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OFFICE OF ADMINISTRATIVE HEARINGS
11/22/2022 11:56 AM

STATE OF NORTH CAROLINA

COUNTY OF LEE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 DHR 00470

Michael Northover-Ramos, Petitioner, v. NC Department of Health and Human Services, Division of Health Service Regulation, Respondent.	**AMENDED FINAL DECISION**

THIS MATTER came on for hearing before Administrative Law Judge Linda F. Nelson on August 15, 2022, in Raleigh, North Carolina.

APPEARANCES

For Petitioner: Michael Northover-Ramos, *pro se*
120 Eugene Chalmers Rd., Broadway, NC 27505

For Respondent: William F. Maddrey, Assistant Attorney General
N.C. Department of Justice
114 W. Edenton St., Raleigh, NC 27603

APPLICABLE STATUTES AND RULES

North Carolina General Statutes § 131E-256, § 150B-1, *et seq.*; and 10A N.C. Admin. Code 13O .0101(1) and 13O .0101(10) (incorporating by reference 42 C.F.R. § 488.301).

ISSUE

Whether Respondent deprived Petitioner of property or otherwise substantially prejudiced Petitioner's rights and exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated the allegations that Petitioner abused and neglected a resident at Forest Hills Family Care Facility, located in Cameron, North Carolina, on November 30, 2020.

EXHIBITS

Petitioner's Exhibits:

Petitioner's Exhibit A, 5/17/21 Letter to Petitioner from Tortora

Petitioner's Exhibit B, Undated Letter to Petitioner from Jones
Petitioner's Exhibit C, 4/30/21 Harris Recommendation Letter
Petitioner's Exhibit D, Daymark Appointment List for Petitioner
Petitioner's Exhibit E, 2/23/22 Email Thread
Petitioner's Exhibit F, 4/29/22 Email Thread
Petitioner's Exhibit G, Text Messages

Respondent's Exhibits:

Respondent's Exhibit A, 12/9/20 and 4/21/22 Letters to Petitioner
Respondent's Exhibit B, Investigation Reports
Respondent's Exhibit C, Petitioner's Personnel File
Respondent's Exhibit D, Statement by Petitioner
Respondent's Exhibit E, Victor and Associates Client Rights Policy
Respondent's Exhibit F, HCPR Interview with Harris
Respondent's Exhibit G, Police Report
Respondent's Exhibit H, ER Report from Central Carolina Hospital
Respondent's Exhibit I, Resident J.D. Medical Records
Respondent's Exhibit J, Investigation Conclusion Report
Respondent's Exhibit K, Video Recording

WITNESSES

For Petitioner:

Michael Northover-Ramos, Petitioner

For Respondent:

James Harris, Director of Quality Management for Victor & Associates, Inc.
Paula Blackburn, Health Care Personnel Investigator for Respondent

PROCEDURAL BACKGROUND

1. By letter dated December 9, 2020, Respondent attempted to notify Petitioner that Respondent would be investigating allegations that Petitioner abused and neglected a resident of at the Forest Hills Family Care Facility, located in Cameron, North Carolina (the "Facility") on November 30, 2020. This notice was not mailed to Petitioner's address, and he did not receive it.

2. On July 7, 2021, Respondent attempted to notice Petitioner that it substantiated the allegations of abuse and neglect. This notice was not mailed to Petitioner's address, and he did not receive it.

3. On July 15, 2021, criminal charges against Petitioner related to the incident at issue in this contested case were dismissed.

4. In January 2022, an agent of the Facility informed Petitioner that Respondent substantiated the allegations of abuse and neglect against him.

5. On February 9, 2022, Petitioner filed a Petition for a Contested Case Hearing (the "Petition"), appealing Respondent's substantiation of abuse and neglect.

6. On March 14, 2022, Respondent moved to dismiss the Petition as untimely filed. Petitioner filed a response to the motion to dismiss on March 28, 2022.

7. Respondent issued a second letter to Petitioner, dated April 21, 2022, notifying him that Respondent had investigated and substantiated the allegations that Petitioner abused and neglected a resident at the Facility on or about November 30, 2020, and that Respondent would enter the following findings on the Health Care Personnel Registry:

> On or about 11/30/2020, Michael Northover-Ramos, a Health Care Personnel, neglected a resident (JD) by failing to secure medications from the resident, which was necessary to avoid physical harm.
>
> On or about 11/30/2020, Michael Northover-Ramos, a Health Care Personnel, abused a resident (JD) by willfully striking the resident's forehead with a cup, resulting in physical harm and pain.

(Res. Ex. A)

8. On April 25, 2022, Respondent filed a Notice of Waiver, in which Respondent accepted service of the Petition and Petitioner accepted service of the Final Agency Action in this case. The Tribunal denied Respondent's Motion to Dismiss on April 26, 2022.

9. This matter came on for hearing before the Undersigned on August 15, 2022, in Raleigh, North Carolina.

FINDINGS OF FACT

UPON CONSIDERATION of the sworn testimony of the witnesses presented at the hearing, the exhibits admitted into evidence, and the entire record in this proceeding, after having weighed the evidence presented and assessed the credibility of witnesses by considering the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witnesses, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable and whether the testimony is consistent with all other believable evidence in the case, the Undersigned finds as follows:

Background

1. Respondent is a division of the North Carolina Department of Health and Human Resources and an administrative agency of North Carolina state government. Respondent is required to maintain the health care personnel registry (the "Registry") which contains "the names of all health care personnel working in health care facilities in North Carolina" against whom Respondent substantiates neglect, abuse, misappropriation, diversion of drugs, or fraud. N.C. Gen. Stat. § 131E-256(a)(1).

2. Petitioner was first employed by Victor & Associates, Inc. ("Victor") in 2017. In 2018, Petitioner was rehired to work at the Forest Hills Family Care Facility, located in Cameron, North Carolina (the "Facility"). (Res. Ex. B) The Facility is a "health care facility" for the purposes of N.C. Gen. Stat. § 131E-256.

3. Petitioner's job duties qualified him as "health care personnel" under N.C. Gen. Stat. § 131E-256(c), which is unlicensed staff of a health care facility with direct access to a resident or client. (Res. Ex. C).

4. Vidya Persad is a Victor director who supervises James Harris, Director of Quality Management for Victor. (T. p. 11-12.)

5. Petitioner was placed on leave on November 30, 2020, and terminated from his employment with Victor on December 2, 2020. (Res. Ex. B). Petitioner was rehired on a temporary basis on May 11, 2021, before his criminal case related to this matter was dismissed. (Pet. Ex. A). Petitioner was terminated from his employment with Victor again in January 2022, when Respondent discovered that Petitioner's name was listed on the Registry. (Pet. Ex. A; T. p. 46).

6. There is no evidence of any prior allegations of abuse, neglect, or exploitation against Petitioner.

7. At the time of the incident at issue in this case (the "Incident"), the Facility had four residents. (Res. Ex. B). One of the residents, J.D., is non-verbal and autistic, with the intellectual capacity of a 4-year-old. J.D. requires supervision and support with daily living skills. He was 30 years old at the time of the Incident. (Res. Ex. B and I).

The Incident

8. The Incident occurred at 6:58 AM on November 30, 2020, and was caught on the Facility's video recorder. (Res. Ex. K).

9. The video shows Petitioner open a pill cup containing K.L.'s, another resident's, medication and place it on the dining room table next to a plastic Solo-type cup filled with water.

10. Shortly after Petitioner leaves the dining room, J.D. enters the room, sees the medication and looks quickly around the room. He then hurriedly takes the medicine and cup of water from the table, swallows the medicine and drinks the water.

11. While J.D. finishes drinking the water, Petitioner re-enters the dining room. Petitioner takes the now empty cup from J.D., admonishes him, and then reaches up, well over an arm J.D. raises to defend his face. Petitioner aims the bottom of the cup at the right side of J.D.'s forehead. Petitioner then strikes either J.D.'s forehead, or the bridge of the right side of his nose with a rapid, controlled movement like a rap or knock.

12. Petitioner then walks away from J.D. into the kitchen, disposes of the empty pill container in a trash can and throws the cup into the sink. J.D. follows Petitioner into the kitchen, walks past Petitioner at proximity to Petitioner, and heads out of the room displaying no signs of fear, pain or distress. Petitioner takes a paper towel and follows J.D. out of the room in the direction of J.D.'s room.

13. On the evening of November 30, 2020, J.D. underwent a medical exam and treatment for a cut. The documentation of the medical exam states J.D. had "a 1.5 cm laceration to the right forehead just medial to eyebrow" and "wound edges are clean with sharp edges." (Res. Ex. H and J). Medical staff closed the laceration with two dissolvable sutures. (Res. Ex. H).

The Investigations

14. Mr. Harris, Victor's Director of Quality Management, investigated the Incident and reported his findings to Respondent. Mr. Harris submitted an Incident Response Improvement Form on December 1, 2020, as updated on December 2, 2020; a second Incident Response Improvement Form, first submitted on December 11, 2020, as updated on December 14, 2020; and additional information as requested by Respondent on July 6, 2020 (the reports and information submitted is referred to collectively herein as the "Harris Report"). (Res. Ex. B).

15. After receiving the initial Harris Report, Ms. Blackburn, Health Care Personnel Investigator for Respondent, screened the allegations of abuse and neglect against Petitioner for an investigation. (Res. Ex. J; T. p. 71). Respondent attempted to notify Petitioner, via certified letter dated December 9, 2020, that Respondent screened the allegations of abuse and neglect against him and would be investigating the allegations. (Res. Ex. A). The letter was not sent to Petitioner's home address as indicated on any of the documentation in his personnel file submitted into evidence. It is unclear when and how Petitioner learned of Respondent's intent to investigate.

16. On December 10, 2020, Ms. Blackburn began her investigation. She reviewed Petitioner's personnel file, J.D.'s medical records, the Facility's investigation documents, the video of the Incident, and the police report of the Incident; interviewed Mr. Harris and one other Facility staff member; visited the Facility; and observed J.D. via Facetime. (T. pp. 72-3, Res. Ex. J).

17. Ms. Blackburn's Investigation Conclusion Report (the "Blackburn Report"), dated July 7, 2021, mistakenly indicates in two places that she interviewed Petitioner in preparing the

Blackburn Report. However, she indicates elsewhere in the Blackburn Report that she contacted Petitioner for an interview, but Petitioner declined to be interviewed until the conclusion of his criminal case, on the advice of his criminal defense attorney. (Res. Ex. J, T. pp. 45, 77-78).

18. Petitioner's criminal case was dismissed one week after the Blackburn Report was completed. Ms. Blackburn testified that she could substantiate the abuse obligation without interviewing Petitioner "based mainly on the video." (T. p. 78).

<u>Additional Facts Pertaining to the Abuse Allegation</u>

19. One week prior to the Incident, an unsanded, raw wood bedframe was installed in J.D.'s room. The headboard of the bedframe was fashioned as a bookcase. (T. p. 28).

20. Petitioner has consistently maintained, since shortly after the Incident on November 30, 2020, that J.D.'s wound occurred in J.D.'s bedroom before the Incident. Although Petitioner claimed he did not see J.D. incur the injury, Petitioner wrote that "[i]t looked as if he [J.D.] fell or tripped when he was getting out of bed because he could not see." (Res. Ex. B). During testimony, Petitioner elaborated on this statement, saying that J.D. "was known to get up in the night when it's pitch black in his room – that happens a lot." (T. p. 82). Petitioner has also maintained that the sharp edges of the bedframe headboard could have made the sharp edges of J.D.'s cut, (T. p. 82), and that the lack of a working light in J.D.'s room made a fall more likely. (Res. Ex. B).

21. Mr. Harris was aware of the bedframe headboard with sharp edges in J.D.'s room on the day of the Incident and Petitioner's hypothesis that a fall against the bedframe caused J.D.'s cut. (T. pp. 28). However, the Harris Report contains no independent description of the bedframe. The Harris Report also does not contain Petitioner's description of the bedframe as a hazard with sharp edges.

22. The Harris Report contains information taken from a video (the "Earlier Video") not in evidence which recorded actions at the Facility before the beginning of the video entered into evidence, *i.e.*, before 6:57 AM. (Res. Ex. B).

23. The Harris Report does not indicate that Mr. Harris went into J.D.'s room to look at the bedframe or to check the lighting.

24. Petitioner testified he telephoned the "QP," or qualified personnel who acted as the Facility manager, before the time of the Incident, to report J.D. received a cut while in his bedroom. Petitioner also testified that he wrote, before the time of the Incident, an incident report stating that J.D. sustained a cut in his bedroom (the "Petitioner's Bedroom Incident Report"). Petitioner noted that the QP was required to write her own incident report regarding the telephone call he made to her (the "QP's Bedroom Incident Report"). (T. pp. 40, 55-59).

25. Petitioner's Bedroom Incident Report was not entered into evidence. Petitioner testified that he did not have a copy of this report. (T. p. 58).

26. Neither the QP Bedroom Incident Report nor any other incident report prepared by the QP was entered into evidence.

27. Mr. Harris did not give copies of Petitioner's Bedroom Incident Report to Respondent's investigator, Ms. Blackburn. (T. p. 89).

28. Mr. Harris did not give copies of any incident report written by the QP to Respondent's investigator, Ms. Blackburn. (T. p. 89).

29. The Harris Report does not mention the QP, and thus does not include an interview of the QP.

30. Ms. Blackburn did not interview the QP. (T. p. 89-90).

31. Mr. Harris testified he was informed of J.D.'s injury the day of the Incident by a telephone call from Ms. Persad. Mr. Harris also testified that the initial report of J.D.'s injury came from Petitioner. Mr. Harris did not testify as to how and when Ms. Persad became aware of J.D.'s injury and that information is not contained in the Harris Report. (T. p. 12).

32. Neither the Harris Report nor the Blackburn Report includes an interview with Ms. Persad regarding when and from whom she received the report of J.D.'s injury.

33. Although the Harris Report does not include a copy of the Petitioner's Bedroom Incident Report, the Harris Report states that "[t]he time of the incident is documented between 6 AM and 7 AM" but does not appear to be quoting the Petitioner's Bedroom Incident Report. (Res. Ex. B).

34. The Harris Report contains information from the Earlier Video not in evidence, stating that it shows Petitioner knocking on J.D.'s door on the morning of November 30, 2020, to awaken J.D., and subsequent activities including Petitioner administering J.D.'s medication. (Res. Ex. B).

35. Respondent's investigator, Ms. Blackburn, considered the possibility that J.D.'s injury came from a fall against the bedframe headboard before the Incident. (T. p. 83).

36. Ms. Blackburn did not discuss the possibility of J.D.'s injury occurring before the Incident with Mr. Harris, nor the possibility that it was the result of J.D. falling against a bedframe.

37. Ms. Blackburn was not aware of, and thus did not discuss, with Mr. Harris, Petitioner's claim that the bedframe had been moved to another resident's (K.L.'s) room shortly after the Incident. (T. p. 82).

38. Ms. Blackburn did not indicate in the Blackburn Report nor in testimony that she viewed the Earlier Video which recorded the time period during which Petitioner claimed to have called the QP about J.D.'s injury and written the Bedroom Incident Report.

39. Although Ms. Blackburn spent fifteen minutes at the Facility on May 4, 2021, (Res. Ex. J), the Blackburn Report does not contain any information regarding bedframes in J.D.'s and K.L.'s bedrooms, or the lighting available in J.D.'s room.

40. The Tribunal finds the investigation which produced the Blackburn Report to be incomplete because of the shortcomings identified in Findings of Fact paragraphs 27, 28, 30, 32, 36, 37, 38, and 39.

41. There was no on-site visit by the Harnett County Department of Social Services ("DSS") following the Incident. Mr. Harris reported to Respondent that the DSS visit did not occur because the Facility reported to DSS that there was no ongoing danger to J.D. (Res. Ex. F). Yet, there is no report, in evidence, that the Facility investigated the bedframe and found Petitioner's report of its danger to J.D. unwarranted.

42. Given the resolution, lighting, and angles of the video images contained in the video entered into evidence in this case, the Tribunal finds a 1.5 cm cut, had it been present, would not be visible.

43. Ms. Blackburn testified that she "believes" the video of the Incident shows that the plastic cup hit J.D. on the forehead. (T. p. 85).

44. The Blackburn Report, quoting the treatment documentation from Central Carolina Hospital, dated November 30, 2020, describes the location of the laceration to J.D.'s face as "to the right forehead just medial to eyebrow." (Res. Exs. H and J). This area is colloquially referred to as the right side of the bridge of the nose.

45. Careful review of the video shows only that the plastic cup struck J.D. either on the right forehead, or on the right side of the bridge of his nose.

46. The controlled, short rap to J.D.'s forehead or bridge of nose with the bottom of a plastic cup captured on the video does not appear likely to cause a cut, particularly a cut the medical staff described as "clean with sharp edges."

47. The Tribunal finds that Petitioner's action of striking J.D. with a plastic cup did not cause physical injury to J.D.

48. Mr. Harris observed no signs of discomfort, pain, emotional distress, or mental anguish in J.D. from being struck with a plastic cup by Petitioner in the Incident. (Res. Ex. F).

49. The video shows J.D. following Petitioner into the kitchen immediately after J.D. was struck with a plastic cup. J.D. walks by the Petitioner, in close proximity to Petitioner, in no apparent fear of Petitioner. (Res. Ex. K).

50. Petitioner testified that during his employment with Victor after the Incident he had interactions with J.D. (T. p. 36).

51. The Tribunal finds that J.D. did not suffer pain or mental anguish from Petitioner striking him with a plastic cup.

Additional Facts Pertaining to the Neglect Allegation

52. J.D. has a behavior support plan which includes a behavior of stealing others' medication. (Res. Ex. B and J; T. p 78).

53. Neither Mr. Harris nor Ms. Blackburn testified that Petitioner had access to J.D.'s behavior plan or otherwise knew or should have known about J.D.'s behavior of taking others' medication.

54. None of the training materials in the record of this matter require staff in Petitioner's position to review a resident's behavior plan, nor explain how the staff can access the behavior plan.

55. Petitioner was not aware of J.D.'s behavior of taking others' medications. (T pp. 39, 61-62).

56. Ms. Blackburn testified that Petitioner's action of leaving K.L.'s medication on the table constituted neglect because proper procedure is for care providers to place the medication in the hands of the intended recipient of the medication. Ms. Blackburn "factored in training" when reaching the conclusion that Petitioner neglected resident J.D. in this regard. Ms. Blackburn was convinced that Petitioner was trained in the proper method of administering medications by her review of Petitioner's file, entered into evidence in this matter, which showed "he had been trained to give medications." (T. p. 74).

57. Although Ms. Blackburn cited Facility training manuals and certificates of training completion signed by Petitioner as evidence of such training, these documents do not contain instructions on the method of administering medications.

58. When asked by the Tribunal, "Are you convinced that [Petitioner] was trained to put [medication] in the residents' hands?" Ms. Blackburn replied, "the facility is responsible for doing that training." (T. p. 88).

59. Petitioner testified he received no training in administering medicines other than from a fellow paraprofessional at the Facility, whose administration method he followed consistently. (T. pp. 39-40, 60-61).

60. Petitioner followed this improper method of administrating medications on the morning of November 30, 2020. (Res. Ex. K).

61. The Tribunal finds that Petitioner administered K.L.'s medicine on November 30, 2020, as he was trained by the Facility. The Tribunal finds further that Petitioner did not know, and was not responsible for knowing, the proper way to administer medicine.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter of this case pursuant to Chapters 131E and 150B of the North Carolina General Statutes.

2. All parties have been correctly designated and there is no question as to misjoinder and nonjoinder.

3. All parties were properly noticed under N.C. Gen. Stat. § 150B-23.

4. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be considered without regard to the given labels. *Charlotte v. Health*, 226 N.C. 750, 755, 40 S.E.2d 600, 604 (1946); *Peters v. Pennington*, 210 N.C. App. 1, 15, 707 S.E.2d 611, 612 (1993).

5. The ALJ must decide the case only on the basis of the evidence presented and facts officially noticed, all of which are made part of the official record for purposes of administrative and judicial review. *N.C. Dep't of Env't & Nat. Res. v. Carroll*, 358 N.C. 649, 657, 599 S.E.2d 888, 893 (2004).

6. Petitioner has the burden of proving that the Respondent agency erred in performing its duties pursuant to N.C. Gen. Stat. § 131E-256, substantially prejudicing Petitioner's rights. N.C. Gen. Stat. § 150B-25.1.

7. Respondent is required to maintain a registry containing the names of all health care personnel working in health care facilities in North Carolina who are subject to findings by Respondent that they abused, neglected, or exploited a resident in a North Carolina health care facility. N.C. Gen. Stat. § 131E-256.

8. The Facility is a "health care facility" as defined in N.C. Gen. Stat. § 131E-256(b).

9. "Health Care Personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. N.C. Gen. Stat. § 131E-256(c). At the time of the Incident, Petitioner was working as health care personnel.

10. "In an administrative proceeding, it is the prerogative and duty of [the ALJ], once all the evidence has been presented and considered, to determine the weight and sufficiency of the evidence and the credibility of the witnesses, to draw inferences from the facts, and to appraise conflicting and circumstantial evidence. The credibility of witnesses and the probative value of particular testimony are for the [ALJ] to determine, and [the ALJ] may accept or reject in whole or part the testimony of any witness." *City of Rockingham v. N.C. Dep't of Env't. & Natural Res., Div. of Water Quality*, 224 N.C. App. 228, 239, 736 S.E.2d 764, 771 (2012).

11. Respondent's loss of employment in January 2022, due to his inclusion on the Registry, substantially prejudiced his rights.

12. “Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. . . . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.” 42 C.F.R. § 488.301. This definition of abuse, as contained in the Code of Federal Regulations, is incorporated in 10A N.C.A.C. 13O.0101(1) by reference.

13. Petitioner’s striking of J.D. with the bottom of a disposable plastic cup was a willful act by Petitioner, but it did not cause J.D. “physical harm, pain, or mental anguish,” necessary for the substantiation of an “abuse” allegation pursuant to 10A N.C.A.C. 13O.0101(1). The cut to J.D.’s face was not caused by Petitioner’s action and there was no evidence of other physical harm to J.D. There was no evidence J.D. suffering pain or mental anguish from Petitioner’s action.

14. Since Petitioner’s actions did not constitute abuse, Respondent acted erroneously in substantiating the allegation of abuse against Petitioner and listing him on the Registry.

15. “Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.” 42 C.F.R. § 488.301. This definition of neglect, as contained in the Code of Federal Regulations, is incorporated in 10A N.C.A.C. 13O.0101(10) by reference.

16. Respondent places the responsibility of training an unlicensed health care provider in the administration of medications on the health care facility employing the unlicensed provider.

17. It is the responsibility of the health care facility employing an unlicensed health care provider to provide its employees with the necessary information contained in residents’ care plans to safeguard the residents.

18. Petitioner’s failure to use the proper method of administrating the medicine ingested by J.D. does not constitute neglect because Petitioner was not trained by the Facility in the proper way to administer medications and was unaware of the proper way to provide this service to J.D.

19. Petitioner’s failure to safeguard another resident’s medication from J.D. does not constitute neglect because Petitioner was not informed by the Facility of J.D.’s behavior of taking others’ medications and did not know J.D. had this behavior.

20. Petitioner has satisfied his burden of proving by a preponderance of the evidence that Respondent substantially prejudiced his rights, and acted erroneously, and failed to act as required by law or rule when it substantiated a finding of abuse and neglect and entered his name on the Registry.

FINAL DECISION

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the Undersigned hereby REVERSES Respondent's substantiated findings of abuse and neglect against Petitioner and ORDERS Respondent to remove the substantiated findings against Petitioner's name from the North Carolina Health Care Personnel Registry.

NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision**. In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision**. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

IT IS SO ORDERED.

This the 22nd day of November, 2022.

Linda F. Nelson
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

Michael Northover-Ramos
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Petitioner

William Foster Maddrey
NC DOJ
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Attorney For Respondent

This the 22nd day of November, 2022.

Christine E Cline
Law Clerk
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