COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF CASANDRA MEHOK

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

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT*
REGARDING THE CONDUCT OF CASANDRA MEHOK, LPN #46836, WHILE A

MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference on March 15, 2024 and November 8, 2024 with the following individuals present:

Hearing Tribunal:
Andrew Otway, Public Member, Chair
Jennifer Vloerbergh, LPN
Nicole Searle, LPN
Don Wilson, Public Member

Independent Legal Counsel: Heidi Besuijen

Staff:
Katrina Haymond, Legal Counsel for the Complaints Director, CLPNA
Vita Wensel, Legal Counsel for the Complaints Director, CLPNA
Susan Blatz, Complaints Officer, CLPNA

Investigated Member:
Casandra Mehok, LPN ("Ms. Mehok" or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

The parties initially convened on March 15, 2024, to present the ASF and Acknowledgement of Unprofessional Conduct and JSP. At that time, the Hearing Tribunal accepted the ASF but asked the parties to provide relevant decisions from

the CLPNA or other regulated professions in Alberta or in Canada relating to the JSP to assist the Hearing Tribunal to consider the appropriateness of it.

The parties reconvened on November 8, 2024. At that time Ms. Milne was not present to represent Ms. Mehok. Ms. Haymond similarly did not attend but Ms. Wensel was present to represent the Complaints Director.

Before proceeding with the continuation of the hearing on November 8, 2024, the Hearing Tribunal confirmed that Ms. Mehok was aware that she was entitled to be represented at the hearing in accordance with section 72(1) of the *Health Professions Act*, RSA 2000, c H-7 (the "Act"). Ms. Mehok confirmed that she was aware that she was entitled to be represented but wanted to continue with the hearing without representation.

Counsel for the Complaints Director also made an application to seek that the Hearing Tribunal canvas certain matters with Ms. Mehok to confirm her understanding of the process and what the Hearing Tribunal was being asked to consider. The Hearing Tribunal agreed and proceeded to make inquiries with Ms. Mehok to that effect.

First, the Hearing Tribunal asked Ms. Mehok to confirm that she had reviewed the ASF, that she understood the factual admissions made in signing the ASF, that she understood what unprofessional conduct she was agreeing to by signing the ASF, and that she understood the Hearing Tribunal would rely on the ASF in determining the appropriate sanction. Ms. Mehok answered affirmatively to each of these inquiries.

Second, the Hearing Tribunal asked Ms. Mehok to confirm that she had reviewed the JSP, that in proceeding with the JSP she was agreeing to all the requirements set out in the JSP, and that she understood that the Hearing Tribunal could order any penalty it might deem appropriate upon hearing submissions about the JSP. Ms. Mehok answered affirmatively to each of these inquiries.

The Hearing Tribunal again confirmed that Ms. Mehok was entitled to seek legal advice or other representation. The Hearing Tribunal also confirmed that Ms. Mehok understood that neither the Complaint's Director legal counsel nor Independent Legal Counsel for the Hearing Tribunal could provide Ms. Mehok with legal advice. Ms. Mehok confirmed she understood that she knew about her right to representation but elected to proceed without and that the legal counsel for the Complaints Director and Independent Legal Counsel would not provide her with legal advice.

Finally, the Hearing Tribunal asked Ms. Mehok to confirm that she understood it was her choice to proceed with the hearing, in acknowledging her conduct and that she was doing so voluntarily. Ms. Mehok confirmed that this was the case.

Being satisfied that Ms. Mehok understood these matters, the Hearing Tribunal proceeded with considering the JSP.

(3) Background

Ms. Mehok was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Mehok was initially licensed as an LPN in Alberta on September 18, 2018.

Four complaints were referred to the Hearing Tribunal for consideration.

(1) Complaint #1

On June 1, 2022, the CLPNA received a complaint (the "**Complaint #1**") about Ms. Mehok. Complaint #1 alleged concerns regarding Ms. Mehok's practice as an LPN while working at Northern Lights Regional Health Centre in Fort McMurray (the "**Facility #1**"). Complaint #1 raised concerns regarding medication administration, documentation, access to client information and the removal of medication from the Facility #1's automated medication dispensing system, Omnicell.

Complaint #1 was made by Ms. Jamiee Atkin, Manager of the Medicine Unit (the "**Unit #1**") at the Facility #1.

Complaint #1 was submitted pursuant to s. 57 of the *Health Professions Act* (the "**Act**") based on Ms. Mehok's termination from the Facility #1 on April 27, 2022.

By letter dated June 1, 2022, the CLPNA's former Complaints Director, Ms. Sandy Davis (the "**Former Complaints Director**") provided Ms. Mehok with Notice of the Complaint. Within the letter, Ms. Davis appointed Ms. Susan Blatz, Complaints Officer for the CLPNA (the "**Complaints Officer**"), to handle Complaint #1 pursuant to s. 20(1) of the Act.

In accordance with s. 55(2)(d) of the Act, Ms. Davis also appointed Katie Emter, Investigator for the CLPNA (the "**Investigator #1**"), to investigate Complaint #1. The Investigator concluded her investigation on March 17, 2023, and submitted her investigation report to the Complaints Officer.

The Complaints Officer determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Mehok received notice that the matter was referred to a hearing by way of letter dated August 21, 2023.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Mehok by way of letter dated September 18, 2023.

(2) Complaint #2

On March 14, 2023, the CLPNA received a complaint (the "**Complaint #2"**) about Ms. Mehok. Complaint #2 alleged concerns regarding Ms. Mehok's practice as an LPN while working at Grey Nuns Hospital (Covenant Health) in Edmonton (the "**Facility #2**"). Complaint #2 raised concerns regarding medication administration, documentation and removal of medication from the Facility #2's automated medication dispensing system, Pyxis.

Complaint #2 was submitted pursuant to s. 57 of the Act based on Ms. Mehok's termination during a probationary period from the Facility #2 on March 10, 2023.

By letter dated March 31, 2023, the CLPNA's Complaints Director, Ms. Sanah Sidhu (the "**Complaints Director**") provided Ms. Mehok with Notice of the Complaint. Within the letter, Ms. Sidhu appointed the Complaints Officer to handle the Complaint pursuant to s. 20(1) of the Act.

In accordance with s. 55(2)(d) of the Act, the Complaints Director also appointed Neal York, Investigator for the CLPNA (the "**Investigator #2**"), to investigate the Complaint. The Investigator concluded his investigation on July 6, 2023, and submitted his investigation report to the Complaints Officer.

The Complaints Officer determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Mehok received notice that the matter was referred to a hearing by way of letter dated September 28, 2023.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Mehok by way of letter dated January 18, 2024.

(3) Section 65 Order #1

Arising from Complaint #2, on March 31, 2023, the Complaints Officer sought an order, pursuant to section 65 of the Act, to restrict Ms. Mehok's practice as an LPN. Specifically, the Complaints Officer sought a narcotics restriction, prohibiting Ms. Mehok from accessing or administering narcotics. Within the Complaints Officer's submissions, she indicated that Ms. Mehok was notified and was advised to make submissions no later than April 11, 2023.

On April 13, 2023, Ms. Lynn Boris, the designated decision maker by the Council of CLPNA, issued a decision and order pursuant to section 65 of the Act to impose a

narcotics restriction on Ms. Mehok's practice permit (the "**Section 65 Order #1"**). The specifically:

> *"You are not permitted to access, co-sign, or administer narcotic or controlled substances. This condition is in effective immediately and failure to comply with this condition will result in immediate suspension of your registration and Practice Permit with the CLPNA."*

The Section 65 Order #1 also emphasized that Ms. Mehok was required to immediately advise CLPNA of any employer with whom she was currently employed and that she must inform any new employer of the narcotics restriction.

(4) Complaint #3

On September 8, 2023, the CLPNA received a complaint (the "**Complaint #3"**) about Ms. Mehok, Complaint #3 alleged concerns regarding Ms. Mehok's practice as an LPN while working at Poundmaker's Lodge Treatment Centres in Edmonton and St. Albert (the "**Facility #3**"). Complaint #3 raised concerns regarding Ms. Mehok's work as an LPN, including being in direct contact and administering narcotics to clients, while bound by the Section 65 Order #1 to not access or administer any narcotics. Additionally, the Complainant #3 raised concerns that they were not informed by Ms. Mehok regarding the narcotics restriction on her practice permit after commencing employment on April 5, 2023.

Complaint #3 was submitted pursuant to s. 57 of the Act based on Ms. Mehok's termination from the Facility #3 on August 30, 2023.

By letter dated October 20, 2023, the Complaints Director provided Ms. Mehok with Notice of the Complaint. Within the letter, the Complaints Director appointed the Complaints Officer to handle the Complaint pursuant to s. 20(1) of the Act.

In accordance with s. 55(2)(d) of the Act, the Complaints Director also appointed Investigator #2 to investigate the Complaint. The Investigator #2 concluded his investigation on November 24, 2023, and submitted his investigation report to the Complaints Officer.

The Complaints Officer determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Mehok received notice that the matter was referred to a hearing by way of letter dated January 11, 2024.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Mehok by way of letter dated January 18, 2024.

(5) Section 65 Order #2

Arising from Complaint #3, on September 11, 2023, Ms. Stephanie Karkutly, a Complaints Officer at CLPNA, sought an order, pursuant to section 65 of the Act, to suspend Ms. Mehok's practice as an LPN. Specifically, Ms. Karkutly sought a narcotics restriction, prohibiting Ms. Mehok from accessing or administering narcotics. Within Ms. Karkutly's submissions, she indicated that Ms. Mehok was notified and was advised to make submissions no later than September 13, 2023.

On September 15, 2023, Ms. Lynn Boris, the designated decision maker by the Council of CLPNA, issued a decision and order pursuant to section 65 of the Act to suspend Ms. Mehok's practice permit (the "**Section 65 Order #2"**).

(6) Complaint #4

On October 18, 2023, the CLPNA received a complaint (the "**Complaint #4"**) about Ms. Mehok, Complaint #4 alleged concerns regarding Ms. Mehok's practice as an LPN while working at Edmonton Remand Centre (Alberta Health Services) in Edmonton (the "**Facility #4**"). The Complainant in Complaint #4 alleged that they were not informed by Ms. Mehok regarding the narcotics restriction on her practice permit or of her subsequent suspension.

Complaint #4 was submitted pursuant to s. 57 of the Act based on Ms. Mehok's termination from the Facility #4 on October 11, 2023.

By letter dated October 20, 2023, the Complaints Director provided Ms. Mehok with Notice of the Complaint. Within the letter, the Complaints Director appointed the Complaints Officer to handle the Complaint pursuant to s. 20(1) of the Act.

In accordance with s. 55(2)(d) of the Act, the Complaints Director also appointed Investigator #2 to investigate the Complaint. The Investigator #2 concluded his investigation on November 24, 2023, and submitted his investigation report to the Complaints Officer.

The Complaints Officer determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Mehok received notice that the matter was referred to a hearing by way of letter dated January 11, 2024.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Mehok by way of letter dated January 18, 2024.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations"), as amended, are as set out below.

"It is alleged that Casandra Mehok, LPN, engaged in unprofessional conduct by:

Complaint #1

Allegation 1

On or about January 15, 2022, failed to document the reason for the withdrawal and/or medication administration of Hydromorphone 1 mg from Omnicell at 1312 hours for client JT on the Medication Administration Record, Pain Management Record and/or Nurses Notes.

Allegation 2

On or about January 16, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client JT:

a. withdrew Hydromorphone 2 mg from Omnicell at 0719 hours, documented on the Medication Administration Record the administration of Hydromorphone 1 mg at 0800 hours but failed to account for the remaining Hydromorphone 1 mg;
b. failed to document the reason for the withdrawal of Hydromorphone 1mg from Omnicell at 1014 hours on the Pain Management Record and/or Nurses Notes;
c. withdrew Hydromorphone 2 mg from Omnicell at 1014 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 2 mg prior to that at 1004 hours;
d. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone 1 mg from Omnicell at 1903 hours on the Nurses Notes and the Medication Administration Record.

Allegation 3

On or about January 16, 2022, failed to follow proper documentation practices by doing one of more of the following with regards to client AP:

a. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 0844 hours on the Pain Management and/or Nurses Notes;
b. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1323 hours on the Pain Management and/or Nurses Notes.

Allegation 4

On or about January 18, 2022, failed to document the reason for the withdrawal and/or medication administration of Hydromorphone 1 mg from Omnicell at 0753 hours for client JT on the Medication Administration Record, Nurses Notes or Pain Management Records.

Allegation 5

On or about March 11, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client DB:

a. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1029 hours on the Pain Management Record and/or Nurses Notes;
b. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1753 hours on the Pain Management Record and/or Nurses Notes;
c. withdrew Hydromorphone 2 mg from Omnicell at 1753 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 2 mg prior to that at 1750 hours.

Allegation 6

On or about March 11, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client TM:

a. withdrew Hydromorphone 6 mg from Omnicell at 0729 hours, documented on the Medication Administration Record the administration of 5 mg of Hydromorphone at 0724 hours but failed to account for the remaining 1 mg of Hydromorphone;
b. failed to document accurately on the Medication Administration Record the administration of Hydromorphone 5 mg at 0724h hours when Hydromorphone 6 mg was withdrawn from Omnicell at 0729 hours;
c. administered Hydromorphone 4 mg at 1320 hours when the order was for Hydromorphone 5 mg every 3-4 hours as needed and the last dose was administered at 1100 hours.

Allegation 7

On or about February 9, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client CS:

a. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1202 hours;
b. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1619 hours on the Pain Management and/or Nurses Notes;
c. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1630 hours.

Allegation 8

On or about February 21, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client GG:

a. withdrew Hydromorphone 2 mg from Omnicell at 0733 hours but failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 0730 hours;
b. withdrew Hydromorphone 2 mg from Omnicell at 1025 hours but failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1033 hours;
c. withdrew Hydromorphone 2 mg from Omnicell at 1314 hours but failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1315 hours;
d. withdrew Hydromorphone 2 mg from Omnicell at 1603 hours but failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1600 hours;
e. withdrew Hydromorphone 2 mg from Omnicell at 1842 hours but failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1855 hours.

Allegation 9

On or about February 18, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client UC:

a. withdrew Hydromorphone 2 mg from Omnicell at 0726 hours but inaccurately documented on the Medication Administration Record a dose of Hydromorphone was administered prior to that at 0720 hours;
b. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 0720 hours;
c. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1040 hours;

d. administered an unknown dose of Hydromorphone at 1040 hours when the order was for every 4 hours and the last dose was administered at 0720 hours;
e. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1358 hours on the Pain Management and/or Nurses Notes;
f. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1438 hours;
g. failed to document the reason for the withdrawal of Hydromorphone 2 mg from Omnicell at 1814 hours on the Pain Management and/or Nurses Notes;
h. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1820 hours.

Allegation 10

On or about February 22, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client UC:

a. administered Hydromorphone 2 mg at 1050 hours, when the order was for every 4 hours and the last dose was administered at 0750 hours;
b. withdrew Hydromorphone 2 mg from Omnicell at 1058 hours but inaccurately documented on the Medication Administration Record the administration of a dose of Hydromorphone prior to that at 1050 hours;
c. withdrew Hydromorphone 2 mg from Omnicell at 1824 hours, then wasted 2 mg at 1900 hours and when the order was for every 4 hours and the last dose was administered at 1500 hours.

Allegation 11

On or about February 27, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client BP:

a. withdrew Hydromorphone 1 mg from Omnicell at 1622 hours but failed to document the reason for the withdrawal on the Pain Management and/or Nurses Notes;
b. withdrew Hydromorphone 1 mg from Omnicell at 1622 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 1 mg prior to that at 1620 hours;
c. failed to document the reason for the withdrawal of Hydromorphone 1 mg from Omnicell at 1852 hours on the Pain Management Record and/or Nurses Notes;

d. withdrew Hydromorphone 1 mg from Omnicell at 0749 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 1 mg prior to that at 0740 hours.

Allegation 12

On or about February 28, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client BP:

a. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone 1 mg from Omnicell at 0745 hours on the Medication Administration Record, Pain Management Record and/or Nurses Notes;
b. withdrew Hydromorphone 1 mg from Omnicell at 1022 hours but inaccurately documented on the Medication Administration Record the administration of a dose of Hydromorphone prior to that at 1020 hours;
c. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1020 hours;
d. withdrew Hydromorphone 1 mg from Omnicell at 1308 hours but failed to document the reason for the withdrawal on the Pain Management and/or Nurses Notes;
e. failed to specify on the Medication Administration Record the dose of Hydromorphone administered at 1310 hours;
f. withdrew Hydromorphone 1 mg from Omnicell at 0745 hours when the order was for every 3 hours as needed and the last dose was administered at 0625 hours.

Allegation 13

On or about March 1, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client BP:

a. withdrew Hydromorphone 1 mg from Omnicell at 1616 hours but failed to document the reason for the withdrawal and/or medication administration on the Medication Administration Record, Pain Management Record and/or Nurses Notes;
b. withdrew Hydromorphone 1 mg from Omnicell at 0743 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 1 mg prior to that at 0730 hours;

c. withdrew Hydromorphone 1 mg from Omnicell at 1036 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 1 mg prior to that at 1030 hours.

Allegation 14

On or about March 2, 2022, failed to follow proper documentation practices by doing one or more of the following with regards to client BP:

a. failed to document on the Medication Administration Record the administration of Hydromorphone 1 mg withdrawn from Omnicell at 1616 hours;
b. withdrew Hydromorphone 1 mg from Omnicell at 1323 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 1 mg prior to that at 1315 hours.

Allegation 15

On or about March 3, 2022, removed Hydromorphone 3 mg from Omnicell at 1649 hours for client TM, documented on the Medication Administration Record the administration of 2 mg of Hydromorphone at 1655 hours but failed to account for the remaining 1 mg of Hydromorphone.

Allegation 16

On or about March 8, 2022, failed to follow proper medication administration practices and/or documentation practices when they did one or more of the following with regards to client TM:

a. withdrew Hydromorphone 4 mg from Omnicell at 0722 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 5 mg at 0740 hours;
b. withdrew the incorrect dose of Hydromorphone at 0722 hours when the order was for Hydromorphone 5 mg and Hydromorphone 4 mg was withdrawn;
c. withdrew Hydromorphone 4 mg from Omnicell at 1017 hours but inaccurately documented on the Medication Administration Record the administration of Hydromorphone 5 mg at 1030 hours;
d. withdrew the incorrect dose of Hydromorphone at 1017 hours when the order was for Hydromorphone 5 mg and Hydromorphone 4 mg was withdrawn;

e. withdrew Hydromorphone 6 mg from Omnicell at 1759 hours when the order was for Hydromorphone 5 mg every three hours and the last dose was administered at 1544 hours;
f. withdrew the incorrect dose of Hydromorphone at 1759 hours when the order was for Hydromorphone 5 mg and Hydromorphone 6 mg was withdrawn, with 1 mg of Hydromorphone wasted by an LPN colleague at 1919 hours;
g. failed to document on the Medication Administration Record the administration of Hydromorphone 6 mg withdrawn from Omnicell at 1759 hours.

Allegation 17

On or about March 11, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client TM:

a. failed to accurately document on the Medication Administration Record the administration of Hydromorphone 5 mg at 1320 hours when a different dose of Hydromorphone 4 mg was withdrawn at 1316 hours from the Omnicell.

Allegation 18

On or about March 12, 2022, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client TM:

a. failed to document the reason for the withdrawal of Hydromorphone 5 mg from Omnicell at 1549 hours on the Pain Management and/or Nurses Notes;
b. withdrew Hydromorphone 6 mg from Omnicell at 0845 hours, documented on the Medication Administration Record the administration of Hydromorphone 5 mg but failed to account for the remaining 1 mg of Hydromorphone.

Allegation 19

On or between January 15, 2022, and March 19, 2022, misappropriated doses of Hydromorphone from their place of employment on multiple occasions for an unauthorized and/or improper purpose, including one or more of the following:

a. doses of Hydromorphone withdrawn from Omnicell where there was no reason documented for the withdrawals;
b. doses of Hydromorphone that were not specified when a dose was documented as administered;

c. doses of Hydromorphone that were withdrawn from Omnicell and/or administered at the incorrect time considering the timing of the last dose administered;
d. doses of Hydromorphone that were documented as administered prior to being withdrawn from Omnicell;
e. doses of Hydromorphone documented as administered to clients that were not administered;
f. doses of Hydromorphone that were not accounted for, specifically:
    i. relating to client JT, Hydromorphone 1 mg on January 16, 2022;
    ii. relating to client TM, Hydromorphone 1 mg on March 3, 2022;
    iii. relating to client TM, Hydromorphone 1 mg on March 11, 2022;
    iv. relating to client TM, Hydromorphone 1 mg on March 12, 2022.

Allegation 20

On or between January 15, 2022, and March 19, 2022, they inaccurately documented on multiple Medication Administration Records, Pain Management Records and/or Nurses Notes for the purpose of misappropriating Hydromorphone for an unauthorized and/or improper purpose.

Allegation 21

On or between February 8, 2022, and March 19, 2022, continued to administer narcotics to patients not under their care without consulting or advising the primary nurse for the client, despite receiving a letter of warning on February 7, 2022, advising them that their conduct was inappropriate.

Allegation 22

On or between January 15, 2022, and March 19, 2022, failed to administer one or more doses of Hydromorphone to a client after documenting they had done so, including one or more of the following:
a. client AP on January 16, 2022;
b. client JT on January 18, 2022;
c. client DB on March 11, 2022;
d. client TU on March 19, 2022.

Allegation 23

On or between February 9, 2022, and March 19, 2022, accessed client health information on multiple occasions without proper authorization or justification and when not assigned to the clients."

Complaint #2

Allegation 1

On or about February 23, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client MJ:

a. failed to document the reason for withdrawal and/or medication administration of Hydromorphone 2 mg from the Pyxis at 1237 hours on the Medication Record and/or Nurse's Assessment and Clinical Record;
b. withdrew Hydromorphone 2 mg from the Pyxis at 1237 hours when the Doctor's order was for 0.5 mg - 1 mg every three hours as needed;
c. failed to document the reason for withdrawal and/or medication administration of Hydromorphone 2 mg from the Pyxis at 1445 hours on the Medication Record and/or Nurse's Assessment and Clinical Record;
d. withdrew Hydromorphone 2 mg from the Pyxis at 1445 hours when the Doctor's order was for 0.5 mg – 1 mg every three hours as needed;
e. withdrew Hydromorphone 2 mg at 1445 hours when the Doctor's order was for 0.5 mg - 1 mg every three hours as needed and the last dose was withdrawn at 1237 hours.

Allegation 2

On or about March 1, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client BH:

a. withdrew Hydromorphone 2 mg from the Pyxis at 0740 hours without a Doctor's order to do so;
b. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone at 0740 hours on the Medication Record and/or Nurse's Assessment and Clinical Record;
c. withdrew Hydromorphone 2 mg from the Pyxis at 1120 hours without a Doctor's order to do so;

f. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone at 1120 hours on the Medication Record and/or Nurse's Assessment and Clinical Record;
g. removed Morphine 10 mg from the Pyxis at 1445 hours, documented on the Medication Record the administration of Morphine 5 mg at 1500 hours but failed to account for the remaining Morphine 5 mg;
h. failed to document the medication administration of Morphine 5 mg on the Nurse's Assessment and Clinical Record.

Allegation 3

On or about March 1, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client RW:

a. failed to document the withdrawal and/or medication administration of Hydromorphone 2 mg from the Pyxis at 1457 hours on the Medication Record and/or Nurse's Assessment and Clinical Record;
b. withdrew Hydromorphone 2 mg from the Pyxis at 1457 hours when the Doctor's order was for Hydromorphone 0.5 mg – 1 mg IM/PO/IV every hour as needed.

Allegation 4

On or about March 2, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client CA:

a. withdrew Hydromorphone 2 mg from the Pyxis at 0752 hours without a Doctor's order to do so;
b. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone at 0752 hours on the Medication Record and/or Nurse's Assessment and Clinical Record.

Allegation 5

On or about March 2, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client DM:

a. withdrew Hydromorphone 2 mg from the Pyxis at 0812 hours without a Doctor's order to do so;

b. withdrew Hydromorphone 2 mg from the Pyxis at 0812 hours, documented on the Medication Record the administration of Hydromorphone 1.5 mg at 0745 hours but failed to account for the remaining Hydromorphone 0.5 mg;
c. withdrew Hydromorphone 2 mg from the Pyxis at 0812 hours but inaccurately documented on the Medication Record the administration of Hydromorphone 1.5 mg prior to that at 0745 hours;
d. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone at 0745 hours on the Nurse's Assessment and Clinical Record;
e. withdrew Hydromorphone 2 mg from the Pyxis at 1022 hours without a Doctor's order to do so;
f. failed to document the reason for the withdrawal and/or medication administration of Hydromorphone 2 mg at 1022 hours on the Medication Record and/or Nurse's Assessment and Clinical Record.

Allegation 6

On or about March 2, 2023, failed to follow proper medication administration practices and/or documentation practices by doing one or more of the following with regards to client JL:

a. withdrew Hydromorphone 2 mg from the Pyxis at 1112 hours, documented on the Medication Record at 1125 hours the administration of 1 mg of Hydromorphone, but failed to account for the remaining Hydromorphone 1 mg;
b. failed to accurately document the medication administration of Hydromorphone 1 mg when they documented the same administration at 1110 hours on the Nurses Assessment and Clinical Record and 1125 hours in the Medication Record.

Allegation 7

On or between February 23, 2023 and March 2, 2023, misappropriated doses of Hydromorphone and Morphine from their place of employment on multiple occasions for an unauthorized and/or improper purpose, including one or more of the following:

a. doses of Hydromorphone withdrawn from the Pyxis where there was no Doctor's order to do so;

b. doses of Hydromorphone withdrawn from the Pyxis where there was no reason documented for the withdrawals;

c. a dose of Hydromorphone that was documented as administered prior to being withdrawn from the Pyxis;

d. a dose of Hydromorphone that was withdrawn from the Pyxis at the incorrect time considering the timing of the last dose administered;

e. doses of Hydromorphone withdrawn from the Pyxis where the doses were more than the Doctor's order;

f. doses of Hydromorphone and Morphine that were not accounted for, specifically:

    i. relating to client BH, Morphine 5 mg on March 1, 2023;

    ii. relating to client DM, Hydromorphone 0.5 mg on March 2, 2023;

    iii. relating to client JL, Hydromorphone 1 mg on March 2, 2023.

Complaint #3

Allegation 1

Between April 13, 2023, and August 30, 2023, failed to inform her employer, Poundmaker's Lodge Treatment Centre, that her LPN practice permit was subject to a condition arising from a section 65 order (the "**Order"**), specifically that she was not permitted to access, co-sign or administer narcotics or controlled substances.

Allegation 2

Between April 13, 2023 and August 30, 2023, while she was employed at Poundmaker's Lodge Treatment Centre, failed to inform CLPNA of her employer's name and contact information, as required by the Order that restricted her practice permit.

Allegation 3

Between April 13, 2023, and August 30, 2023, while employed as an LPN at Poundmaker's Lodge Treatment Centre, breached the Order when on at least one occasion, she accessed, co-signed and/or administered suboxone, a Schedule 1 controlled substance (buprenorphine/naloxone) pursuant to the *Controlled Drugs and Substances Act*.

Complaint #4

Allegation 1

Between June 16, 2023 and August 30, 2023, failed to inform her employer, Alberta Health Services (Edmonton Remand Centre), that her LPN practice permit was subject to a condition arising from the Order, specifically that she was not permitted to access, co-sign or administer narcotics or controlled substances.

Allegation 2

Between June 16, 2023 and August 30, 2023, while she was employed with Alberta Health Services (Edmonton Remand Centre), failed to inform CLPNA of her employer's name and contact information, as required by the Order.

(5) Admission of Unprofessional Conduct

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

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	Attachments to the Agreed Statement of Facts
Exhibit #4:	Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the ASF and the Attachments to the ASF which were admitted as Exhibits #2 and #3 respectively.

(8) Decision of the Hearing Tribunal and Reasons

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

The Hearing Tribunal has reviewed the documents included in Exhibit #2 and #3 and finds as facts the events as set out in the Agreed Statement of Facts.

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

For the purposes of this decision, given the length of the allegations, the Hearing Tribunal will not repeat the allegations, which are set out above, but instead address only the facts relating to each. The Hearing Tribunal accepts all the allegations presented as true and as constituting conduct sufficiently serious to be unprofessional conduct. The Hearing Tribunal will provide its reasons in respect of all four complaints together as several of the underlying facts are similar and give rise to the same considerations in respect of unprofessional conduct.

Complaint #1

Casandra Mehok admitted to Allegations 1-23 arising in respect of Complaint #1. The conduct giving rise to this complaint is set out as follows. The conduct relating to Allegations 1-18 relate to issues in medication and documentation practices. The conduct relating to Allegations 19-23 relate to issues arising from misappropriation of Hydromorphone.

Background Information relating to Complaint #1

(1) History of concerns on the Unit #1

Ms. Mehok was a regulated member of the CLPNA and employee of Facility #1 at all times material to the allegations under Complaint #1. Ms. Mehok was initially registered with the CLPNA on September 18, 2018, and began her employment with the Facility #1 in the fall of 2019. She was hired to work in a full-time position on the Unit #1.

In or about January of 2022, Ms. Atkins began receiving verbal complaints from Ms. Mehok's co-workers, who alleged that Ms. Mehok was withdrawing and administering Hydromorphone to clients who were not assigned to her care, and then neglected to notify them that medication had been administered. There were also concerns regarding her documentation.

Ms. Mehok was placed on administrative leave with pay pending an investigation. Upon conclusion of the internal investigation, Ms. Atkin provided Ms. Mehok a letter of warning on February 7, 2022, a copy of which is attached at Exhibit #3, TAB 23, regarding her non-compliance with the Medication Administration Policy, and the failure to do proper charting when administering Hydromorphone by failing to chart pre and post pain assessments on multiple patients. It was also determined that Ms. Mehok had routinely administered narcotics to patients not under her care, without checking with the patient's primary nurse. Ms. Mehok was warned that her conduct was inappropriate and could not continue. After receiving her letter of warning, Ms. Mehok returned to her full-time position on the Unit #1.

Throughout January 2022 until March 2022, Ms. Atkins received multiple written concerns from nursing colleagues and other staff on the Unit #1 about Ms. Mehok.

In March 2022, Ms. Atkins continued to receive concerns abut Ms. Mehok's medication administration from colleagues. On March 21, 2022, Ms. Mehok was placed on administrative leave with pay pending a further investigation. Upon conclusion of the internal investigation, Ms. Mehok was terminated on April 27, 2022 [Exhibit #3, TAB 2].

During the second investigation, Ms. Mehok's Hydromorphone withdrawals overall compared to other nurses working on the Unit #1 were reviewed. The reports revealed that between January 1, 2022, and March 22, 2022, Ms. Mehok withdrew 151 doses of Hydromorphone over 30 shifts with a rate of 5.03 doses per shift. Comparatively the next highest dose rate was 23 doses over 8 shifts with a rate of 2.67 doses per shift. A copy of the report is attached at Exhibit #3, TAB 24.

A report of Ms. Mehok's Hydromorphone withdrawals between February 7, 2022 (the date of her letter of warning and return to work) and March 22, 2022 (when she was placed on administrative leave the second time) was also requested. In this period, she withdrew 99 doses of Hydromorphone over 21 days, with a rate of 4.71 doses per day. Comparatively, the next highest dose rate was 29 doses over 11 shifts with a rate of 2.64 doses per shift. A copy of the report is attached at Exhibit #3, TAB 25.

(2) Unit #1 work assignments and shifts

The Unit #1 where Ms. Mehok worked has forty-three (43) beds. The Unit #1 is divided into two sides, Side A and Side B. Both sides are divided into hubs of client

beds. On Side A there are two hubs, Hub A and Hub B. On Side B, there are three hubs, Hub B, Hub C and Hub D.

Nursing care is generally split into teams of two for each hub but depending on client acuity and staffing, there may also be only one nurse assigned to a hub. There was also often a "float" nurse on Side B who assists all hubs answering client call bells. There is also one charge nurse who covers both sides of the Unit #1.

The Unit #1 has two twelve-hour shifts, day shift (0700 hours – 1900 hours) and night shift (1900 hours – 0700 hours). Ms. Mehok worked the day shift.

Ms. Mehok was working and on shift for all relevant dates of the allegations.

(3) Omnicell and Medication Rooms

The Unit #1 uses an electronic medication management system, specifically, Omnicell. There are two medication rooms, each with a Omnicell, on the Unit #1. Nursing staff are expected to document their medication administration on the Medication Administration Records ("MAR") but their withdrawal is also recorded by the Omnicell. Additionally, their wastage, if it is entered into the Omnicell, is recorded.

A copy of Omnicell abbreviations is attached at Exhibit #3, TAB 26**.** The most relevant abbreviations are:

a. "I-UN" – meaning standard issue;

b. "WA" and "W-WS" – meaning waste; and

c. "W-PD" – meaning partial dose waste.

The Omnicell reports indicate the precise time withdrawn, the type, form and dose of medication withdrawn and the user's name.

Nursing staff on the Unit #1 are also expected to document pre and post medication administration assessments, a client's pain level or a reason for medication administration in the Nurses Notes and Pain Management Records, especially for "as needed" orders, also known as "PRN" orders.

Injectable vials of Hydromorphone are dispensed from the Omnicell on the Unit #1 in doses of 2 mg/1 ml. It is common to immediately waste a partial dose of Hydromorphone, with wastage documented in the Omnicell, depending on the dose prescribed in the physician's order. For example, if 1 mg was ordered, 1 mg should be administered and the remaining 1 mg should be immediately recorded as wasted by a nurse, with a witness, within the Omnicell.

Wastage of Hydromorphone on the Unit #1 must be witnessed by another member of the nursing staff.

The conduct specifically relating to Allegation #1 is as follows.

Ms. Mehok was not the primary nurse assigned to client JT on January 15, 2022. Client JT had a physician's order for Hydromorphone 1 mg every four hours (with required doses on the day shift at 0800 hours, 1200 hours and 1600 hours). Client JT also had a physician's order for Hydromorphone 1 mg every hour PRN. A copy of client JT's MAR is attached at Exhibit #3, TAB 27, a copy of client JT's medical record is attached at Exhibit #3, TAB 28 and the Omnicell record from January 15, 2022 is attached at Exhibit #3, TAB 29.

Despite not being assigned to the client, Ms. Mehok withdrew and administered Hydromorphone 1 mg to client JT at 0800h (withdrawn at 0718 hours), 1200h (withdrawn at 1113 hours) and 1600 hours (withdrawn at 1551 hours) and documented her administration on the MAR. Each dose described above had 1 mg properly wasted within the Omnicell records.

At 1312 hours, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell and failed to document the reason for the withdrawal for the PRN dose on the MAR, Pain Management Record and the Nurses Notes. There was no reported pain or request from client JT nor is there documentation of Ms. Mehok's medication administration of the Hydromorphone 1 mg dose withdrawn from the Omnicell.

Client JT's primary nurse did not ask Ms. Mehok to administer any of the doses withdrawn from the Omnicell by Ms. Mehok, including the PRN dose at 1312 hours.

The conduct specifically relating to Allegation #2 is as follows.

Ms. Mehok was not assigned to client JT on January 16, 2022. Similar to the day prior, client JT had a physician's order for Hydromorphone 1 mg every four hours (with required doses on the day shift at 0800 hours, 1200 hours and 1600 hours). Client JT also had the same physician's order for Hydromorphone 1 mg every hour PRN [Exhibit #3, TAB 27]. A copy of client JT's medical record is attached at TAB 30 and the Omnicell record from January 16, 2022 is attached at Exhibit #3, TAB 31.

Despite not being assigned to the client, Ms. Mehok withdrew and administered Hydromorphone 1 mg to client JT at 0800h (withdrawn at 0719 hours) and documented her administration on the MAR of 1 mg [Exhibit #3, TAB 27], the dose required by the physician order. However, Ms. Mehok did not record any wastage in the Omnicell [Exhibit #3, TAB 31], failing to account for Hydromorphone 1 mg.

At 1014 hours, Ms. Mehok withdrew an additional dose of Hydromorphone 2 mg from the Omnicell and wasted 1 mg. There was no documented reason for

withdrawal in the Pain Management Record nor Nurses Notes, despite the order for Hydromorphone 1 mg every hour being a PRN order. Ms. Mehok documented medication administration on the MAR at 1004 hours. However, the documented time is inaccurate because she withdrew the Hydromorphone at 1014 hours from the Omnicell [Exhibit #3, TAB 31], ten minutes after the recorded time of medication administration on the MAR.

At 1903 hours, around the time of shift report, Ms. Mehok withdrew another dose of Hydromorphone 2 mg from the Omnicell and wasted 1 mg. There was no reason documented for the withdrawal nor was her medication administration documented in the Nurses Notes or the MAR [Exhibit #3, TAB 27]. For this dose, Ms. Mehok asked client JT's primary nurse to witness the wastage, who agreed to do so. The primary nurse had not asked Ms. Mehok to administer Hydromorphone to client JT.

The conduct specifically relating to Allegation #3 is as follows.

On the same shift related to Allegation 2, Ms. Mehok was not the primary nurse assigned to client AP on January 16, 2022. Client AP had a physician's order for Hydromorphone 1-2 mg every four hours PRN. A copy of client AP's MAR is attached at Exhibit #3, TAB 32, a copy of their medical record is attached at Exhibit #3, TAB 33 and the Omnicell record from January 16, 2022 is attached at Exhibit #3, TAB 34. Client AP requested pain relief for his leg from his primary nurse but when the primary nurse went to withdraw the PRN dose of Hydromorphone, they noticed Ms. Mehok's withdrawal at 1323 hours. When the primary nurse asked the client about receiving Hydromorphone from Ms. Mehok, client AP denied receiving anything from Ms. Mehok and indicated that they had been sleeping. The primary nurse and Ms. Mehok went to discuss the medication administration with client AP together. Ms. Mehok indicated that she gave client AP Hydromorphone around 1330 hours and client AP asserted that she had not done so.

Client AP also advised the primary nurse that they received an unprompted dose of medication that was presented as Hydromorphone in the morning but that it did not sting like usual. They were then transferred to a different room and slept the remainder of the morning. Finally, client AP also told the primary nurse that they did not feel safe in Ms. Mehok's care.

After leaving client AP's room, the primary nurse reviewed the MAR and was immediately confused as the 1330 hours administration discussed with client AP was not documented by Ms. Mehok, but a dose of Hydromorphone administered at 0845 hours by Ms. Mehok was documented in the MAR [Exhibit #3, TAB 32].

When questioned, Ms. Mehok told the primary nurse that she also gave a dose at 0845 hours to client AP. The primary nurse requested that Ms. Mehok document all doses that were administered in the MAR and continued on with her tasks. The

primary nurse's recollection of this incident is documented within the Nurse's Notes in Client AP's medical record at 1450 hours [Exhibit #3, TAB 33].

The Omnicell record [Exhibit #3, TAB 34] shows that Ms. Mehok withdrew Hydromorphone 2 mg at 0844 hours and 1323 hours. The MAR has two entries by Ms. Mehok at 0845 hours for 2 mg (indicated in the MAR by a "2" with a circle around it) and 1330 hours for 2 mg. The 0845 hours entry on the MAR is written over or edited [Exhibit #3, TAB 32]. There is no documentation within the Pain Management Record nor Nurses Notes noting the reason for the withdrawal of Hydromorphone 2 mg by Ms. Mehok at 0844 hours and 1323 hours [Exhibit #3, TAB 33].

Neither the primary nurse, nor their nurse partner, asked Ms. Mehok to administer medication to client AP. Ms. Mehok did not communicate their withdrawal of Client JT's Hydromorphone to the primary nurse until client AP complained to the primary nurse and she requested that Ms. Mehok come to the client's room for a discussion.

The conduct specifically relating to Allegation #4 is as follows.

Ms. Mehok was not the primary nurse assigned to client JT on January 18, 2022, and was working in another hub. Client JT had a physician's order for Hydromorphone 1 mg every three hours with required doses at 0600 hours, 0900 hours and 1200 hours. The order was changed around midday to an order for Hydromorphone 2 mg every four hours with the first dose required at 1600 hours. Client JT also had a physician's order for Hydromorphone 1 mg every hour PRN. A copy of client JT's MAR is attached at Exhibit #3, TAB 35, their medical record is attached at Exhibit #3, TAB 36 and the Omnicell record from January 18, 2022 is attached at Exhibit #3, TAB 37.

Despite not being assigned to the client, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 0753 hours. Ms. Mehok did not document the reason for the withdrawal nor her medication administration in the MAR, Nurses Notes or Pain Management Records [Exhibit #3, TAB 35; TAB 36].

Client JT was in pain around 0900 hours and requested Hydromorphone from their primary nurse. When the primary nurse went to withdraw Hydromorphone from the Omnicell, they noticed that Ms. Mehok had withdrawn Hydromorphone at 0753 hours. Upon returning to the client's room, client JT's family told the primary nurse that no one had been in client JT's room since around 0600 hours with medication [Exhibit #3, TAB 36].

Neither the primary nurse, nor their nurse partner, asked Ms. Mehok to administer medication to client AP. Ms. Mehok did not communicate their withdrawal of Client JT's Hydromorphone to the primary nurse nor their nurse partner.

The conduct specifically relating to Allegation #5 is as follows.

Ms. Mehok was assigned to client DB on March 11, 2022 during the day shift. Client DB had a physician's order for long-acting Hydromorphone 6 mg tablets twice daily (0800 hours and 2000 hours) along with numerous other medications. Client DB also had an order for short-acting Hydromorphone 2 mg tablets every four hours. A copy of client DB's MAR is attached at Exhibit #3, TAB 38, their medical record is attached at Exhibit #3, TAB 39 and the Omnicell record from March 11, 2022 is attached at Exhibit #3, TAB 40.

Ms. Mehok withdrew client DB's morning dose for Hydromorphone 6 mg tablets at 0833 hours. Client DB advised their primary nurse that on March 11, 2022, Ms. Mehok handed him a cup with tablets, but he noticed that the Hydromorphone pills were missing and asked Ms. Mehok about them. Ms. Mehok advised him that the blue and white pills were Hydromorphone, which he responded that they were Cymbalta (Duloxetine) a newly ordered medication. However, client DB had ingested his medication so he could not disprove Ms. Mehok's assertion at the time. He later checked his medication in the evening and saw green Hydromorphone pills and complained to his night shift primary nurse that he had not received Hydromorphone earlier in the day.

In addition to client DB's morning dose, Ms. Mehok withdrew from the Omnicell two doses of Hydromorphone 2 mg tablets, at 1029 hours and 1753 hours [Exhibit #3, TAB 40]. She documented administration of the Hydromorphone on the MAR at 1030 hours and 1750 hours, which was inaccurate and prior to her withdrawal from the Omnicell at 1753 hours. She did not document the reason for the withdrawals on the Pain Management Record and Nurses Notes for either withdrawal [Exhibit #3, TAB 39].

The conduct specifically relating to Allegation #6 is as follows.

Ms. Mehok was not assigned to client TM on March 11, 2022 and was working in a different hub. Client TM had a physician's order for Hydromorphone 5 mg every three to four hours PRN. A copy of client TM's MAR is attached at Exhibit #3, TAB 41, their medical record is attached at Exhibit #3, TAB 42 and the Omnicell record from March 11, 2022 is attached at Exhibit #3, TAB 43.

Ms. Mehok withdrew Hydromorphone 6 mg from the Omnicell at 0729 hours [Exhibit #3, TAB 43] and did not record any wastage from the dose, failing to account for the remaining 1 mg [Exhibit #3, TAB 43]. Despite withdrawing Hydromorphone 6 mg at 0729 hours, Ms. Mehok then inaccurately documented the administration of Hydromorphone 5 mg at 0724 hours on the MAR, which was prior to the withdrawal [Exhibit #3, TAB 42]. After leaving client TM's room, the primary nurse went to see the client who indicated she had not requested Hydromorphone but was woken up by Ms. Mehok early to administer medication and was happy with the pain relief.

At 1316 hours, Ms. Mehok withdrew Hydromorphone 6 mg, wasting 2 mg [Exhibit #3, TAB 43]. She then recorded in the MAR that she administered Hydromorphone 4 mg, the remaining dose, to client TM at 1320 hours [Exhibit #3, TAB 40]. Ms. Mehok did not follow the physician's order for Hydromorphone every three to four hours as the last dose had been administered at 1100 hours (two hours and twenty minutes prior) by another nurse.

The primary nurse did not ask Ms. Mehok to administer Hydromorphone to client TM.

The conduct specifically relating to Allegation #7 is as follows.

Ms. Mehok was not assigned to client CS on February 9, 2022 and was working in a different hub. Client CS had a physician's order for Hydromorphone 1-2 mg every three hours PRN. A copy of client CS's MAR is attached at Exhibit #3, TAB 44, their medical record is attached at Exhibit #3, TAB 45 and the Omnicell record from February 9, 2022 is attached at Exhibit #3, TAB 46.

Ms. Mehok withdrew Hydromorphone from the Omnicell for client CS at 1157 hours, specifically she withdrew 2 mg and wasted 1 mg [Exhibit #3, TAB 44]. Ms. Mehok documented on the MAR that she administered Hydromorphone at 1202 hours but did not indicate the dose that she administered to client CS [Exhibit #3, TAB 44]. She also documented the reason for the withdrawal in the Nurses Notes at 1200 hours but did not indicate the dose she administered [Exhibit #3, TAB 45].

Ms. Mehok withdrew Hydromorphone 2 mg from the Omnicell at 1619 hours for client CS. However, she did not document the reason for the withdrawal on the Pain Management Record nor the Nurses Notes [Exhibit #3, TAB 45]. She did document that she administered Hydromorphone to client CS on the MAR at 1630 hours but failed to specify the dose administered [Exhibit #3, TAB 44].

The conduct specifically relating to Allegation #8 is as follows.

Ms. Mehok was assigned to client GG on February 21, 2022. Client GG had a physician's order for Hydromorphone 1-2 mg every three hours PRN. A copy of client GG's MAR and physician orders are attached at Exhibit #3, TAB 47, their medical record is attached at Exhibit #3, TAB 48 and the Omnicell record from February 21, 2022 is attached at Exhibit #3, TAB 49.

Ms. Mehok withdrew Hydromorphone 2 mg from the Omnicell for client GG at 0733 hours, 1025 hours, 1314 hours, 1603 hours and 1842 hours [Exhibit #3, TAB 49]. There was no recorded wastage for any of the doses.

Ms. Mehok documented client GG's pain within the Pain Management Records for all withdrawals and administrations of Hydromorphone, noting client GG's pain level

as 9/10 and 10/10 throughout the day. She also documented administration of Hydromorphone in the MAR at 0730 hours, 1033 hours, 1315 hours, 1600 hours and 1855 hours [Exhibit #3, TAB 47]. However, she did not document the dose administered for any of the entries.

The conduct specifically relating to Allegation #9 is as follows.

Ms. Mehok was assigned to client UC on February 18, 2022. Client UC had a physician's order for Hydromorphone 1-2 mg every four hours PRN. A copy of client UC's MAR is attached at Exhibit #3, TAB 50, their medical record is attached at Exhibit #3, TAB 51 and the Omnicell record from February 18, 2022 is attached at Exhibit #3, TAB 52.

Ms. Mehok withdrew Hydromorphone 2 mg from the Omnicell for client UC at 0726 hours [Exhibit #3, TAB 52]. She recorded client UC's pain as 9/10 around this time on the Pain Management Record [Exhibit #3, TAB 57]. However, she inaccurately documented that the dose was administered at 0720 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 50]. She also did not document the dose administered to client UC on the MAR.

Ms. Mehok then withdrew Hydromorphone 2 mg from the Omnicell for client UC at 1026 hours [Exhibit #3, TAB 52]. She recorded client UC's pain as 10/10 around this time on the Pain Management Record [Exhibit #3, TAB 35]. She documented a dose was administered at 1030 hours on the MAR but did not specify the dose administered [Exhibit #3, TAB 34]. Ms. Mehok did not follow the physician's order for Hydromorphone every four hours as the last dose was recorded as administered at 0720 hours (three hours and ten minutes prior) and the order was for every four hours.

Ms. Mehok next withdrew Hydromorphone 2 mg from the Omnicell for client UC at 1358 hours [Exhibit #3, Tab 36]. However, there was no reason for the withdrawal documented in the Pain Management Record nor the Nurses Notes [Exhibit #3, TAB 51]. Ms. Mehok documented a dose was administered at 1438 hours on the MAR but did not specify the dose administered [Exhibit #3, TAB 50].

Similarly, Ms. Mehok withdrew Hydromorphone 2 mg from the Omnicell for client UC at 1814 hours [Exhibit #3, Tab 52]. However, there was no reason for the withdrawal documented in the Pain Management Record nor the Nurses Notes [Exhibit #3, TAB 51]. Ms. Mehok documented a dose was administered at 1820 hours on the MAR but did not specify the dose administered [Exhibit #3, TAB 50].

The conduct specifically relating to Allegation #10 is as follows.

Ms. Mehok was assigned to client UC on February 22, 2022. Client UC had a physician's order for Hydromorphone 1-2 mg every four hours PRN. A copy of client

UC's MAR [Exhibit #3, TAB 50] is attached, their medical record is attached at Exhibit #3, TAB 53 and the Omnicell record from February 22, 2022 is attached at Exhibit #3, TAB 54.

Ms. Mehok withdrew a dose of Hydromorphone 2 mg at 0749 hours from the Omnicell and recorded that it was administered to client UC at 0750 hours in the MAR [Exhibit #3, TAB 48]. She recorded client UC's pain level as 10/10 related to this dose at 0725 hours in the Pain Management Record [Exhibit #3, TAB 53].

Ms. Mehok then withdrew a dose of Hydromorphone 2 mg at 1058 hours. However, she inaccurately documented that the dose was administered at 1050 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 50]. She recorded client UC's pain level as 10/10 related to this dose at 1040 hours in the Pain Management Record [Exhibit #3, TAB 53]. Ms. Mehok did not follow the physician's order for Hydromorphone every four hours as the last dose was recorded as administered at 0750 hours (three hours prior) and the order was for every four hours.

Finally, Ms. Mehok withdrew a dose of Hydromorphone 2 mg at 1824 hours [Exhibit #3, TAB 54]. However, the last dose had been administered at 1500 hours by another nurse, meaning the dose withdrawn by Ms. Mehok could not be administered since client UC was not due for another dose until 1900 hours. An entry was made in the MAR but then crossed out. The dose of Hydromorphone 2 mg was later wasted by Ms. Mehok at 1900 hours. There was no pain level recorded by Ms. Mehok related to this withdrawal nor any documentation in the Nurses Notes to account for why Ms. Mehok withdrew Hydromorphone at 1824 hours.

The conduct specifically relating to Allegation #11 is as follows.

Ms. Mehok was assigned to client BP on February 27, 2022. Client BP had a physician's order for Hydromorphone 0.5 mg – 1 mg every three hours PRN as an injection or orally with a tablet. A copy of client BP's MAR is attached at Exhibit #3, TAB 55, their medical record is attached at Exhibit #3, TAB 56 and the Omnicell record from February 27, 2022 is attached at Exhibit #3, TAB 57.

Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 0749 hours [Exhibit #3, TAB 57]. However, she inaccurately documented that the dose was administered at 0740 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55].

Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 1623 hours [Exhibit #3, TAB 57]. However, she inaccurately documented that the dose was administered at 1620 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55]. She did not document client BP's pain level or the reason for the withdrawal in the Pain Management Record nor the Nurses Notes.

Finally, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 1852 hours [Exhibit #3, TAB 57]. She documented that the dose was administered at 1900 hours in the MAR but did not document client BP's pain level or the reason for the withdrawal in the Pain Management Record nor the Nurses Notes.

The conduct specifically relating to Allegation #12 is as follows.

Ms. Mehok was assigned to client BP again on February 28, 2022. Client BP had the same orders as the day prior [Exhibit #3, TAB 55]. Their medical record is attached at Exhibit #3, TAB 58 and the Omnicell record from February 28, 2022 is attached at Exhibit #3, TAB 59.

Ms. Mehok withdrew Hydromorphone 1 mg at 0745 hours from the Omnicell. She did not document her medication administration on the MAR [Exhibit #3, TAB 55] nor document the reason for the withdrawal in the Pain Management Record and Nurses Notes [Exhibit #3, TAB 58]. Additionally, Ms. Mehok did not follow the physician's order for Hydromorphone every three hours as the last dose was recorded as administered by another nurse at 0625 hours (one hour and ten minutes prior).

Ms. Mehok then withdrew Hydromorphone 1 mg from the Omnicell at 1022 hours [Exhibit #3, TAB 59]. However, she inaccurately documented that the dose was administered at 1020 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55]. Additionally, she did not specify the dose of Hydromorphone administered where the physician's order was for 0.5 mg – 1 mg. She also documented that client BP's pain was 8/10 on the Pain Management Record at 1030 hours [Exhibit #3, TAB 58].

Next, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 1308 hours [Exhibit #3, TAB 59]. She did not document client BP's pain nor a reason for the withdrawal on the Pain Management Record and the Nurses Notes [Exhibit #3, TAB 58]. She documented the administration of a dose at 1310 hours on the MAR but did not specify the dose of Hydromorphone administered where the physician's order was for 0.5 mg – 1 mg [Exhibit #3, TAB 55].

The conduct specifically relating to Allegation #13 is as follows.

Ms. Mehok was assigned to client BP again on March 1, 2022. Client BP had the same orders as previous days [Exhibit #3, TAB 55]. Their medical record is attached at Exhibit #3, TAB 60 and the Omnicell record from March 1, 2022 is attached at Exhibit #3, TAB 61.

Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 0743 hours [Exhibit #3, TAB 61]. She documented client BP's pain as 9/10 on the Pain Management Record at 0730 hours [Exhibit #3, TAB 60]. However, she inaccurately documented that the dose was administered at 0730 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55].

Ms. Mehok next withdrew Hydromorphone 1 mg from the Omnicell at 1036 hours [Exhibit #3, TAB 45]. She documented client BP's pain as 8/10 on the Pain Management Record at 1025 hours [Exhibit #3, TAB 44]. However, she inaccurately documented that the dose was administered at 1030 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55].

Finally, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell at 1616 hours. However, she did not document client BP's pain nor the reason for the withdrawal in the Pain Management Record nor the Nurses Notes [Exhibit #3, TAB 60]. She also did not document the administration of the Hydromorphone withdrawn on the MAR [Exhibit #3, TAB 55].

The conduct specifically relating to Allegation #14 is as follows.

Ms. Mehok was assigned to client BP again on March 2, 2022. Client BP had the same orders as previous days as described above in Allegation 13 [Exhibit #3, TAB 55]. Their medical record is attached at Exhibit #3, TAB 63 and the Omnicell record from March 2, 2022 is attached at Exhibit #3, TAB 63.

Ms. Mehok made regular withdrawals of Hydromorphone for client BP throughout the morning, documenting her administration in the MAR.

At 1323 hours, Ms. Mehok withdrew Hydromorphone 1 mg from the Omnicell [Exhibit #3, TAB 63]. She documented client BP's pain as 8/10 on the Pain Management Record at 1315 hours [Exhibit #3, TAB 62]. However, she inaccurately documented that the dose was administered at 1315 hours on the MAR, prior to the withdrawal [Exhibit #3, TAB 55].

Ms. Mehok next withdrew Hydromorphone 1 mg from the Omnicell at 1616 hours [Exhibit #3, TAB 63]. She documented client BP's pain as an 8/10 on the Pain Management Record at 1610 hours. [Exhibit #3, TAB 62]. However, she did not document the administration of the Hydromorphone withdrawn on the MAR [Exhibit #3, TAB 55].

The conduct specifically relating to Allegation #15 is as follows.

Ms. Mehok was not assigned to client TM on March 3, 2022. She did not work a full shift, instead worked 1300 hours to 1900 hours. Client TM had an order for Hydromorphone 2 mg – 3 mg every four hours PRN. A copy of client TM's MAR and orders are attached at Exhibit #3, TAB 64 and the Omnicell record from March 3, 2022 is attached at Exhibit #3, TAB 65.

Ms. Mehok withdrew Hydromorphone 3 mg from the Omnicell at 1649 hours [Exhibit #3, TAB 54]. She then documented that she administered Hydromorphone 2 mg on the MAR at 1655 hours, failing to account for the remaining 1 mg.

The conduct specifically relating to Allegation #16 is as follows.

Ms. Mehok was assigned to client TM on March 8, 2022. Client TM had an order for Hydromorphone 5 mg every three hours PRN [Exhibit #3, TAB 62]. A copy of client TM's medical record is attached at Exhibit #3, TAB 66 and the Omnicell record from March 8, 2022 is attached at Exhibit #3, TAB 67.

At 0722 hours, Ms. Mehok withdrew a total of 6 mg of Hydromorphone and wasted a total of 2 mg [Exhibit #3, TAB 67]. By doing so, she withdrew the incorrect dose of 4 mg and did not follow the physician's order for a dose of 5 mg [Exhibit #3, TAB 62]. She then inaccurately documented that she administered Hydromorphone 5 mg at 0740 hours on the MAR when she had only withdrawn a total of 4 mg, after wastage, from the Omnicell [Exhibit #3, TAB 62].

At 1017 hours, Ms. Mehok withdrew a total of 6 mg of Hydromorphone and wasted a total of 2 mg [Exhibit #3, TAB 51]. By doing so, she withdrew the incorrect dose of 4 mg and did not follow the physician's order for a dose of 5 mg [Exhibit #3, TAB 48]. She then inaccurately documented that she administered Hydromorphone 5 mg at 1030 hours on the MAR when she had only withdrawn a total of 4 mg, after wastage, from the Omnicell [Exhibit #3, TAB 48].

Ms. Mehok then withdrew Hydromorphone 6 mg from the Omnicell at 1759 hours, without wasting any of the doses [Exhibit #3, TAB 67]. By doing so, Ms. Mehok did not follow the physician's order for Hydromorphone 5 mg every three hours as the last dose was recorded as administered by another nurse at 1544 hours (two hours and fifteen minutes prior) [Exhibit #3, TAB 62]. She also had withdrawn the incorrect dose of 6 mg and did not follow the physician's order for a dose of 5 mg. [Exhibit #3, TAB 67].

Despite withdrawing Hydromorphone 6 mg from the Omnicell at 1759 hours, Ms. Mehok Exhibit #3, did not document on the MAR any medication administration for the dose withdrawn [TAB 62]. At 1919 hours, 1 mg of Hydromorphone was wasted by another nurse.

The conduct specifically relating to Allegation #17 is as follows.

Ms. Mehok was not assigned to client TM on March 11, 2022, and was working in a different hub (see Allegation 6). Client TM had a physician's order for Hydromorphone 5 mg every three to four hours PRN [Exhibit #3, TAB 41]. A copy of client TM's medical record is attached [Exhibit #3, TAB 42] and the Omnicell record from March 11, 2022 is attached [Exhibit #3, TAB 43].

Ms. Mehok withdrew Hydromorphone 4 mg from the Omnicell at 1316 hours by withdrawing a total of 6 mg and wasting a total of 2 mg [Exhibit #3, TAB 43]. By doing so, she withdrew the incorrect dose and did not follow the physician's order for a

dose of 5 mg [Exhibit #3, TAB 41]. She then inaccurately documented that she administered Hydromorphone 5 mg at 1320 hours on the MAR when she had only withdrawn a total of 4 mg, after wastage, from the Omnicell [Exhibit #3, TAB 41].

The primary nurse did not ask Ms. Mehok to administer Hydromorphone to client TM. See Allegation 6 for additional concerns regarding client TM on March 11, 2022.

The conduct specifically relating to Allegation #18 is as follows.

Ms. Mehok was not assigned to client TM on March 12, 2022. Client TM had an order for Hydromorphone 5 mg every three to four hours PRN [Exhibit #3, TAB 62]. There was also an order from the physician to use "minimal" narcotic pain killers, a copy of which is attached at Exhibit #3, TAB 68. A copy of client TM's medical record is attached at Exhibit #3, TAB 69 and the Omnicell record from March 12, 2022 is attached at Exhibit #3, TAB 70.

Ms. Mehok withdrew Hydromorphone 6 mg from the Omnicell at 0845 hours [Exhibit #3, TAB 70]. She then documented the administration of Hydromorphone 5 mg on the MAR around the same time [Exhibit #3, TAB 62]. By doing so, she failed to account for the remaining 1 mg of Hydromorphone. Ms. Mehok documented client TM's pain in the Pain Management Record and on the Nurse's Notes documented that a student had approached Ms. Mehok and asked to withdraw pain medication for client TM [Exhibit #3, TAB 69].

At 1549 hours, Ms. Mehok withdrew Hydromorphone 5 mg from the Omnicell [Exhibit #3, TAB 70] and documented the administration of the dose on the MAR at 1550 hours [Exhibit #3, TAB 62]. However, she did not document the reason for the withdrawal in the Pain Management Record nor the Nurses Notes [Exhibit #3, TAB 69].

The conduct specifically relating to Allegation #19 is as follows.

Throughout January 2022 until March 19, 2022, Ms. Mehok misappropriated Hydromorphone, in injection and tablet format, from the Unit #1. Her misappropriation of Hydromorphone was not for an employment related purpose but instead an unauthorized and improper purpose. Ms. Mehok's extremely high rate of withdrawal of Hydromorphone, when compared to her colleagues, on the Unit #1 [Exhibit #3, TAB 24, TAB 25] between January 2022 and March 19, 2022 reflects her pattern of misappropriation from the Unit #1.

Hydromorphone is a highly potent opioid and is a controlled substance within the *Controlled Substances and Drugs Act.* It is a much more potent than morphine and is commonly used for the treatment of pain for clients on the Unit #1.

The Medication Administration Policy in force during the relevant period of time requires nursing staff to follow the eight rights of medication administration, namely: right patient, right medication, right dose, right time and frequency, right route, right reason, right documentation and right to refuse [Exhibit #3, TAB 71]. By misappropriating Hydromorphone for an improper purpose and documenting client care inaccurately for the purpose of misappropriating Hydromorphone, she took advantage and failed to follow these eight rights of medication administration for multiple clients.

Ms. Mehok had a pattern of withdrawing doses of Hydromorphone available under PRN orders without documenting any reported pain nor an assessment of the client for the purposes of misappropriating Hydromorphone, and sometimes without documenting any administration on the MAR. This pattern included near the end of the day shift around 1900 hours (see e.g. Allegation 2; Allegation 8; Allegation 9; Allegation 10; Allegation 11).

She also withdrew doses from Omnicell and failed to document what specific dose was administered, leaving unaccounted for wastage or ambiguous doses administered to a client (see e.g. Allegation 7; Allegation 8; Allegation 9; Allegation 12). By doing so, she was able to misappropriate remaining doses without different wastage recorded in Omnicell.

Next, Ms. Mehok withdrew Hydromorphone as well as documented that she administered Hydromorphone to clients, at the incorrect time considering the timing of the last dose administered. By doing so, Ms. Mehok's withdrawals and administrations looked to be erroneous but instead she misappropriated the Hydromorphone or a part of the dose of Hydromorphone.

Specifically, she failed to account for specific doses of Hydromorphone because she had misappropriated them:

a. On January 16, 2022, she withdrew 2 mg of Hydromorphone for client JT and documented administering 1 mg, misappropriating the remaining 1 mg, despite withdrawing the correct doses for client JT the day prior on three occasions (see Allegation 1; Allegation 2).

b. On March 3, 2022, she withdrew 3 mg of Hydromorphone for client TM and documented administering 2 mg, misappropriating the remaining 1 mg (see Allegation 15).

c. On March 11, 2022, she withdrew 6 mg of Hydromorphone for client TM and documented administering 5 mg, misappropriating the remaining 1 mg (see Allegation 6).

d. On March 12, 2022, she similarly withdrew 6 mg of Hydromorphone for client TM and documented administering 5 mg, misappropriating the remaining 1 mg (see Allegation 18).

Overall, Ms. Mehok misappropriated Hydromorphone that was intended for clients as well as took advantage of clients' orders for Hydromorphone to misappropriate Hydromorphone. She also withdrew or documented administration of doses to clients, impacting their future care and causing clients to not receive doses that they were intended to receive based on physicians' orders.

The conduct specifically relating to Allegation #20 is as follows.

Ms. Mehok also had a pattern of withdrawing Hydromorphone after she had documented a dose as administered, so she could keep the withdrawn dose. On numerous occasions, she would withdraw Hydromorphone a short period of time after her documented administration. On these occasions, she would document the administration of numerous doses of Hydromorphone without administering the doses. She also would document the administration of numerous doses of Hydromorphone only on the MAR, but not document the reason for the withdrawals on the Pain Management Record and/or Nurses Notes, prior to misappropriating the Hydromorphone (see e.g. Allegation 2; Allegation 5; Allegation 10; Allegation 13).

Overall, Ms. Mehok inaccurately documented on multiple MARs, Pain Management Records and Nurses Notes to misappropriate Hydromorphone for an authorized and improper purpose.

The conduct specifically relating to Allegation #21 is as follows.

Ms. Mehok commonly withdrew and documented administration of Hydromorphone to clients on the Unit #1 without consulting their primary nurse, and where she was not primarily responsible for their care, despite having been asked to stop doing so in a letter of warning by Ms. Atkins [Exhibit #3, TAB 23].

This included for client TM on March 3, 2022, March 11, 2022 and March 12, 2022, client TU on March 19, 2022 and client CS on February 9, 2022 (only two days after her letter of warning).

The conduct specifically relating to Allegation #22 is as follows.

Some clients reported that they had not received their Hydromorphone from Ms. Mehok where she had documented that she had done so. This was commonly reported through clients to their primary nurse. Specifically:

a. On January 16, 2022, client AP reported that they had not received Hydromorphone and reported leg pain to their primary nurse (see Allegation 3). Ms. Mehok contradicted client AP and asserted to

the primary nurse and client AP that she had administered the dose when she had not done so but instead had misappropriated the Hydromorphone that was documented as administered for client AP at 0845 hours and 1323 hours.

b. On January 18, 2022, client JT reported pain to their primary nurse around 0900 hours (see Allegation 4). However, Ms. Mehok had withdrawn 1 mg of Hydromorphone at 0753 hours, without documenting any administration nor actually administering the dose but instead had misappropriated the dose. Client JT's family had been in the room, as client JT was palliative, and reported to the primary nurse that no one had been in since around 0600 hours.

c. During the evening of March 11, 2022, client DB reported to his primary nurse that during the day shift, he had not received his Hydromorphone tablets from Ms. Mehok during his morning medication (see Allegation 5). Ms. Mehok had been assigned to client DB during the dayshift. When client DB checked his evening medication, he confirmed that the Hydromorphone tablets were green and that he had not received them in the morning. At the time of receiving his medication, client DB believed it was missing but Ms. Mehok told him that the Hydromorphone tablets were blue and white and that they were included. Ms. Mehok had documented that she administered the Hydromorphone tablets but had misappropriated them. The next day, Ms. Mehok was also assigned to client DB's care and when providing him his medication cup in the morning, he again noticed that his green Hydromorphone tablets were missing, and Ms. Mehok returned to the medication room and came back with the Hydromorphone tablets and they were administered to client DB.

d. On March 19, 2022, Ms. Mehok reported to client TU's primary nurse that she had administered Hydromorphone early into her shift, documented in the MAR at 0725 hours, a copy of which is attached at Exhibit #3, TAB 72. A copy of client TU's medical record is attached at Exhibit #3, TAB 73 and the Omnicell record showing a withdrawal at 0724 hours from March 19, 2022 is attached at Exhibit #3, TAB 74. However, the primary nurse went into the client's room and both the client and their family member were asleep with the lights off. Ms. Mehok also withdrew Hydromorphone 2 mg from the Omnicell at 0927 hours, documenting administration to client TU at 0927 hours on the MAR. Finally, Ms. Mehok withdrew an additional Hydromorphone

2 mg from the Omnicell at 1203 hours and documented administration at 1203 hours on the MAR. Client TU reported significant pain in the early afternoon around 1300 hours to their primary nurse. When asked, the family member denied that Ms. Mehok administered Hydromorphone to client TU in the morning and only one dose had been administered around 1200 hours.

The conduct specifically relating to Allegation #23 is as follows.

Throughout January 2022 until March 19, 2022 and at the start of her shifts, Ms. Mehok would review client profiles of patients she was not assigned to in order to view what medications they were prescribed, specifically Hydromorphone. A copy of the access records is attached at Exhibit #3, TAB 75.

Ms. Mehok had no reason to access information about patients she was not assigned to care for, and by doing so, she breached client confidentiality and privacy.

Complaint #2

The conduct specifically relating to Allegation #1 is as follows.

Ms. Mehok was not assigned to client MJ on February 23, 2023 while they were on Unit #2. Client MJ was admitted to Facility #2 and transferred to another unit, where it came to a nursing colleague's attention that client MJ had not received doses of Hydromorphone while on Unit #2, despite the Hydromorphone being withdrawn by Ms. Mehok.

Client MJ had a physician's order for Hydromorphone 0.5 mg – 1 mg SC every three hours PRN. A copy of client MJ's MAR is attached at Exhibit #3, TAB 77, their medical record is attached at Exhibit #3, TAB 78 and the Pyxis record is attached at Exhibit #3, TAB 79.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client MJ's name at 1237 hours [Exhibit #3, TAB 79]. No reason for the withdrawal was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB 78]. She did not document the dose administered to client MJ on the MAR [Exhibit #3, TAB 77].

Ms. Mehok withdrew too much Hydromorphone from Pyxis at 1237 hours when the physician's order for 0.5 mg – 1mg of Hydromorphone every three hours when she withdrew 2 mg of Hydromorphone from Pyxis and no wastage was recorded from the withdrawn 2 mg dose [Exhibit #3, TAB 78].

Ms. Mehok also withdrew Hydromorphone 2 mg from Pyxis under client MJ's name at 1445 hours [Exhibit #3, TAB 79]. No reason for the withdrawal was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB

78]. She did not document the dose administered to client MJ on the MAR [Exhibit #3, TAB 77].

Ms. Mehok withdrew too much Hydromorphone from Pyxis at 1445 hours when the physician's order for 0.5 mg – 1mg of Hydromorphone every three hours when she withdrew 2 mg of Hydromorphone from Pyxis and no wastage was recorded from the withdrawn 2 mg dose. Additionally, Ms. Mehok did not follow the physician's order for every three hours on a PRN basis when the last dose withdrawn was 1237 hours (two hours and eight minutes prior) [Exhibit #3, TAB 78].

The conduct specifically relating to Allegation #2 is as follows.

Ms. Mehok was assigned to client BH on March 1, 2023 while they were on Unit #2. Client BH had a physician's order for Morphine 5 mg every six hours. Client BH did not have an order for Hydromorphone documented in their chart. A copy of client BH's MAR is attached at Exhibit #3, TAB 80, their medical record is attached at Exhibit #3, TAB 81 and the Pyxis record is attached at Exhibit #3, TAB 82.

Despite there being no physician's order for Hydromorphone, Ms. Mehok withdrew Hydromorphone 2 mg on two occasions from Pyxis at 0740 hours and 1120 hours [Exhibit #3, TAB 82]. No reason for the withdrawal was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB 81]. She did not document the dose administered to client BH on the MAR [Exhibit #3, TAB 80].

Additionally, Ms. Mehok withdrew Morphine 10 mg from Pyxis at 1445 hours [Exhibit #3, TAB 82]. Although there was a physician's order for Morphine, the order was for only 5 mg and no Morphine wastage was recorded by Ms. Mehok [Exhibit #3, TAB 82]. Ms. Mehok documented administration of Morphine 5 mg to client BH at 1500 hours and failed to account for the remaining 5 mg of the dose.

The conduct specifically relating to Allegation #3 is as follows.

Ms. Mehok was not assigned to client RW on March 1, 2023 while they were on Unit #2. Client RW had a physician's order for Hydromorphone 0.5 mg – 1 mg IM/PO/IV every hour PRN. A copy of client RW's MAR is attached at Exhibit #3, TAB 83, their medical record is attached at Exhibit #3, TAB 84 and the Pyxis record is attached at Exhibit #3, TAB 82.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client RW's name at 1457 hours [Exhibit #3, TAB 82]. No reason for the withdrawal was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB 84]. She did not document the dose administered to client RW on the MAR [Exhibit #3, TAB 83].

Ms. Mehok did not follow the physician's order for 0.5 mg – 1mg of Hydromorphone every three hours when no wastage was recorded from the withdrawn 2 mg dose [Exhibit #3, TAB 84].

The conduct specifically relating to Allegation #4 is as follows.

Ms. Mehok was assigned to client CA on March 2, 2023 while they were on Unit #2 and received client CA in her care at 0730 hours. Client CA did not have a physician's order for Hydromorphone. A copy of client CA's MAR is attached at Exhibit #3, TAB 85, their medical record is attached at Exhibit #3, TAB 86 and the Pyxis record is attached at Exhibit #3, TAB 82.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client CA's name at 0752 hours despite there being no physician's order to do so [Exhibit #3, TAB 82]. No reason for the withdrawal was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB 86]. She did not document the dose administered to client CA on the MAR [Exhibit #3, TAB 85].

Although Ms. Mehok failed to document any administration of Hydromorphone, Ms. Mehok did document her administration of numerous other medications on the MAR including at 0750 hours (Lasix 80 mg IV), at 0830 hours (a nitro patch) and later in the morning.

The conduct specifically relating to Allegation #5 is as follows.

Ms. Mehok was assigned to client DM on March 2, 2023 while they were on Unit #2. Client DM did not have a physician's order for Hydromorphone. A copy of client DM's MAR is attached at Exhibit #3, TAB 87, their medical record is attached at Exhibit #3, TAB 88 and the Pyxis record is attached at Exhibit #3, TAB 82.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client DM's name at 0812 hours despite there being no physician's order to do so [Exhibit #3, TAB 82]. No reason for the withdrawal at 0812 hours was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB 88].

Ms. Mehok inaccurately documented on the MAR that she administered Hydromorphone 1.5 mg at 0745 hours (twenty-seven minutes prior to the withdrawal from Pyxis) [Exhibit #3, TAB 87]. Additionally, despite having withdrawn Hydromorphone 2 mg, she only documented the administration of Hydromorphone 1.5 mg, leaving 0.5 mg unaccounted for.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client DM's name again at 1022 hours despite there being no physician's order to do so [Exhibit #3, TAB 82].

No reason for the withdrawal at 1022 hours from Pyxis was recorded in the Medication Record and the Nurse's Assessment and Clinical Record [Exhibit #3, TAB

88]. She did not document the dose administered to client DM on the MAR [Exhibit #3, TAB 87].

The conduct specifically relating to Allegation #6 is as follows.

Ms. Mehok was assigned to client JL on March 2, 2023 while they were on Unit #2. Client JL had a physician's order for Hydromorphone 0.5 mg – 1 mg every two hours PRN. A copy of client JL's MAR is attached at Exhibit #3, TAB 89, their medical record is attached at Exhibit #3, TAB 90 and the Pyxis record is attached at Exhibit #3, TAB 82.

Ms. Mehok withdrew Hydromorphone 2 mg from Pyxis under client JL's name at 1112 hours [Exhibit #3, TAB 82]. Ms. Mehok recorded no wastage, despite that the physician's order for 0.5 mg – 1mg of Hydromorphone and she withdrew a 2 mg dose [Exhibit #3, TAB 90]. Ms. Mehok documented that pain medication was administered for client JL's left shoulder pain in the Nurses Assessment and Clinical Record.

Ms. Mehok inaccurately documented her medication administration of Hydromorphone 1 mg on the MAR when they documented administration at 1110 hours on the Nurses Assessment and Clinical Record [Exhibit #3, TAB 90] but 1125 hours on the MAR [Exhibit #3, TAB 89]. Based on her documentation, Hydromorphone 1 mg was unaccounted for by Ms. Mehok.

The conduct specifically relating to Allegation #7 is as follows.

Between February 23, 2023 – March 2, 2023, Ms. Mehok misappropriated Hydromorphone and Morphine, in injection format, from Unit #2. Her misappropriation of Hydromorphone and Morphine was not for an employment related purpose but instead an unauthorized and improper purpose.

As described above, Hydromorphone is a highly potent opioid and is a controlled substance within the *Controlled Substances and Drugs Act.* It is a much more potent than morphine and is commonly used for the treatment of pain.

Ms. Mehok had a pattern of withdrawing doses of Hydromorphone available under PRN orders without documenting any reported pain nor an assessment of the client for the purposes of misappropriating Hydromorphone, and without documenting any administration on the MAR (Allegation 1; Allegation 2; Allegation 3; Allegation 5; Allegation 6). Ms. Mehok also withdrew doses of Hydromorphone where there was no physician's order to do so (Allegation 2; Allegation 4; Allegation 5). Finally, Ms. Mehok withdrew doses of Hydromorphone from Pyxis that were higher doses than the physician's order, with no subsequent wastage recorded in Pyxis (Allegation 1; Allegation 2; Allegation 3; Allegation 5; Allegation 6).

At least three doses of Hydromorphone and Morphine were not accounted for including:

a. Client BH on March 1, 2023 (Morphine 10 mg was withdrawn from Pyxis at 1445 hours and where the physician's order was for 5 mg and Ms. Mehok documented the administration of 5 mg of morphine at 1500 hours, leaving 5 mg of Morphine unaccounted for and not documented as wasted);

b. Client DM on March 2, 2023 (Hydromorphone 2 mg was withdrawn from Pyxis at 0812 hours, without a physician's order to do so, and Ms. Mehok documented the administration of 1.5 mg of Hydromorphone at 0745 hours, leaving at least 0.5 mg of Hydromorphone unaccounted for and not documented as wasted);

c. Client JL on March 2, 2023 (Hydromorphone 2 mg was withdrawn from Pyxis at 1112 hours and where the physician's order was for 0.5 mg – 1 mg and Ms. Mehok documented the administration, at inaccurate and inconsistent times, of Hydromorphone 1 mg leaving 1 mg of Hydromorphone unaccounted for and not documented as wasted).

Ms. Mehok also inaccurately documented administration of Hydromorphone prior to withdrawing the dose from Pyxis (Allegation 5; Allegation 6) as well as withdrew Hydromorphone before another dose was due (Allegation 1). Overall, Ms. Mehok inaccurately documented on multiple MARs and Nurses Assessment and Clinical Records to misappropriate Hydromorphone for an authorized and improper purpose.

Based on Ms. Mehok's pattern of documentation and Pyxis withdrawals, Ms. Mehok's withdrawals and administrations looked to be erroneous but instead she misappropriated the Hydromorphone or a part of the dose of Hydromorphone, including where there was no physician's order for Hydromorphone.

Overall, Ms. Mehok misappropriated Hydromorphone that was intended for clients as well as took advantage of clients' orders for Hydromorphone to misappropriate Hydromorphone. She withdrew or documented administration of doses to clients, impacting their future care and ability to receive further doses of pain medication.

Complaint #3

Background Information Relating to Complaint #3

Ms. Mehok was a regulated member of the CLPNA and employee of the Facility #3 at all times material to the allegations. She began her employment with the Facility #3

on April 5, 2023. She was hired to work in a casual position, a copy of her employment offer is attached at Exhibit #3, TAB 91.

Facility #2 learned that Ms. Mehok's practice permit was bound by a narcotics restriction on August 30, 2023 and terminated her [Exhibit #3, TAB 14].

Facility #3 is a residential addiction treatment centre for indigenous clients.

The conduct specifically relating to Allegation #1 is as follows.

On March 31, 2023, the Complaints Director notified Ms. Mehok of Complaint #2 via email to Casandra.mehok@live.com and advised her that the Complaints Officer would be seeking an order pursuant to section 65 of the Act and that she may provide written submissions by April 11, 2023 [Exhibit #3, TAB 8].

Although Ms. Mehok began working at Facility #3 on April 5, 2023, prior to the Section 65 Order #1 being imposed, on April 13, 2023, the Section 65 Order #1 was provided to Ms. Mehok via email that outlined the narcotics restriction imposed on her practice permit to Casandra.mehok@live.com [Exhibit #3, TAB 12].

The Section 65 Order #1 decision was downloaded by Ms. Mehok via the confidential link provided to her, proof of which is attached at Exhibit #3, TAB 92. Additionally, Ms. Mehok acknowledged the existence of the narcotics restriction on her practice permit on June 26, 2023 during an investigation interview into Complaint #2. Overall, Ms. Mehok had knowledge of the Section 65 Order #1 that imposed a narcotics restriction on her practice permit or was willfully blind to the narcotics restriction until August 30, 2023.

Despite Section 65 Order #1 being imposed on April 13, 2023, that restricted her ability and access to narcotics, Ms. Mehok continued working for Facility #3 and did not inform Facility #3 about the narcotics restriction at any time until it was discovered by Facility #3.

Within Ms. Mehok's role at Facility #3, she was expected to administer, monitor, access and handle medication, a copy of which is attached at Exhibit #3, TAB 93.

On August 30, 2023, an anonymous source advised Facility #3 that Ms. Mehok's practice permit was bound by a narcotics restriction. Upon being questioned, Ms. Mehok denied that she was practicing with a restricted practice permit.

The Clinical Director of Facility #3 contacted CLPNA for further information and was advised of the Section 65 Order #1. Subsequent to being contacted by the Clinical Director, CLPNA contacted Ms. Mehok. Ms. Mehok did not disclose the narcotics restriction to Facility #3 until she was contacted by the CLPNA on August 30, 2023 and after it had already been discovered by Facility #3.

The conduct specifically relating to Allegation #2 is as follows.

The Section 65 Order #1 [Exhibit #3, TAB 12] required that Ms. Mehok inform CLPNA of any new employer's name and contact information:

> "You are required to immediately advise the CLPNA of any employer(s) you are currently employed with as a Licensed Practical Nurse and provide the contact information for your current employer(s). If you accept another position as a Licensed Practical Nurse at any time during the CLPNA investigative process and disciplinary proceedings, you are required to inform your employer of the condition on your Practice Permit and provide the CLPNA with your employer's name and contact information for your direct supervisor."

Despite the direction above, Ms. Mehok failed to inform CLPNA that she was hired at Facility #3 until August 30, 2023, after the Clinical Director of Facility #3 contacted CLPNA and Ms. Mehok subsequently confirmed that she was employed at Facility #3 over the phone and when asked by CLPNA.

Ms. Mehok failed to meet the explicit requirements to report any new employer described in the Section 65 Order #1.

The conduct specifically relating to Allegation #3 is as follows.

Suboxone (buprenorphine/naloxone) is a narcotic, as defined by the *Controlled Drugs and Substances Act*, Schedule 1, a copy of which is attached at Exhibit #3, TAB 94. Suboxone is a common medication provided for individuals living with an addiction to narcotics, known as opiate agonist therapy.

Arising from the Section 65 Order #1, Ms. Mehok was prohibited from April 13, 2023 onwards from accessing, co-signing, or administering narcotic or controlled substances [Exhibit #3, TAB 12].

While working in a casual role at Facility #3, Ms. Mehok accessed, co-signed and/or administered suboxone on at least one occasion. Specifically, on August 19, 2023, Ms. Mehok administered four (4) tablets of suboxone to Client T.B., a copy of which is attached at Exhibit #3, TAB 95. Administrating suboxone was a common, and expected duty, of Ms. Mehok's casual LPN role at Facility #3. Ms. Mehok, at the time of access and administering suboxone, was restricted from doing so.

Complaint #4

Background Information Relating to Complaint #4

Ms. Mehok was a regulated member of the CLPNA and employee of the Facility #4 at all times material to the allegations. She began her employment with the Facility #4 in the June 2023. She was hired to work in a temporary full-time position at Facility #4 and had not conducted any nursing shifts at Facility #4 at the time of her termination but had participated in virtual orientation on August 28, 2023 and in-person orientation training session on August 29, 2023.

Facility #4 conducted an investigation and subsequently learned that Ms. Mehok's practice permit had been suspended by the Section 65 Order #2 and was later terminated on October 11, 2023 as she no longer met the requirements of the role for which she was hired [Exhibit #3, TAB 20].

Facility #4 is a provincial incarceration facility that houses a high-risk patient population.

The conduct specifically relating to Allegation #1 is as follows.

On March 31, 2023, the Complaints Director notified Ms. Mehok of Complaint #2 via email to Casandra.mehok@live.com and advised her that the Complaints Officer would be seeking an order pursuant to section 65 of the Act and that she may provide written submissions by April 11, 2023 [Exhibit #3, TAB 8].

On April 13, 2023, the Section 65 Order #1 was provided to Ms. Mehok via email that outlined the narcotics restriction imposed on her practice permit to Casandra.mehok@live.com [Exhibit #3, TAB 12].

The Section 65 Order #1 decision was downloaded by Ms. Mehok via the confidential link provided to her [Exhibit #3, TAB 92]. Ms. Mehok acknowledged the existence of the narcotics restriction on her practice permit on June 26, 2023 during an investigation interview into Complaint #2. Overall, Ms. Mehok had knowledge of the Section 65 Order #1 that imposed a narcotics restriction on her practice permit or was willfully blind to the narcotics restriction until August 30, 2023.

On June 16, 2023, Ms. Mehok signed and accepted an offer of employment with Facility #4, a copy of which is attached at Exhibit #3, TAB 96. The effective start date was July 17, 2023 [Exhibit #3, TAB 96]. The position for which she was hired required that she held active registration and a practice permit with CLPNA. The job description is at Exhibit #3, TAB 97.

On August 30, 2023, Ms. Mehok attended the Assistant Healthcare Manager's office and informed her that she had just learned there was a narcotics restriction on her practice permit. Ms. Mehok was upset and explained she needed to tell her other employer and that she believed she had administered suboxone at her other place of employment.

Ms. Mehok did not disclose the narcotics restriction to Facility #4 until she was contacted by the CLPNA on August 30, 2023.

The conduct specifically relating to Allegation #1 is as follows.

The Section 65 Order #1 [Exhibit #3, TAB 12] required that Ms. Mehok inform CLPNA of any new employer's name and contact information, as described above.

Despite this clear direction within the Section 65 Order #1, Ms. Mehok failed to inform CLPNA that she was hired at Facility #4 until August 30, 2023, where she was directed to immediately provide CLPNA with the contact information for her manager at Facility #4 over the phone and complied.

The Assistant Healthcare Manager at Facility #4 confirmed their contact information on August 30, 2023 to CLPNA after they were contacted about the Section 65 Order #1.

Ms. Mehok failed to meet the explicit requirements to report any new employer described in the Section 65 Order #1.

<u>Hearing Tribunal's Findings and Reasons Respecting the Allegations and Conduct relating to Complaints #1-#4</u>

The Hearing Tribunal accepts as proven the allegations and conduct set out in the ASF. This is in light of the substantial documentary evidence provided to the Hearing Tribunal as well as Ms. Mehok's admission to the conduct.

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

> vii. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> viii. Contravention of the Act, a code of ethics or standards of practice;
>
> ix. contravention of another enactment that applies to the profession; and
>
> x. Conduct that harms the integrity of the regulated profession.

There are numerous ways in which Ms. Mehok's conduct demonstrated a lack of knowledge, skill or judgment in the provision of professional services.

There are multiple instances of issues with Ms. Mehok failing to follow proper medication administration practices. On numerous occasions, she incorrectly and/or failed to:

a. document the reasons for medication administration;

b. accurately document the administration of medication;

c. account for medication not administered/wasted; and

d. failed to follow orders for medications accurately.

All members of a health care team rely on the documentation relating to a client to make evidence-based decisions about the care given to a client. Where the evidence relied on is incorrect or incomplete, the team members cannot make appropriate decisions and clients may be placed at risk. Medication administration is central to the work of an LPN and must be done dutifully and faithfully for this reason and others.

Internal assignments of clients to LPNs relates to the management of client needs, Ms. Mehok interfered when she withdrew and administered narcotics to clients to whom she was not assigned. Doing so caused confusion and difficulties for her colleagues creating difficulty in the work environment and distrust of Ms. Mehok. It is important that LPNs and other healthcare workers trust one another, where that trust breakdowns, the care to clients is diminished.

On some occasions, clients who had pain management needs, including palliative patients, did not have those needs met causing them to suffer without relief when it was not necessary. On other occasions, Ms. Mehok administered medications contrary to the directions in physician's orders. Clients lost confidence in Ms. Mehok and advised they did not feel safe in her care. This demonstrates a fundamental breakdown in Ms. Mehok's ability to provide care.

The medications in question were powerful and highly controlled narcotics. Ms. Mehok administered these narcotics at a markedly higher rate than her coworkers providing care to the same group of clients.

Not only did these issues occur but they occurred numerous times, with numerous clients, and continued to occur after issues were drawn to her attention. Ms. Mehok engaged in a pattern of conduct lacking knowledge, skill, and judgment with respect to medication administration.

In failing to advise her employers of her practice restrictions, Ms. Mehok showed a lack of judgment. Self-regulated professionals must be entrusted to be forthright with employers on such matters. They hold positions where they are entrusted to undertake significant responsibility, failing to disclose conditions on one's practice

permit is a breach of this trust. It demonstrates a lack of understanding of the requirements of a regulated professional.

Further to failing to disclose the conditions on her practice permit, Ms. Mehok also engaged in activities restricted under it contrary to a clear limitation placed on her by her regulator.

Any member of the public, properly informed as to this conduct, would reasonably question the integrity of the profession. Not only is the conduct serious but the repeated pattern of purposeful conduct and deliberate omissions by Ms. Mehok are a marked departure from what the public would expect from an LPN. This is compounded considering the known impacts to clients.

In administering medications to clients not assigned to her, Ms. Mehok inappropriately accessed health information. This is a breach of the *Health Information Act* which binds LPNs. It is an inappropriate breach of privacy of the clients concerned. This would also additionally diminish the public's view of LPNs, people receiving health care rightfully expect that their privacy will be respected, and deeply personal health information used only to further their care.

Ms. Mehok's conduct also breached Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("Code of Ethics"), the Standards of Practice for LPNs in Canada adopted by the CLPNA on June 3, 2013 ("2013 Standards of Practice") (with respect to Complaint #1), and the 2020 Standards of Practice for Licensed Practical Nurses in Canada ("2020 Standards of Practice") adopted by the CLPNA on June 14, 2022 (with respect to Complaints #2-4).

The relevant provisions of the Code of Ethics are 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:

a. Maintain standards of practice, professional competence and conduct.

1.5 Provide care directed toward the health and well-being of the person, family, and community.

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

2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.

2.9 Identify and minimize risks to clients.

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

3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

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

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

Principle 5: Responsibility to Self - LPNs recognize and function within their personal and professional competence and value systems.

5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

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

5.5 Inform the appropriate authority in the event of becoming unable to practise safely, competently and/or ethically.

2. The relevant provisions of the 2013 Standards of Practice applicable to Complaint #1, are as follows:

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:

1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.

1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

1.7. Incorporate established client safety principles and quality assurance/improvement activities into LPN practice;

1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.

1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 2: LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice.

2.1 Possess current knowledge to support critical thinking and professional judgement.

2.2. Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice.

2.11 Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

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:

3.2. Collaborate with clients and co-workers in the analysis, development, implementation and evaluation of LPN practice and policy that guide client-focused care delivery.

3.3. Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

3.5. Provide relevant and timely information to clients and co-workers.

3.6. Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

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.

4.5. Advocate for the protection and promotion of clients' right to autonomy, respect, privacy, confidentiality, dignity and access to information.

4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

4.9 Support and contribute to healthy and positive practice environments.

4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

3. The relevant provisions of the 2020 Standards of Practice, applicable to Complaints #2-4, are as follows:

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

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

1.5. Have a duty to report any circumstances that potentially and/or actually impede professional, ethical, or legal practice.

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

1.9. Document and report according to established legislation, regulations, laws, and employer policies.

Standard 2: Evidence-informed Practice - LPNs apply evidence- informed knowledge in practice. Standard 2 specifically provides that LPNs:

2.1. Attain and maintain evidence-informed knowledge to support critical thinking and professional judgement.

2.3. Maintain relevance in practice, in response to changes affecting the profession.

2.8. Apply the nursing process (assess, diagnose, plan, implement and evaluate).

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

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

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

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

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

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

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

4.2. Identify ethical issues and respond in the interest of the public.

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

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

4. The Hearing Tribunal agrees that Ms. Mehok's conduct was unprofessional conduct by reason (in additions to the others provided above) that the conduct breached the Code of Ethics, 2013 Standards of Practice and 2020 Standards of Practice.

5. Ms. Mehok's conduct was not directed towards ensuring the health and well-being of her clients to their family. In some cases, her actions were directly

contradictory to that purpose. In other cases, her conduct left clients vulnerable to negative health outcomes. In both, she introduced rather than minimized risk to clients.

6. She repeatedly failed to meet clear documentation and medication administration and did not follow the requirements of evidence based practice.

7. It is obvious Ms. Mehok did not respect client privacy as she accessed health information without any purpose for doing so which is a violation of their privacy.

8. Her actions negatively impacted her coworkers and diminished their relationships with her rather than encouraging collaboration and trust. Again, the way in which she did this detracted from the care clients received and that her colleagues could provide. Rather than present as a leader, Ms. Mehok detracted from the objectives of her profession, her colleagues, her workplace and those in her care.

9. By engaging in a lengthy period and pattern of conduct which was clearly outside of the range of what is expected by LPNs, in doing so even though concerns had been brought to her attention and in practicing contrary to limitations on her permit and without advising employers of those limitations, Ms. Mehok demonstrated disregard for the responsibility and privilege of self-regulation. She also neglected to report circumstances that could impede her practice or to be accountable for those circumstances by failing to be forthright about conditions on her practice.

10. For these reasons, and those articulated above, the Hearing Tribunal is satisfied that Ms. Mehok engaged in unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Mehok jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #4. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Ms Mehok shall pay 25% of the costs of the investigations for all four (4) complaints and the hearing to a maximum of $12,500.00 (the “Costs”) to be paid over a period of 36 months from service of the Decision.

a) A letter advising of the final costs will be forwarded to Ms. Mehok when final costs have been confirmed by CLPNA;

b) the Costs must be paid to the CLPNA, whether or not Ms. Mehok holds an active practice permit with the CLPNA; and

c) the Costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.

3. Ms. Mehok's suspension arising from the section 65 order dated September 11, 2023 shall continue until the Decision is issued and served upon Ms. Mehok.

4. Upon receipt of the Decision, Ms. Mehok's practice permit shall remain suspended until she has complied with the following:

a) Ms. Mehok shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Mehok shall provide a signed written declaration to the Complaints Director attesting she has reviewed the CLPNA's documents:

i. Code of Ethics for Licensed Practical Nurses in Canada;
ii. Standards of Practice for Licensed Practical Nurses in Canada;
iii. The CLPNA Policy: Professional Responsibility and Accountability;
iv. The CLPNA Policy: Medication Management;
v. The CLPNA Policy: Documentation.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Director.

b) Ms Mehok shall complete the following remedial education, at her own cost. Ms. Mehok shall provide the Complaints Director with documentation confirming successful completion of the following:

i. **NURS 0161: Medication Management** available online at www.macewan.ca;
ii. **Nursing Documentation 101** available online at www.clpna.com;
iii. **LPN Ethics Course** available online at www.learningnurse.org.

c) Ms. Mehok shall undergo a Substance Use Assessment, at her own cost, provided by Homewood Health or an assessment acceptable to the Complaints Director by a psychiatrist or psychologist qualified in substance use disorders (the "Assessor") subject to the following terms and conditions:

i. The Assessor will be provided with a copy of the Agreed Statement of Facts and Admission of Unprofessional Conduct, the Joint Submission on

Penalty and if available at the time of the Substance Use Assessment, a copy of the Hearing Tribunal's written decision;

ii. The Assessor will indicate whether they are making any recommendations for ongoing counselling or treatment;

iii. The assessment will be provided to Ms. Mehok and to Susan Blatz, Complaints Officer;

iv. Ms. Mehok shall comply with all recommendations made by the Assessor and provide proof of completion of all recommendations to the Assessor and Susan Blatz, Complaints Officer.

5. Upon successful completion of the above orders in paragraph 4 of the Decision, the suspension of Ms Mehok's practice permit will be removed.

6. Upon Ms. Mehok's suspension being removed, Ms Mehok's practice permit shall be subject to a condition that she engage in supervised medication administration for a period of 250 hours. Ms Mehok must be under direct supervision during medication administration subject to the following:

   a) Ms Mehok must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;

   b) Following the completion of 250 hours of supervised medication administration, Ms Mehok must be deemed knowledgeable and competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

   c) Following the completion of the 250 hours of supervised medication administration, Ms Mehok must provide to the Complaints Director a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and Ms Mehok.

7. If following the completion of 250 hours of supervised medication administration, the Evaluator is unable to indicate Ms Mehok is deemed knowledgeable and competent as set out above at paragraph 6(b):

   a) The condition requiring Ms Mehok to practice under supervised medication administration will remain on Ms Mehok's practice permit for an additional 200 hours;

   b) Ms Mehok must be under direct supervision during medication administration;

c) Following the completion of the additional 200 hours of supervised medication administration, Ms Mehok must provide proof to the Complaints Director that she has successfully completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and Ms Mehok.

8. In the event that Evaluator(s) do not deem Ms Mehok knowledgable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 200 hours of supervised medication administration, the matter may be remitted to the Hearing Tribuanl for further consideration.

9. The conditions on Ms. Mekok's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2-8.

10. Ms Mehok 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 Mehok will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms Mehok be unable to comply with any of the sanctions' deadlines identified above, Ms Mehok may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms Mehok will be notified by the Complaints Officer, in writing, if the extension has been granted.

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

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

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

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

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

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

The Hearing Tribunal did have concerns with respect to the proposed sanctions and sought the parties' input with respect to other decisions which would provide the Hearing Tribunal with guidance as to the appropriateness of the proposed sanction. The parties provided the Hearing Tribunal with such further information for its consideration. Reference is made to that information in respect of the Hearing Tribunal's decision on penalty below.

The Hearing Tribunal carefully considered the Joint Submission on Penalty proposed by Ms. Mehok and the Director as well as the full range of submissions made in respect of them.

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

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

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

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred

- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

1. The nature and gravity of the proven allegations:

The conduct under consideration is on the more serious end of the spectrum. This is due to the repetitive pattern of failing to meet fundamental obligations, the purposeful nature of the conduct, the concerns arising from that conduct, and the failure to disclose conditions when required to do so. All of these on their own would be serious in isolation and in combination the severity is heightened.

2. The age and experience of the investigated member:

Ms. Mehok has been an LPN since 2018. She was not a new LPN at the time the issues arose.

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

The Hearing Tribunal notes that it was not made aware of prior complaints or convictions but does note that Ms. Mehok attracted three further complaints relating to her conduct after the first was made.

4. The age and mental condition of the victim, if any:

The Hearing Tribunal did not receive any specific information with respect to any of the clients but does note that some of the clients affected were receiving palliative care and others were accessing addiction recovery services. These are highly vulnerable individuals.

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

As has been noted a number of times in this decision so far, this was a pattern of conduct with many incidents supporting the complaints under consideration. Further, the offending conduct occurred at multiple sites, with multiple clients and continued despite corrective actions. This factor is aggravating.

6. The role of the investigated member in acknowledging what occurred:

Ms. Mehok admitted to the conduct in question and that such conduct was unprofessional. This demonstrates that she is willing to accept the consequences of her actions. The impact of this cannot be underestimated; in doing so she saved the time and expense of a full hearing in these matters and also spared a number of individuals impacted by her conduct from having to appear at a hearing to give evidence which can be a difficult process of its own. This is a mitigating factor.

7. 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 notes that Ms. Mehok has not been permitted to practice her profession since September 2023. She was terminated from four practice settings. There have been significant financial consequences for Ms. Mehok.

8. The impact of the incident(s) on the victim, and/or:

The Hearing Tribunal became aware of disagreements that occurred with clients, including as to whether they had received medications designed to improve quality of life by alleviating pain. There is also the fact that critical information was not included in the records for clients and therefore impacted the care decisions which would have assumed the records available were complete and accurate.

9. The presence or absence of any mitigating circumstances:

The Hearing Tribunal did not receive any specific submissions with respect to mitigating circumstances not otherwise accounted for under the other factors.

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

It is important that the Hearing Tribunal's decision on sanction has the dual effect of deterring Ms. Mehok from engaging in similar conduct in the future but also that members of the LPN professional are also deterred from similar conduct.

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

The public must have confidence that LPNs uphold the standards and requirements expected of them. Where that does not occur, the response to unprofessional conduct should signal to the public that such conduct is not accepted by the CLPNA and that LPNs who engage in unprofessional conduct are appropriately sanctioned.

In this way the public can feel confident that LPNs providing care to them will meet the requirements to ensure safe and effective health care.

12. The range of sentence in other similar cases:

Upon the further submissions of the parties the Hearing Tribunal received eleven decisions and resolution summaries with respect to LPNs in Alberta, other health professions in Alberta and other provinces as well as other professions in Alberta and other provinces. These authorities offered the Hearing Tribunal benchmarks against which it could weigh and assess the proposed joint sanction. In considering those authorities the Hearing Tribunal was mindful that the exercise in arriving at a sanction is a fact specific one and that finding an authority which is even substantially similar can be difficult. Nonetheless, the Hearing Tribunal found significant value in the authorities provided as they offered the ability to understand and appreciate the overall approach taken by other decision makers in similar cases as well as to understand the reasoning behind those decisions. In this way the Hearing Tribunal felt it was able to assess the appropriateness of the joint sanction from an informed position.

Of the authorities available to the Hearing Tribunal there were four prior decisions relating to CLPNA members.

The first arose in respect of concerns around narcotic documentation, removal of narcotics without orders, and issues with the timing of medication administration. The resulting order was relatively similar to the joint submission proposed to the Hearing Tribunal but that LPN was ordered to undertake 300 hours of supervised practice.

The second related to similar concerns with narcotics in which a pattern of conduct reflecting that under consideration here led the matter to a complaint. In that case the education requirements ordered were less stringent than those proposed here but there the conduct was less serious and there were less instances of it occurring.

The facts of the third decision included large amounts of oxycontin being accessed and wasted and a pattern of repeated concerns about that conduct. The resulting sanction required a fitness to work practice assessment as well as ongoing requirements to ensure safe practice.

The fourth decision had similar facts, the LPN was unfit to be at work and presented exhausted and slurring speech. That LPN did not attend the hearing and the proposal was not joint. In that case the resulting proposal was similar to what is presented in this case and was aimed at ensuring protection of the public.

Counsel for the Complaints Director submitted that each of the Hearing Tribunals in the above decisions grappled with serious concerns and that generally the outcome was designed to address remediation of the LPN, a suspension for ongoing protection and the requirement for the LPN to demonstrate fitness to practice.

The Hearing Tribunal found these decisions particular instructive and found significant support in these decisions for the proposed joint sanction.

In relation to other health professionals the cases the Hearing Tribunal received information about the sanctions reacted to similar conduct by directing remediation and monitored practice which reflect what the parties proposed.

Finally, in respect of other professions, the Hearing Tribunal considered the authorities presented including the lengthy suspensions imposed and the requirement for the professional in question, in one case, to demonstrate the ability to engage in skilled practice and to undergo a period of monitoring before being permitted to practice independently.

In hearing the submissions of the parties, the Hearing Tribunal particularly noted that monitored practice has the dual merits of providing oversight to confirm ethical practice and habits and offer mentorship ensuring that a professional who has experienced a long period away from practice can return to practice with confidence in their skills and ability to engage in the profession.

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

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

(11) Orders of the Hearing Tribunal

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

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

2. Ms Mehok shall pay 25% of the costs of the investigations for all four (4) complaints and the hearing to a maximum of $12,500.00 (the "Costs") to be paid over a period of 36 months from service of the Decision.

   a) A letter advising of the final costs will be forwarded to Ms. Mehok when final costs have been confirmed by CLPNA;

   b) the Costs must be paid to the CLPNA, whether or not Ms. Mehok holds an active practice permit with the CLPNA; and

   c) the Costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.

3. Ms. Mehok's suspension arising from the section 65 order dated September 11, 2023, shall continue until the Decision is issued and served upon Ms. Mehok.

4. Upon receipt of the Decision, Ms. Mehok's practice permit shall remain suspended until she has complied with the following:

   a) Ms. Mehok shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Mehok shall provide a signed written declaration to the Complaints Director attesting she has reviewed the CLPNA's documents:

      i. Code of Ethics for Licensed Practical Nurses in Canada;
      ii. Standards of Practice for Licensed Practical Nurses in Canada;
      iii. The CLPNA Policy: Professional Responsibility and Accountability;
      iv. The CLPNA Policy: Medication Management;
      v. The CLPNA Policy: Documentation.

      If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Director.

   b) Ms Mehok shall complete the following remedial education, at her own cost. Ms. Mehok shall provide the Complaints Director with documentation confirming successful completion of the following:

      i. **NURS 0161: Medication Management** available online at www.macewan.ca;
      ii. **Nursing Documentation 101** available online at www.clpna.com;
      iii. **LPN Ethics Course** available online at www.learningnurse.org.

c) Ms. Mehok shall undergo a Substance Use Assessment, at her own cost, provided by Homewood Health or an assessment acceptable to the Complaints Director by a psychiatrist or psychologist qualified in substance use disorders (the "Assessor") subject to the following terms and conditions:

i. The Assessor will be provided with a copy of the Agreed Statement of Facts and Admission of Unprofessional Conduct, the Joint Submission on Penalty and if available at the time of the Substance Use Assessment, a copy of the Hearing Tribunal's written decision;

ii. The Assessor will indicate whether they are making any recommendations for ongoing counselling or treatment;

iii. The assessment will be provided to Ms. Mehok and to Susan Blatz, Complaints Officer;

iv. Ms. Mehok shall comply with all recommendations made by the Assessor and provide proof of completion of all recommendations to the Assessor and Susan Blatz, Complaints Officer.

5. Upon successful completion of the above orders in paragraph 4 of the Decision, the suspension of Ms Mehok's practice permit will be removed.

6. Upon Ms. Mehok's suspension being removed, Ms Mehok's practice permit shall be subject to a condition that she engage in supervised medication administration for a period of 250 hours. Ms Mehok must be under direct supervision during medication administration subject to the following:

a) Ms Mehok must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;

b) Following the completion of 250 hours of supervised medication administration, Ms Mehok must be deemed knowledgeable and competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

c) Following the completion of the 250 hours of supervised medication administration, Ms Mehok must provide to the Complaints Director a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and Ms Mehok.

7. If following the completion of 250 hours of supervised medication administration, the Evaluator is unable to indicate Ms Mehok is deemed knowledgeable and competent as set out above at paragraph 6(b):

    a) The condition requiring Ms Mehok to practice under supervised medication administration will remain on Ms Mehok's practice permit for an additional 200 hours;

    b) Ms Mehok must be under direct supervision during medication administration;

    c) Following the completion of the additional 200 hours of supervised medication administration, Ms Mehok must provide proof to the Complaints Director that she has successfully completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and Ms Mehok.

8. In the event that Evaluator(s) do not deem Ms Mehok knowledgable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 200 hours of supervised medication administration, the matter may be remitted to the Hearing Tribuanl for further consideration.

9. The conditions on Ms. Mekok's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2-8.

10. Ms Mehok 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 Mehok will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms Mehok be unable to comply with any of the sanctions' deadlines identified above, Ms Mehok may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms Mehok will be notified by the Complaints Officer, in writing, if the extension has been granted.

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

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

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

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

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

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

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 6th DAY OF FEBRUARY 2025 THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Andrew Otway
Chair, Hearing Tribunal