COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

RE: CONDUCT OF **HOSIN KEE**, R.N., REGISTRATION **#86,172**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

November 3, 4, 5, 2025
January 13, 2026

INTRODUCTION

A hearing was held on November 3, 4, 5, 2025 and January 13, 2026, via Zoom videoconferencing by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**" or "**CRNA**") to hear a complaint against Hosin Kee R.N. Registration #86,172.

Those present at the hearing were:

a. Hearing Tribunal Members:

Jacqueline Senych, RN Chairperson
Claire Mills, RN
Debra Gust, Public Member
Brett Huculak, Public Member

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon
Maya Gordon (attending the afternoon of November 4, 2025, in the absence of Ms. Gagnon)

c. CRNA Counsel:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Hosin Kee (sometimes hereinafter referred to as the "**Registrant**")

e. Registrant's Legal Counsel:

Simon Renouf

f. CRNA Staff:

Marina Skoreiko, Hearings Coordinator

g. Additional Participants:

Kelly Cochrane, Court Reporter

PRELIMINARY MATTERS

[1] Conduct Counsel and Legal Counsel for the Registrant confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

[2] The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was open to the public. No application was made to close the hearing. A member of the public was present during the hearing.

ALLEGATIONS

[3] The allegations ("**Allegations**") in the Notice to Attend a Hearing are as follows:

1. On or about June 21, 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they physically abused Patient [redacted].

2. On or about between 2023 and 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they struck Patient [redacted] with a book.

3. On or about between 2023 and 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they pulled Patient [redacted]'s hair.

4. On or about June 21, 2024, the Registrant failed to adequately and/or accurately document their interactions with Patient [redacted].

It is further alleged that the Registrant's conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the *Health Professions Act*, RSA 2000, c H-7 ("***HPA***"), and in particular:

1. The conduct underlying **Allegation 1**:

    a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)*; *CRNA's Practice Standards for Registrants (2023)*; and/or

    b. Contravenes one (1) or more employer policies, contrary to *CRNA's Practice Standards for Registrants (2023)*.

2. The conduct underlying **Allegation 2**:

    a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)*; *CRNA's Practice Standards for Registrants (2023)*; CRNA's *Practice Standards for Regulated Members (2013)*; and/or

    b. Contravenes one (1) or more employer policies, contrary to *CRNA's Practice Standards for Registrants (2023)* or CRNA's *Practice Standards for Regulated Members (2013).*

3. The conduct underlying **Allegation 3**:

    a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)*; *CRNA's Practice Standards for Registrants (2023)*; *Practice Standards for Regulated Members (2013)*; and/or

b. Contravenes one (1) or more employer policies, contrary to *CRNA's Practice Standards for Registrants (2023)* or CRNA's *Practice Standards for Regulated Members (2013)*.

4. The conduct underlying **Allegation 4**:

a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)*; *CRNA's Practice Standards for Registrants (2023)*; *Documentation Standards (2022)*; and/or

b. Contravenes one (1) or more employer policies, contrary to *CRNA's Practice Standards for Registrants (2023)*.

EVIDENCE

[4] The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend a Hearing
Exhibit #2 – Complaint
Exhibit #3 – Summary of Interviews
Exhibit #4 – Third Floor Schematic
Exhibit #5 – Wound Pictures
Exhibit #6 – Fall Event Summary
Exhibit #7 – Staffing Pattern
Exhibit #8 – Prescriber Record
Exhibit #9 – PCA Care Guide
Exhibit #10 – Care Planning Report
Exhibit #11 – Care Path Interventions
Exhibit #12 – To do List Report
Exhibit #13 – Good Samaritan Society Policies
Exhibit #14 – Annual Required Education
Exhibit #15 – Education Log

[5] The following individuals were called as witnesses by the Complaints Director:

Bright Uzzi
Jed Flores
Maria Fe Austria-Salter
Thelma Perdido
Jonarlyn Punzal
Vilma Pettoco
Hanieh Kamalipour

[6] The following individuals were called as witnesses by the Registrant:

Hosin Kee

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

Bright Uzzi

Examination in Chief

[8] Bright Uzzi is currently a Manager, Site and Clinical Services with Good Samaritan Society. Mr. Uzzi is a Registered Nurse. He has worked at Good Samaritan Society since 2019. In June 2024, he was the Manager, Site and Clinical Services for the Southgate Good Samaritan (the "**Centre**").

[9] Mr. Uzzi made a complaint to the College about the Registrant (Exhibit 2) regarding reported conduct by the Registrant of physical abuse towards a resident of the Centre, [redacted] ("**Patient** [redacted]"), which resulted in the termination of the Registrant's employment.

Objections by Legal Counsel for the Registrant

[10] Legal Counsel for the Registrant objected to Mr. Uzzi providing evidence related to his investigation of the complaint, on the basis that it was hearsay evidence since Mr. Uzzi was not present at the time of the events and witnesses would be called to speak to the evidence. Legal Counsel for the Registrant noted that the Hearing Tribunal has a duty of fairness to the Registrant and it is not fair for Mr. Uzzi to testify to what other individuals, who were not affirmed or sworn to tell the truth at the time told him.

[11] In addition, Legal Counsel for the Registrant objected to the Summary of Interviews prepared by Mr. Uzzi on the basis that it contained hearsay evidence. He also objected to wound photographs being admitted through Mr. Uzzi as he did not take the photographs.

[12] Conduct Counsel noted that under section 79(5) of the HPA, the Hearing Tribunal can hear evidence in any manner it considers appropriate and is not bound by the rules of law respecting evidence in judicial hearings. Mr. Uzzi submitted the complaint to the College and should be permitted to give evidence.

[13] The Hearing Tribunal determined it would allow the witness to answer questions relating to the complaint and would determine the weight to place on his evidence in its deliberations. The Hearing Tribunal further decided to mark the Summary of Interviews as Exhibit 3 and the Wound Pictures as Exhibit 5 and determine the weight to place on these in its deliberations.

Examination in Chief Continued

[14] Mr. Uzzi noted that he received an anonymous call from a lady who worked at the Centre reporting conduct of the Registrant. Mr. Uzzi provided evidence related to the steps he took once the matter was reported and what information was provided to him.

[15] Exhibits 4 and 6 to 15 were entered through Mr. Uzzi's testimony with no objections.

Cross-Examination

[16] Mr. Uzzi gave evidence regarding staffing changes at the Centre, including reductions in staffing. He acknowledged receiving emails from staff, including the Registrant on suggestions regarding staffing.

[17] Mr. Uzzi was challenged in cross-examination on various issues, including regarding unexpected sick calls by staff, his internal investigation and the investigation by the College investigator.

Re-Examination

[18] Mr. Uzzi provided evidence that Patient [redacted] was over 90 years old. She had a diagnosis of dementia. He described her as a small lady. He confirmed that the Registered Nurses and Health Care Aides were responsible for checking the bed and wheelchair alarms.

Hearing Tribunal Questions

[19] The Hearing Tribunal asked Mr. Uzzi to clarify the explanation he received from the Registrant as to how Patient [redacted] ended up on the floor. Mr. Uzzi could not remember exactly but indicated that the Registrant said Patient [redacted] had fallen on the floor between the wheelchair and the bed.

Jed Flores

Examination in Chief

[20] Jed Flores is a Health Care Aide who has worked at the Centre since 2018. On June 21, 2024, Mr. Flores worked from 15h00 to 21h15 on the third floor, C-Wing. At the beginning of shift, they do rounds and check on all the residents. Then they get them ready for supper, which is at 17h00. They porter the residents to the dining area. The kitchen staff serve the food and they will help some of the residents to eat if they need assistance. When dinner is done, they porter the residents back to get ready for bedtime. This is around 18h00 to 18h30. Some of the residents stay in the dining area after dinner because they are restless.

[21] Mr. Flores and his partner helped Patient [redacted] to eat supper. She goes to bed later, around 20h30 or 21h00 and so they left her in the dining area.

[22] Mr. Flores described an incident he observed between the Registrant and Patient [redacted] around 20h45. It was near the end of his shift. He was on the computer in C-Wing making notes of what had occurred on the shift. He heard someone screaming, saying “Stop. Please stop.” He got up from the computer to go check what was going on. He observed Patient [redacted] sitting in her wheelchair and he saw the Registrant standing, facing her, hitting her in the head or in the face and kicking her in the legs a few times.

[23] The incident occurred in front of the entrance of the dining area, in the middle of the hallway. Mr. Flores was four bedrooms away. He told the Registrant to stop. He rushed over to them and while he was rushing to them, the Registrant stopped what he was doing and went to the nurse station. Ms. Austria-Salter was also present, just next to them around one or two metres away attending to her medication cart. Mr. Flores asked her to remove Patient [redacted] with him, and to bring her to C-Wing and he asked her to attend to her wounds because she was bleeding, from the head mostly and from the arm.

[24] Mr. Flores described that there was a lot of blood dripping from Patient [redacted], and he saw a lot of blood on the floor. They grabbed some towels to wipe it up as they would not want other residents to slip from it. Other staff were there, trying to help. He took Patient [redacted] to

C-Wing and his partner, Ms. Perdido, who had been attending to another resident, came and they tried to clean Patient [redacted] up, and to wipe off the blood from her face and her arm.

[25] Mr. Flores testified that he saw that Patient [redacted] had wounds on her head and arm. He could not determine if she had wounds on her legs because she was wearing pants.

[26] Mr. Flores described hearing Patient [redacted] yelling at the time of the incident: "Please stop. Please stop. Help. Help. Help." He heard the Registrant saying "Let her die. Let her die." He believes the Registrant said this twice.

[27] Mr. Flores testified that his shift ended at 21h15 and so he asked his partner to finish the care of Patient [redacted]. The Registrant thanked him for what he did, for telling him to stop.

[28] Mr. Flores clarified that while he had asked Ms. Austria-Salter to attend to Patient [redacted]'s wounds, the Registrant came back to C-Wing and said he would do the nursing of the wounds. It was the Registrant who did the wound care for Patient [redacted].

Cross-Examination

[29] Mr. Flores testified that there are six Health Care Aides ("**HCAs**"), two Licensed Practical Nurses ("**LPNs**") and one Registered Nurse who work on the evening shift. Half of the Health Care Aides leave at 21h15. Ms. Perdido was his partner on C-Wing that evening.

[30] Mr. Flores described that the computer room is the lounge with a tv, sometimes also referred to as the TV lounge. This is referred to as "sun room 381" on Exhibit 4. He estimated that the TV lounge is 48 feet from the dining area. The Registrant and Patient [redacted] were in the hallway. Patient [redacted]'s wheelchair was facing towards him, towards C-Wing. The Registrant was facing to the door opposite the dining room, facing Patient [redacted]. The Registrant was on the left side of the wheelchair. Ms. Austria-Salter was behind them, attending to her cart, right in front of the phone, facing the dining area. Ms. Kamalipour was the other LPN on shift that evening. Mr. Flores recalled as well that Ms. Punzal tried to help him and Ms. Austria-Salter. However, he did not see Ms. Punzal close to the incident. He did not recall seeing Ms. Pettoco close to the area during that time.

[31] Mr. Flores testified that Patient [redacted] was restless that evening during supper and that is how she usually is. He described that the Registrant left to go to the nursing station when Mr. Flores arrived. Mr. Flores testified that before the incident, Patient [redacted] had a dressing on her arm, but it was a clean dressing. After the incident, her arm was bleeding. Mr. Flores indicated it was her left arm, but then stated he was not sure which arm was bleeding. He stated that Patient [redacted] was bleeding from her head, but did not recall exactly where the wounds were, noting that the incident occurred near the end of his shift. He stated he was the one who went to the linen room to grab towels to wipe up the blood from the floor. The linen room is next to the nurse station, going to B-Wing. Ms. Austria-Salter was with Patient [redacted] when he went to get the towels.

[32] Mr. Flores testified that he was not able to document anything, because it was the end of his shift. At that time, he worked at another job at 23h00, and so he had to leave to go to his other job. He recalled being off for two days from the Centre following the incident. The incident was on a Friday and he was back on Monday. He did not do any charting about the incident on Monday, stating that Ms. Austria-Salter was there as a witness. Ms. Austria-Salter and the Registrant could do the charting and they are his immediate

supervisors. He did not speak with Ms. Austria-Salter about charting, noting that it is Ms. Austria-Salter's responsibility.

[33] Mr. Flores testified that he was interviewed by Mr. Uzzi and someone else. Mr. Flores recalled telling Mr. Uzzi that Patient [redacted] was part of Ms. Perdido's assignment that evening. At some point, the Registrant told Mr. Flores to leave Patient [redacted] alone, and that was when the Registrant said to "let her die". The Registrant was rushing towards them, they were in the hallway in front of the TV lounge. Mr. Flores believes that Ms. Austria-Salter was still with Registrant [redacted] at this time.

Re-Examination

[34] Mr. Flores indicated that Patient [redacted] was bleeding from her face and he was not sure if that was also the blood on her arm.

Hearing Tribunal Questions

[35] The Hearing Tribunal asked Mr. Flores to describe again the incident in more detail. He stated he observed the Registrant hitting Patient [redacted] in the face or head with his hand and kicking her in the legs a few times. The Registrant was on the left side of the wheelchair, facing Patient [redacted], on her left side.

Maria Fe Austria-Salter

Examination in Chief

[36] Maria Fe Austria-Salter is an LPN and has worked at the Centre since 2015. On June 21, 2024, she worked the shift from 15h00 to 22h30. She worked half of B-Wing and C-Wing.

[37] At around 21h00, Ms. Perdido, one of the HCAs, told her that Patient [redacted] was refusing care. Ms. Austria-Salter instructed Ms. Perdido to just leave her alone and she would settle. Ms. Austria-Salter saw Patient [redacted] wheeling her wheelchair and she offered her something to drink as she had apple juice on her cart. Patient [redacted] took a sip and said "yuck", so Ms. Austria-Salter offered her a coffee mocha (also referred to by other witnesses as an Ensure) which Patient [redacted] wanted. Ms. Austria-Salter pushed her cart to the dining area and made Patient [redacted] a warm coffee mocha. Ms. Austria-Salter initially left but then returned and parked her cart in the dining area. She was looking for her medicine for her back pain and heard the Registrant say: "say sorry to me". She was not paying a lot of attention and continued with her work checking the Medication Administration Record ("**MAR**"). All of a sudden she heard Patient [redacted] saying "help". Ms. Austria-Salter said "what do you want to help, Mama?" She did not hear anything else, it was just yelling.

[38] Ms. Austria-Salter testified that the Registrant was facing C-Wing, so his back was to her and she could not really see what was going on. She heard again "help me" and she stepped back and looked up. She saw the Registrant "standing tall in front of [Patient [redacted]]. His hands is up in the sky with his palms spread and ready to slap the resident." However, his hand did not reach her face. Ms. Austria-Salter looked at the Registrant and he just stomped his feet, put his hands down and started saying "don't help her, let her die." He was hollering "don't help her, let her die."

[39] She testified that she did not know at the time that Patient [redacted] was already hit. She left to give out her medicine. Before she left, she told Mr. Flores, who was in the C-Wing hallway to stop the Registrant because he was hollering very, very loud. When she returned she saw "the small blood drop" and Mr. Flores was there trying to take Patient [redacted] back to her room. Ms. Austria-Salter asked whose blood it was and Mr. Flores said it was Patient [redacted]'s and that the Registrant had done it. She told him she was there but did not see him hitting her. She saw a bruise on the nose bridge. She asked Patient [redacted] what happened and Patient [redacted] said "kaput" and shook her head. Ms. Austria-Salter grabbed a towel and put it on the floor and another towel which she gave to Mr. Flores to wipe Patient [redacted]'s face. It appeared that Patient [redacted] had a cut on her nose, so she took the wound cart, but the Registrant came by and said "don't help her, let her die". He appeared mad and she was scared at that moment. She did not report him or call anyone. She went around to her cart. She froze and was not sure what she was doing in the moment.

[40] Ms. Austria-Salter testified that she called another LPN, Ms. Kamalipour, and showed her what happened and they did not know what to do. They were scared. After that, she went and did some charting. She did not chart about the incident. The Registrant came back and told her that next time she comes to bring an extra uniform "so when resident spills drinks for you … you have clothes to change." At around 22h30, Ms. Perdido came and said that Patient [redacted] had a wound on the legs, two wounds on the shin and asked how it happened. She said that the Registrant had dressed it. Ms. Austria-Salter indicated that she saw a bruise on the jaw line which was fading and the small bruise she noted on the nose bridge which Mr. Flores said were caused by the Registrant.

[41] Ms. Austria-Salter stated she was scared of the Registrant at the time because she thought that he might hit her if she helped Patient [redacted]. She has never experienced anything like it and it took her a long time to move forward. She did not report the incident right away. She initially wrote an email when she went home but did not send it. The next day at work she told the Registrant that what he did was wrong and he said sorry. They were getting report at 15h00 and it said that Patient [redacted] had a fall and her face was bruised. She stated she knew that Patient [redacted] did not have a fall. She did not send the email. She waited and then the following Wednesday she spoke to Mr. Uzzi. She called him on her way to work. She told him she was so scared and didn't come forward right away. Mr. Uzzi told her that the Registrant would not come back.

[42] Ms. Austria-Salter clarified that she was facing the dining area when the incident occurred, maybe an arm away from the Registrant. The Registrant was facing C-Wing, on her right hand side. She could not really see what was happening until she stepped back to look. Before the incident, Patient [redacted] only had a fading bruise around the jaw line. After the incident, Patient [redacted] had a bruise on the nose bridge. She saw a few drops of blood on the floor, which she observed after she came back from providing medicine to another resident. She estimated that she saw Patient [redacted]'s state after about 5 to 10 minutes. Patient [redacted] was wearing pants that day. She confirmed that she did not hear a bed or wheelchair alarm near the end of her shift.

Cross-Examination

[43] Ms. Austria-Salter confirmed that LPNs on the shift go off duty at 22h30. When the night shift employees arrive, the LPNs have already left. She did not observe Patient [redacted] having a fall.

[44] When she spoke to Mr. Uzzi on June 26, he asked her to send him the draft email. She sent it as a screen shot. Legal Counsel for the Registrant put it to Ms. Austria-Salter that Mr. Uzzi's evidence was that the first time he spoke to her was on July 2. Ms. Austria-Salter indicated she spoke to Mr. Uzzi on June 26 and he told her that he had already heard a report about the incident from someone else. Mr. Uzzi's evidence was that he first heard about the incident on June 28. Ms. Austria-Salter stated she was certain she spoke to him on June 26.

[45] Ms. Austria-Salter noted that at the time of the incident she was by the "stub wall" which she described as a pony wall about the height of the medication cart. While she was at the medication cart, the Registrant gave her the MAR and pills for a resident and left. It had been reported to her that Patient [redacted] was restless that evening and was refusing care. She had given Patient [redacted] a warm chocolate drink. Patient [redacted] is able to propel her wheelchair with her feet. Patient [redacted] was about one arm length from the medication cart and Ms. Austria-Salter was on the side of cart. Ms. Austria-Salter was looking at her medications and then saw a cup land on the stub wall near her. She "put the cup back" and then continued her paperwork. She heard "help" a second time and that is when she finished looking at her MAR and stepped back. The Registrant was facing C-Wing and Patient [redacted] was facing the cart, but blocked by the Registrant. She saw the Registrant's back. She did not see him slap or kick Patient [redacted]. She saw Mr. Flores and called him and he came. She saw Ms. Punzal in the dining room prior. She did not know where Ms. Punzal was during the incident. She recalled seeing Ms. Punzal washing her hands at one of the sinks.

[46] Ms. Austria-Salter testified that the Registrant was hollering "don't help her, let her die" more than 10 times. There were six HCAs still on duty, two in each wing. She examined Patient [redacted] and saw a small amount of blood and mucus coming from her nose. She did not see anything unusual with Patient [redacted]'s arms or legs. She saw three small drops of blood on the floor after the wheelchair was moved. She gave one towel to Mr. Flores to wipe Patient [redacted] and she used another towel to wipe up the blood on the floor. Ms. Austria-Salter denied that Patient [redacted] had previously fallen although she had previously slid from her chair.

[47] Ms. Austria-Salter testified that she did not see the Registrant doing any dressings for Patient [redacted] or take the wound cart to C-Wing. She had not checked the chair alarm that shift. Ms. Austria-Salter testified that she heard the Registrant say "apologize to me" or "say sorry to me" when the cup fell. In her interview with the investigator she said she heard him say "[redacted] why did you do that?".

Re-Examination

[48] Ms. Austria-Salter did not think that anyone else had wiped up blood from the floor. She confirmed she could not see Patient [redacted]'s bare legs.

<u>Thelma Perdido</u>

Examination in Chief

[49] Thelma Perdido is an HCA who has worked at the Centre for 16 years. On June 21, 2024 Ms. Perdito worked a shift from 15h00 to 23h00 on the third floor in C-Wing. Her shift partner was Mr. Flores.

[50] Ms. Perdido stated that she did not witness the incident and did not see Patient [redacted] until Mr. Flores brought her in the hallway of C-Wing lounge. At that time, she saw blood dripping from Patient [redacted]'s nose. After less than five minutes, the Registrant came to C-Wing lounge with the wound cart. She asked the Registrant what happened and he said that Patient [redacted] fell down. She left as she had another resident to care for. She saw the Registrant "giving dressing to the feet of [[redacted]]". It was 20h15 when she observed Patient [redacted] with blood dripping from her nose. She went to get paper towel and put cold water on it in a nearby sink, which is when she saw the Registrant. She also saw blood on Patient [redacted]'s feet when she passed by and saw the Registrant putting dressings on. Patient [redacted] also had an old bruise on her face.

[51] Ms. Perdido stated that Patient [redacted]'s attitude was unpredictable. She did not witness Patient [redacted] fall or hear any bed or wheelchair alarm.

Cross-Examination

[52] Ms. Perdido did not check the bed alarm and stated that they are checked when the residents are in bed. Only some beds on C-Wing have bed alarms. She did not recall if Patient [redacted] had a bed alarm or a wheelchair alarm. Ms. Perdido confirmed that Mr. Flores finished his shift at 21h15 and the LPN on the wing finished her shift at 22h30. Between 22h30 and when the night shift starts, she is alone on C-Wing. The Registrant comes to check as he can, as he covers all three wings.

[53] Ms. Perdido confirmed that she was told by the Registrant that Patient [redacted] fell when she asked what happened, at around 20h15. The Registrant told her at that time that Patient [redacted] had fallen. Patient [redacted] was wearing leggings and the Registrant pulled off the leggings. It was suggested to her that the Registrant changed the dressings twice on the shift and that the first time, he had to cut off her leggings with scissors. Ms. Perdido did not remember this.

Hearing Tribunal Questions

[54] Ms. Perdido clarified that she witnessed Patient [redacted]'s leggings being removed and the dressing being applied while she was in the C-Wing lounge room, by the hallway. Patient [redacted] was sitting in her wheelchair. The Registrant cut the leggings going down.

[55] Legal Counsel for the Registrant clarified Ms. Perdido's evidence and her statement to the College investigator. Ms. Perdido indicated that the leggings were too tight to pull down, so the Registrant cut the leggings. After the leggings were cut, they were taken off. She was asked if she was present when the Registrant took the leggings off a second time to do the dressing. Ms. Perdido did not recall this.

<u>Jonarlyn Punzal</u>

Examination in Chief

[56] Jonarlyn Punzal is an HCA and has worked at the Centre for over five years. She worked on June 21, 2024 from 16h00 to 23h30 on the third floor on B-Wing.

[57] Ms. Punzal described Patient [redacted] as small but chubby. Ms. Punzal described that she was in the dining room on June 21, 2024. She saw Patient [redacted] with a cup which she poured towards the Registrant. She then saw the Registrant kicking left and right Patient [redacted] and slapping her in the face.

[58] Ms. Punzal was asked about the Registrant dressing the wounds of Patient [redacted]. She does not recall the time, but it was before 22h00 because her other colleague was there, and he works until 21h15. She stated that she saw the Registrant walking around with the wound cart.

[59] Ms. Punzal saw a bruise on Patient [redacted] around her eyes and there was a wound on her legs and blood on the floor. She went to check Patient [redacted] as the HCA who works until 23h30 has to check all the residents for safety and she saw the dressing dripping blood on the bed. This was around 23h00. She saw her eyes and described it "looks like a raccoon."

[60] Ms. Punzal described that she was shocked by the incident. She was very scared of the Registrant. She heard Patient [redacted] asking for help at the time of the incident. The Registrant was talking to Patient [redacted] and was really mad. Ms. Punzal went to Ms. Pettoco and another staff in A-Wing to tell them what happened. Ms. Punzal stated that she did not witness Patient [redacted] fall at any point during her shift that evening. She did not hear any bed or chair alarms near the end of her shift for Patient [redacted].

[61] After a few days, she could not sleep and was upset because of what happened to Patient [redacted] and after seeing a photo of the wound. She reported the incident to her site manager, Mr. Uzzi.

[62] Ms. Punzal described other incidents she observed with the Registrant. On one occasion in 2024, he hit a resident, [redacted], on the head using the communication book. This occurred on the third floor nursing station. The resident was wandering around the nursing station. The Registrant was waiting for the evening RN. He took the communication book and hit the resident on the top of the head with it. She described the hit a "really strong" and that Patient [redacted] is really skinny and the communication book is really heavy. Patient [redacted] did not react, she was quiet. Ms. Punzal could not recall the date, or the season, but stated it was in 2024.

[63] On another occasion, the Registrant pulled the hair of one of the residents, [redacted], for no reason. This also occurred in 2024. The resident was a wanderer, she was walking around the hallway and the Registrant pulled her hair. The Registrant pulled her hair so hard that the resident's head tilted back. This incident also occurred on the third floor, in the hallway.

Cross-Examination

[64] Ms. Punzal stated that she did not write anything down about the incidents at the time or later, as she was not assigned to that wing. She reported to the manager. She was called for an investigation interview, but could not recall the date. When she reported to Mr. Uzzi, she indicated that she did not want her name used, for her protection and safety.

[65] The hair pulling and book incident occurred before the incident with Patient [redacted]. She knew it was in 2024 because that is when her new position working evening shifts started. She indicated that she did not recall when the new position started. She clarified that when the

book incident occurred, they were waiting for the night RN, not the evening RN. Another HCA was there. No one else was there when the hair pulling incident occurred. She did not report the book incident or hair pulling incident at the time.

[66] On June 21, 2024, she had gone to the dining room to get a resident a drink. The resident was still in his room. Patient [redacted] was in front of the door of the C-Wing (noted in blue on Exhibit 4). She was at the door of the servery. The Registrant walked by her toward Patient [redacted]. Patient [redacted] threw her drink at the Registrant. The Registrant's back was to her. She saw his feet kicking Patient [redacted]. He was standing in front of Patient [redacted]. She did not observe Patient [redacted] moving her legs to try to kick Patient [redacted]. She could see his hands were slapping "left and right". She could not see Patient [redacted]'s face or the Registrant's hands when they were towards the centre of his body. She could not tell if the Registrant was trying to block Patient [redacted]'s kicks. Ms. Austria-Salter was there as well, standing in front of her medication cart. After the incident, she went back to the other resident's room with the drink. She saw Patient [redacted] later between 23h00 and 23h30 when she went to do her safety checks. Patient [redacted] had bruises around her eyes, like a raccoon. She moved the blanket covering Patient [redacted] and observed that she had a dressing on her legs and there was blood dripping. She moved the blanket as you need to check if the resident's brief is wet and if so, you need to change them.

Vilma Pettoco

Examination in Chief

[67] Vilma Pettoco is an HCA and has worked at the Centre for the past 16 years. On June 21, 2024, she worked from 16h00 to 23h00 on the third floor, A-Wing. She described that they prepare the residents to go to the dining room and dinner is at 17h00. After supper, they start preparing the residents for bed. She described that Patient [redacted] has dementia, like all residents on that floor. They can have behaviour issues and can be unpredictable. At dinner time, Patient [redacted] looked fine.

[68] Ms. Pettoco took another resident to C-Wing later, around 21h00 and she saw Patient [redacted] again. She had dressings on her legs and a bruise on her face. She did not speak to anyone about the incident. She asked the Registrant what happened who said, "don't disturb her anymore because she's quiet already." Ms. Pettoco went back to her wing and then Ms. Punzal talked to her about Patient [redacted].

Objection by Legal Counsel for the Registrant

[69] Legal Counsel for the Registrant objected to a question about the discussion between Ms. Pettoco and Ms. Punzal on the basis that it would be hearsay to hear from Ms. Pettoco what Ms. Punzal observed about Patient [redacted]. Conduct Counsel pointed to section 79(5) of the HPA, which allows the Hearing Tribunal to hear evidence in any manner it considers appropriate. The Hearing Tribunal adjourned to consider the objection. The Hearing Tribunal determined that the hearsay evidence would go directly to the Allegations in terms of what had occurred between the Registrant and Patient [redacted]. The Hearing Tribunal determined that it was hearing directly from witnesses who were present when the incident occurred and there was little probative value in hearing the hearsay evidence. For these reasons, the objection was sustained.

Examination in Chief Continued

[70] Ms. Pettoco confirmed that she did not witness Patient [redacted] fall at any point that evening. She did not hear any alarms going off near the end of her shift.

Cross-Examination

[71] Ms. Pettoco confirmed that Patient [redacted] could be unpredictable in terms of her behaviour. Ms. Pettoco had witnessed Patient [redacted] throw her drink at someone on other occasions. She does at times show up with bruises on her arms, but Ms. Pettoco had not previously observed Patient [redacted] having injuries on her legs and not generally bruises on her face.

Re-Examination

[72] Ms. Pettoco was asked what has occurred when Patient [redacted] has thrown drinks previously. Ms. Pettoco stated that when she starts to get agitated, they remove anything in front of her, they take her out of the dining room and keep her away so she will not hurt anyone. They let her calm down before they approach her again. They do not engage in any kind of physical altercation with her.

Hearing Tribunal Questions

[73] The Hearing Tribunal clarified the timing of Ms. Punzal discussing the matter with Ms. Pettoco. They spoke that evening and again the next day. Ms. Punzal asked her what she should do.

<u>Hanieh Kamalipour</u>

Examination in Chief

[74] Hanieh Kamalipour is an LPN who has worked at the Centre since 2009. On June 21, 2024, she worked the evening shift from 15h00 to 20h30 in A-Wing. At approximately 20h30, she was in the staff break room on her supper break, speaking to her son on the phone, when she heard the Registrant yelling. At first, she thought he was mad at the staff, but then she heard Patient [redacted] saying “help me” a few times. She realized something was happening. She then heard the Registrant saying “don’t help her” a few times. She saw Ms. Austria-Salter, the other LPN, frozen and shocked. She believes she then saw Ms. Perdido, HCA taking Patient [redacted] to C-Wing. She saw the Registrant return to the nursing station.

[75] Ms. Kamalipour then saw blood and asked Ms. Austria-Salter what happened. Ms. Austria-Salter said that the Registrant and Patient [redacted] had a fight with each other. She said to Ms. Austria-Salter, there are drops of blood on the floor. She and Ms. Austria-Salter went to the report room and started charting. It was about 21h15 or 21h20.

[76] Ms. Kamalipour did not interact with Patient [redacted] that night, but the next day saw that she had wounds and a bruise on her face. She did not take any steps.

[77] Ms. Kamalipour described the fall protocol. If a resident can get up on their own, they may assist them, but they let them get up on their own. Most residents cannot get up on their own and they use a mechanical lift machine. They need at least two persons to get them

up from the floor to the chair or bed. For aggressive residents like Patient [redacted], it is a three person assist. One person can hold the hand, one person holds the legs and one person controls the machine. Patient [redacted] can move her legs, but she cannot get up on her own.

Cross-Examination

[78] Ms. Kamalipour stated that she heard the noise around 20h45. She first heard Patient [redacted] saying 'help me". She then heard the Registrant. She was not sure if Mr. Flores was involved in taking Patient [redacted] back to her room. She believes that when she saw the blood, Ms. Austria-Salter went to get a towel to wipe up the blood.

Hearing Tribunal Questions

[79] The Hearing Tribunal asked Ms. Kamalipour to clarify her evidence that she thought the Registrant was yelling at staff. She stated that it does happen that he gets mad at staff, for example, for self-transferring or being late.

[80] Ms. Kamalipour also testified that Patient [redacted] had fallen many times prior and they always transfer her with a mechanical lift machine with the help of three persons.

Hosin Kee

Examination in Chief

[81] The Registrant graduated from the University of Alberta Nursing program in 2008 and is a Registered Nurse.

[82] The Registrant described his shift on June 21, 2024. He worked evening shifts from 15h00 to 23h15. He usually started 30 minutes early to check the staffing and workload, including requests from management or doctor's orders to process or work left behind from the day shift. If everything is manageable, he would go to the report room and do stretching exercises before his shift. He did a regular round after the report and saw Patient [redacted] with another resident, Mr. [redacted] on B-Wing in his room. He directed Patient [redacted] to the dining room. When he did his initial round on C-Wing, he saw her confronting another resident, Mrs. [redacted] in the hallway, so he again redirected her to the dining room. After he finished his initial round, he went back to his office, which is the medication room and checked email. There was a new resident who was at a high risk of falling.

[83] The Registrant testified that Ms. Austria-Salter was there on the right side of her medication cart. He was not sure if another LPN was there as well. He did not notice Patient [redacted] sitting nearby in a wheelchair until she threw her drink at him, covering his eyes, his eyeglasses, his face and his shirt. He was startled and tried to hold her hand. That is how he usually interacts with her because she never shows those behaviours towards him. He speaks a little bit of German and Patient [redacted] is German-speaking, so they communicate in German. He testified that he was more surprised than angry.

[84] The Registrant testified that he tried to hold her hand and she kept pushing away. He tried several times. He then wanted to check her carotid pulse. He tried multiple times and eventually got it. He did this because he was wondering what could be the underlying reason for those unusual behaviours, especially towards him. He tried to get her vital signs. He was concerned about a possible UTI (urinary tract infection), because that is

very common. He stated that he did get fluid intake and things like that as part of change over report, but did not remember the details. He recalls intake was fine, but still tried to take her pulse and temperature. He noted that when he palpates the skin, he is within an error range of 0.01. She was moving and pushing his hand away, so he tried to get her carotid pulse first. The heart rate was a little high, but it was not significant. So, he thought it was fine.

[85] The Registrant described that he had a very close therapeutic relationship with Patient [redacted] and she treated him like a son. When he is talking with someone, she approaches and rubs his cheeks and he does that too sometimes. That and a brief conversation in German will help calm her down.

[86] The Registrant testified that in that moment, nothing was working. Patient [redacted] was swinging her arms and kicking. She is small and over 90 years old, but relatively strong. The Registrant stated he instinctively blocked with his feet. It was not a "sparring thing" but was in a "somewhat playful manner" as he knows he needs to maintain professionalism. He knows not to take anything personally but he instinctively blocked her kicking with his feet. It was very light.

[87] The Registrant stated that he did not slap Patient [redacted] or kick her at any time. He stepped back and decided to give her a little time to calm down. She was moved to the C-Wing TV lounge. The Registrant stated that Mr. Flores moved her, although the Registrant did not direct him to do that.

[88] Patient [redacted] was saying "leave me alone" in German and so, he told Ms. Austria-Salter to leave her alone, somewhat bluntly. He testified that he never said, and would never say, "let her die".

[89] The Registrant testified that he went to the sink in the medication room and washed his face, his glasses and cleaned up his shirt. About 15 to 20 minutes later he visited Patient [redacted] in the C-Wing TV lounge. Patient [redacted] was resting. She had a scratch mark on the left side of her face and old facial bruising, although he does not remember the exact location of the fading bruise. He did not see any bloody area on her face but noticed that small amounts of blood seeped through the pants on both sides of her shins. He was not able to assess because she refused and she got agitated. He decided to give her time to settle. He does not recall which HCA was sitting with her, Mr. Flores or Ms. Perdido, but the Registrant said, "leave her alone. I'll be back." He returned to the C-Wing TV lounge approximately 20 minutes later.

[90] The Registrant testified that when the incident occurred, he was in the hallway close to the C-Wing with his back to the dining room and his front to the staff lounge. He does not remember exactly how he was facing the wheelchair, noting it was probably perpendicular or diagonal.

[91] The Registrant described steps he took to address the bleeding on Patient [redacted]'s legs. When he went back, she was more relaxed. He was able to assess the shin wound, but she was wearing tight leggings and they were stuck to the skin because of the wound. He brought the entire dressing cart in and used a saline bottle to soak both sides of her shins. It took a while because it seemed to have dried up. He was not able to detach them from the skin, so he ended up cutting the leggings from the ankle to below the knee on both sides. He told Ms. Perdido who was charting there, "we are not losing the pant" because

family members sometimes complain of missing clothes. In those situations, they are required to take a photograph, but the digital camera was not available on the unit. He put on a dressing material, although he did not recall what type of dressing was used. He could not tell when the injuries had occurred. He noted that if he had been able to expose the wound without saline-soaking the wound, he may have been able to tell the approximate time. Patient [redacted] was not very friendly, but she was not like she had been in the dining area. He placed the dressing cart back in its place and went to the medication room to do his regular work.

[92] The Registrant testified that around 22h00, Ms. Perdido came by his office and reported that she ended up sewing the leggings. Patient [redacted] had been put into her gown as part of her nighttime routine by the HCAs.

[93] The Registrant stated that it is his routine to do rounds around 22h30. At that time, there are three HCAs on the unit with him. When he opened the door to Patient [redacted]'s room, she was lying on the floor, not far from her bed. The dressings were totally displaced. He saw a moderate amount of blood and he noticed a blood stain on the bed frame. He called for assistance more than three times, but no one showed up. He did a quick assessment and at that time she was very friendly. She was stable. He covered the open wound with paper wipes and he ran to the nursing station to retrieve the vital sign machines and the dressing materials. He was in a rush that evening, as he needed to leave by 23h30. His shift ends at 23h15, but he usually leaves between 23h30 and 24h00 as he stays to do charting. This was a special shift for him and so he lifted her and put her onto the bed himself. According to the care plan, Patient [redacted] is a one person assist and she helped him a little bit. She did not complain of any pain and was very friendly. Usually they need two people to transfer her, but she was very friendly and tried to help him. He was able to lift her without injuring himself. When Patient [redacted] was on the bed, he put dressings on the wounds. He noted that the bed alarm had not gone off, although he was not sure if the bed alarm was in place.

[94] The Registrant stated that he was in a rush to leave that evening and he was in a rush to complete the documentation, including the wound report and incident report. Patient [redacted]K is a frequent faller and so he copied and pasted from his previous wound report the fall report. He updated the wound section and GCS assignment section but overlooked the rest. He testified that the entry in the charting was incorrect. He took photographs of Patient [redacted]'s injuries the next day. The Registrant noted that in long term care they only chart by exception. This was an exceptional case and so he should have charted the first dressing change, but because he was in a rush, he decided to make a late entry the next shift. He charted minimal information for the night shift nurse. He then did a combined wound report. He picked the bigger wound, which was on the right side on June 21, 2024. He added a progress note to let the night shift know to follow up and to let them know there was also a wound on the left side.

[95] The Registrant clarified that the fall report (Exhibit 6) is incorrect in noting that Patient [redacted] was "transferred back to wheelchair via FML and 2PA." He cut and pasted as he was rushing. The full mechanical lift was not done.

[96] The Registrant reviewed the photographs in Exhibit 5. The photographs at pages 4, 5, 8 and 9 are from July 2024. The Registrant was no longer there at that time. The photograph at page 10 is undated. The Registrant took the photographs at pages 6 and 7. The Registrant testified that Patient [redacted] moves around on her own. The shin injury may be

from when she was trying to kick him or from his knee contacting her shins when he cradled her face to check her carotid. However, she might have injured her shins earlier from an unwitnessed altercation with other residents or bumped against a wall or furniture.

[97] The Registrant denied the allegations relating to the book incident and hair pulling incident. He recalled the one incident where Patient [redacted] was holding a knife from the kitchen and she was asking for something. The resident was always threatening people. He did not want to expose himself so he pushed the knife down using a binder. He did not hit Patient [redacted] on the head with the binder. In terms of the hair pulling incident, the Registrant indicated that he did not specifically recall the incident but stated that he interacts with staff and residents playfully by pulling their hair. He testified that it builds a therapeutic rapport with them. He noted that it appears that Ms. Punzal misinterpreted the incident.

[98] The Registrant noted that medication may affect a person's reaction to a bruising incident.

Cross-Examination

[99] The Registrant has a military background. He received basic U.S. army training. He also has martial arts training.

[100] The Registrant acknowledged that he was significantly stronger than Patient [redacted]. Patient [redacted] was strong enough to propel her wheelchair with her legs, but could not walk on her own, because of her balance and strength.

[101] The Registrant noted that he did not attend the College investigation based on advice of prior counsel.

[102] The Registrant confirmed that he did not document the incident between himself and Patient [redacted]. He stated that he decided to document it on the next shift and make a late entry "detailing all the things" but that he overlooked it.

[103] The Registrant stated that at the time of the incident, he did not document the wound on the shin. There is usually a camera on each floor. There are three floors. But often the wound digital camera would be borrowed by other floors. He called the other floors, one floor said they did not have one and the other did not answer.

[104] The Registrant was asked about certain Good Samaritan policies and noted they are reviewed as part of annual education.

[105] The Registrant was asked why he tried to take Patient [redacted]'s pulse at the time of the incident. He gave evidence regarding goals of care designation and that the majority of residents are comfort care. With that they take temperature, pulse and respiration. He can easily check those without using a machine. It was a Friday evening and it is really hard to reach physicians, especially Patient [redacted]'s physician. As such, he tried to get baseline information. He was concerned about a possible UTI. If he called the physician without getting temperature, pulse and respiration, the physician will be upset. His findings were not significant so he decided not to call the physician.

[106] The Registrant was asked about his evidence that he was "more surprised than angry". He stated that his vision was obstructed and it took him a little longer to approach her and locate her hands because the fluid material on both sides of his glasses and in his eyes.

He was surprised because he had never experienced those kinds of interactions with Patient [redacted].

[107] The Registrant stated that he blocked Patient [redacted]'s attempted kicks in an unintentional manner, in a reflex style. In martial arts training, you don't think, you just respond and that is what he was trying to describe. The Registrant stated that he only recalled the fading bruising through hearing witnesses in this hearing. He confirmed seeing blood seeping through Patient [redacted]'s leggings when he first went to the TV room.

Re-Examination

[108] The Registrant testified about principles of taekwondo, including courtesy, integrity and self-control.

Hearing Tribunal Questions

[109] The Hearing Tribunal clarified with the Registrant when he first saw wounds on Patient [redacted]'s shins, which was in his first visit to the C-Wing TV lounge. He was asked if he considered letting Patient [redacted] settle after she threw the drink at him. He referenced that because it was Friday evening, if he needed to call the on-call physician, it takes time to discuss resident issues with the direct doctor.

CLOSING SUBMISSIONS

[110] The parties suggested that they would provide closing submissions in writing and that the Hearing Tribunal should convene again to hear further oral submissions. The Hearing Tribunal agreed to the procedure proposed by the parties. The Hearing Tribunal reconvened on January 13, 2026 for closing submissions.

Submissions by Conduct Counsel:

[111] Conduct Counsel noted that the Registrant was trained in the U.S. military and is a certified taekwondo instructor. The Registrant received training from his employer at the Centre, with 149 hours of education logged on required education. The Registrant's employer investigated a complaint of patient abuse, which led to his termination of employment and a complaint to the College. The Complaints Director investigated the complaint. The Registrant did not participate in the College's investigation. The complaint was referred to a hearing following investigation.

[112] Conduct Counsel noted that the standard of proof is on the balance of probabilities, that is whether it is more likely than not that the alleged events occurred. The evidence must be clear, convincing and cogent. The College bears the burden of proving the Allegations on a balance of probabilities. The Hearing Tribunal must determine if the Allegations have been factually proven on a balance of probabilities and if so, whether the conduct constitutes unprofessional conduct. The present case turns on credibility and reliability of the witnesses called to give evidence.

[113] Conduct Counsel reviewed the factors for assessing credibility, noting that there were some discrepancies and inconsistencies in the evidence of the witnesses. A trier of fact may accept all, some or none of a witness's evidence. The following factors should be

considered: appearance or demeanor; ability to perceive; ability to recall, motivation, probability or plausibility; internal consistency; and external consistency.

[114] Conduct Counsel noted that some of the Registrant's testimony called into question the reliability of his evidence. The Registrant had received education from his employer on how to deal with distressed patients which was not followed by the Registrant who testified that he "tried to get her vital signs" after Patient [redacted] threw her cup of Ensure at him. The testimony of Ms. Punzal is consistent with the testimony of Mr. Flores that the Registrant was kicking and slapping the face of Patient [redacted]. Further, Ms. Perdido saw blood dripping from Patient [redacted]'s nose, which is consistent with the testimony of Mr. Flores who testified she was bleeding from her face and Ms. Austria-Salter who saw a cut on her nose.

[115] Further, the Registrant testified that he was "more surprised than angry when I got all those messes" referring to the cup of Ensure being thrown at him. Mr. Flores heard the Registrant say "let her die. Let her die." Ms. Austria-Salter testified to hearing the Registrant say "don't help her. Let her die." Ms. Kamalipour testified to the Registrant saying "don't help her, don't help her." Although there is some discrepancy in the testimony of the Complaint Director's witnesses, there is significant overlap in what they described hearing. These statements contradict the Registrant's claim that he was more surprised than angry.

[116] Conduct Counsel submitted that the Registrant charted the alleged unwitnessed fall inaccurately, which calls into question the plausibility of the fall itself. In addition, if the proper protocol had been followed, there would have been witnesses to whether the fall occurred or not.

[117] Conduct Counsel submitted that the Registrant's testimony is inconsistent with the testimony of a variety of witnesses which calls into question the plausibility of the Registrant's evidence.

[118] With respect to Allegation 1, Conduct Counsel noted that the Centre's Policy defines abuse as "an act or omission with respect to a client (patient, resident) receiving care or support services from a service provider that: causes serious bodily harm." (Exhibit 13). This definition is further expanded by the education received by the Registrant that physical abuse: "is any physical force that is excessive for or is inappropriate to a situation involving a person in care by a perpetrator(s)." Conduct Counsel pointed to the photographs taken after the incident of Patient [redacted]'s injuries (Exhibit 5). The Registrant is approximately 194 lbs. and has military and taekwondo training. Patient [redacted] is an over 90-year-old wheelchair-bound women with dementia. The evidence supports that witnesses observed the Registrant kicking and slapping Patient [redacted]. Multiple witnesses testified that Patient [redacted] had facial wound and that the Registrant dressed wounds on her legs after the incident. Multiple witnesses noted blood on the ground after the incident. The Registrant demonstrated a lack of knowledge, skill and/or judgment in relation to patient care.

[119] With respect to Allegation 2, Ms. Punzal testified that she observed the Registrant hit Patient [redacted] with a communication book. The Registrant described an interaction where he used a Kardex binder to push down when a resident had utensils. A nurse demonstrating adequate knowledge, skill or judgment would not strike someone with a book as part of an appropriate therapeutic relationship.

[120] With respect to Allegation 3, Ms. Punzal testified that she saw the Registrant pull a resident's hair causing her head to tilt back. The Registrant stated that he does "interact with staffs and residents, you know, playfully by pulling --- I thought it's just one of my way to build therapeutic rapport with them". It was submitted that pulling hair is not part of a therapeutic relationship with patients or part of building "therapeutic rapport".

[121] With respect to Allegation 4, Conduct Counsel noted the Documentation Policy: "All information related to resident health status, care and services provided must be documented in the resident's medical record" and that the "documentation must be legible, objective, timely, complete, and accurate" (Exhibit 13). The Registrant failed to document the incident between himself and Patient [redacted] and failed to complete an incident report in relation to the altercation between him and Patient [redacted] and the wound care he provided after. The Registrant also failed to photograph the wounds directly after the incident. The complete lack of documentation surrounding the incident led to documentation that was not timely and complete in contravention of the employer's Documentation Policy. The Registrant also admitted during his testimony that documentation of Patient [redacted]'s fall was "the wrong entry. That's the – that's the false information." The Registrant admitted the documentation was incorrect and his reasoning was that he "copied and pasted from my previous wound report."

[122] Conduct Counsel took the position that the Allegations are factually proven and constitute unprofessional conduct on the basis of section 1(1)(pp) of the HPA:

a. displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services (section 1(1)(pp)(i));
b. conduct that contravenes the HPA, a code of ethics or standards of practice (section 1(1)(pp)(ii)); and
c. conduct that harms the integrity of the regulated profession (section 1(1)(pp)(xii)).

[123] It is submitted that Allegation 1 is unprofessional conduct pursuant to section 1(1)(p)(i), (ii) and (xii) and the following provisions are applicable:

a. Code of Ethics: A1, A2, A12, A13, B1, D1, D2, E6, G1;
b. Standards of Practice: 1.2, 1.3, 1.4, 2.4, 2.7, 3.1, 3.5, 3.6.

[124] It is submitted that Allegations 2 and 3 are unprofessional conduct pursuant to section 1(1)(p)(i) and (ii) and the following provisions are applicable:

a. Code of Ethics: A1, A12, A13, B1, D1, D2, D6, G1;
b. Standards of Practice: 1.2, 1.3, 1.4, 2.4, 2.7, 3.1, 3.5, 3.6.

[125] It is submitted that Allegation 4 is unprofessional conduct pursuant to section 1(1)(p)(i) and (ii) and the following provisions are applicable:

a. Standards of Practice: 1.3, 1.4, 2.4;
b. Documentation Standards: 1.1., 1.2, 1.6, 2.1, 2.2.

Submissions by Legal Counsel for the Registrant:

[126] In his written submissions, Legal Counsel for the Registrant reviewed the evidence of the witnesses for the Complaints Director, noting the differing accounts of various witnesses,

in particular the positioning of Patient [redacted] and the Registrant, where the incident allegedly occurred, the wounds allegedly inflicted on Patient [redacted] and the amount of blood on the floor. It was submitted that Mr. Uzzi was argumentative and evasive and Mr. Flores was not an objective witness, was argumentative and clearly exaggerated certain facts. It was also submitted that it was clear that various witnesses had shared rumours and that the Centre did nothing to discourage the gossip. It is likely the gossip and rumours shaped the witnesses' narrative.

[127] Legal Counsel for the Registrant reviewed the evidence of the Registrant. The Registrant's evidence was that Patient [redacted] threw her cup of Ensure at his face, covering his eyes, eye-glasses, face and shirt. He was startled and tried to hold her hand. He reached towards her to try to obtain her pulse, however, she was swinging her arms and kicking out at him. The Registrant's evidence was that he instinctively blocked her kicks with his feet. He categorically testified that he did not kick or slap Patient [redacted]. He may have said "leave her alone" but did not say "let her die." When he attended C-Wing, 20 minutes later, he did not see any blood on Patient [redacted]'s face but noticed a small amount of blood that had seeped through her pants on both sides of her shins and that she had a scratch on her nose. He provided wound care and used scissors to cut off her leggings. The Registrant gave evidence that he later found Patient [redacted] on the floor and replaced her dressings. He acknowledged that his charting regarding the lifting of Patient [redacted] was inaccurate because he had cut and pasted the charting from a previous occasion. The Registrant denied the allegations of earlier incidents in 2023 or 2024.

[128] Legal Counsel for the Registrant submitted that there was nothing improbable in the Registrant's evidence. His evidence was plausible and consistent. His evidence about leaning forward in an attempt to obtain vital signs and that he found Patient [redacted] on the floor were not contradicted by any other witness. His actions are entirely consistent with his efforts to obtain vital signs. With respect to the fall, the fact of incorrectly charting the lift off the ground does not call into question that the fall occurred. It was submitted that the Complaints Director seems to conflate military or martial arts training with a propensity to abuse residents.

[129] Legal Counsel for the Registrant reviewed principles regarding assessing evidence and witness credibility, noting the factors of: demeanour of a witness; memory; plausibility; internal consistency; external consistency; motivation; and ability to perceive. The Hearing Tribunal must consider credibility but also reliability, that is, whether the witness is attempting to tell the truth but is mistaken.

[130] Legal Counsel for the Registrant took the position that there were flaws in the College investigation, noting that the nurse practitioner who treated Patient [redacted] on June 24, 2024 did not provide any evidence and no attempts were made to obtain a statement from her. There was no attempt made to speak to the nursing staff in the shifts following the incident. Further, full charting for Patient [redacted] was not obtained. These are serious omissions and should be considered as adverse to the case of the Complaints Director. Further, the College investigator took the photographs selected by Mr. Uzzi but did not obtain all the photographs of Patient [redacted]'s injuries. It was submitted that it was also shocking that none of the witnesses were asked to write down their statement.

[131] Legal Counsel for the Registrant noted the serious nature of the allegations of abuse. The charting error was acknowledged, in that the Registrant cut and pasted the charting, intending to rectify it when he next came back to work and that he did not do so. There is

a charting error and it will be for the Hearing Tribunal to determine if that is conduct deserving of sanction. However, it was submitted that on the allegations of patient abuse, the Registrant was entitled to a finding of not guilty.

Reply Submissions by Conduct Counsel:

[132] Conduct Counsel delivered reply submissions during the January 13, 2026 hearing. Conduct Counsel noted that the issue of military or martial arts training was not conflated with the propensity to physically abuse a resident but was noted for the harm that could come to an over 90-year-old wheelchair bound resident by the Registrant.

[133] It was also noted that there are techniques for dealing with distressed residents which do not involve immediate engagement and entering into their personal space in the form of taking vitals. Given the Registrant's experience, it seems unlikely that the Registrant would ignore his training and try to take vital signs at the time of the incident.

[134] Conduct Counsel addressed the submissions regarding inconsistencies in evidence and noted that it is unlikely that multiple witnesses saw strikes, heard yelling and saw damage after the incident if the altercation involving Patient [redacted] did not occur.

HEARING TRIBUNAL DECISION

[135] The Hearing Tribunal considered the submissions of the parties and the evidence entered during the hearing by way of witness testimony and exhibits.

[136] The Hearing Tribunal finds that Allegations 1, 3 and 4 are proven on a balance of probabilities and that the conduct constitutes unprofessional conduct as follows:

a. Allegations 1, 3 and 4 demonstrate a lack of knowledge, skill or judgment pursuant to HPA section 1(1)(p)(i);
b. Allegations 1, 3 and 4 are a breach of the Standards of Practice and Code of Ethics pursuant to HPA section 1(1)(p)(ii);
c. Allegations 1 and 3 are conduct that harms the integrity of the profession pursuant to HPA section 1(1)(p)(xii);

[137] The Hearing Tribunal finds that Allegation 2 was not proven on a balance of probabilities and dismisses Allegation 2.

[138] The Hearing Tribunal's reasons are set out below.

HEARING TRIBUNAL FINDINGS AND REASONS

[139] The Hearing Tribunal considered the credibility of the witnesses having consideration to the factors as noted by the parties: appearance or demeanor; ability to perceive; ability to recall; motivation; probability or plausibility; internal consistency; and external consistency. The Hearing Tribunal noted it can accept all, some or none of a witness's evidence.

Credibility of the Witnesses

[140] The Hearing Tribunal considered the evidence of Mr. Uzzi. Mr. Uzzi is the manager of the Centre. He conducted an internal investigation of the incident and is the complainant in

the complaint to the College. The Hearing Tribunal considered that Mr. Uzzi was not present when the incident occurred. The Hearing Tribunal placed no weight on the evidence of Mr. Uzzi in relation to the evidence collected in the internal investigation, preferring to consider only the evidence of the witnesses (including the Registrant) who were present on the day of the incident and who were called to give evidence during the hearing. Mr. Uzzi conducted an internal investigation at the Centre. However, the documentation of the incident was poor. No reliance was placed on the documentation created as part of the investigation, Exhibit 3.

[141] The Hearing Tribunal considered the evidence of Mr. Flores. The Hearing Tribunal found Mr. Flores to be credible. He reported witnessing the Registrant strike Patient [redacted] by kicking her legs and hitting her head. While he was four rooms down, the Hearing Tribunal accepted that he was able to see what was occurring. Mr. Flores also stated in his evidence when he could not remember something, including where the wounds to the face were. Mr. Flores' evidence was also generally consistent with other witnesses. The Hearing Tribunal also found his evidence to be plausible and probable, having consideration to all the evidence before it.

[142] The Hearing Tribunal considered the evidence of Ms. Austria-Salter. Her evidence was in many ways consistent with the evidence of Mr. Flores. The Hearing Tribunal accepted that Ms. Austria-Salter was afraid of reporting, as she feared retribution. The Hearing Tribunal accepted that she heard Patient [redacted] ask for help, that she heard the Registrant say "say sorry to me" and saw the Registrant raise his hands. The Hearing Tribunal also accepted that she saw blood on the floor and that there was blood and mucus coming from Patient [redacted]'s nose. The Hearing Tribunal found Ms. Austria-Salter to be a credible witness with respect to some of her evidence, but considered that she might be minimizing the events, given that she might have been expected as an LPN to have reported the incident or charted what occurred.

[143] The Hearing Tribunal considered the evidence of Ms. Perdido. Ms. Perdido did not see the incident but did see Patient [redacted] after the incident in C-Wing. The Hearing Tribunal noted that Ms. Perdido appeared confused about the timeline. As such, limited weight was placed on her evidence, although the Hearing Tribunal accepted that she helped clean up Patient [redacted]'s face and her evidence that Patient [redacted] had blood on her feet.

[144] The Hearing Tribunal considered the evidence of Ms. Punzal. Ms. Punzal was there at the time of the incident. She witnessed the interaction of the Registrant kicking and slapping Patient [redacted] in the face. She saw blood on the floor and bruising around the eyes later that evening. The Hearing Tribunal accepted her evidence that she was shocked and scared. She later came forward and reported to Mr. Uzzi. When the matter was investigated, she reported incidents about hair pulling and the book incident. The Hearing Tribunal found her to be a credible witness. She acknowledged when she did not recall something, particularly with the timelines.

[145] The Hearing Tribunal considered the evidence of Ms. Pettoco. Ms. Pettoco had more limited firsthand testimony. However, the Registrant told her not to disturb Patient [redacted] because she was quiet. She did note that Patient [redacted] had dressings on her legs and a bruise on her face at 21h00 on June 21, 2024 and the next day. Ms. Pettoco also spoke to the general approach when Patient [redacted] is agitated, which is to let her calm down before they approach her. The Hearing Tribunal accepted the evidence of Ms. Pettoco on these points.

[146] The Hearing Tribunal considered the evidence of Ms. Kamalipour. Ms. Kamalipour heard Patient [redacted] asking for help and heard the Registrant yelling. She also saw blood on the floor and testified that Ms. Austria-Salter wiped up the blood. She heard the Registrant saying not to help Patient [redacted]. Ms. Kamalipour observed the wounds on Patient [redacted]'s legs and face the next day. There was some inconsistency with Mr. Flores' evidence in that she testified that Ms. Perdido took Registrant [redacted] away after the incident. However, the Hearing Tribunal found that the inconsistencies did not affect the overall credibility of her evidence.

[147] The Hearing Tribunal considered the evidence of the Registrant. The Hearing Tribunal found the Registrant's evidence neither plausible nor probable. In particular, the Hearing Tribunal found it was not plausible that the Registrant would try to take Patient [redacted]'s carotid pulse at the time of the incident, when Patient [redacted] was agitated and moving around and the Registrant's face, eyes, glasses and shirt were covered in Ensure as he described. Further, it was not probable to the Hearing Tribunal that the Registrant would not simply back away from the wheelchair if Patient [redacted] was kicking. There would be no reason to stay near her and try to block her kicks with his feet.

[148] The Registrant also described his behaviour as playful towards Patient [redacted] when he was blocking her kicks and described that he pulls the hair of other residents and staff in a playful manner. The Hearing Tribunal found this explanation to lack credibility. Overall, the Hearing Tribunal found that the Registrant lacked credibility in terms of the incident with Patient [redacted] and the hair pulling incident.

[149] The Hearing Tribunal noted that there was consistency in how the witnesses called by Conduct Counsel recalled events. There were discrepancies in what they relayed, which could be accounted for by where each witness was positioned in relation to the incident and the fact that they may each have observed a slightly different moment in time of the incident. The Hearing Tribunal also considered that Patient [redacted] can propel herself in her wheelchair and so there may have been some movement over the course of her throwing her drink at the Registrant and the subsequent altercation. The passage of time may also have impacted some of the specific details of the witnesses' recollections. However, there was significant consistency, including that two witnesses saw the Registrant strike Patient [redacted], one other witness saw the Registrant with his hands elevated, more than one heard Patient [redacted] call for help, more than one heard the Registrant say "leave her alone" and "let her die". More than one witness saw blood on the floor, saw blood on Patient [redacted] and bruising on her face. The Hearing Tribunal also considered that English was not the first language for most or all of the witnesses and so terminology used differed between witnesses.

[150] In addition, the account of the incident is to some extent consistent with the Registrant's evidence. The Registrant described Patient [redacted] throwing her Ensure at him. He testified to actions towards Patient [redacted] in terms of trying to touch her head to take her temperature and pulse and that he was blocking her kicks instinctively. The Hearing Tribunal did not accept the Registrant's evidence in this respect and noted he may have been trying to create a story that would align with the other witness testimony. The Hearing Tribunal found that it was not plausible that having Ensure thrown on him and having it in his eyes, and on his glasses, face and clothing and with Patient [redacted] agitated, kicking and waving her arms, he would try to take her temperature and pulse. The Registrant stated that there was some urgency in getting this done, as it was a Friday night and it can be difficult to

get a hold of a physician. This version of events did not seem plausible to the Hearing Tribunal. Given the evidence that Patient [redacted] has been known to be agitated and throw things, the Registrant's evidence that he suspected a UTI and needed to take vitals urgently is not probable.

[151] The Hearing Tribunal was concerned about the lack of documentation by the various witnesses about the incident and the lack of reporting. It appears there was a culture of fear in reporting and uncertainty in how to document incidents. However, the conduct of the Centre or of the Complaints Director's witnesses is not at issue here.

Allegation 1 On or about June 21, 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they physically abused Patient [redacted].

[152] The Hearing Tribunal considered the evidence of all witnesses in relation to Allegation 1. Much of the testimony of the Complaints Director's witnesses in this case overlap with admissions made by the Registrant in his testimony.

[153] While the exhibits were considered, the Hearing Tribunal's findings are based primarily on the witness testimony. In particular, little weight was placed on the wound assessment report and photographs (Exhibit 5). The Hearing Tribunal noted that, although the wound assessment report provides details of the wounds and two of the photographs were taken the next day on June 22, 2024, the report was not prepared and the photographs were not taken contemporaneously with the incident.

[154] The Hearing Tribunal found that an incident occurred between the Registrant and Patient [redacted] on June 21, 2024. The Hearing Tribunal found that Patient [redacted] was in the hallway outside the dining area (noted in blue on the third-floor schematic, Exhibit 4) after dinner. Patient [redacted] was often restless and often stays in the dining area after dinnertime. While there were discrepancies in the evidence regarding exactly what time the events occurred, the consensus of the witnesses, including the Registrant, is that an incident occurred. The incident was witnessed by some witnesses and is admitted to by the Registrant.

[155] The Hearing Tribunal found that Ms. Austria-Salter made Patient [redacted] a cup of warm Ensure. The Registrant was walking by Patient [redacted] and she threw her cup of Ensure at him. The Registrant admits this. Ms. Austria-Salter who was standing nearby a half wall attending to her medication cart saw the cup roll by. Ms. Punzal also witnessed Patient [redacted] throw her drink at the Registrant. The Registrant's evidence, which was accepted by the Hearing Tribunal, was that he was covered in the Ensure, including his face, eyes, glasses and shirt.

[156] The witnesses then have differing versions of events. The Hearing Tribunal found Mr. Flores' evidence to be credible and reliable. He described hearing "stop, please stop" and "help" and he got up from where he was seated in the TV lounge in C-Wing to check what was happening. He observed the Registrant was slapping Patient [redacted] in the head or face and kicking her and went over to where Patient [redacted] was and told the Registrant to stop. Ms. Austria-Salter heard the Registrant say "say sorry to me" and heard Patient [redacted] say "help" and when she looked up from the medication cart, the Registrant was standing tall in front of Patient [redacted] with his hands raised. However, Ms. Austria-Salter did not witness the Registrant hitting Patient [redacted]. Ms. Punzal testified that she heard Patient [redacted] asking for help, that the Registrant was really mad and that she saw the Registrant kicking and

slapping Patient [redacted]. Ms. Kamalipour did not witness the incident but heard Patient [redacted] say "help me" and heard the Registrant say "don't help her." Mr. Flores and Ms. Austria-Salter testified that the Registrant said "let her die". This aligns with Ms. Punzal describing that the Registrant was very mad and Ms. Kamalipour describing that the Registrant was yelling.

[157] The Registrant's evidence regarding this incident is that after Patient [redacted] threw her Ensure at him, he was more surprised than angry. He thought she might have a UTI and proceeded to try to cradle her face to get her temperature and carotid pulse. He testified that he needed to do this right away because if he needed to call the physician, he had to do it quickly as it was a Friday night. His evidence was that Patient [redacted] was agitated and that she was swinging her arms and kicking and he instinctively blocked her with his feet. As noted previously, the Hearing Tribunal did not find the Registrant's evidence credible on this point. Patient [redacted] was known to throw things and become agitated. The protocol was to let her settle when she was agitated. The Registrant's version of events is neither probable nor plausible.

[158] The Hearing Tribunal considered the evidence that Patient [redacted] sustained injuries from the altercation. While the details differed between the witnesses, there was overall consistency in their evidence. Mr. Flores, Ms. Austria-Salter, Ms. Punzal and Ms. Kamalipour saw blood on the floor. Even though they described the amount of blood differently, the Hearing Tribunal accepted that there was blood on the floor where Patient [redacted] and the Registrant were at the time of the incident.

[159] Mr. Flores testified that Patient [redacted] had blood on her face and arms. Ms. Austria-Salter testified that Patient [redacted] had blood and mucus coming from her nose and bruising on the bridge of her nose. Ms. Perdido saw blood dripping from Patient [redacted]'s nose and on her feet. Ms. Punzal testified that Patient [redacted] had a bruise around her eyes and a wound on her legs. Ms. Pettoco saw Patient [redacted] after the incident and she had a bruise on her face and dressings on her legs. Ms. Kamalipour saw Patient [redacted] the next day and she had bruises on her face. The Registrant testified that Patient [redacted] had a scratch on her face after the incident and that blood seeped through her leggings. He cut off her leggings and dressed the wounds. The Hearing Tribunal finds that Patient [redacted] suffered some injuries to her face and legs from the incident with the Registrant.

[160] The Hearing Tribunal found the evidence of Mr. Flores, Ms. Austria-Salter, Ms. Punzal and Ms. Kamalipour more credible and more reliable than the Registrant's version of events. While there was some discrepancy between their versions of events, including how much blood there was on the floor or on Patient [redacted], exactly what was said by Patient [redacted] and the Registrant and their positioning in relation to C-Wing, there is also much consistency in what the witnesses heard and observed. There is consistency on the significant details, that is that Patient [redacted] asked for help and told the Registrant to stop and that the Registrant slapped Patient [redacted] in the head or face and kicked her and said "let her die". While the witnesses gave different accounts of the position of Patient [redacted] and the Registrant, it is possible that because they observed the incident from different vantage points there are differences in the details. It is also possible that they each observed the incident at slightly different moments and that Patient [redacted], who was able to propel her chair, and the Registrant may not have been in a static position throughout the incident. The Hearing Tribunal also considered the passage of time which might have affected the memories of the witnesses regarding some details. The Hearing Tribunal found that the discrepancies in the accounts were not material in terms of finding that

Registrant [redacted] asked for help, asked the Registrant to stop and the Registrant slapped Patient [redacted] in the head or face and kicked her in the shins.

[161] As noted above, the Hearing Tribunal found that the Registrant's version of events was not plausible nor probable. The Hearing Tribunal found that it would be inconsistent with human nature and a nursing background that the Registrant, having his face, eyes and glasses covered in Ensure would find it necessary to try to take the temperature and pulse of Patient [redacted] in that moment. Further, Patient [redacted] was agitated and shaking her arms. It would be very difficult to try to take vital signs in that moment. It is much more likely that a nurse, wanting to take vital signs, would go clean up from the Ensure and give Patient [redacted] time to calm down before trying to take vital signs. In addition, the Hearing Tribunal found it improbable that if Patient [redacted] was kicking, the Registrant would not simply reflexively step back, rather than trying to block her legs "playfully". The Hearing Tribunal also accepted the evidence of the witnesses that Patient [redacted] could be unpredictable and become agitated and that the protocol when she was agitated was to leave her and let her calm down. Patient [redacted] was known to have thrown drinks in the past and was known to get agitated. The Hearing Tribunal found that this behaviour was known on the unit. For these reasons, the Registrant's account did not seem plausible to the Hearing Tribunal.

[162] The Hearing Tribunal found that striking a patient is physical abuse. It is inappropriate to a situation involving a person in care. Based on the evidence, the Hearing Tribunal finds that on a balance of probabilities, on June 21, 2024 the Registrant struck Patient [redacted] on the head or face and the legs, constituting physical abuse.

[163] The issue of whether or not Patient [redacted] fell sometime later during the evening of June 21, 2024 was also considered by the Hearing Tribunal. It is acknowledged that Patient [redacted] had injuries to her face and that her legs were bleedings before any purported fall. The Registrant has acknowledged dressing her leg wounds after the incident in the dining room. The Hearing Tribunal found it was not necessary to determine whether or not Patient [redacted] fell later that evening in considering Allegation 1.

[164] The Hearing Tribunal then considered if the conduct in Allegation 1 was unprofessional conduct. The physical abuse of Patient [redacted] showed a clear lack of judgment, skill or knowledge by the Registrant. Patient [redacted] was an elderly patient who is over 90 years old and who suffers from dementia. Even if a patient throws a drink at a Registered Nurse, causing them to get angry, Registered Nurses are trained to react appropriately. The use of violence against a Patient is never justified. Such conduct demonstrates a very serious lack of knowledge, skill or judgment and is serious unprofessional conduct under section 1(1)(pp)(i) of the HPA.

[165] The Hearing Tribunal also considered the following sections of the Code of Ethics and Standards of Practice:

Code of Ethics:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).

13. Nurses work toward preventing and minimizing all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves (CNA, 2016a; CNA & CFNU, 2015; Canadian Nursing Students' Association, 2014).

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.

2. Nurses support persons receiving care in maintaining their dignity and integrity.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

Standards of Practice:

Standard 1: Professional Responsibility and Accountability

The registrant is personally responsible and accountable for their nursing practice, professional conduct, and fulfilling their professional obligations.

Indicators

The registrant

1.1 is accountable at all times for their actions;

1.2 follows all current and relevant legislation and regulations;

1.3 meets expectations in the CRNA standards, and follows directions in guidelines, and other regulatory guidance;

1.4 follows policies and employer requirements relevant to their practice setting;

Standard 2: Knowledge-Based Practice

The registrant continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

The registrant

2.4 exercises reasonable judgment and sets justifiable priorities in practice;

2.7 applies nursing knowledge and skill in providing safe, competent, ethical care and professional service; and

Standard 3: Ethical Practice

The registrant complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of HPA (2000) and College bylaws.

Indicators

The registrant

3.1 practises with honesty, integrity and respect;

3.5 protects and promotes a client's right to autonomy, respect, privacy, dignity and access to information;

3.6 ensures their relationships with clients are therapeutic and maintains professional boundaries;

[166] The Registrant breached the above sections of the Code of Ethics and Standards of Practice. He did not provide safe, compassionate, competent or ethical care. The Registrant actively engaged in harm to Patient [redacted].

[167] The breaches of the Code of Ethics and Standards of Practice are very serious and constitute unprofessional conduct under section 1(1)(pp)(ii) of the HPA.

[168] Finally, the Hearing Tribunal found that the conduct harms the integrity of the profession. Striking a patient clearly undermines the trust that members of the public, patients and their family members place in Registered Nurses. Registered Nurses are trusted to care for vulnerable patients who may not be able to speak out or defend themselves. The conduct seriously undermines the integrity of the profession and constitutes unprofessional conduct under section 1(1)(pp)(xii) of the HPA.

Allegation 2 On or about between 2023 and 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they struck Patient [redacted] with a book.

[169] The Hearing Tribunal considered the testimony of Ms. Punzal and the Registrant with respect to Allegation 2. Ms. Punzal described one occasion in 2024, where the Registrant hit patient [redacted] on the head using the communication book. This occurred at the nursing station on the third floor. Ms. Punzal testified that the patient was wandering around the nursing station, the Registrant took the communication book and hit the resident on the top of the head with it. She described the hit a “really strong”, that Patient [redacted] was really skinny and the communication book was really heavy.

[170] The Registrant recalled an incident where Patient [redacted] was holding a knife from the kitchen and she was asking for something. The Registrant stated that the patient was always threatening people. He did not want to expose himself so he pushed the knife down using a binder. The Registrant denied hitting the patient on the head with a book or binder.

[171] The Hearing Tribunal considered that there were two different versions of the incident. The Registrant described using a binder to push down the knife held by the patient. Protecting oneself with a book would not be inappropriate. Ms. Punzal did not report the incident at the time and it was not documented. No other witness gave evidence respecting this incident.

[172] Given the different versions, that it was not reported and that no other witnesses observed this incident, the Hearing Tribunal found Allegation 2 was not proven. The evidence did not establish on a balance of probabilities that the Registrant struck Patient [redacted] with a book in a manner that failed to demonstrate adequate knowledge, skill or judgment.

[173] For these reasons, the Hearing Tribunal found Allegation 2 was not proven. Allegation 2 is dismissed.

Allegation 3 On or about between 2023 and 2024, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of Patient [redacted] when they pulled Patient [redacted]’s hair.

[174] The Hearing Tribunal considered the testimony of Ms. Punzal and the Registrant with respect to Allegation 3. Ms. Punzal's evidence was that sometime in 2024, the Registrant pulled the hair of one of the residents, [redacted], for no reason. Ms. Punzal described the resident as a wanderer and she was walking around the hallway when the Registrant pulled her hair. The Registrant pulled her hair so hard that the resident's head tilted back. This incident occurred in a hallway, on the third floor.

[175] The evidence of the Registrant was that he did not specifically recall the incident but stated that he interacts with staff and residents playfully by pulling their hair. He testified that it builds a therapeutic rapport with them.

[176] Although Ms. Punzal did not remember the exact date, she was clear in her recollection of which resident was involved and where the incident occurred. She described that the resident's head tilted back from the hair pulling. The Registrant testified that he did not recall the particular incident but admitted that at times he does pull the hair of staff and residents to build therapeutic rapport.

[177] The Hearing Tribunal placed significant weight on the fact that the Registrant admitted to pulling the hair of residents and staff. In addition, the Hearing Tribunal accepted the evidence of Ms. Punzal regarding the incident. Ms. Punzal described that the patient's head tilted back from the hair pulling. The Hearing Tribunal could not ascertain the level of force that was applied to the hair pulling, but with an elderly resident, even slight force may have an impact. The Hearing Tribunal found that, on a balance of probabilities, the Registrant failed to demonstrate adequate knowledge, skill or judgment in his care of Patient [redacted] when he pulled the hair of Patient [redacted] in 2024. Allegation 3 is proven.

[178] The Hearing Tribunal then considered if the conduct in Allegation 3 was unprofessional conduct. The Hearing Tribunal rejected the Registrant's statement that hair pulling can build therapeutic rapport with a patient. Hair pulling is not an appropriate manner of building rapport with patients (nor with staff, although the Hearing Tribunal recognized that was not part of the allegation). It is not playful and is not appropriate behaviour by a Registered Nurse towards a patient. Such conduct demonstrates a lack of knowledge, skill or judgment and is sufficiently serious to constitute unprofessional conduct under section 1(1)(pp)(i) of the HPA.

[179] The Hearing Tribunal considered the following sections of the Code of Ethics and Standards of Practice:

Code of Ethics:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).

13. Nurses work toward preventing and minimizing all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves (CNA, 2016a; CNA & CFNU, 2015; Canadian Nursing Students' Association, 2014).

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.

2. Nurses support persons receiving care in maintaining their dignity and integrity.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

Standards of Practice:

Standard 1: Professional Responsibility and Accountability

The registrant is personally responsible and accountable for their nursing practice, professional conduct, and fulfilling their professional obligations.

Indicators

The registrant

1.3 is accountable at all times for their actions;

1.4 follows all current and relevant legislation and regulations;

1.3 meets expectations in the CRNA standards, and follows directions in guidelines, and other regulatory guidance;

1.4 follows policies and employer requirements relevant to their practice setting;

Standard 2: Knowledge-Based Practice

The registrant continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

The registrant

2.4 exercises reasonable judgment and sets justifiable priorities in practice;

2.7 applies nursing knowledge and skill in providing safe, competent, ethical care and professional service; and

Standard 3: Ethical Practice

The registrant complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of HPA (2000) and College bylaws.

Indicators

The registrant

3.1 practises with honesty, integrity and respect;

3.5 protects and promotes a client's right to autonomy, respect, privacy, dignity and access to information;

3.6 ensures their relationships with clients are therapeutic and maintains professional boundaries;

[180] Hair pulling does not foster a safe environment for patients and is not respectful conduct. This conduct is inconsistent with maintaining the integrity and dignity of patients. Pulling a

patient's hair is not appropriate. It is not conduct that places the patient's wellbeing first. This is not consistent with a Registered Nurse who takes accountability for their practice and who exercises reasonable judgment, or who demonstrates safe, competent, ethical and professional services. The conduct also constitutes a breach of professional boundaries.

[181] The breaches of the Code of Ethics and Standards of Practice are serious and constitute unprofessional conduct under section 1(1)(pp)(ii) of the HPA.

[182] Finally, the Hearing Tribunal found that the conduct harms the integrity of the profession. Hair pulling of a patient by a Registered Nurse would undermine the trust that members of the public, patients and their family members place in Registered Nurses. Registered Nurses are trusted to care for vulnerable patients who may not be able to speak out for themselves. In addition, the Registrant was exhibiting serious inappropriate behaviour in front of other staff, where he was the individual in charge. He would be responsible to establish an appropriate culture with staff. The conduct undermines the integrity of the profession and constitutes unprofessional conduct under section 1(1)(pp)(xii) of the HPA.

Allegation 4 On or about June 21, 2024, the Registrant failed to adequately and/or accurately document their interactions with Patient [redacted].

[183] The Hearing Tribunal considered the evidence, in particular, the testimony of the Registrant and the documentation (Exhibit 6) with respect to Allegation 4. The Registrant admitted that he did not document Patient [redacted]'s fall accurately.

[184] The Hearing Tribunal found that there was no documentation about the incident in the hallway by the dining hall on June 21, 2024, including that Patient [redacted] threw her Ensure at the Registrant or the steps he took after. The Registrant described that he was concerned about an underlying condition and whether Patient [redacted] might have a urinary tract infection and that is why he tried to take her pulse and temperature. He did not document any of these concerns. He did not document his interactions with Patient [redacted], or that she had injuries, including on her face or her shins. The Registrant changed the dressings on her legs after the incident as blood had seeped through the dressings. None of this is documented.

[185] Further, the Registrant testified that Patient [redacted] fell, that he found her between her bed and wheelchair and that he picked her up, contrary to the lifting protocol and put her back in her bed. The Registrant admits to not documenting the fall appropriately. The documentation states that she was "Transferred back to wheelchair via FML (full mechanical lift) and 2PA (two person assist)" (Exhibit 6). The Registrant stated that he charted incorrectly as he was in a rush to leave at the end of his shift. He chose options from a drop-down menu in charting.

[186] The charting (Exhibit 6) indicates there are "skin tears noted on bilateral shin 7 x 5 cm, left 10 x 5 cm." The Hearing Tribunal finds that the charting suggests that the skin tears were new on examination at 22h40. However, there were existing shin wounds, based on the evidence of the witnesses, including the Registrant prior to 22h40. The Registrant admits to dressing the wounds after the incident in the hallway by the dining room.

[187] The Hearing Tribunal finds that, on a balance of probabilities, on or about June 21, 2024, the Registrant failed to adequately and accurately document the incident in the hallway by

the dining hall on June 21, 2024, including that Patient [redacted] threw her Ensure at the Registrant or the steps he took after, the wounds sustained by Patient [redacted] to her face and shins. In addition, the Hearing Tribunal finds that the Registrant failed to accurately document the fall and the steps he took when he found Patient [redacted] on the ground, including that he picked up Patient [redacted] on his own. Allegation 4 is proven.

[188] The Hearing Tribunal then considered if the conduct in Allegation 4 was unprofessional conduct.

[189] Registered Nurses are required to document interactions with patients and professional services provided. The evidence of the Registrant is that documentation is by exception. The events on June 21, 2024 should have been charted, including that Patient [redacted] threw her Ensure at the Registrant and his interactions with Patient [redacted]. The fact that Patient [redacted] had injuries should have been documented, as well as the dressing of her injuries to her shins in the first instance. The fall and steps taken also needed to be accurately documented. The failure to document appropriately demonstrates a lack of knowledge, skill or judgment and is sufficiently serious to constitute unprofessional conduct under section 1(1)(pp)(i) of the HPA.

[190] The Hearing Tribunal considered the following sections of the Standards of Practice and Documentation Standards:

Standards of Practice:

Standard 1: Professional Responsibility and Accountability

The registrant is personally responsible and accountable for their nursing practice, professional conduct, and fulfilling their professional obligations.

Indicators

The registrant

1.3 meets expectations in the CRNA standards, and follows directions in guidelines, and other regulatory guidance;

1.4 follows policies and employer requirements relevant to their practice setting;

Standard 2: Knowledge-Based Practice

The registrant continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

The registrant

2.4 exercises reasonable judgment and sets justifiable priorities in practice;

Documentation Standards:

Standard 1: Accountability

Registrants demonstrate accountability for safe, competent and ethical care through documentation by ensuring their documentation of client care is accurate, timely, factual and complete.

Criteria

The registrant must

1.1 adhere to federal and provincial legislation, and standards of practice applicable to documentation relevant to their practice;

1.2 follow employer requirements regarding documentation, including interactions with other databases;

1.6 document

a) clearly, legibly, and in English, using established terminology,

b) accurately, completely, and objectively,

c) only the care personally provided (unless in an **emergency situation** when acting as a designated recorder),

d) all relevant client information in an organized, logical, and sequential manner,

e) **Contemporaneously**,

f) late entries at the next available opportunity, with the entry clearly identified as such, and include any additional employer requirements. Document late entries only when able to accurately recall the event or the care provided,

g) in permanent ink when on paper records, and

h) the date and time that nursing care was provided;

Standard 2: Communication and Safe Provision of Care

Registrants document the nursing care they provide ensuring it is a complete, accurate, objective, and person-centred representation of the client's needs and perspectives, the registrant's interventions, and the client's care outcomes.

Criteria

The registrant must

2.1 record a complete account of their nursing care and decision-making processes of the client's needs and perspectives, including

a) identified issues and concerns,

b) assessment findings,

c) diagnosis,

d) plan of care,

e) intervention(s) provided, and

f) evaluation of the client care outcomes;

2.2 document the following aspects of care:

a) relevant objective information related to client care

b) follow-up of client assessments, observations, or interventions completed

c) meet the expectations for medication management and documentation as outlined in the *Medication Management Standards*(2022a)

d) formal and informal educational/teaching activity provided to the client and family

e) any **adverse event** or **adverse outcome**

f) communication with other care providers, including name, protected title (if applicable) and outcomes of discussion

g) communication with clients following discharge from care according to employer requirements

h) the client's response and outcomes to the care and interventions provided

[191] The Centre's Documentation Policy states: "All information related to resident health status, care and services provided must be documented in the resident's medical record" and "Documentation must be legible, objective, timely, complete, and accurate" (Exhibit 13). The Registrant failed to document the incident between himself and Patient [redacted]. There was no incident report in relation to the incident between him and Patient [redacted] and the wound care he provided to her. The Registrant also failed to photograph the wounds directly after the incident. The complete lack of documentation surrounding the incident led to documentation that was not timely and complete in contravention of the employer's Documentation Policy. The Registrant admitted the documentation was incorrect and his reasoning was that he "copied and pasted from my previous wound report."

[192] The Registrant did not meet the expectations regarding documentation. He did not exercise reasonable judgment respecting what was required to be documented. He did not document accurately or completely the identified issues and concerns, interventions

provided or the relevant objective information related to the patient's care. He did not follow the Centre's Documentation Policy.

[193] The breaches of the Code of Ethics and Standards of Practice are serious and constitute unprofessional conduct under section 1(1)(pp)(ii) of the HPA.

CONCLUSION

[194] The Hearing Tribunal finds that Allegations 1, 3 and 4 are proven on a balance of probabilities and constitute unprofessional conduct pursuant to HPA. Allegations 1 and 3 are unprofessional conduct pursuant to HPA section 1(1)(p)(i), (ii) and (xii). Allegation 4 is unprofessional conduct pursuant to HPA section 1(1)(p)(i) and (ii). Allegation 2 is dismissed.

[195] The Hearing Tribunal will receive submissions from the parties on sanction. The Hearing Tribunal requests that the parties discuss and determine the timing and method of providing submissions on penalty to the Hearing Tribunal. If the parties are unable to agree on a proposed procedure and timing, the Hearing Tribunal will make further directions as required.

Jacqueline Senych, RN, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: May 7, 2026