this information was known to her and accordingly the Hearing Tribunal accepts that she did not access that information.

This was unprofessional conduct when the information was shared with fellow co-workers without authorization or justification. This is a breach of confidentiality.

Allegation 5b has been proven.

The Hearing Tribunal finds that the conduct alleged in Allegation 5(a) was not proven but that the conduct alleged in Allegation 5(b) was proven. Further, that the conduct alleged at Allegation 5(b) amounts to unprofessional conduct as defined in s. 1(1)(pp) of the *Health Professions Act* (“HPA”), in particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

- a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
- b) Contravention of the Act, a code of ethics or standards of practice;
- c) Contravention of another enactment that applies to the profession, and
- d) Conduct that harms the integrity of the regulated profession.

Ms. Draghici displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services in that Ms. Draghici disclosed her manager’s date of birth to a colleague without authorization or justification. This was a breach of confidentiality. This was a serious allegation as LPNs are expected to keep information that they work with to be confidential. With respect to the circumstances, Ms. Draghici did not initiate the breach of information. However, in Ms. Draghici's testimony she did admit to sharing the information once she saw it. The Hearing Tribunal did not find that there was clear access to the information but Ms. Draghici did admit to the disclosure which results in unprofessional conduct.

The Hearing Tribunal finds the conduct breached in the CLPNA Code of Ethics and the CLPNA Standards of Practice were sufficiently serious to constitute unprofessional conduct.

Ms. Draghici was in contravention of another enactment that applies to the profession in that she violated the *Health Information Act* by looking at the personal health information of her manager as Ms. Draghici did not require access to this information. Ms. Draghici also did not have permission from her manager to share this information among her co-workers.

Ms. Draghici’s conduct harmed the integrity of the regulated profession as she behaved in a manner that is not expected of an LPN in a similar situation. LPNs are expected to keep personal health information confidential whether it be a patient’s information or a co-worker’s information.

Ms. Draghici’s conduct breached the following principles and standards set out in CLPNA’s Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics:

Ms. Draghici breached the CLPNA Code of Ethics listed below by not demonstrating responsibility to the profession in that Ms. Draghici saw L.P.’s date of birth and disclosed this information to another colleague. Privacy and confidentiality is something that is essential when working as an LPN as LPNs are entrusted with medical information.

**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.

CLPNA Standards of Practice:

Ms. Draghici breached the CLPNA Standards of Practice listed below by disclosing L.P.'s date of birth to colleagues when Ms. Draghici was not required to be looking at L.P.'s immunization record as L.P. was not a patient. Confidentiality is an expectation of an LPN when it comes to health care information whether it be of a patient or colleague. Ms. Draghici did not seek out the information on the immunization record as it was shown to her by a colleague; however, Ms. Draghici did go on to share the information with another colleague.

**Standard 1:** Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

**Standard 3:** Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

- 3.8 Practice within the relevant laws governing privacy and confidentiality of personal health information.

**Standard 4:** Ethical Practice – LPNs uphold, promote, and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.
- 4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

The Hearing Tribunal will contact the parties through its counsel for the purpose of addressing sanction.

**DATED THE 14<sup>TH</sup> DAY OF JULY 2023 IN THE CITY OF EDMONTON, ALBERTA.**

**THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

A handwritten signature in cursive script that reads "Kelly Anesty".

Kelly Anesty, LPN  
Chair, Hearing Tribunal

**IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE  
CONDUCT OF CRISTINA DRAGHICI, LPN #28648, WHILE A MEMBER OF THE COLLEGE OF  
LICENSED PRACTICAL NURSES OF ALBERTA**

**DECISION ON SANCTION OF THE HEARING TRIBUNAL**

**(1) Submissions**

The submissions of the parties on sanction were submitted to the Hearing Tribunal in writing. The Hearing Tribunal convened for a further hearing to review written submissions by videoconference on June 21, 2024, with the following individuals present:

**Hearing Tribunal:**

Kelly Anesty, Licensed Practical Nurse (“LPN”), Chairperson  
Michelle Stolz, LPN  
James Lees, Public Member  
Vincent Paniak, Public Member

**Independent Legal Counsel for the Hearing Tribunal:**

Heidi Besuijen

**Staff:**

Gregory Sim, Legal Counsel for the Complaints Director, CLPNA  
Susan Blatz, Complaints Officer, CLPNA

**Investigated Member:**

Cristina Draghici, (“Ms. Draghici” or “Investigated Member”) LPN  
Simon Renouf, Legal Counsel for the Member

**(2) Preliminary Matters**

The Hearing Tribunal considered the following:

1. Written submissions from Counsel for the Complaints Officer.
2. Written submissions from Counsel for Ms. Draghici.
3. Oral submissions of Counsel for the Complaints Officer.
4. Oral submissions of Counsel for Ms. Draghici.

### **(3) Findings of Unprofessional Conduct**

Upon consideration of the evidence presented before it at the Hearing as well as the submissions of the Parties, the Hearing Tribunal determined Ms. Draghici had engaged in the following conduct that was also determined to rise to the level of unprofessional conduct:

- 1) On or about 2020, while employed as an LPN at Wedman and Village, failed to foster a respectful or collaborative relationship with one or more of her co-workers: L.P., D.S., E.C., P.B., S.P., B.D., M.I., and/or M.S. particulars of which include:
  - a. On or about April 22, 2020, spoke in a raised voice to her manager, L.P.
  - g. On or about June 14, 2020, spoke to her colleague S.P. in a rude and disrespectful manner by saying words to the effect that S.P. was “unprofessional” and that “enough is enough” in a raised voice;
  - h. On or about June 14, 2020, interfered with the performance of her colleague S.P.’s duties by refusing to allow S.P. to sign the medication administration record following the medication count and/or refusing to give S.P. keys to the medication administration room so that S.P. could obtain medication for a client;
- 5) On or about 2019 to 2020, breached confidentiality and privacy by engaging in one or more of the following:
  - b. disclosing L.P.’s date of birth to her colleague M.S. without authorization or justification.”

### **(4) Submissions on the Factors to be Considered in Sanction**

Both parties referred to *Jaswal v Newfoundland (Medical Board)*, 1996 CANLII 11630 at para 35 (NL SCTD)(“*Jaswal*”) in which the Court identified a list of factors to take into account when deciding the appropriate sanction in cases such as this. The list of factors offered in *Jaswal* includes:

- 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;

- 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 degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- The range of sentence in other similar cases.

The parties each provided submissions in respect of these factors; they disagreed in several important ways. The Hearing Tribunal carefully considered the full submissions in this regard but provides only an overview of each below.

**The nature and gravity of the proven allegations:**

The Complaints Officer argued Ms. Draghici's conduct with respect to Allegation 1 was serious as the Hearing Tribunal had found that Ms. Draghici should not have spoken to her manager in a raised voice or been disrespectful to a colleague. Further the Complaints Officer submitted Ms. Draghici's conduct impacted on a colleague's ability to provide proper patient care and was unacceptable. Ms. Draghici failed to foster a respectful work environment, and this can have a significant impact on patient care and safety.

Regarding Allegation #5, the Complaints Officer argued the nature and gravity of that conduct is serious because it showed a failure to adhere to basic nursing principles relating to confidentiality.

The Complaints Officer suggested this is an aggravating factor demonstrating a need for significant sanctions particularly those with a remedial focus.

Counsel for Ms. Draghici argued Ms. Draghici was found not guilty in respect of the most serious allegations and proposes a caution relating to Allegation 1 and a reprimand relating to Allegation 5 would be appropriate.

**The age and experience of the investigated member:**

Ms. Draghici was a 14-year LPN at the time of the hearing, which the Complaints Officer argued is aggravating as given her knowledge and experience she ought to have known her conduct was unacceptable.

Counsel for Ms. Draghici noted that she acknowledges she is a mature and experienced LPN.

**The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:**

The Complaints Officer refers to a previous finding of unprofessional conduct in January 2017 in which Ms. Draghici had admitted to conduct similar to the conduct at hand: failing to foster respectful or collaborative relationships with her co-workers. The Complaints Officer noted Ms. Draghici was required to complete two courses at that time: Communication in Nursing Leadership offered by Course Park, and the LPN Ethics Course offered by Learning Nurse.

The Complaints Officer argued this is an aggravating factor.

Counsel for Ms. Draghici confirms that Ms. Draghici acknowledges the prior complaint.

**The number of times the offending conduct was proven to have occurred:**

The Complaints Officer argued the conduct took place over a period of months and was a pattern of conduct. Further that the number of times the conduct occurred shows a need for serious penalties as this was not a single one-off but shows issues in Ms. Draghici's conduct over a period of time, on multiple occasions and with multiple people. The Complaints Officer argued this is an aggravating factor.

**The role of the investigated member in acknowledging what occurred:**

The Complaints Officer submitted this is a neutral factor and cautions the Hearing Tribunal to take care not to treat a failure to admit conduct as aggravating. Further, the admission of some of the proven allegations by Ms. Draghici should not be attributed as mitigating for her as that did not arise until she was giving testimony.

Counsel for Ms. Draghici noted she acknowledged disclosing L.P.'s date of birth and that she had apologized to L.P. when it happened. Further, Ms. Draghici's evidence was that she speaks in a loud voice which is sometimes interpreted as criticism by others.

Counsel also noted it had been confirmed Ms. Draghici did not breach the Health Information Act and the Hearing Tribunal had erroneously indicated otherwise in its decision. The Hearing Tribunal confirms this is the case.

**Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:**

The Complaints Officer advised she is not aware of any financial impact on Ms. Draghici.

Counsel for Ms. Draghici submitted Ms. Draghici had been forced to participate in a multi-day hearing and to retain her own legal counsel to do so. Further, most of the allegations and particulars were dismissed as a result.

**The impact of the incident on the victim(s):**

The Complaints Officer cited the Hearing Tribunal's acknowledgement of stress resulting for some of Ms. Draghici's co-workers due to working with her. Further, S.P. found it stressful to work with Ms. Draghici stating she was not a good listener or team worker.

Respecting the disclosure of L.P.'s birthdate, the Complaints Officer points to L.P.'s experience.

The Complaints Officer argued there is no doubt Ms. Draghici's conduct negatively impacted L.P., S.P. and other colleagues and this is therefore an aggravating factor.

**The presence or absence of any mitigating circumstances:**

The Complaints Officer did not note any mitigating circumstances for consideration.

Counsel for Ms. Draghici argued the length of time for a determination in the matter is a mitigating factor.

**The need to promote specific and general deterrence and, thereby protect the public and ensure the safe and proper practice:**

The Complaints Officer cited two aspects of deterrence: general and specific deterrence.

In relation to specific deterrence – for Ms. Draghici – the Complaints Officer suggested Ms. Draghici's conduct suggested a lack of understanding of the importance of respectful workplace communications and a lack of respect for confidentiality. As such the sanction should address this to deter Ms. Draghici from engaging in similar conduct in the future.

The Complaints Officer noted general deterrence is required to show other members of the LPN profession such conduct is not acceptable and to deter them from engaging in such similar conduct.

Counsel for Ms. Draghici cited *Alsaadi v Alberta College of Pharmacy*, 2021 ABCA 313 in which the Court cautioned general deterrence does not justify imposing an unreasonably harsh sanction on an individual. Sanction need only meet denunciation and deterrence and once this is done there is no need for additional sanction.

He also argued the lack of intent (or a lack of finding respecting intent) is an appropriate consideration in determining sanction.

**The need to maintain the public's confidence in the integrity of the profession:**

The Complaints Officer argued it is important to hold members of the CLPNA to the standards and obligations expected of them and the Hearing Tribunal must consider the message to the public that will be sent by its sanction. The public would expect the Hearing Tribunal to sanction Ms. Draghici in a manner that demonstrates the regulator takes such conduct seriously. Maintaining public confidence in the profession is an important consideration to take account of for that reason.

Counsel for Ms. Draghici submitted the allegations which were dismissed most strongly engaged the concern for the integrity of the profession. The allegations which were proven are of limited significance with respect to protecting the public's confidence in the integrity of the profession.

**The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct**

The Complaints Officer states it is clear Ms. Draghici's conduct is a departure from the conduct expected of an LPN.

Counsel for Ms. Draghici acknowledged the comments raised by the Complaints Officer in her submissions but suggested that nonetheless it is clear the proven conduct is at the low end of the scale in terms of a departure from expected conduct.

**The range of sentences in other similar cases**

Counsel for the Complaints Officer provided three prior decisions with respect to members of the CLPNA in furtherance of the Complaints Officer's submissions.

*In College of Licensed Practical Nurses of Alberta and Smith*, the member admitted to a single allegation of breaching the duty to maintain confidentiality in sharing sensitive medical information with another staff member without justification. In that case the parties agreed to a reprimand, fine of \$1500, payment of 25% of costs and education measures were appropriate sanctions.

*In College of Licensed Practical Nurses of Alberta and Baxter*, the member also admitted to a single allegation of breaching the duty to maintain confidentiality. The parties agreed to a sanction including a reprimand, fine of \$1500, payment of 25% of costs and education measures were appropriate sanctions.

*In College of Licensed Practical Nurses of Alberta and Leduc*, the member admitted to several allegations of failing to act in a respectful and collaborative manner towards coworkers.

Again, the sanction was by agreement and included a reprimand, fine of \$1500, payment of 25% of costs to a maximum of \$3500, education measures and counselling for the member.

The Complaints Officer argued on the strength of these prior decisions, the sanction she proposes is appropriate.

Overall, the Complaints Officer argued the sanction represents an appropriate mix of punitive and rehabilitative measures.

Counsel for Ms. Draghici disagrees the cases presented have any instructive value and are, in fact, distinguishable. Particularly, counsel argued L.P.'s date of birth was not "sensitive medical information". It is argued asking Ms. Draghici to undertake counselling is an overreaction to the conduct proven.

### **Specific submissions respecting costs**

The Complaints Officer argued costs are appropriate to be awarded in this case. The mixed success of the parties in the hearing does not preclude an order of costs and the issue is not one of simply adding up the number of allegations total and comparing to those proven. Further, given the allegations proven relate to core competencies of an LPN, violated privacy and impacted the workplace that the conduct represents a marked departure from the conduct expected of LPNs.

Counsel for Ms. Draghici confirms the Hearing Tribunal may order costs for all or part of the investigation and hearing but argued none are appropriate in this case. First, while the Complaints Officer is seeking 25% of the costs of the hearing and investigation, no amount is offered to show what this might be. Further, the bulk of the allegations were dismissed but had constituted the bulk of the time spent at the hearing.

Counsel for Ms. Draghici also argued there is no basis for ordering costs in this matter in light of *Jinnah v Alberta Dental Association and College*, 2022 ABCA 336, which held costs are only ordered in these matters if particular circumstances are proven to be operative and none of those are presently applicable.

### **Further and other comments respecting sanction**

The Complaints Officer submitted Ms. Draghici engaged in serious unprofessional conduct on a number of occasions which also tends to merit a costs order.

Counsel for Ms. Draghici argued monetary fines are most often imposed in the criminal or regulatory context and the purpose of such sanction is to remove profit from the offender. As such, no penalty is necessary and would be disproportionate to Ms. Draghici's culpability.

## **(5) Submissions of the Complaints Officer on Sanction**

The Complaints Officer requests the following orders pursuant to section 82 of the HPA:

- a) The Hearing Tribunal's Decision shall serve as a reprimand.
- b) Ms. Draghici shall pay 25% of the costs of the investigation and hearing to be paid in full within 24 months of the date when Ms. Draghici is provided with a letter advising her of the total investigation and hearing costs.
- c) Ms. Draghici shall pay a fine for the total amount of \$500.00 to be paid in full within 12 months from service of the Hearing Tribunal's decision on sanction (the "Sanction Decision").
- d) Ms. Draghici 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. Draghici shall provide the Complaints Officer a signed declaration attesting she has read the documents within 30 days of service of the Sanction Decision:
  - i. Code of Ethics for Licensed Practical Nurses in Canada;
  - ii. Standards of Practice for Licensed Practical Nurses in Canada;
  - iii. CLPNA Policy: Client and & Co-worker Abuse;
  - iv. CLPNA Policy: Professional Responsibility & Accountability;
  - v. CLPNA Practice Guideline: Confidentiality;
  - vi. CLPNA Practice Guideline: Addressing Co-Worker Abuse in the Workplace.
- e) Ms. Draghici shall complete, at her own cost, the following remedial education. Ms. Draghici shall provide the Complaints Officer with a certificate confirming successful completion of all required education within 3 months of service of the Sanction Decision.
  - i. LPN Code of Ethics Module offered online by Learning Nurse at <http://www.learninglpn.ca/index.php/courses>. Cristina Draghici shall provide the Complaints Officer with a certificate confirming successful completion of the Module;
  - ii. Managing Workplace Communication Challenges available online at [www.nurse.com](http://www.nurse.com);
  - iii. Conflict Management and Resolution available online at [www.alison.com](http://www.alison.com)

If any of the required remedial education becomes unavailable, then Ms. Draghici 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. Draghici will be notified by the Complaints Officer, in writing, advising of the new education required.

f) The sanctions set out above at paragraphs (b) to (e) will appear as conditions on Ms. Draghici's practice permit and the Public Registry subject to the following:

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

i. Readings

ii. LPN Code of Ethics Course

iii. Managing Workplace Communication Challenges

iv. Conflict Management and Resolution

ii. The requirement to pay costs and fine, will appear as "Conduct Cost/Fines" on Ms. Draghici's practice permit and the Public Registry until all costs have been paid in full as set out above at paragraph 8(b) and 8(c).

g) According to the CLPNA's Regulations and Bylaws, Ms. Draghici shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Draghici will keep her contact information current with the CLPNA on an ongoing basis.

h) Should Ms. Draghici 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.

i) Should Ms. Draghici 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:

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

ii. Treat Ms. Draghici non-compliance as information for a complaint under s. 56 of the Act; or

iii. In the case of non-payment of the costs described in paragraph 8(b) above, suspend Ms. Draghici'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.

#### **(6) Submissions of Ms. Draghici on Sanction**

Ms. Draghici submitted the appropriate sanction in this case is for the Hearing Tribunal to issue a warning in respect of the findings at Allegation 1 and a reprimand with respect to the findings relating to Allegation 5.

Ms. Draghici did not agree with the order of payment of costs of the investigation and hearing nor fines. Ms. Draghici did not agree with the other sanctions that were proposed by the CLPNA Complaints Officer.

#### **(7) Decision of the Hearing Tribunal on Sanction**

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 Ms. Draghici has engaged in. In making its decision on penalty, the Hearing Tribunal considered the number of factors identified in *Jaswal* as follows:

##### **The nature and gravity of the proven allegations:**

The nature and gravity of the allegations are on the lower end of the scale of severity.

##### **The age and experience of the investigated member:**

Ms. Draghici had been an LPN for approximately 14 years at the time of the allegations, well experienced and was aware of the expectations of an LPN.

##### **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:**

Ms. Draghici did have a prior complaint from January 2017 which was in relation to not fostering respectful relationships within the workplace. This was relevant as it was three years prior to these allegations and shows a pattern of behavior.

##### **The age and mental condition of the victim, if any:**

The Hearing Tribunal heard nothing with respect to this factor.

**The number of times the offending conduct was proven to have occurred:**

This conduct took place over a period of months from 2019 until June 2020 and happened on three separate occasions which included four incidents. Two of the four incidents occurred on the same day. This shows a pattern of behavior over a limited period of time.

**The role of the investigated member in acknowledging what occurred:**

Ms. Draghici did not admit to all the allegations that were brought against her and this was not an aggravating factor. This is a neutral factor.

Ms. Draghici did acknowledge with respect to LP's date of birth what occurred. Ms. Draghici did apologize to LP at the time of the incident. Ms. Draghici also acknowledged that sometimes she speaks in a loud voice, and this is sometimes interpreted in another way by others. This was not a breach of the *Health Information Act* as LP was not in the care of Ms. Draghici.

**Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:**

The Hearing Tribunal did not take this into account as while it was Ms. Draghici's decision to engage legal counsel, this is not thought of as a penalty as contemplated by *Jaswal*.

**The impact of the incident on the victim(s):**

Ms. Draghici's conduct had a significant impact on the individuals. Ms. Draghici's conduct did affect how they felt being at the workplace.

**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 protect the public and ensure the safe and proper practice:**

Specific deterrence is required to keep Ms. Draghici from repeating the same conduct in the future. General deterrence is required to ensure that other members of the LPN profession do not engage in similar conduct as well as to make sure that it is known that this type of conduct will not be tolerated by the CLPNA.

With regards to specific deterrence regarding Ms. Draghici; Ms. Draghici did have a prior complaint in 2017 and then another complaint in 2020 which were similar in nature. Specific deterrence is ensured by the orders that were made in respect to Ms. Draghici that are in

response to the allegations. These orders would deter other LPNs in the profession from engaging in this type of behavior.

**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 in 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 degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct:**

Ms. Draghici did partake in unprofessional conduct which was found by the Hearing Tribunal. It fell outside of the range of expected conduct but was on the low end of severity.

**The range of sentences in other similar cases:**

The Complaints Officer provided the Hearing Tribunal with three similar cases, in which two of the cases dealt with breaches in confidentiality in respect to medical information which is slightly different to the information that Ms. Draghici accessed which was non-medical information. There was another case which was about failing to foster respectful relationships in the workplace. These are to show the type of sanctions that were deemed appropriate for the type of conduct and proportionate to the sanctions that are being purposed.

The Hearing Tribunal notes these cases preceded the *Jinnah* decision of the Alberta Court of Appeal which has resulted in significant change in the approach to costs in this context. The Hearing Tribunal does not find this to be a case where costs are warranted considering *Jinnah*. The conduct in question does not rise to the severity as mandated under *Jinnah*.

**(8) Orders of the Hearing Tribunal**

The Hearing Tribunal hereby orders the following pursuant to section 82 of the Act:

- a) The Hearing Tribunal's Decision shall serve as a reprimand.
- b) Ms. Draghici shall pay a fine for the total amount of \$500.00 to be paid in full within 24 months of when this decision is provided to the parties. No costs are awarded.
- c) Ms. Draghici shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website <http://www.clpna.com> under "Governance". If such

documents become unavailable, they may be substituted by equivalent documents approved in advance by the Complaints Officer. Ms. Draghici shall provide the Complaints Officer a signed declaration attesting that she has read the documents within **30 days** of service of the Sanction Decision:

- i. Code of Ethics for Licensed Practical Nurses in Canada;
  - ii. Standards of Practice for Licensed Practice Nurses in Canada;
  - iii. CLPNA Policy: Client and Co-worker Abuse;
  - iv. CLPNA Policy: Professional Responsibility and Accountability;
  - v. CLPNA Practice Guideline: Confidentiality;
  - vi. CLPNA Practice Guideline: Addressing Co-Worker Abuse in the Workplace.
- d) Ms. Draghici shall complete, at her own cost, the following remedial education. Ms. Draghici shall provide the Complaints Officer with a certificate confirming successful completion of all required education within **3 months** of service of the Sanction Decision.
- i. **LPN Code of Ethics Module** offered online by Learning Nurse at <http://www.learninglpn.ca/index.php/courses>. Ms. Draghici shall provide the Complaints Officer with a certificate confirming successful completion of the module;
  - ii. **Managing Workplace Communication Challenges** available online at [www.nurse.com](http://www.nurse.com);
  - iii. **Conflict Management and Resolution** available online at [www.alison.com](http://www.alison.com)

If any of the required remedial education becomes unavailable, then Ms. Draghici shall request, in writing to the Complaints Officer, to be assigned alternative education **prior to the deadline**. The Complaints Officer shall, under their sole discretion, reassign the education. Ms. Draghici will be notified by the Complaints Officer, in writing, advising Ms. Draghici of the new education required.

- e) The sanctions set out above at paragraphs 8(b) to 8(d) will appear as conditions on Ms. Draghici's practice permit and the Public Registry subject to the following:
- i. The requirement to complete the remedial education and readings outlined at paragraph 8(c) will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Draghici's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

- i. Readings
  - ii. LPN Code of Ethics Course
  - iii. Managing Workplace Communication Challenges
  - iv. Conflict Management and Resolution
- ii. The requirement to pay the fine, will appear as “Conduct Fines” on Ms. Draghici’s practice permit and the Public Registry until the fine has been paid in full as set out above at paragraph 8(b).
- f) According to the CLPNA’s Regulations and Bylaws, Ms. Draghici shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Draghici will keep her contact information current with the CLPNA on an ongoing basis.
- g) Should Ms. Draghici 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.
- h) Should Ms. Draghici 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:
- i. Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
  - ii. Treat Ms. Draghici as non-compliance as information for a complaint under s.56 of the Act.

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

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 17<sup>th</sup> DAY OF JULY 2024 IN THE CITY OF EDMONTON, ALBERTA.**

**THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

A handwritten signature in cursive script that reads "Kelly Anesty".

Kelly Anesty, LPN,  
Chair, Hearing Tribunal