

**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 CHLOE KILKENNY**

**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 CHLOE KILKENNY, LPN #27195, 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 January 29, 2026 with the following individuals present:

**Hearing Tribunal:**

Nicole Searle, Licensed Practical Nurse (“LPN”) Chairperson  
Cindy McLeod, LPN  
Brett Huculak, Public Member  
Leanne Axelsen, Public Member

**Staff:**

Kimberly Precht, Legal Counsel for the Complaints Director, CLPNA  
Susan Blatz, Complaints Director, CLPNA

**Regulated Member:**

Chloe Kilkenny, LPN (“Ms. Kilkenny” or “Investigated Member” or “Regulated Member”)  
Jesse Prince, Legal 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**

Ms. Kilkenny was an LPN within the meaning of the *Health Professions Act*, RSA 2000, c H-7 (“Act”) at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Kilkenny was initially licensed as an LPN in Alberta on June 30, 2004.

In early 2023, the College of Licensed Practical Nurses of Alberta (“CLPNA”) received two complaints about the professional nursing practices of Ms. Chloe Kilkenny, LPN, under s. 55 of the *Health Professions Act* (the “Act”):

- a) The first complaint was received on March 21, 2023 from Dr. Murtaza Amirali, a medical doctor (the “First Complaint” or “File C-23-049”).
- b) The second complaint was received on April 18, 2023 from Rajab Ali, a pharmacist (the “Second Complaint” or “File C-23-064”).

By letters dated March 23, 2023, and May 1, 2023, respectively, Ms. Sanah Sidhu, who was at that time the Complaints Director of the CLPNA, acknowledged receipt of the First Complaint and the Second Complaint, and appointed Judy Palyga, Investigator for the CLPNA, to conduct an investigation under s. 55(2)(d) of the Act. Ms. Sidhu delegated her powers under Part 4 of the Act to Ms. Susan Blatz, who was at that time a Complaints Officer but has since been appointed as Complaints Director of the CLPNA (referred to throughout as the “Complaints Director”), under s. 20 of the Act.

By letters dated June 7, 2023, with respect to each Complaint, the Complaints Director advised Ms. Kilkenny that Ms. Palyga had completed a preliminary investigation, and the Complaints Director had appointed David Burke, Investigator for the CLPNA, to conduct further investigation and provide the CLPNA with a written report.

On December 18, 2023, Mr. Burke submitted Investigation Reports to the Complaints Director regarding each Complaint. After reviewing the reports, the Complaints Director determined that further investigation was needed. On April 3, 2024, the Complaints Director requested further documentation from Dr. Amirali. Dr. Amirali provided the requested documentation on June 20, 2024.

On July 15, 2024, Ms. Kilkenny’s practice permit was suspended under s. 65 of the Act. The suspension was quashed on October 8, 2024, and was replaced with a voluntary agreement under which Ms. Kilkenny agreed to an interim condition on her practice permit of “unable to receive and/or process verbal medication orders”, until the conclusion of the professional conduct process under Part 4 of the Act.

The matter was referred to the Hearings Director for a hearing, pursuant to s. 66(3)(a) of the Act. Ms. Kilkenny received notice of the referral, as well as a copy of the Statement of Allegations and the Investigation Report, on October 23, 2024.

On March 4, 2025, at Ms. Kilkenny’s request, the Complaints Director reopened the investigation to make further inquiries to Ava Industries Inc., an electronic medical record service provider. After undertaking further investigation, the Complaints Director referred the amended allegations to the Hearings Director for a hearing. Ms. Kilkenny received the Amended Statement of Allegations and disclosure of the further investigation materials on May 28, 2025, and a final Amended Statement of Allegations on December 19, 2025.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Kilkenny on November 19, 2025, for a hearing scheduled for January 29, 2026.

#### **(4) Allegations**

The Allegations in the Statement of Allegations (the “Allegations”) are:

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

1. On or about January 17, 2023, failed to follow proper medication management practices with respect to patient TM, by failing to properly document verbal and/or telephone orders received from an authorized prescriber.
2. On or about January 18, 2023, failed to follow proper medication management practices with respect to patient RL, by failing to properly document verbal and/or telephone orders received from an authorized prescriber.
3. On or about February 27, 2023, failed to follow proper medication management practices with respect to vitamin injections for one or more of the following patients, by failing to properly document verbal and/or telephone orders received from an authorized prescriber:
  - a. SS;
  - b. CP1;
  - c. CP2;
  - d. TS;
  - e. JK1;
  - f. JK2;
  - g. MH;
  - h. LF;
  - i. GD.
4. On or about February 24, 2023, saw one or more of the following patients at the Coulee Creek Clinic in Medicine Hat (the "Clinic") without Dr. A's presence at the Clinic:
  - a. AN;
  - b. CE;
  - c. CT;
  - d. DG;
  - e. JG;
  - f. KG;
  - g. MB;
  - h. MK;
  - i. OM;
  - j. PS;
  - k. RB;
  - l. SW;
  - m. TP;
  - n. YM;
  - o. ZB;
  - p. MM.
5. With respect to one or both of the following patients, failed to properly document verbal and/or telephone orders received from a physician:
  - a. On or about December 16, 2022, with respect to an x-ray for patient WL;

- b. On or about February 24, 2023, with respect to an x-ray for patient MM.

It is further alleged that this conduct constitutes “unprofessional conduct” as defined in s. 1(1)(pp)(i), (ii) and (xii) of the *Health Professions Act, RSA 2000, c H-7*, or any of them, 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 1.1, 1.4, 1.8, 1.9;
2. Standards of Practice for Licensed Practical Nurses in Canada, Standard 2: Evidence-Informed Practice, Indicators 2.4, 2.10;
3. Standards of Practice for Licensed Practical Nurses in Canada, Standard 3: Protections of the public through self-regulation, Indicators 3.5;
4. Standards of Practice for Licensed Practical Nurses in Canada, Standard 4: Professional and Ethical Practice, Indicators 4.6;
5. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 1: Responsibility to the Public, Indicators 1.1, 1.2;
6. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 2: Responsibility to Clients, Indicators 2.8, 2.9;
7. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principal 3: Responsibility to the Profession, Indicator 3.1, 3.3;
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. Kilkenny 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: 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. Kilkenny'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. Kilkenny.

**Background Facts Relating to Allegations**

Certain context is helpful to establish before addressing the facts relating to each of the specific allegations.

***Professional Relationship Between Ms. Kilkenny and Dr. Amirali***

Ms. Kilkenny met Dr. Amirali in 2021. In mid-2022, Ms. Kilkenny agreed to help Dr. Amirali start up a new clinic, Coulee Creek Clinic (the "Clinic"). From September 2022 until March 2023, Ms. Kilkenny had a nursing role and an administrative role at the Clinic.

As well, Ms. Kilkenny offered vitamin injection and infusion services out of the Clinic through her own company, Kilkenny Wellness, using Farsk Health as a supplier. Dr. Amirali served as medical director for Kilkenny Wellness.

On March 13, 2023, Dr. Amirali contacted Farsk Health and terminated his medical directorship of Kilkenny Wellness. The business relationship between Ms. Kilkenny and Dr. Amirali ended.

***Ava Electronic Medical Record System***

With Dr. Amirali's consent, Ms. Kilkenny set up an electronic medical record (EMR) system from Ava Industries Inc. ("Ava") as the Clinic's EMR system. Until mid-March 2023, Ms. Kilkenny was set up as the Clinic's moderator on Ava.

Ava maintains a complete backup system of records created within it and can confirm who created a specific clinical note or prescription, whether a clinical note or prescription was altered, and other details as set out below. Ava specifically confirmed that none of the sampled clinical notes or prescriptions at issue in this matter had been altered.

An Ava user can create a clinical note on behalf of another user. For example, an LPN may prepare a clinical note on behalf of a Physician. In a typical clinic setting, a nurse or Medical Office Assistant (MOA) will often start a Clinical Note to give the physician some background information about the patient before the physician examines the patient or reviews the note. After the initial note is created, the nurse or MOA assigns the note to the physician, making the physician the official author of the document. This process is standard practice in clinics.

When an LPN assigns a clinical note to a Physician, a “Task” is created in Ava. The Task will appear in the Physician’s Task Box, notifying them to review the clinical note. The Task will remain in the Physician’s Task Box until completed. If the Task is not completed – for example, if the clinical note remains “Active” and not “Completed” – it will stay in the Physician’s Task Box until addressed.

An Ava user can also prepare a prescription on behalf of another user. For example, an LPN may be an “Authorized Employee” for the purposes of preparing a prescription on behalf of an “Authorized Prescriber”. Tasks are not automatically generated in Ava when a prescription is prescribed unless a clinical note is also created. However, an LPN may create a Task for a prescription prepared for an Authorized Prescriber, in which case it is possible to tell whether the Authorized Prescriber reviewed the prescription. If no Task is created, it is not possible to tell in Ava whether the Authorized Prescriber reviewed the prescription.

### ***Documenting Verbal and Telephone Orders***

At all times material to the allegations, Dr. Amirali was the Authorized Prescriber at the Clinic. Ms. Kilkenny was an Authorized Employee in Ava for the purposes of creating prescriptions on Dr. Amirali’s behalf.

Authorized Prescribers are expected to provide written medication orders wherever possible, and only to provide verbal or telephone orders in emergent or urgent situations. When an LPN receives a verbal or telephone order, the LPN is expected to transcribe the order and to document the date and time the order was transcribed, a notation that it was a verbal or telephone order, the LPN’s signature and credentials, and identification of the authorized prescriber.

#### **Allegation 1**

Ms. Kilkenny admitted that on or about January 17, 2023, she failed to follow proper medication management practices with respect to patient TM, by failing to properly document verbal and/or telephone orders received from an authorized prescriber.

TM was a vulnerable patient who initially attended the Clinic as a walk-in patient in October 2022 for an opioid prescription refill, after losing access to their regular doctor.

On January 17, 2023, while Dr. Amirali was out of the country, Ms. Kilkenny met with TM at the Clinic, prepared a prescription for TM on Dr. Amirali’s behalf, and sent the prescription to Rexall Pharmacy in Medicine Hat.

On January 17, 2023, Ms. Kilkenny created a Task for Dr. Amirali in Ava, with respect to the January 17, 2023, prescription for TM. On April 2, 2025, Ava confirmed the Task remained incomplete, indicating that Dr. Amirali did not review the prescription.

Ms. Kilkenny also prepared and assigned a clinical note to Dr. Amirali.

Ms. Kilkenny acknowledges she did not properly document the verbal or telephone order received from Dr. Amirali for TM's January 17, 2023 prescription.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and the admission of the Member with respect to Allegation 1. 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.

#### **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services**

The Tribunal finds that the Member's conduct demonstrates a lack of professional judgment in the provision of nursing services. The proper receipt, documentation, and authorization of verbal or telephone medication orders is a fundamental component of competent nursing practice. In this matter, the Member prepared and transmitted a prescription, including opioid medication, without ensuring that the prescriber's authorization was properly documented in accordance with required standards. The Tribunal finds that this failure reflects a lapse in professional judgment and skill. A reasonably prudent Licensed Practical Nurse would recognize the necessity of complete documentation of a verbal or telephone order, particularly where the prescriber was out of the country and the medication involved carries heightened regulatory and safety considerations.

#### **Conduct that harms the integrity of the regulated profession**

The Tribunal also finds that the Member's conduct harms the integrity of the regulated profession. The public relies on Licensed Practical Nurses to adhere strictly to medication management standards and legislative requirements. Conduct that bypasses or fails to comply with required safeguards undermines public confidence in both the individual practitioner and the regulatory framework designed to protect patients. Even in the absence of evidence of actual patient harm, the potential risk created by the Member's actions is sufficient to engage this subsection.

#### **Contravention of the Act, a Code of Ethics, or Standards of Practice**

Ms. Kilkenny did not abide by the provisions of the Code of Ethics for Licensed Practical Nurses in Canada (2013) ("CLPNA Code of Ethics") or the 2020 Standards of Practice for Licensed Practical Nurses in Canada (the "2020 LPN Standards of Practice") as acknowledged by Ms. Kilkenny in the Agreed Statement of Facts and Admission of Unprofessional Conduct. The Hearing Tribunal finds the conduct in question breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and did not demonstrate the competence expected of Ms. Kilkenny.

The conduct breached the following principles and standards set out in the CLPNA Standards of Practice and the CLPNA Code of Ethics.

## 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 provides that LPNs:

1.1 Maintain standards of practice, professional competence and conduct.

1.2: Provide only those functions for which they are qualified by education and experience.

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

2.8 Use evidence and judgment to guide nursing decisions.

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.

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

5.2: Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgement.

## 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 provides that LPNs:

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

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 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:

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

With respect to the provisions of the CLPNA Code of Ethics and CLPNA Standards of Practice, the Tribunal considered each and reached the following conclusions.

The Tribunal finds that the Member's conduct fell below the standards expected of the profession and diminished the integrity of it as a result. Medication management is an area of practice that attracts significant public scrutiny and requires strict adherence to regulatory safeguards. The failure to ensure proper documentation of prescriber authorization undermines those safeguards and reflects conduct inconsistent with maintaining ethical obligations and professional standards.

Self-regulation requires regulated members to adhere strictly to legislative, ethical, and professional requirements without external oversight. The Member's failure to comply with documentation standards demonstrates conduct inconsistent with the responsibilities inherent in self-regulation and therefore breaches this provision.

Documentation is an important aspect of what an LPN does; it ensures all members of the health care team are aware of the care provided and the reasons for it. Proper documentation also ensures an understanding as to the reasons for the provision of a medication or, more generally, as to changes to a course of care.

The Tribunal finds that although medication management falls within the Member's scope of practice, she did not demonstrate the level of judgment required to carry out this function in compliance with regulatory standards. The failure to properly document the verbal or telephone order indicates a lapse in the application of professional knowledge and judgment required for safe practice. Failing to properly document reflects a lack of accountability

By failing to properly document the prescriber's authorization for the January 17, 2023 prescription, the Member breached her professional obligations relating to accountability, documentation integrity, and safe medication practices. Documentation is not optional or administrative in nature; it is a professional requirement that supports continuity of care, transparency, and patient safety. The Tribunal therefore finds that s. 1(1)(pp)(ii) has been met.

For the reasons set out above, the Hearing Tribunal accepts and confirms that the conduct in question was unprofessional conduct.

#### Allegation 2

Ms. Kilkenny admitted on or about January 18, 2023, she failed to follow proper medication management practices with respect to patient RL, by failing to properly document verbal and/or telephone orders received from an authorized prescriber.

On January 18, 2023, while Dr. Amirali was returning from overseas, Ms. Kilkenny met with RL at the Clinic, prepared a prescription for RL on Dr. Amirali's behalf, and sent the prescription to a Costco pharmacy.

On January 19, 2023, Ms. Kilkenny created a Task for Dr. Amirali in Ava, with respect to the January 18, 2023 prescription for RL. On April 2, 2025, Ava confirmed the Task remained incomplete, indicating that Dr. Amirali did not review the prescription.

Ms. Kilkenny also prepared and assigned a clinical note to Dr. Amirali.

Ms. Kilkenny acknowledges she did not properly document the verbal or telephone order received from Dr. Amirali for RL's January 18, 2023 prescription.

The Hearing Tribunal has reviewed the Agreed Statement of Facts and the admission of the Member with respect to Allegation 2. Based on the evidence before it, the Tribunal finds that the conduct admitted by the Member constitutes unprofessional 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:

- 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.

Medication management is a fundamental component of nursing practice. The proper receipt and documentation of verbal and telephone orders are essential safeguards designed to: confirm prescriber authorization, ensure clarity and accuracy of medication instructions, maintain accountability within the health record, protect patient safety, & support continuity of care.

The documentation of verbal or telephone orders is not optional. It is a mandatory professional requirement grounded in standards of practice, employer policy, and regulatory expectations. In this case, the Member prepared and transmitted a prescription in circumstances where the prescriber was not physically present. While the Member created a Task and assigned a clinical note, she acknowledges that she did not properly document the verbal or telephone order authorizing the prescription.

The Tribunal finds that the Member's conduct demonstrates a lack of professional judgment in the provision of nursing services. By failing to ensure a prescriber's verbal or telephone order before preparing and transmitting a prescription for patient RL, she acted outside of her scope of practice.

The absence of proper documentation compromises the reliability of the medical record and undermines safeguards intended to protect patients. The Tribunal further notes that, as of April 2, 2025, the Task created for Dr. Amirali remained incomplete, indicating that the prescriber did not review the prescription. This fact underscores the importance of strict compliance with documentation requirements when acting on verbal or telephone authorization.

The Tribunal finds that the Member's conduct contravened the provisions of the *Standards of Practice* and the *Code of Ethics* cited above and for substantially the same reasons as provided in respect of Allegation #1.

Finally, the Tribunal finds that the Member's conduct harms the integrity of the regulated profession. Licensed Practical Nurses are entrusted with significant responsibility in medication management. The public, patients, and healthcare colleagues rely on LPNs to adhere strictly to documentation and authorization requirements which are put in place to support safe and effective care. By issuing and transmitting a prescription without properly documenting the prescriber's verbal or telephone authorization, the Member undermined those safeguards designed to protect patients. Such conduct

erodes confidence in the profession's ability to self-regulate effectively and undermines trust in the integrity of nursing practice.

The Tribunal is satisfied that the admitted conduct did occur, that it breached the noted provisions of the Act and that the conduct was sufficiently serious to constitute unprofessional conduct for the reasons provided.

### Allegation 3

Ms. Kilkenny admitted on or about February 27, 2023, she failed to follow proper medication management practices with respect to vitamin injections for one or more of the following patients, by failing to properly document verbal and/or telephone orders received from an authorized prescriber:

- a. SS;
- b. CP1;
- c. CP2;
- d. TS;
- e. JK1;
- f. JK2;
- g. MH;
- h. LF;
- i. GD.

On February 27, 2023, Ms. Kilkenny prepared prescriptions for the patients identified in Allegation 3 on Dr. Amirali's behalf. The prescriptions fell within the services offered by Kilkenny Wellness. Specifically, they were for Vitamin B12 injections and, in the case of JK2, for Vitamin C infusion.

Ms. Kilkenny acknowledges she did not properly document the verbal or telephone order received from Dr. Amirali for the prescriptions identified in Allegation 3.

The Hearing Tribunal is satisfied that the admitted conduct 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.

Further, the Hearing Tribunal finds that the conduct proven in Allegation 3 is sufficiently serious to constitute unprofessional conduct under s. 1(1)(pp) of the Act.

The Tribunal finds that the Member demonstrated a lack of professional judgment and skill in preparing and transmitting prescriptions for multiple patients without properly documenting prescriber authorization. For the reasons provided in respect of Allegation #2, this conduct demonstrates a lack of judgment on the part of the Member.

The Tribunal finds that the Member's conduct contravened the *Code of Ethics and Standards of Practice* governing Licensed Practical Nurses cited above. The reasons for this finding are the same as the reasons cited in respect of Allegation #1 and Allegation #2.

#### Allegation 4

Ms. Kilkenny admitted on or about February 24, 2023, she saw one or more of the following patients at the Coulee Creek Clinic in Medicine Hat (the "Clinic") without Dr. A's presence at the Clinic:

- a. AN;
- b. CE;
- c. CT;
- d. DG;
- e. JG;
- f. KG;
- g. MB;
- h. MK;
- i. OM;
- j. PS;
- k. RB;
- l. SW;
- m. TP;
- n. YM;
- o. ZB;
- p. MM.

On February 24, 2023, Dr. Amirali was working an obstetrics shift at the Lethbridge hospital and was not present at the Clinic. No physician was physically present at the Clinic on February 24, 2023.

Most of the patients identified in Allegation 4 attended the Clinic in person on February 24, 2023, and were seen by Ms. Kilkenny despite no physician being present. Two of these patients (AN and CT) did not attend the Clinic in person, but received phone calls from Ms. Kilkenny following up on previous appointments. Two of these patients (MK and RB) were new patients. The remaining patients were not new patients to the Clinic.

Ms. Kilkenny created clinical notes for each of these patients in Ava, and assigned the clinical notes to Dr. Amirali.

When Ms. Kilkenny assigned each clinical note to Dr. Amirali, a Task was created in Ava. The Task would have appeared in Dr. Amirali's Task Box, notifying Dr. Amirali to review the clinical note. Each Task would have remained in Dr. Amirali's Task Box until completed.

On April 2, 2025, Ava confirmed that the Tasks for each of these clinical notes remained incomplete, indicating that Dr. Amirali did not review the clinical notes.

Ms. Kilkenny maintains that Dr. Amirali was aware that she was seeing these patients without Dr. Amirali's presence at the Clinic, and that she did so at the direction of Dr. Amirali. However, Ms. Kilkenny

acknowledges that in the circumstances, it was inappropriate for her to see patients at the Clinic without a physician present.

The Hearing Tribunal is satisfied that the conduct in question has been proven and that it is sufficiently serious to constitute unprofessional conduct as described below.

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.

The Hearing Tribunal finds that the conduct proven in Allegation 4 is sufficiently serious to constitute unprofessional conduct under s. 1(1)(pp) of the Act.

The Tribunal finds that the Member demonstrated a lack of professional judgment in seeing patients without a physician physically present at the Clinic. A reasonably prudent Licensed Practical Nurse would recognize the limitations of their scope of practice and the professional expectation that patient care requiring prescriber oversight cannot be provided independently. By proceeding with patient encounters in the absence of a physician, the Member failed to exercise the necessary skill, knowledge, and judgment to ensure safe, professional care.

The Tribunal finds that the Member's conduct contravened the *Standards of Practice* and *Code of Ethics* for Licensed Practical Nurses first cited in relation to Allegation #1. Specifically, the Standards of Practice requires members to practice within their competence and scope of practice, collaborate appropriately with other healthcare professionals, and maintain accountability for all clinical decisions. The failure to ensure a physician was present during patient encounters constitutes a breach of these standards and ethical obligations, including the responsibility to provide safe and competent care.

This conduct does not reflect a recognition of an LPN's responsibility to the public, to those in their care, to their profession or themselves. Practicing outside of one's scope exposes those receiving care to risk. It undermines the therapeutic relationship with a patient but also the necessary trust amongst the members of a healthcare team including an LPN and a physician. It also demonstrates a lack of accountability in the sense that it fails to show that the Member considered and applied their competence, skills, and responsibilities when providing care. It shows a lack of understanding of self-regulation which relies on practitioners to provide care within their training, scope and capability.

The Tribunal finds that seeing patients without a physician present undermines public confidence in the profession. The public and other healthcare professionals must be able to rely on LPNs to practice safely and in accordance with regulatory safeguards. By conducting patient care outside of the expected standard and without appropriate physician oversight, the Member's conduct erodes trust in the reliability and integrity of nursing practice. The Tribunal therefore finds that this conduct harms the integrity of the regulated profession.

### Allegation 5

Ms. Kilkenny admitted with respect to one or both of the following patients, she failed to properly document verbal and/or telephone orders received from a physician:

- a. On or about December 16, 2022, with respect to an x-ray for patient WL;
- b. On or about February 24, 2023, with respect to an x-ray for patient MM.

Patient WL attended the Clinic on December 8, 2022 and was seen by Dr. Amirali, at which time Dr. Amirali ordered an x-ray of patient WL's abdomen and pelvis.

Subsequently, on December 16, 2022, when Dr. Amirali was out of the country, Ms. Kilkenny prepared a new x-ray requisition for patient WL on behalf of Dr. Amirali for the same purpose as the December 8, 2022 x-ray ordered by Dr. Amirali.

The x-ray ultimately occurred on January 3, 2023, based on the December 16, 2022 requisition prepared by Ms. Kilkenny.

Ms. Kilkenny acknowledges that she did not properly document the verbal or telephone order received from Dr. Amirali for the December 16, 2022 requisition for patient WL.

Patient MM is one of the patients Ms. Kilkenny saw on February 24, 2023, without a physician present at the Clinic, as set out with respect to Allegation 4. On February 24, 2023, Ms. Kilkenny prepared an x-ray requisition for patient MM on behalf of Dr. Amirali.

Ms. Kilkenny acknowledges that she did not properly document the verbal or telephone order received from Dr. Amirali for the February 24, 2023 requisition for patient MM.

The Hearing Tribunal is satisfied that the conduct related to Allegation #5 has been proven and that is sufficiently serious to constitute unprofessional conduct as further described below.

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.

The Tribunal finds that the Member's conduct demonstrates a lack of professional judgment in the provision of nursing services. The Member failed to comply with required professional standards and procedures, resulting in a departure from the expected skill and judgment of a Licensed Practical Nurse. In particular, the Member undertook actions that required careful adherence to documentation, authorization, or scope-of-practice safeguards and failed to do so appropriately. These omissions reflect a lapse in professional judgment and a lack of the knowledge or skill necessary to safely and competently perform the professional functions in question.

The Tribunal finds that the Member's conduct contravened the provisions of the *Standards of Practice* and the *Code of Ethics* for Licensed Practical Nurses set out above. Licensed Practical Nurses are required to act within their competence, adhere to regulatory requirements, and maintain accountability for their actions. By failing to follow established professional requirements in this instance, the Member breached multiple obligations relating to safe, competent, and ethical practice. The reasons for the Tribunal's conclusion in this regard are substantially similar to the reasons provided above that relate to the failure to properly document verbal orders of a physician, only that in this case, the issue relates to a requisition for diagnostic imaging rather than medication.

The Tribunal finds that the Member's conduct harms the integrity of the regulated profession. Licensed Practical Nurses are trusted to practice safely, competently, and in accordance with regulatory safeguards. Conduct that deviates from these expectations erodes public and professional confidence in the profession's reliability and integrity. By failing to meet the standards required, the Member's conduct undermines trust in the self-regulatory framework and in the profession's ability to ensure safe and accountable practice.

#### **(9) Joint Submission on Penalty**

The Complaints Director and Ms. Kilkenny 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 pay 25% of the costs, to a cap of \$2,500, of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.
  - a. A letter advising of the final costs will be forwarded to the Regulated Member when final costs have been confirmed by the CLPNA.
3. The Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice. These documents are available on <http://clpna.com> in the "Knowledge Hub":
  - 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;
  - d. The CLPNA Policy: Documentation
  - e. The CLPNA Policy: Medication Management;
  - f. The CLPNA Practice Guideline: Determining Licensed Practical Nurse Scope of Practice.
4. The Regulated Member shall complete, at their own cost, the following remedial education and provide documentation of successful completion to the Complaints Director **within 30 days** of service of the Decision:
  - a. **Determining LPN Scope of Practice** available online at [MD32 | Study with CLPNA](#).

If any of the remedial education becomes unavailable, the Regulated Member shall request, in writing and prior to the deadline, an alternative remedial education. The Complaints Director shall, in their sole discretion, assign alternative remedial education and notify the Regulated Member in writing of the alternative remedial education.

5. The Regulated Member shall complete a coaching session **within 60 days** of service of the Decision. The Regulated Member must contact a Practice Advisor at the CLPNA, via [practice@clpna.com](mailto:practice@clpna.com) to schedule the session and is accountable for attending the session on the scheduled date. The Practice Advisor will advise the Complaints Director when the coaching session has been completed and whether it was satisfactory or where there are any attendance-related issues. In the event the Practice Advisor deems the coaching session not satisfactory or there are attendance-related issues, the Complaints Director may assign further remedial activity. The Regulated Member will be notified in writing of the assigned remedial activity.
6. The orders set out above at paragraphs 2, 4 and 5 will appear as conditions on the Regulated Member's practice permit and the Public Registry subject to the following:
  - a. The requirement to pay costs, will appear as "Conduct Cost/Fines" on the Regulated Member's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.
  - b. The requirement to complete the remedial education and coaching outlined at paragraphs 4 and 5 will appear as "CLPNA Monitoring Orders (Conduct)", on the Regulated Members practice permit and the Public Registry until the following sanctions have been satisfactorily completed;
    - i. Determining LPN Scope of Practice;
    - ii. Coaching Session.
7. The conditions on the Regulated Members practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.
8. The Regulated Member 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. The Regulated Member will keep her contact information current with the CLPNA on an ongoing basis.
9. Should the Regulated Member be unable to comply with any of the sanctions deadlines 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 accepted. The Regulated Member will be notified by the Complaints Director, in writing, if the extension has been granted.

10. 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 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 described in paragraph 2 above, suspend the Regulated Member's practice permit until such costs are paid in full or the Complaints Director 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 Chloe Kilkenny 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. Kilkenny 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

**Applying those factors to this case:**

**The nature and gravity of the proven allegations:** The proven allegations are serious and engage core professional obligations relating to a range of practice obligations: medication management, documentation, scope of practice, and physician oversight. The Member repeatedly failed to properly document verbal or telephone orders and, on one occasion, saw patients in the absence of a physician physically present at the Clinic. These safeguards are fundamental components of safe nursing practice and are designed to protect patient safety, ensure accountability, and maintain regulatory compliance.

Although there is no evidence of actual patient harm, the conduct created a foreseeable risk and reflects more than an isolated lapse. The repetitive nature of the documentation failures and the scope-of-practice concerns increase the gravity of the misconduct.

**The age and experience of the Regulated Member:** Ms. Kilkenny has been a member of the CLPNA since 2004 and is an experienced practitioner. Her years of practice demonstrate that this conduct occurred within the context of an otherwise established professional career. Ms. Kilkenny worked for 17 years as an LPN with no complaints. While experienced members are expected to understand and adhere to evolving standards of practice, it is also worth noting that the regulatory landscape has increasingly emphasized individual accountability and self-regulation over time.

**The previous character of the Regulated Member and in particular the presence or absence of any prior complaints or convictions:** Ms. Kilkenny was in a previous hearing with the CLPNA on July 12, 2023. The complaint and allegations from that hearing were separate from this hearing.

The decision from the prior hearing was issued on August 14, 2023. This is relevant because in that previous hearing the allegations involved failure to obtain approval from AHS before attending for job shadowing, a breach of patient privacy during that job shadowing, failure to complete proper documentation on multiple occasions, as well as failure to follow proper medication administration processes. That hearing was uncontested, and there were sanctions imposed on Ms. Kilkenny. This prior finding of unprofessional conduct is a valid consideration, and there was overlap in the prior hearing and this current one.

Dr. Amirali was listed in the previous hearing and is also the same Doctor listed in this current hearing, but the specific circumstances and concerns were not the same. Ms. Kilkenny did not repeat the conduct of concern between the prior hearing and this one. It is not a case that Ms. Kilkenny was repeatedly doing the same behavior that the College had imposed sanctions on.

The dates are another consideration. The previous hearing occurred after the conduct that's in issue in this hearing. The opportunity for Ms. Kilkenny to reflect on the concerns in the previous hearing and how she may change her conduct moving forward, occurred only after the events that are in issue for this hearing took place.

**The age and mental condition of the victim, if any:** There is no evidence that age or mental condition was a contributing factor in the majority of the patients involved. While one patient (TM) may be characterized as vulnerable, there is no indication that the Member's conduct was directed at or took advantage of that vulnerability. The concerns in this matter relate to professional standards and documentation practices rather than the exploitation of a patient's age or mental condition.

**The number of times the offending conduct was proven to have occurred:** The offending conduct was proven to have occurred on multiple occasions rather than as a single isolated incident. The documentation failures relating to verbal or telephone orders were repeated over a period of time, and there was at least one separate incident involving practicing in the absence of a physician physically present at the Clinic. The repeated nature of the conduct increases its seriousness, as it reflects a pattern of non-compliance with professional standards rather than an inadvertent or one-time error.

**The role of the Regulated Member in acknowledging what occurred:** Ms. Kilkenny has cooperated fully throughout the investigation and disciplinary process. She acknowledged the concerns raised, accepted responsibility for her conduct, and worked collaboratively with the College, which has allowed this matter to proceed by way of joint submission. Her cooperation demonstrates accountability and insight into the seriousness of the issues, and it has contributed to a more efficient resolution of the matter.

**Whether the Regulated Member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Ms. Kilkenny had her practice permit suspended from July 15, 2024 to October 4, 2024. Then that was replaced by interim conditions placed on her license. Prior to the suspension, Ms. Kilkenny had several employment pieces in place. She was unable to earn a paycheck. This put immense strain on her family as she was her family's main source of income.

**The impact of the incident(s) on the victim, and/or:** The conduct created a potential risk to patients, particularly in relation to documentation and scope-of-practice safeguards. However, there is no evidence that any patient suffered actual harm as a result of the incidents. While the absence of harm is a neutral factor, the risk to patient safety remains a significant consideration given the profession's mandate to prioritize public protection.

**The presence or absence of any mitigating circumstances:** A relevant mitigating circumstance is that nurses are permitted to receive verbal or telephone orders in appropriate circumstances, provided they are properly documented and subsequently reviewed by the physician. The concerns in this matter relate not to the acceptance of verbal orders itself, but to deficiencies in documentation and follow-through. This context suggests that the conduct arose within the course of routine clinical practice rather than from intentional disregard of professional standards.

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

type of conduct will not be tolerated by the CLPNA. The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches of the CLPNA Code of Ethics and CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

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

The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches of the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public. Unprofessional conduct must be met with a responsive sanction which shows the public that, where needed, the College will take action to correct the course, so the public is assured of a high quality of care when engaging with LPNs.

**The range of sentence in other similar cases:** The Hearing Tribunal was made aware of one other case as a reference point to use in the hearing for Ms. Kilkenny. The decision dated from October 2021 was similar to the allegations and sanctions made in that case, to give the Hearing Tribunal confidence in making their decision on sanctions in this case.

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. The Regulated Member shall pay 25% of the costs, to a cap of \$2,500, of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.
  - a. A letter advising of the final costs will be forwarded to the Regulated Member when final costs have been confirmed by the CLPNA.
3. The Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice. These documents are available on <http://clpna.com> in the “Knowledge Hub”:
  - 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;
  - d. The CLPNA Policy: Documentation
  - e. The CLPNA Policy: Medication Management;
  - f. The CLPNA Practice Guideline: Determining Licensed Practical Nurse Scope of Practice.
4. The Regulated Member shall complete, at their own cost, the following remedial education and provide documentation of successful completion to the Complaints Director **within 30 days** of service of the Decision:
- a. **Determining LPN Scope of Practice** available online at [MD32 | Study with CLPNA](#).

If any of the remedial education becomes unavailable, the Regulated Member shall request, in writing and prior to the deadline, an alternative remedial education. The Complaints Director shall, in their sole discretion, assign alternative remedial education and notify the Regulated Member in writing of the alternative remedial education.

5. The Regulated Member shall complete a coaching session **within 60 days** of service of the Decision. The Regulated Member must contact a Practice Advisor at the CLPNA, via [practice@clpna.com](mailto:practice@clpna.com) to schedule the session and is accountable for attending the session on the scheduled date. The Practice Advisor will advise the Complaints Director when the coaching session has been completed and whether it was satisfactory or where there are any attendance-related issues. In the event the Practice Advisor deems the coaching session not satisfactory or there are attendance-related issues, the Complaints Director may assign further remedial activity. The Regulated Member will be notified in writing of the assigned remedial activity.
6. The orders set out above at paragraphs 2, 4 and 5 will appear as conditions on the Regulated Member's practice permit and the Public Registry subject to the following:
- a. The requirement to pay costs, will appear as "Conduct Cost/Fines" on the Regulated Member's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.
  - b. The requirement to complete the remedial education and coaching outlined at paragraphs 4 and 5 will appear as "CLPNA Monitoring Orders (Conduct)", on the Regulated Members practice permit and the Public Registry until the following sanctions have been satisfactorily completed;
    - i. Determining LPN Scope of Practice;
    - ii. Coaching Session.
7. The conditions on the Regulated Members practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.
8. The Regulated Member 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. The Regulated Member will keep her contact information current with the CLPNA on an ongoing basis.

9. Should the Regulated Member be unable to comply with any of the sanctions' deadlines 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 accepted. The Regulated Member will be notified by the Complaints Director, in writing, if the extension has been granted.
10. 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 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
  - a. In the case of non-payment of the costs described in paragraph 2 above, suspend the Regulated Member's practice permit until such costs are paid in full or the Complaints Director 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 16<sup>th</sup> DAY OF MARCH 2026 IN THE CITY OF EDMONTON, ALBERTA.**

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

*Nicole Searle*

Nicole Searle, LPN  
Chair, Hearing Tribunal