STATE OF NORTH CAROLINA	**IN THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF PITT	**14 DHR 01958**

DANA ERIC WEAVER, Petitioner, v. N. C. DEPARTMENT of HEALTH and HUMAN SERVICES, DIVISION of HEALTH SERVICE REGULATION, Respondent.	)	**FINAL DECISION**

THIS MATTER came on to be heard before the undersigned Administrative Law Judge, Augustus B. Elkins II, on July 24, 2014 in Farmville, North Carolina. After presentation of testimony and exhibits, the record was left open for the parties' submission of materials, including but not limited to supporting briefs, further written arguments and proposals after receipt of the official transcript. Mailing time was allowed for submissions including the day of mailing as well as time allowed for receipt by the Administrative Law Judge.

The Petitioner submitted timely proposals and argument to the Clerk's Office of the Office of Administrative Hearings on October 7, 2014 which was received by the Undersigned on October 13, 2014. Respondent submitted timely proposals and argument electronically which was received by the Undersigned on October 13, 2014. For good cause shown and by order of the Chief Administrative Law Judge, the Undersigned was granted an extension until December 19, 2014 to file the decision in this case.

APPEARANCES

For Petitioner: Mary-Ann Leon
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For Respondent: W. Thomas Royer
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ISSUE

Whether Respondent substantially prejudiced the rights of the Petitioner and exceeded its authority or jurisdiction, acted erroneously; failed to use proper procedure, acted arbitrarily or capriciously, or otherwise failed to act as required by law or rule when Respondent substantiated two allegations of negligence and entered two findings of neglect by Petitioner's name in the Health Care Personnel Registry.

APPLICABLE STATUTES AND RULES

N.C. Gen. Stat. § 131E-256
N.C. Gen. Stat. § 150B-1, *et seq.*
42 C.F.R. § 488.301
10 N.C.A.C. 13O.0101

EXHIBITS

For Petitioner Exhibits 1-3, 5-8 and 20

For Respondent Exhibits 2-4, 6-11, 13, 14, and 16-18

WITNESSES

For Petitioner
Dana Weaver (Petitioner)
Ruth V (Mother of MV)
Barbara Perkins (Mother of CC)
Pamela Anderson

ForRespondent
Delafea Dixon
Mary Grace Bright
Pamela Anderson

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents, and exhibits received and admitted into evidence, and the entire record in this proceeding, the undersigned Administrative Law Judge makes the following Findings of Fact by a preponderance of the evidence. In making these Findings of Fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account 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 this case.

FINDINGS OF FACT

1. For the last eighteen years, Petitioner Dana Weaver has been employed by the Pitt County Group Homes (PCGH) in Grifton, North Carolina. Petitioner has been a lead teacher/parent at one of the PCGH's residential facilities for intellectually disabled male adults. Prior to becoming employed with the PCGH Petitioner worked as a caregiver at other health care facilities, including the Beaufort County Developmental Center and Neuse Enterprises. In all, Petitioner has spent the last twenty-five years of his life caring for adults with developmental disabilities.

2. Petitioner has been highly regarded as a care giver by his employer, as well as by residents and guardians of the residents in his care. During the twenty-five years that he has cared for developmentally disabled adults, Petitioner has never been reported for abuse or neglect of a client. During the time that he has been employed with PCGH, he has not had any performance issues. The director of the PCGH stated that Petitioner was "an exemplary employee" and that, in particular, he does an excellent job of caring for residents MV and CC. He is regarded as a "conscientious and caring employee" including when he undertakes the responsibility of transporting residents to activities outside the PCGH facilities. T p 14; 65-66; 69; 71; 168; 182. Resp. Ex. 16; Pet. Ex. 20. Resp. Ex. 9.

3. Mary Grace Bright is the executive director of the PCGH. Bright has a degree in occupational therapy from the Medical College of Georgia and has worked in the health care field since 1977. Bright is responsible for the general operations of the homes, including supervising and training staff and writing the facility's policies and procedures.

4. On September 16, 2013, Petitioner was assigned to transport three adult male residents, SC, MV, and CC, from the homes in Grifton and Ayden, respectively, to take them on a planned outing at a skating arena in Kinston, North Carolina. Petitioner left the home in Grifton with resident SC seated in one of the PCGH's vehicles. He drove in a facility van to the group home in Ayden in order to pick up Residents CC, a resident with Autism and Moderate Mental Retardation, and MV, a resident with Autism and Profound Mental Retardation.

5. Petitioner received training on Pitt County Group Homes policies of vehicle safety. Petitioner's training for transporting residents included the following: "make sure all occupants of vehicles are buckled up." Resp. Ex. 2. T p 43; 137. Petitioner normally checked the occupants' seatbelts by looking in the rearview mirror. Petitioner had observed other staff members also using the rearview mirror to check occupants' seatbelts. The policy did not specify when the seat belt check was to be done.

6. In addition to the above, PCGH has a policy titled "Vehicle Safety" which was in effect on September 16, 2013. It instructs employees to "check behind the van before you get in it, if you are going to back the van . . . . Take the time to do a visual inspection." The

policy in effect on September 16, 2013, did not specifically state that employees must walk behind the van to do a visual inspection. Resp. Ex. 3.

7. The vehicle being driven by Petitioner on September 16, 2013 day was a Ford E350 passenger van. Passengers climb into the van via side doors that open similar to French doors.

8. At approximately 5:40 p.m., Petitioner arrived at the Pitt County Group Home in Ayden with another Resident SC, from the Pitt County Group Home located in Grifton, North Carolina.

9. Petitioner parked the van perpendicular to the home's sidewalk that provided a direct path from the front door of the home to the driveway. Petitioner deliberately stopped the vehicle where the driveway intersected the sidewalk so that MV and CC would naturally follow the path down the sidewalk, in front of the vehicle, and to the side door of the van, where they would enter the van. Petitioner left SC in the van and proceeded toward the Ayden Pitt County Group Home.

10. When Petitioner reached the front door of the home MV and CC were at the door waiting for Petitioner and they exited the home while Petitioner went into the home to get medications as he was required to do. While MV and CC were at the home in Ayden, they were supervised by Delafea Dixon and Shaniqua Washington .

11. In the past, MV and CC had sometimes exited the home and gone to the vehicle ahead of Petitioner. On those occasions, they would get inside the van with their belongings. They had never stood behind the van waiting for Petitioner. Nothing in Petitioner's experience or training suggested that MV and CC would go to the back of the van instead of to the side door.

12. On September 16, 2013, there was no PCGH policy in place that prohibited staff from allowing residents to exit the home and board the van unsupervised. Prior to September 16, 2013, Petitioner's training had never included instructions to keep residents from exiting the home without a staff member, a procedure where two staff members would assist in getting residents seated in the vehicle, or an instruction to check seatbelts while staff members were on the outside of the van.

13. When Petitioner exited the home, the sun was beginning to set and was shining brightly and directly behind the van. Petitioner looked to the back of the van and did not see that any doors at the back of the van were opened. Petitioner believed that when he exited the home and looked behind the van that he could see everything that could have been seen behind the van.

14. Petitioner opened the driver's side door to get into the van, glancing into the back seat as he did. He believed that he saw MV and CC seated in the van. Petitioner climbed into the van and put the medication box between the two front seats. Petitioner realized that the sun interfered with vision through the rear view mirror so he looked to the side view

mirrors in the van. Because the sun was so bright, Petitioner did not look in the rearview mirror as he usually would have. Instead, he used the side view mirrors. He noted that the side doors were closed. He buckled his seat belt and closed the driver's side door.

15. Petitioner turned the engine on, placed his foot on the brake pedal and checked his side view mirrors a second time. Seeing no obstructions, he put the van in gear, took his foot off the brake pedal and placed it onto the gas pedal. The van speed at this point was too slow to have registered on the speedometer. As soon as the van began to move, Petitioner became cognizant of several things simultaneously: he realized he had not done a head count and seatbelt check, he noticed that the rear door of the van was ajar and heard a thump at the back of the van. Realizing that CC and MV were behind the van, Petitioner immediately turned off the engine and went behind the van where he saw CC sitting on the pavement and MV standing behind the van. Petitioner saw that CC had an abrasion on his leg and that MV had a nose bleed.

16. Petitioner went to get Delafea Dixon, the Lead Teacher/Parent for the Ayden Pitt County Group Home from inside the group home, where Petitioner told Mr. Dixon, "I had an accident. I actually hit the guys." The two immediately went to MV and CC where Dixon saw that CC "had a couple of scrapes on his knee," and that "MV's nose was bleeding." (T. pp 131-2) They brought MV and CC back into the house and Shaniqua Washington got material to clean up MV's nose and Band-Aids and Neosporin for CC. Dixon was also trying to calm Petitioner down noting he was "shaky and in shock" by telling him, "it will be okay" and "I understand accidents happen." (T. pp132-33)

17. While Dixon and Washington were helping MV and CC, Petitioner immediately called his nurse supervisor, as well as the executive director, Mary Grace Bright, and another qualified professional, Angie Humphrey. Within approximately 15 minutes from the accident, Ms. Bright was at the home. A PCGH nurse, Norman Thurn was assessing MV and CC to determine what type of medical treatment they needed.

18. CC did not require treatment at a medical facility for his scrapes. MV had a bloody nose and an abrasion on the back of his head. MV was taken to an urgent care facility where diagnostic tests were negative for any internal injuries. Neither CC nor MV had any permanent or serious injuries from the incident and both have maintained the same warm relationship with the Petitioner that they had with him prior to the incident.

19. MV's mother, Ruth V, observed MV the day following the accident and noted that although he had some superficial lacerations, a little bruising around his face and a scrape on his knee, she saw no indication of pain or unhappiness. Ms. V testified that she would know if something had frightened MV or in any way upset him and that on the day following the accident she observed MV to be normal and happy. Ms. V has observed no sign that MV was permanently affected by the accident.

20. CC's mother, Barbara Perkins, observed that CC's injury was a scratch on his knee. CC has never again mentioned the accident to his mother.

21. MV is happy and content when he is with Petitioner and displays an attachment to the Petitioner. Ms. V believes that MV would suffer not to have Petitioner in his life. Ms. Perkins believes that her son, CC, would suffer if Petitioner were no longer a caregiver at PCGH. Executive Director Mary Grace Bright stated that Petitioner does an excellent job of looking out for CC and MV and that not having Petitioner interact with them would create a void in their lives.

22. After the incident PCGH made significant changes to the procedure and training that staff use to transport residents. Those changes include: vehicles remain locked when not in use; residents are not permitted to exit the home without being accompanied by staff; when residents approach the van, the doors are locked and can only be unlocked by staff who are now responsible for seeing residents get into the van and for doing a headcount; staff are also required to walk around the perimeter of the vehicle before getting into the vehicle. The responsibility for the procedures lie with all staff, including driver and any and all staff members with the driver.

23. PCGH's new vehicle safety policy is a more detailed policy with multiple security steps because executive director Mary Grace Bright recognized that even when staff were doing their job to the very best of their ability, unforeseen accidents could happen.

24. The incident was reported to HCPR on September 19, 2014 by executive director Mary Grace Bright using HCPR's form identified as the "five day working report." Although Bright acknowledged that she had checked "Yes" in response to the question on the five day working report that asked whether the allegation had been substantiated, she believed that her response to the question was constrained by limitations in the form and she would have characterized the incident as an "accident" or a "momentary lapse in judgment" rather than an act of negligence. Resp. Ex. 8; T p 153; 168; 173.

25. Bright testified that, because she had no experience with an investigation by HCPR prior to providing the report on September 19, 2014, she did not understand the significance to the investigation of the five day working report or of checking "Yes" to the question regarding whether the allegation was substantiated. Bright believed that the additional information that she provided on the five day working form would assist the HCPR to understand that she did not view the incident as an incidence of negligence on the part of Petitioner.

26. Upon receipt of the allegation against Petitioner, Penny Owen-Keiper, Investigator for HCPR, was assigned to conduct the investigation into the allegation against Petitioner. As a part of the investigation, Owen-Keiper visited the Ayden Pitt County Group Home facility and reviewed CC's and MV's medical records, Petitioner's personnel file, health care facility investigation documentation of this incident. Owen-Keiper interviewed Petitioner, Delafea Dixon, Shanikqua Washington Bright, and CC. Based on the investigation, Owen-Keiper determined that Weaver neglected CC and MV on September 16, 2013. Owen-Keiper did not testify at this hearing as she is out on disability and is no longer working for Respondent at this point.

27. Pamela Anderson is a regional supervisor with the Health Care Personnel Registry section and testified as to the investigation of the September 16, 2013 incident conducted by HCPR investigator Penny Owen-Keiper. Anderson did not speak with any of the witnesses who participated in the investigation.

28. Ms. Anderson testified that the agency's normal procedure is to complete investigations within 60 to 65 days from the time that the incident is reported to the agency. The agency normally completes investigations during that time period in order to get the most competent evidence that it can. The agency also recognizes that fairness to the accused is a consideration in its normal process of completing an investigation closer to the time of the incident.

29. HCPR screened the five day working reports on September 24, 2013 and September 25, 2013 and determined that the investigation should be completed no later than December 23, 2013. Although the incident was reported to the Health Care Personnel Registry on September 19, 2014 by PCGH, no one from HCPR contacted the PCGH prior to February 3, 2014 and no one spoke with Petitioner or any other witnesses about the incident until February 10, 2014.

30. In addition to its own investigation, the agency typically relies on the information compiled by the facility at or near the time of the incident. In this case, the facility did not conduct any investigation beyond the incident report submitted by the Petitioner. The executive director of the PCGH did not believe that statements other than Petitioner's were necessary for an investigation of the incident. The additional staff that provided information to Owen-Keiper five months after the incident had not previously provided statements to their employer.

31. Although he had not provided a statement at or near the time of the incident, staff member Delafea Dixon was interviewed by Owens-Keiper on February 10, 2014. He stated to Owen-Keiper that the residents had exited with Petitioner. At the hearing, Dixon admitted that the residents could not have exited the facility with Petitioner and that what he had told Owen-Keiper was incorrect.

32. CC reads on the first grade level and has an IQ of 55 or 56 points. CC has some ability to apprehend and follow safety rules on his own. CC was interviewed by Owens-Keiper, who summarized CC's statements. Owen-Keiper did not ask CC whether he normally got himself in the van. Owen-Keiper did not ask CC whether he understood that he should not stand behind the van. CC was not capable of reading through the summary statement prepared by Owen-Keiper and would not have been able to understand the summary statement in its entirety even if it had been read to him by Owen-Keiper. There is no indication in Owen-Keiper's investigative report that she was able to verify that CC understood what he was signing.

33. HCPR supervisor Pamela Anderson did not have any independent knowledge as to whether Owen-Keiper had read the questions and answers on CC's signed statement or if

Owen-Keiper had read the questions and answers back to CC before having him sign the document.

34. Staff witnesses who had not been asked to provide statements at or near the time of the incident provided incorrect information to Owen-Keiper. Further; there is no indication that resident CC understood the record of his statement as it was prepared by Owen-Keiper; and, the information which Owen-Keiper summarized from CC contained internal inconsistencies as well as observations that were inconsistent with other verified observations.

35. Petitioner believed CC and MV were on the van before he climbed into the van. It is unclear from Owen-Keiper's report whether she had any evidence to contradict Petitioner's statement. Owen-Keiper reported both that CC stated Petitioner was aware that CC was not on the van and that CC stated that Petitioner was unaware that CC was not on the van.

36. Investigator Penny Owen-Keiper did not examine the PCGH facility in Petitioner's presence in order to determine where the van was parked or what could be seen from the facility's sidewalk. Owen-Keiper did not document whether she had investigated the effect of the sunlight on Petitioner's ability to see behind the van. Owen Keiper conducted her investigation in the morning and took pictures of the scene of the accident in the morning, rather than in the afternoon.

37. Petitioner was emotionally distraught following the incident and continued to be distraught from the time of the incident through the time that he was questioned by Owen-Keiper. During his interview with Owen-Keiper, and while he was in an emotional state, Owen-Keiper asked Petitioner whether he had "failed to provide for the safety of residents . . . because [he was] not aware that the two residents were not on the van before [he] began backing the van up" and Petitioner answered in the affirmative. Resp. Ex. 7.

38. Petitioner testified that prior to speaking with HCPR Investigator Penny Owen-Keiper he had not had an opportunity to study any materials related to the incident. Petitioner testified that some of the responses he gave to Owen-Keiper were "reconstructive," based on what he had learned after the incident and not necessarily what he had been able to observe prior to the incident.

39. Owen-Keiper did not investigate whether allowing residents to exit the facility without supervision was a cause of harm to the residents. Executive Director Mary Grace Bright admitted that it is foreseeable that residents, excited about an activity or outing, would exit the home and run out to the van unsupervised and that allowing residents to leave the home unsupervised could result in physical harm.

40. Owen-Keiper's investigation failed to consider whether there were contributing factors to the incident that were not within Petitioner's control.

41. Owen-Keiper's investigative report indicated that CC stated that both residents had fallen to the ground, although all of the other evidence in the investigation indicates that only CC had fallen to the ground. MV was standing behind the van when Petitioner went behind it.

42. Neither the facility nor Owen-Keiper investigated whether one resident had bumped into the other one during the incident. Owen-Keiper did not ask CC whether MV had bumped into him, causing him to fall to the ground. PCGH Executive Director Mary Grace Bright testified that their review could not verify one way or the other what had caused CC to fall to the ground.

43. Owen-Keiper's conclusion to her investigation was that "on or about September 16, 2013, Dana Eric Weaver, a health care personnel, neglected a resident, MV, by failing to ensure that the resident was on the van prior to backing the van up, resulting in physical harm" and that "on or about September 16, 2013, Dana Eric Weaver, a health care personnel, neglected a resident, CC, by failing to ensure that the resident was on the van prior to backing the van up, resulting in physical harm." Resp. Ex. 16.. Owen-Keiper concluded that the allegations of two separate instances of negligence should be substantiated based upon the admission of the Petitioner and "interviews with staff and a resident." Resp. Ex. 16.

44. It is the agency's procedure to treat each outcome to any resident as an instance of neglect, even though a single act on the part of a health care personnel could have caused multiple outcomes. It was Owen-Keiper's decision to substantiate two, rather than one, allegation of negligence against Petitioner. The procedure used by the agency to regard two outcomes based on a single act as two acts of negligence is not contained in N.C. Gen. Stat. §131E or in the accompanying administrative regulations.

45. Although Anderson took the position that "any break in the skin, even redness can be considered physical harm," there is no agency guideline in the record which serves as a basis for that position. Executive Director Bright has never been instructed that a skin abrasion was normally viewed as an example of physical harm resulting from negligent conduct..

BASED UPON the foregoing findings of fact and upon the preponderance or greater weight of the evidence in the whole record, the Undersigned makes the following Conclusions of Law.

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings (OAH), and jurisdiction and venue are proper. All parties have been correctly designated and there is no question as to misjoinder or nonjoinder. 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 so considered without regard to the given labels.

2. A court need not make findings as to every fact that arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612, *aff'd*, 335 N.C. 234, 436 S.E.2d 588 (1993).

3. As a lead teacher / parent working for the Pitt County Group Homes, Petitioner is a healthcare personnel and is subject to the provisions of North Carolina General Statute §131E-256.

4. With the exception of a finding of a single instance of neglect, substantiated findings against health care personnel are permanently listed on the HCPR. N.C. Gen. Stat. §131E-256(i). Before hiring health care personnel into a health care facility or service, every employer is required to access the Health Care Personnel Registry. N.C. Gen. Stat. §131E-256(d2). A permanent listing on the HCPR is intended to have the effect of barring health care personnel against whom there are substantiated findings from being employed at a health care facility.

5. Neglect, as used in the context of Health Care Personnel regulations means "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 10 NCAC 13O.0101. 42 C.F.R. 488.301.

6. The Undersigned reviews the Respondent's decision using the whole record test to determine whether the agency's investigation and decision is supported by substantial admissible evidence in view of the entire record, taking into account whatever in the record fairly supports or contradicts the decision. N.C. Gen. Stat. 150B-51(b). *N.C. Dep't of Nat. Res. v. Carroll*, 358 N.C. 649, 599 S.E.2d 888 (2004); *Thompson v. Wake County Board of Education*, 292 N.C. 406, 233 S.E.2d 538 (1977); *Overton v. Goldsboro City Board of Education*, 304 N.C. 312, 283 S.E.2d 495 (1981); *N.C. Dep't of Health & Human Services v. Maxwell*, 156 N.C. App. 260, 576 S.E.2d 688 (2003).

7. Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. It is more than a scintilla of evidence or a permissible inference. *Comr. of Insurance v. Automobile Rate Office*, 287 N.C. 192, 214 S.E.2d 98 (1975).

8. While Respondent may assess the credibility of those individuals who provide information to it where there is a proper basis to determine credibility without a hearing, the agency is not free to disregard evidence for whimsical or arbitrary reasons. In conducting its investigation and in its decision, Respondent has a duty to give fair and careful consideration to all of the evidence it receives. *Comm'r of Ins. v. Rate Bureau*, 300 N.C. 381, 269 S.E.2d 547 (1980).

9. An arbitrary decision is one which disregards facts. *Black's Law Dictionary* 119 (9th ed. 2011). An arbitrary decision lacks "adequate determining principle . . . . without consideration or adjustment with reference to principles, circumstances, or significance . . . ." *U.S. v. Carmack*, 329 U.S. 230, 243 n.14 (1946). Capriciousness is "contrary to evidence or established rules of law." *Blacks Law Dictionary* 239 (9th ed. 2011). A decision is arbitrary and capricious if it is "without any rational basis in the record such that a decision made thereon amounts to an abuse of discretion." *Abell v. Nash County Bd of Educ.*, 71 N.C. App. 48, 52-53, 321 S.E.2d 502, 506 (1979). *Accord*. *Joyner v. Perquimans County Bd of Educ*., No. COA 13-446, 2013 N.C. App. LEXIS 1315, 752 S.E.2d 517, 522 (Dec. 17, 2013).

10. The Petitioner has met his burden to establish that Respondent's decision to substantiate two allegations of negligence based on the September 16, 2013 incident was arbitrary and capricious because the evidence introduced at the hearing showed that Respondent relied on incompetent or ambiguous evidence to substantiate its allegations of negligence.

a) Respondent failed to consider relevant evidence that Petitioner followed his employer's procedures as written and that Petitioner took reasonable care under the circumstances.

b) Respondent based its decision on incompetent evidence that was gathered after a long delay, where one witness admitted to giving incorrect information to the investigator, where another witness admitted that the information given to the investigator was based on "reconstructions" of facts that were learned after the incident, and where the investigator failed to verify that the statement it attributed to a resident was understood by the resident to be an accurate statement of his observations and/or recollections of the incident. Respondent has not established that the resident meets the test of competency pursuant to *State v. Higginbottom*, 312 N.C. 760 (1985) demonstrating sufficient understanding of the questions asked to assist the finder of fact in rendering a decision.

c) Respondent has failed to articulate any reasoned principle to substantiate its position that Petitioner's conduct amounted to a failure to deliver goods or services to the residents which caused physical harm, where unusual circumstances combined to distract Petitioner from his normal routine, where the residents had deviated from their normal routine of going to the side rather than the rear door of the vehicle, and where other staff who were assigned to supervise the residents in the Ayden facility allowed the residents to exit the facility unsupervised.

d) Respondent based its decision on what it characterized as Petitioner's admission. However, Petitioner's agreement to the investigator's statement that he had failed to provide goods and services to the residents because he was "not aware" that the residents were behind the van is ambiguous because Petitioner was emotionally distraught, was not advised that the words "failed to provide goods and services" had a specific meaning as a standard for judging Petitioner's conduct and it was not clear that Petitioner's response to the investigator's question was an

unambiguous acknowledgement of the legal standard used by the investigator.

11. The Petitioner has met his burden to establish that Respondent's decision was arbitrary and capricious where Respondent determined that resident CC had suffered physical harm as a result of Petitioner's failure to provide goods and services. The preponderance of the evidence showed that CC had a mild abrasion to his knee that did not require medical treatment and which may have been the result of being bumped by MV. The evidence introduced at the hearing was that it was the investigator's decision to characterize the impact on CC as physical harm. The investigator did not testify and Respondent's witness only stated that this decision seemed to be consistent with the agency's usual practice.

12. The right to a fair and impartial hearing, with the right to cross-examine witnesses for the Respondent, is afforded to petitioners to enable them to hear and refute the evidence against them. Without the testimony of Respondent's investigator Petitioner is prejudiced by the agency's reliance on conclusions contained in the investigator's report that could not be tested through cross-examination.

13. "[T]he touchstone of due process is protection of the individual against arbitrary action of government, ... whether the fault lies in a denial of fundamental procedural fairness, . . . or in the *exercise of power without any reasonable justification in the service of a legitimate government objective* . . . ." *Robins v. Town of Hillsborough*, 176 N.C. App. 1, 625 S.E.2d 813, 818 (2006), quoting *County of Sacramento v. Lewis*, 523 U.S. 833, 845-46 (1998) (Emphasis and '. . .' in original).

14. The government's attempt to protect public health cannot be unreasonable in degree, "compared with the probable public benefit." *Hartford Accident and Indemnity Co. v Ingram*, 290 N.C. 457, 466, 226 S.E.2d 498, 504 (1976). Whenever the state acts to deprive an individual of the right to engage in a lawful occupation, this deprivation is so great that the government must show "a substantially greater likelihood of benefit to the public" in order to survive the constitutional challenge. *In re Hospital*, 282 N.C. 542, 550, 193 S.E.2d 729, 735 (1973).

15. The Respondent's decision to substantiate two allegations of negligence, rather than a single allegation of negligence, against the Petitioner is not in accordance with established law because the Respondent has failed to articulate a reasonable relationship between its decision to substantiate two, rather than one, allegation of negligence and its need to protect the health of individuals for whose protection the provisions of N.C.Gen.Stat.§131E are designed. In particular, where the facility has established procedures to safeguard against the kind of momentary lapse on the part of an employee which occurred in this case and where the evidence shows that Petitioner's absence would hurt the residents, the Respondent has failed to show that its prohibitions against Petitioner's fundamental right to work in his chosen occupation is narrowly tailored to protect the government's legitimate interests.

16. The government's denial of a citizen's rights must be based on reasons that are articulated as well as significant. *King v. Beaufort County Board of Education*, 364 N.C. 368, 377-378, 704 S.E.2d 259, 265 (2010). Here Respondent has determined that Petitioner's singular act should be substantiated as two acts of negligence because there were two residents involved. The agency has not articulated a justification for taking this position, especially in light of the circumstances of this case. The agency's determination that there were two acts of negligence is not based on a standard articulated in the enabling legislation or its accompanying regulations, nor did the agency's witness identify a reason for this practice.

17. By exercising discretion to substantiate two, rather than one, allegation of negligence against the Petitioner, the agency will effectively prohibit Petitioner from ever again working as a health care provider, a field in which he has worked for over twenty-five years. In this case, because the facility recognized that the harm to residents could result from a momentary lapse on the part of an employee, even when an excellent employee is competently performing his or her job, it put into place measures to insulate residents from simple human inadvertence. Thus, it is incumbent upon the Respondent to identify a compelling interest in keeping Petitioner from working in his chosen occupation, or, at the very least, to articulate a significant reason given that there is no demonstrated risk to public health or safety from allowing Petitioner to return to work as a lead teacher / parent with the PCGH or any other health care provider.

BASED UPON the foregoing Findings of Fact and Conclusions of Law the Undersigned makes the following Final Decision.

FINAL DECISION

The Undersigned finds and holds that there is sufficient evidence in the record to properly and lawfully support the Conclusions of Law cited above. The Undersigned enters the following Final Decision based upon the preponderance of the evidence, having given due regard to the demonstrated knowledge and expertise of the Agency with respect to facts and inferences within the specialized knowledge of the Agency.

Based on those conclusions and the facts in this case, the Undersigned holds that Petitioner did carry his burden of proof by a greater weight or preponderance of the evidence that Respondent was in error when it substantiated neglect against the Petitioner, regarding his care of residents CC and MV on September 16, 2013. As such two findings of neglect by Petitioner's name in the Health Care Personnel Registry should be removed.

NOTICE

THIS IS A FINAL DECISION issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statutes Chapter 150B, Article 4, 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 in which the party resides. 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. N.C. Gen. Stat. §150B-46 describes the contents of the Petition and requires service of the Petition on all parties.

In conformity with the Office of Administrative Hearings' Rules, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision.

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 is the 5th day of December, 2014.

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Augustus B. Elkins II
Administrative Law Judge