COLLEGE OF LICENSED PRACTICAL NURSES AND HEALTH CARE AIDES OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING THE CONDUCT OF DANSON CARY MEERA

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF LICENSED PRACTICAL NURSES AND HEALTH CARE AIDES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF DANSON CARY MEERA, LPN #45388, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES AND HEALTH CARE AIDES OF ALBERTA ("CLHA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference on February 5, 2026 with the following individuals present:

Hearing Tribunal:
Jeff Bell, Licensed Practical Nurse ("LPN") Chairperson
Patricia Geusebroek, LPN
Deborah Gust, Public Member
Peter Sherstan, Public Member

Staff:
Kimberly Precht, Legal Counsel for the Complaints Director, CLHA
Susan Blatz, Complaints Director, CLHA

Regulated Member:
Danson Cary Meera, LPN ("Mr. Meera" or "Investigated Member" or "Regulated Member")
Jaime Oyarzun, AUPE Representative for the Regulated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

The Regulated Member has been registered as a Licensed Practical Nurse ("LPN") with the College of Licensed Practical Nurses of Alberta ("CLPNA", which became the CLHA) since January 4, 2018, and was registered at all times material to the allegations.

On November 28, 2024, the CLPNA (currently CLHA) received a complaint from KH, Member of the Public (the "Complainant"), about the Regulated Member, while employed at AgeCare – Glenmore in Calgary, Alberta (the "Facility"), in relation to the Complainant's mother, Client LH.

The Complaints Director appointed Keith O'Neill, Investigator, to conduct an investigation into the complaint.

Following the receipt and review of the Investigation Report, the Complaints Director determined there was sufficient evidence of unprofessional conduct by the Regulated Member to refer the matter to a hearing in accordance with s. 66(3)(a) of the *Health Professions Act*, RSA 2000, c H-7 (the "Act"). The Regulated Member received notice that the matter was referred to a hearing, as well as a copy of the Statement of Allegations dated October 7, 2025.

A Notice of Hearing was served upon the Regulated Member under cover letter dated November 2, 2025.

A revised Statement of Allegations was issued and provided to the Regulated Member on December 19, 2025.

The Member's Representative did not provide an opening statement.

(4) Allegations

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

"It is alleged that **DANSON CARY MEERA, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or between December 25, 2020, and February 14, 2021, while working as a Health Care Aide at AgeCare – Glenmore, failed to follow the "no male caregiver" specification in Client LH's care plan, on twelve occasions, or any of them:
    a. by showering or bathing Client LH, or
    b. by remaining in the shower room while Client LH was being showered or bathed.

It is further alleged that this conduct constitutes "unprofessional conduct" as defined in s. 1(1)(pp)(ii) and (xii) of the Health Professions Act, RSA 2000, c H-7, and in particular that this conduct breaches one or more of the following:

1. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 2: Responsibility to Clients, Indicators 2.1, 2.6;
2. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 3: Responsibility to the Profession, Indicator 3.1;
3. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 5: Responsibility to Self, Indicator 5.1, 5.3."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits a Regulated 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.

Mr. Meera acknowledged unprofessional conduct to all the allegations as evidenced by his 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: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2: Joint Submission on Penalty

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Mr. Meera'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 Mr. Meera.

Allegation 1

Mr. Meera admitted that on or between December 25, 2020, and February 14, 2021, while working as a Health Care Aide at AgeCare – Glenmore, he failed to follow the "no male caregiver" specification in Client LH's care plan, on twelve occasions, or any of them:

a. by showering or bathing Client LH, or
b. by remaining in the shower room while Client LH was being showered or bathed.

The Regulated Member was aware of the "no male caregiver" specification in Client LH's care plan.

Despite this specification, the Regulated Member showered or bathed Client LH on twelve occasions, including: December 25, 2020, January 1, 2021, January 3, 2021, January 8, 2021, January 15, 2021, January 17, 2021, January 22, 2021, January 29, 2021, January 31, 2021, February 5, 2021, February 12, 2021, and February 14, 2021.

The Regulated Member documented in Client LH's Point of Care record that he completed Client LH's shower or bath on each of the above-noted dates.

Although the Regulated Member was not working in the capacity of an LPN when he showered or bathed Client LH, as an LPN he should have understood the importance of the "no male caregiver" specification in Client LH's care plan and should have ensured compliance with it.

The Regulated Member admits to the conduct described above and as set out in Allegation 1(a). He admits that he was not merely present in the shower room while Client LH was being showered or bathed, but that he showered or bathed Client LH on these twelve occasions, despite the "no male caregiver" specification in Client LH's chart.

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

i. Contravention of the Act, a code of ethics or standards of practice; and
ii. Conduct that harms the integrity of the regulated profession.

The Tribunal finds that the Regulated Member was aware of the "no male caregiver" restriction in Client LH's care plan, yet he personally showered or bathed the client on twelve occasions between December 25, 2020, and February 14, 2021. He documented in the Point of Care record that he completed this care on each occasion and admits that he was not merely present, but directly provided the bathing care, contrary to the care plan.

Although the Regulated Member was working as a Health Care Aide at the time, he was also a Licensed Practical Nurse and was expected to understand the clinical, ethical, and professional significance of such a restriction. His actions failed to meet the standards expected of an LPN, particularly in respecting client-specific directives and safeguarding vulnerable clients.

The Tribunal concludes that this conduct harmed the integrity of the licensed practical nursing profession. The public is entitled to expect that LPNs will follow care plans, respect client-specific restrictions, and exercise sound professional judgment, particularly when providing intimate care. The repeated nature of the conduct, despite clear awareness of the restriction, undermines public confidence in the profession's commitment to ethical, accountable, and client-centered care. Accordingly, the Tribunal finds that the conduct constitutes unprofessional conduct under the Act.

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

CLPNA Code of Ethics:

Mr. Meera acknowledged his conduct breached one or more of the following Code of Ethics:

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

- 2.1 Respect the right and responsibility of clients to be informed and make decisions about their health care.

- 2.6 Provide care to each client recognizing their individuality and their right to choice.

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.

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

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

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

Mr. Meera's actions violated the ethical and professional obligations of a Licensed Practical Nurse because he knowingly provided intimate care to Client LH despite a clear "no male caregiver" restriction in the care plan. By disregarding this directive, he failed to honor the client's autonomy and personal boundaries, and ignored the very instructions designed to protect the client's safety, dignity, and well-being. Care plans exist to ensure that vulnerable individuals are treated with respect and receive care that aligns with their needs and wishes.

Even though Mr. Meera was working as a Health Care Aide at the time, Mr. Meera was a Licensed Practical Nurse and expected to understand the professional and ethical significance of adhering to care directives. Repeatedly providing care in contradiction to the care plan reflects a lapse in judgment, and a failure to act with the honesty, integrity, and accountability required of the profession. It also demonstrates a missed opportunity to model ethical practice and safeguard the trust that clients, colleagues, and the public place in nurses.

By choosing to ignore the care plan, Mr. Meera compromised not only the client's safety and dignity, but also the integrity of the profession. This conduct serves as a reminder of the importance of aligning professional knowledge with ethical responsibility, following care directives faithfully, and always centering the needs and rights of clients. Reflecting on this, it is clear that respecting client choice, exercising sound judgment, and maintaining professional accountability are not optional—they are fundamental to ethical nursing practice.

(9) Joint Submission on Penalty

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

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.
2. The Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. Client & Co-Worker Abuse;
    d. Documentation;
    e. Professional Responsibility and Accountability.

    These documents are available on CLHA's website and will be provided to the Regulated Member. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Director.

3. Within **60 days** of the date of the hearing, the Regulated Member shall complete the following remedial education, at their own cost, and shall provide the Complaints Director with documentation confirming successful completion:

    a. Code of Ethics for LPNs available at www.clha.com ;

    b. Documentation available at www.clha.com ;

    c. Person-Centred Care (PCC) in Nursing available at www.alison.com.

    If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Director.

4. The Regulated Member shall pay a portion of the costs of the investigation and hearing, in the amount of $1,000.00, to be paid over a period of **24 months** of the date of the hearing.

    a. The costs must be paid to the CLHA, whether or not the Regulated Member holds an active practice permit with the CLHA. Any outstanding costs are a debt owed to the CLHA and if not paid by the deadline indicated, may be recovered as an action in debt.

5. The orders set out above at paragraphs 3-4 will appear as conditions on the Regulated Member's practice permit and the Public Registry, subject to the following:

    a. The requirements at paragraph 3 will appear as "CLHA Monitoring Orders (Conduct)";

    b. The requirement at paragraph 4 will appear as "Conduct Cost/Fines".

6. The conditions on the Regulated Member's practice permit and on the Public Registry will be removed upon completion of each order. The CLHA will provide the required notices in accordance with s. 119 of the HPA.

7. The Regulated Member shall ensure their contact information with the CLHA, including home mailing address, telephone number(s), e-mail address and employment information, is up to date. The Regulated Member will keep their contact information current with the CLHA on an ongoing basis.

8. Should the Regulated Member be unable to comply with any of the deadlines for completion of the orders identified above, the Regulated Member may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension, and state a reasonable timeframe for completion. The Complaints Director shall, in their sole discretion, determine whether a time extension is granted. The Regulated Member will be notified, in writing, if the extension has been granted.

9. Should the Regulated Member fail or be unable to comply with any of the above orders, or if any dispute arises regarding the implementation of these orders, the Complaints Director 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 the Regulated Member's non-compliance as information for a complaint under s. 56 of the Health Professions Act; or

    c. In the case of non-payment of the costs, suspend the Regulated Member's practice permit until such costs are paid in full or there is satisfaction that the costs are being paid in accordance with a schedule of payment agreed to by the CLHA.

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. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Mr. Meera and the Complaints Director.

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

The nature and gravity of the proven allegations
The allegations against Mr. Meera were serious in nature. He knowingly provided intimate care to Client LH on twelve occasions despite a clear and explicit "no male caregiver" restriction in the client's care plan. This conduct disregarded the client's autonomy, personal boundaries, and well-being, and represented a repeated failure to follow fundamental directives intended to protect a vulnerable individual. The Tribunal considered this conduct to be a significant breach of professional and ethical standards.

The age and experience of the Regulated Member
Mr. Meera has been a Licensed Practical Nurse since January 2018. While he was employed as a Health Care Aide at the time of the incidents, he retained the professional knowledge, ethical understanding, and judgment expected of an LPN. His experience heightened the expectation that he would understand and comply with care plan directives and act consistently with ethical and professional standards.

The previous character of the Regulated Member and in particular the presence or absence of any prior complaints or convictions
The Tribunal noted that Mr. Meera had no prior complaints or disciplinary history. His professional record was otherwise unblemished, and there was no evidence of prior unprofessional conduct. This absence of previous issues was considered a mitigating factor when assessing a proportionate and fair penalty.

The age and mental condition of the victim, if any
Client LH was a vulnerable adult receiving continuing care. The care plan, including the "no male caregiver" restriction, was specifically designed to safeguard the client's safety, dignity, and autonomy. The client's vulnerability increased the seriousness of the conduct and reinforced the need for appropriate corrective measures.

The number of times the offending conduct was proven to have occurred
The conduct occurred twelve separate times over a period of approximately seven weeks, between December 25, 2020, and February 14, 2021. The repeated nature of the conduct indicated a pattern of behavior rather than an isolated lapse in judgment, which the Tribunal found to be an aggravating factor.

The role of the Regulated Member in acknowledging what occurred
Mr. Meera admitted to all allegations both in the Agreed Statement of Facts and verbally during the hearing. The Tribunal noted that this acknowledgment demonstrated insight and a willingness to accept responsibility, which was a factor in considering a fair and proportionate penalty.

Whether the Regulated Member has already suffered other serious financial or other penalties as a result of the allegations having been made
There was no evidence that Mr. Meera had previously suffered any financial or other penalties in relation to these allegations prior to the hearing.

The impact of the incident(s) on the victim, and/or
The conduct directly affected Client LH by compromising their safety, dignity, and autonomy during intimate care. The repeated breaches of the care plan had the potential to cause emotional distress or feelings of violation, emphasizing the seriousness of the conduct and the importance of protective measures.

The presence or absence of any mitigating circumstances
The Tribunal considered mitigating factors, including Mr. Meera's full admission of unprofessional conduct, his cooperation throughout the investigation and hearing, and the absence of prior complaints or disciplinary action. These factors weighed in favor of a penalty that was remedial and educational, rather than purely punitive.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
The Tribunal recognized the importance of both specific and general deterrence. The sanctions imposed were intended to prevent recurrence by Mr. Meera and to signal to the profession the critical importance of following care directives and ethical standards. The remedial education and monitoring requirements were designed to reinforce professional and ethical obligations, ensuring safe and proper practice in the future.

The need to maintain the public's confidence in the integrity of the profession
Maintaining public confidence in the integrity of Licensed Practical Nurses was a key consideration. By imposing a fair, proportionate, and structured penalty, the Tribunal ensured that the public could have confidence that breaches of professional and ethical standards are addressed and that client safety and dignity remain paramount.

The range of sentence in other similar cases
The Tribunal considered prior cases involving breaches of care plans or client-specific restrictions. Sanctions in similar matters have included written reprimands, educational requirements, and contributions toward costs. The Tribunal found that the joint submission on penalty in this case was consistent with the range of sanctions applied in comparable cases and was appropriate given the circumstances.

It is important to the profession of LPNs to maintain the Code of Ethics 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 Regulated 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 decision (the "Decision") shall serve as a reprimand.
2. The Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. Client & Co-Worker Abuse;
    d. Documentation;
    e. Professional Responsibility and Accountability.

    These documents are available on CLHA's website and will be provided to the Regulated Member. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Director.
3. Within **60 days** of the date of the hearing, the Regulated Member shall complete the following remedial education, at their own cost, and shall provide the Complaints Director with documentation confirming successful completion:

a. Code of Ethics for LPNs available at www.clha.com;

b. Documentation available at www.clha.com;

c. Person-Centred Care (PCC) in Nursing available at www.alison.com.

If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Director.

4. The Regulated Member shall pay a portion of the costs of the investigation and hearing, in the amount of $1,000.00, to be paid over a period of **24 months** of the date of the hearing.

    a. The costs must be paid to the CLHA, whether or not the Regulated Member holds an active practice permit with the CLHA. Any outstanding costs are a debt owed to the CLHA and if not paid by the deadline indicated, may be recovered as an action in debt.

5. The orders set out above at paragraphs 3-4 will appear as conditions on the Regulated Member's practice permit and the Public Registry, subject to the following:

    a. The requirements at paragraph 3 will appear as "CLHA Monitoring Orders (Conduct)";

    b. The requirement at paragraph 4 will appear as "Conduct Cost/Fines".

6. The conditions on the Regulated Member's practice permit and on the Public Registry will be removed upon completion of each order. The CLHA will provide the required notices in accordance with s. 119 of the HPA.

7. The Regulated Member shall ensure their contact information with the CLHA, including home mailing address, telephone number(s), e-mail address and employment information, is up to date. The Regulated Member will keep their contact information current with the CLHA on an ongoing basis.

8. Should the Regulated Member be unable to comply with any of the deadlines for completion of the orders identified above, the Regulated Member may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension, and state a reasonable timeframe for completion. The Complaints Director shall, in their sole discretion, determine whether a time extension is granted. The Regulated Member will be notified, in writing, if the extension has been granted.

9. Should the Regulated Member fail or be unable to comply with any of the above orders, or if any dispute arises regarding the implementation of these orders, the Complaints Director 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 the Regulated Member's non-compliance as information for a complaint under s. 56 of the Health Professions Act; or

c. In the case of non-payment of the costs, suspend the Regulated Member's practice permit until such costs are paid in full or there is satisfaction that the costs are being paid in accordance with a schedule of payment agreed to by the CLHA.

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 Regulated 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.
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> **(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 18th of FEBRUARY 2026 IN THE CITY of LETHBRIDGE, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES AND HEALTH CARE AIDES OF ALBERTA

Jeff Bell, LPN
Chair, Hearing Tribunal