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 LAIYILA PEWUDIE

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 LAIYILA PEWUDIE, LPN #47303, 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 October 29, 2025 with the following individuals present:

Hearing Tribunal:
Sarah Kawaleski, Licensed Practical Nurse ("LPN"), Chair
Anita Loughran, LPN
David Rolfe, Public Member
Andrew Otway, Public Member

Staff:
Allie Quigley, Legal Counsel for the Complaints Director, CLPNA
Gregory Sim, Legal Counsel for the Complaints Director, CLPNA
Susan Blatz, Complaints Director, CLPNA

Regulated Member:
Laiyila Pewudie, LPN ("Ms. Pewudie" or "Investigated Member" or "Regulated Member")

(2) Preliminary Matters

The hearing was open to the public.

When the hearing began, Chair advised the Regulated Member she had the right to legal counsel under section 72(1) of the *Health Professions Act* ("the Act"). The Regulated Member confirmed she wished to proceed with the hearing without legal counsel.

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

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

(3) Background

Ms. Pewudie was an LPN within the meaning of the Act at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Pewudie was initially licensed as an LPN in Alberta on January 17, 2019.

On March 1, 2024, the CLPNA received a complaint from Lisa James, Member of the Public (the "Complainant"), about the Regulated Member, while employed as an agency nurse at Meadow Ridge Seniors Village in Medicine Hat, Alberta (the "Facility").

The Complaints Director appointed Marnie Heberling, Investigator, to conduct an investigation into the complaint. After review of the investigation report, the Complaints Director appointed Neal York, Investigator, to conduct a further investigation.

Following the receipt and review of the Investigation Reports, the Complaints Director determined there was sufficient evidence of unprofessional conduct by the Regulated Member that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of 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 June 16, 2025.

A Notice of Hearing was served upon the Regulated Member under cover letter dated August 18, 2025.

The Investigated Member did not provide an opening statement.

(4) Allegations

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

"It is alleged that LAIYILA PEWUDIE, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about February 22, 2024, while working at Meadows Ridge Seniors Village (the Facility), failed to respond in an appropriate or safe manner after finding Client SA in an altered state, particulars of which include one or more of the following:

    a) Failed to complete or document further assessments of Client SA between approximately 0929 hours and 1245 hours;
    b) Failed to treat Client SA with compassion and dignity by leaving SA in her bed which was surrounded with dried emesis; and
    c) Failed to act promptly or appropriately in response to indications of harmful conditions or behaviours.

2. On or between February 18-21, 2024, while working at the Facility, did one or more of the following with regard to Client SA:

a) Failed to clearly and accurately document each dose of PRN Hydromorphone administered on a separate line on the PRN Documentation Record;
b) Failed to document the effectiveness of each dose of PRN Hydromorphone administered on the PRN Documentation Record;
c) Failed to document PRN doses of Hydromorphone administered on February 18, 2024, at 1100 hours and 1745 hours on the Medication Administration Record;
d) Failed to document the PRN dose of Hydromorphone administered at 1800 hours on February 20, 2024, on the Medication Administration Record or the PRN Documentation Record; and
e) Failed to clearly and accurately document each dose of PRN Hydromorphone administered on February 21, 2024, in a separate entry in the Progress Notes.

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. Standards of Practice for Licensed Practical Nurses in Canada, Standard 1: Professional Accountability and Responsibility, Indicators 1.8, 1.9;
2. Standards of Practice for Licensed Practical Nurses in Canada, Standard 2: Evidence-Informed Practice, Indicators 2.1, 2.7, 2.8, 2.10;
3. Standards of Practice for Licensed Practical Nurses in Canada, Standard 3: Protections of the public through self-regulation, Indicators 3.3, 3.4;
4. Standards of Practice for Licensed Practical Nurses in Canada, Standard 4: Professional and Ethical Practice, Indicators 4.1, 4.3, 4.6.;
5. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 1: Responsibility to the Public, Indicators 1.1, 1.5;
6. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 2: Responsibility to Clients, Indicators 2.4, 2.8, 2.9;
7. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 3: Responsibility to the Profession, Indicator 3.1;
8. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 4: Responsibility to Colleagues, Indicator 4.2."

(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.

Ms. Pewudie 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 that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Ms. Pewudie'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. Pewudie.

Allegation 1

Ms. Pewudie admitted on or about February 22, 2024, while working at Meadows Ridge Seniors Village (the "Facility"), she failed to respond in an appropriate or safe manner after finding Client SA in an altered state, particulars of which include one or more of the following:

a) Failed to complete or document further assessments of Client SA between approximately 0929 hours and 1245 hours;
b) Failed to treat Client SA with compassion and dignity by leaving SA in her bed which was surrounded with dried emesis; and
c) Failed to act promptly or appropriately in response to indications of harmful conditions or behaviours.

The Complainant is a family member of Client SA, who was a resident at the Facility at the time of the Allegations. The Facility offers supportive living services to its residents.

The Regulated Member worked shifts at the Facility between February 18 to February 22, 2024 and at all times material to the allegations provided professional services of an LPN.

On or about February 22, 2024 the Regulated Member commenced a shift at the Facility at approximately 0630 hours. At shift report, the Regulated Member was informed that Client SA may have consumed alcohol the previous night and was sleeping.

At approximately 0630 hours, a Health Care Aide (the "HCA") at the Facility attended Client SA's room and observed emesis on the toilet, coat, and bed. The HCA completed an Incident Report.

The Regulated Member was informed of Client SA's state and directed the HCA not to attend to Client SA until they woke up. There are no documented assessments of Client SA in their Progress Notes at this time by the Regulated Member.

At approximately 0929 hours, the Regulated Member completed an assessment of Client SA in which Client SA's vitals were taken, and it was documented in Client SA's Progress Notes that Client SA was slow to respond and there was dried emesis on Client SA's jacket and floor. The Regulated Member documented that the physician and Client SA's daughter had been notified of Client SA's status.

The Regulated Member emailed Client SA's physician at approximately 1047 hours, indicating that Client SA had been found passed out and unresponsive for about twenty seconds before responding to her name being called. The Regulated Member reported her vitals and 0930 medications were held as she was not lucid enough to take medicaon [sic].

A family member of Client SA attended the Facility at approximately 1200 hours at which time Client SA had still not awoken, and dried emesis was observed on the bed, floor, bathroom, couch, and SA herself.

The dried emesis was cleaned up by Facility Staff after the request of Client SA's family member.

The Regulated Member met the family in Client SA's room. It was at this time it was decided to contact EMS, as the Regulated Member discovered from the family that Client SA had been self-medicating with Tylenol. Prior to the events of February 22, 2025, the Regulated Member and Facility were not aware that Client SA was self-medicating with Tylenol beyond the administrations of the medications being provided to her at the Facility.

The Regulated Member documented in Client SA's Progress Notes at 1245 hours that paramedics were called for Client SA.

The Regulated Member did not complete any assessments of Client SA between 0929 and 1245 hours after being notified and observing harmful conditions or behaviours with respect to Client SA.

The Regulated Member did not treat Client SA with compassion and dignity by leaving SA with dried emesis on and around her from approximately 0630 to 1230 hours.

The Regulated Member failed to act promptly or appropriately in response to indications of harmful conditions or behaviours.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pewudie's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 1 did in fact occur.

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

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

Ms. Pewudie displayed a lack of knowledge, skill, and judgement by failing to complete or document further assessments of SA. Completing physical assessments and documentation are core competencies of any LPN. Ms. Pewudie demonstrated a lack of skill and judgment by failing to treat SA with compassion and by failing to appreciate her vulnerability due to her medical concerns. Ms. Pewudie's conduct harms the integrity of the regulated profession as Ms. Pewudie did not act in a manner which would be expected of an LPN.

In addition, Ms. Pewudie did not abide by the Code of Ethics for Licensed Practical Nurses in Canada adopted June 3, 2013 ("CLPNA Code of Ethics") and the 2020 Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice"). Information as to the particular code provisions and standards that were breached is set out below.

CLPNA Code of Ethics:

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 states that LPNs:

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

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

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

2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.

2.8 Use evidence and judgement to guide nursing decisions.

2.9 Identify and minimize 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 states that LPNs:

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

Principal 4: Responsibility to Colleagues - Licensed Practical Nurses develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals.

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.

CLPNA Standards of Practice:

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

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 – Licensed Practical Nurses apply evidence-informed knowledge in practice. Standard 2 specifically states that LPNs:

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

2.7 Provide holistic evidence-informed practice that supports the concepts of health promotion, illness prevention, health maintenance and restorative care.

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

2.10 Assess client and collaborate with the appropriate person(s) when client status is changed, new, or not as anticipated.

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

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

4.1 Identify personal values, beliefs, and biases and take accountability for the impact they may have on professional relationships and nursing practice.

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.

The Hearing Tribunal finds the conduct contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 2

Ms. Pewudie admitted on or between February 18-21, 2024, while working at the Facility, she did one or more of the following with regard to Client SA:

a) Failed to clearly and accurately document each dose of PRN Hydromorphone administered on a separate line on the PRN Documentation Record;
b) Failed to document the effectiveness of each dose of PRN Hydromorphone administered on the PRN Documentation Record;
c) Failed to document PRN doses of Hydromorphone administered on February 18, 2024, at 1100 hours and 1745 hours on the Medication Administration Record;
d) Failed to document the PRN dose of Hydromorphone administered at 1800 hours on February 20, 2024, on the Medication Administration Record or the PRN Documentation Record; and
e) Failed to clearly and accurately document each dose of PRN Hydromorphone administered on February 21, 2024, in a separate entry in the Progress Notes.

The Complainant is a family member of Client SA, who was a resident at the Facility at the time of the Allegations. The Facility offers supportive living services to its residents.

The Regulated Member worked shifts at the Facility between February 18 to February 22, 2024 and at all times material to the allegations provided professional services of an LPN.

All medication administrations must be documented in a Client's Medication Administration Record (the "MAR"). Additionally, medications that are prescribed on an as needed basis, also referred to as PRN medications, need to be documented in the Client's Progress Notes.

It is an expectation of the LPN profession that client documentation is clear, which includes documenting each medication administration on separate lines in client records, such as Progress Notes and the PRN Documentation Record.

On or between February 18-21, 2024, Client SA had an authorized prescriber's orders for one to two tablets of Hydromorphone 1 mg every three hours as needed, for pain management. The Hydromorphone 1mg was a PRN medication for Client SA.

On or about February 18, 2024, the Regulated Member administered 2 mg of Hydromorphone at 1100 hours and 1745 hours and documented the administrations in the Progress Notes and PRN Documentation Record; however, failed to document in the MAR.

On or about February 20, 2024, the Regulated Member administered 2mg of Hydromorphone at 0930, 1500, and 1800 hours. The Regulated Member failed to document the 1800 hours administration in the MAR and PRN Documentation Record.

On or about February 21, 2024, the Regulated Member administered 2 mg of Hydromorphone at 0900 and 1300 hours and documented in the MAR, PRN Documentation Record and Progress

Notes; however, failed to clearly and accurately document each dose administered in a separate entry in the Progress Notes.

On or between February 18 to 21, 2024, the Regulated Member documented more than one dose administration on the same line in the PRN Documentation Record and failed to assess and/or document the effectiveness of the medication administered on the PRN Documentation Record.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pewudie's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 2 did in fact occur.

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

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

Ms. Pewudie demonstrated a lack of knowledge, skill, and judgment. Medication administration and documentation are core competencies of any LPN. Between the period of February 18-21, 2024, Ms. Pewudie made multiple medication documentation errors when she failed to document the administration and assessment of several of SA's doses of Hydromorphone. This demonstrated a lack of knowledge, skill and judgment as there could have been other errors made with SA's medications on these dates due to her errors, putting SA's health potentially at risk. Ms. Pewudie should have had the knowledge to document correctly, and the judgment to ensure it was done correctly.

Ms. Pewudie did not abide by the provisions of the CLPNA Code of Ethics the CLPNA Standards of Practice, as set out above under Allegation 1, and the same reasoning expressed there applies to Allegation 2 as well. Such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Pewudie made multiple medication documentation errors as detailed above. Inaccurate patient records may later be relied on for the purposes of making health care decisions which are then grounded in incorrect information.

The public expects that LPNs maintain the standards of practice, professional competence and conduct at all times. Ms. Pewudie failed to demonstrate these expectations that the public has and thereby could cause the public to lose confidence in the profession. She did not practice in a manner that is consistent with the privilege and responsibility of self-regulation.

The above proven allegations clearly demonstrate Ms. Pewudie failed in her responsibilities to the public, her client SA, the profession, as well as herself.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Pewudie 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. Within **30 days** of the date of the hearing, 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. The CLPNA Policy: Professional Responsibility and Accountability; and
    d. The CLPNA Policy: Documentation.

    These documents are available on CLPNA's website and will be provided. 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 online at Home | Study with CLPNA;
    b. Health Assessment available online at Home | Study with CLPNA; and
    c. Medication Management available online at Home | Study with CLPNA.

    If such remedial education becomes unavailable, alternate remedial education may be substituted where approved in advance and 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 $2,000.00, to be paid over a period of **36 months** of the date of the hearing.
    a. The costs must be paid to the CLPNA, whether or not the Regulated Member holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA 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 to 4 will appear as conditions on the Regulated Member's practice permit and the Public Registry, subject to the following:
    a. The orders at paragraph 3 will appear as "CLPNA Monitoring Orders (Conduct)"; and
    b. The order 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 CLPNA will provide the required notices under s. 119 of the HPA.

7. The Regulated Member shall ensure their contact information with the CLPNA, 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 CLPNA 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 by the Complaints Director, 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 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 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 described in paragraph 4 above, suspend the Regulated Member'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 Director.

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 Ms. Pewudie 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 Ms. Pewudie 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

1. **The nature and gravity of the proven allegations:** The Hearing Tribunal agrees with the submission of counsel for the Complaints Director that the proven allegations are serious, as they relate to basic core competencies of an LPN, dealing with assessment, documentation, and client care. Ms. Pewudie failed to meet the minimum obligations of providing safe, competent care and proper documentation.

2. **The age and experience of the regulated member:** The Hearing Tribunal is not aware of the age of the member but does recognize that she had obtained her license in 2019. She had been practicing for approximately five years at the time of the allegations and had been in the profession long enough to know that this conduct was inappropriate.

3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Legal Counsel advised that there were no previous findings in relation to the member, and this is a mitigating factor.

4. **The age and mental condition of the victim:** The Hearing Tribunal was informed that SA was 59 years old and suffered from several mental health diagnoses as well as having terminal cancer. The vulnerability of this patient was an aggravating factor.

5. **The number of times the offending conduct was proven to have occurred:** The Hearing Tribunal agrees with the submissions of the Complaints Director that there are two separate instances of unprofessional conduct that have been proven. There was a single incident that occurred on February 22, 2024, as well as documentation errors that occurred between February 18 - 21, 2024. Both relate to a lack of clinical knowledge and knowledge; this was an aggravating factor.

6. **The role of the investigated member in acknowledging what occurred:** The Hearing Tribunal recognizes that Ms. Pewudie did admit to all the allegations and has demonstrated accountability for her actions, which 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 is not aware of any serious financial or other penalties suffered by Ms. Pewudie.

8. **The impact of the incident(s) on the victim:** Ms. Pewudie failed to respond to hazardous conditions inside SA's room. She failed to assess SA in a timely manner, ultimately delaying Emergency response taking over care.

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

10. **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** The Hearing Tribunal considered this factor to be significant, as it is part of the CLPNA's mandate to protect the public and ensure safe and proper practice. Therefore, the penalties imposed need to be enough of a deterrent to show the public that the profession takes these findings seriously.

11. **The need to maintain the public's confidence in the integrity of the profession:** The Hearing Tribunal considered this factor to be significant. It is important that the public recognizes LPNs as professionals with integrity when interacting with them.

12. **The range of sentence in other similar cases:** The Hearing Tribunal has considered the sentencing in similar cases. The decisions provided by counsel for the Complaints Director

indicate that a sanction focusing on remedial education and an order for costs are appropriate in similar situations.

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 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. Within **30 days** of the date of the hearing, 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. The CLPNA Policy: Professional Responsibility and Accountability; and
    d. The CLPNA Policy: Documentation.

    These documents are available on CLPNA's website and will be provided. 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 online at Home | Study with CLPNA;
    b. Health Assessment available online at Home | Study with CLPNA; and
    c. Medication Management available online at Home | Study with CLPNA.

If such remedial education becomes unavailable, alternate remedial education may be substituted where approved in advance and 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 $2,000.00, to be paid over a period of **36 months** of the date of the hearing.

    a. The costs must be paid to the CLPNA, whether or not the Regulated Member holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA 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 to 4 will appear as conditions on the Regulated Member's practice permit and the Public Registry, subject to the following:
    a. The orders at paragraph 3 will appear as "CLPNA Monitoring Orders (Conduct)"; and
    b. The order 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 CLPNA will provide the required notices under s. 119 of the HPA.

7. The Regulated Member shall ensure their contact information with the CLPNA, 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 CLPNA 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 by the Complaints Director, 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 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 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 described in paragraph 4 above, suspend the Regulated Member'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 Director.

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.
>
> **(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 4th DAY OF FEBRUARY 2026 IN CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Sarah Kawaleski, LPN
Chair, Hearing Tribunal