STATE OF NEW HAMPSHIRE
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

BOARD OF NURSING

In Re: Ari Williams,
LNA Lic. #058665-24

Docket No.: 2022-NUR-012

ORDER ON HEARING PURSUANT TO PRELIMINARY AGREEMENT NOT TO PRACTICE – 04/28/22

I. ATTENDEES:

Samantha O'Neill, Board Chair
Joni Menard, Vice Chair
Melissa Tuttle, Board Member
Matthew Kitsis, Board Member
Maureen Murtaugh, Board Member
Gene Harkless, Board Member
Wendy Stanley Jones, Board Member
Michele Melanson-Schmitt, Board Member
Attorney Michael Haley, DOJ Board Counsel
Ashley Czechowicz, OPLC Board Administrator
Attorney Marissa Schuetz, OPLC Hearing Counsel
Ari Williams, Licensee (unrepresented via Zoom video conferencing)
Attorney Nikolas K. Frye, OPLC Hearings Examiner and Presiding Officer
Attorney John Garrigan, OPLC Chief Prosecutor (Observing)
Attorney Michael Porter, OPLC Investigations Bureau Chief (Observing)
Karen Belair, OPLC Investigator (witness)
Brianna Miller, OPLC Investigator (witness)
Modupe Mary Ainenehi (witness via Zoom telephone conferencing)

II. CASE SUMMARY/PROCEDURAL HISTORY:

On 09/10/2021, the Board of Nursing ("Board") received a complaint alleging that Ari Williams ("Licensee") had physically injured a resident patient while working at Mount Carmel Rehab and Nursing Center. OPLC Enforcement investigative staff conducted an expedited investigation, which coincided

with other investigations of the Licensee already underway for violation of a previous Settlement Agreement and accidentally discharging his firearm at his home in March of 2021. On 10/08/21, the Board found Licensee's alleged actions were an imminent threat to the public health, safety, and welfare and thus warranted emergency suspension of his license pursuant to RSA 326-B:37(IV). Before the required 10-day hearing on the emergency suspension occurred, the Licensee signed a Preliminary Agreement Not to Practice ("PANP"). In December of 2021, the Licensee requested a hearing on the temporary suspension of his License pursuant to the terms of the PANP. A Hearing was scheduled for 01/27/22 but later continued at the request of the Licensee. The Board held the hearing on 04/28/22 and this order follows.

III. SUMMARY OF THE EVIDENCE:

The Board received the following evidence pursuant to RSA 541-A:33 and Rule 207.09:

A. Exhibits were submitted by Hearing Counsel, labeled as follows:

1. Mt. Carmel Internal Investigation Report
2. Photographs of Resident's Injuries
3. Hanover Hill Employment Records
4. Empowered Employment Records
5. Williams' Response to Allegations
6. October 25, 2019 Settlement Agreement
7. Manchester Police Department Reports
8. Hillsborough North Superior Court Records

B. Testimony was received from the following witnesses called by Hearing Counsel:

1. Karen Belair, Investigator OPLC
2. Brianna Miller, Investigator OPLC
3. Modupe Mary Ainenehi, LNA

The Licensee neither submitted exhibits nor called any witnesses.

VI. PRELIMINARY MATTERS:

At his request, the Licensee attended the hearing via Zoom.[1] The Board's Chair and Presiding Officer started by explaining the purpose of the hearing, how it would operate, and what everyone's roles were in attendance. As the Licensee was unrepresented by an attorney, the Board Members and the Presiding Officer made a concerted team effort to ensure those matters were explained to the Licensee in basic, non-legal language. While reviewing the procedure with the Licensee, the Presiding Officer learned that although the Licensee had received all of Hearing Counsel's proposed Exhibits, he had not reviewed them thoroughly and was unable to view them through his own technology at the same time he participated in the hearing via Zoom. The Board Chair proposed having the Board Administrator share the exhibits with the Licensee via Zoom. The Presiding Officer agreed with this suggestion.

The Board Administrator shared the exhibits with the Licensee via Zoom, who affirmed he could view them. Given the Licensee had indicated he had not fully reviewed the Exhibits, the Presiding Officer asked that Hearing Counsel have one or more of her witnesses explain each of the exhibits in more depth than would normally be necessary, while the Board Administrator shared with the Licensee the exhibit being discussed. The Licensee neither objected to this process nor indicated he was unable to view or understand what the exhibits were. Hearing Counsel followed the proposed process and had Investigator Karen Belair authenticate and explain each proposed exhibit. At the close of Ms. Belair's direct testimony, the Presiding Officer then reviewed with the Licensee what each exhibit was and provided him with an opportunity to object to each. The Licensee had no objection to any of the exhibits. Based upon his own review of the exhibits and the Licensee voicing no objections, the Presiding Officer decided that all the exhibits were material and relevant to the proceeding and thus should be admitted as full exhibits.

IV. **CONDUCT OF HEARING AND EVIDENCE PRESENTED:**

[1] The Presiding Officer made efforts throughout the hearing to ensure the Licensee was hearing what was being said. The Licensee never indicated that he could not.

The Board's inquiry at this hearing is narrow. Pursuant to Rule 207.10, Hearing Counsel has the burden of proving, by a preponderance of the evidence, that the Licensee being licensed pending full adjudication of this matter poses an imminent danger to public health, safety, or welfare. RSA 326-B:37, IV. The credible evidence presented at the hearing allows the Board to find the following facts.

Licensee currently holds New Hampshire license # 058665-24 as an LNA. Karen Belair was Hearing Counsel's first witness at the hearing. She began by testifying that she is an Investigator for the OPLC Enforcement Division. She then explained the events which had led to OPLC Enforcement Division requesting the Board consider emergently suspending the Licensee's license. In March of 2021, the Licensee was involved in a firearm incident at his home in which he accidentally discharged one of his guns into a neighboring apartment. Although no one was harmed in this incident, there were people present in the neighboring apartment, including a child. The Manchester Police Department subsequently charged the Licensee with reckless conduct with a deadly weapon. The criminal proceeding related to that charge ended with the Licensee pleading guilty to a lower count of reckless conduct. While testifying about this incident, Investigator Belair authenticated and explained Exhibits 7 and 8, which include police reports and court records related to this incident.

Investigator Belair then explained that in September of 2021 OPLC Enforcement Division received, on behalf of the Board, a complaint made against the Licensee in relation to a patient he treated at Mt. Carmel Rehab and Nursing Center in Manchester, New Hampshire. Ms. Belair's testimony revealed that the patient's daughter had filed the complaint and it generally alleged that on or about 09/04/21, the Licensee had caused injuries to the resident's face, neck, and hand. Investigator Belair testified that she investigated the complaint by reviewing some of the Licensee's employment records, Mt. Carmel's investigation records relating to the incident, police records involving the Licensee, pictures of the Licensee's injuries, and speaking with the nursing home staff at Mount Carmel.

Investigator Belair then reviewed Hearing Counsel's Exhibits 1 through 6 and explained how they each related to her investigation. Exhibit 1 is Mt. Carmel's investigation report. She explained its findings rely upon staff interviews, statements, and surveillance video. Ms. Belair noted that she was able to verify various portions of the report by speaking with staff, but she was unable to view the video because the facility no longer had it. Investigator Belair highlighted the following facts reflected in Exhibit 1: 1) at 9:00 PM on 09/04/21, the Licensee was alone with the patient for approximately 17 minutes before she went to sleep; 2) there is no surveillance video footage documenting the interactions between Licensee and the patient during this 17 minutes; 3) no other staff or family members of the patient had noticed injuries on her before the Licensee was alone with her for that 17 minutes; and 4) the injuries were later noted at approximately midnight the next day when the patient got out of her bed on her own and entered the hallway. Investigator Belair also stated that the nursing staff written accounts as to what happened are inconsistent with what Mr. Williams stated occurred. *Compare* Exhs. 1 and 5. She also noted the Licensee did not speak with her about the incident when she was first investigating, though he later responded to the allegations on or about 12/10/21 through email.

Investigator Belair then turned to Exhibit 2, which she testified are pictures of the injuries on the patient that the patient's daughter had taken.[2] The pictures show bruising on the patient's hands, neck, and face from various angles. While discussing the pictures, Investigator Belair informed the Board that the matter had also been reported to the Bureau of Elderly and Adult Services, the Office of the Long-Term Care Ombudsman, and the Manchester Police Department. She explained that the investigation into what occurred is still ongoing.

Ms. Belair's testimony next turned to a 2019 Settlement Agreement that the Licensee had previously entered into with the Board. She testified that the previous Settlement Agreement, which is

[2] It was unclear from Ms. Belair's testimony how long after the incident the pictures were taken, and they were not time stamped. It was clear from her testimony, however, that the pictures were taken after the incident occurred.

Exhibit 6, stemmed from a disciplinary matter involving the Licensee mishandling a patient at a nursing home. Specifically, the Settlement Agreement shows the Licensee stipulated to the following finding of fact: "On or about September 1, 2018, Respondent [Licensee] caused BD pain and potential harm by covering her mouth with his hand, hitting her in the back of the head with his hand, and pulling on her sore arm while transferring her into bed." Exh. 6. Ms. Belair testified that as part of the Settlement Agreement, Licensee was placed on probation for two years. During the probationary period, the Licensee was required to notify the Board when he was terminated or changed employment, provide his nursing supervisor with a copy of the Settlement Agreement before obtaining employment, provide a written report and performance evaluations to the Board from his nursing supervisor, partake in continuing nursing education related to his conduct, and pay an administrative fine. Investigator Belair explained that the employment records she had reviewed, *see* Exhs. 3 and 4, indicated that neither Hanover Hill nor Mt. Carmel were aware of the Settlement Agreement when the Licensee was hired. Based upon the evidence before her, Investigator Belair, testified that the Licensee had not followed the aforementioned conditions of probation. She explained that under the terms of the Settlement Agreement, the period of probation was not set to expire until at least 10/21/21.

Upon Board questioning, Investigator Belair acknowledged there was no evidence that the patient at Mt. Carmel had suffered non-accidental injuries. She also stated that some of the Hospitals reports indicate that the patient had previously fallen, indicating she was a fall risk. The Licensee asked no questions, despite being given the opportunity to do so.

Hearing Counsel next called Modupe Mary Ainenehi as a witness, who appeared via telephone due to transportation and technology barriers. She testified that she was an LNA at Mt. Carmel and worked there on the 11:00 PM to 7:00 AM shift for 09/04/21 to 09/05/21. She stated that she had previously worked with the Licensee before the night in question. She explained that she and the Licensee did rounds

together at approximately 11:00 PM on 09/04/21. According to her testimony, during that night round she and the Licensee found the patient asleep in bed but with a lot of blankets on her. LNA Ainenehi explained that she told the Licensee that the patient did not like that many blankets on her and he should remove some. Her testimony also indicated that the Licensee should have known of the patient's preference for fewer blankets. Not long after this testimony, it became difficult to understand what LNA Ainenehi was saying due to the telephone set up. Upon the request of the Board, Hearing Counsel agreed to have Investigative Paralegal Brianna Miller, who appeared in-person at the hearing, testify to what Ms. Ainenehi had told her about the night in question and have Ms. Ainenehi listen to her testimony. Ms. Ainenehi was asked to correct or elaborate upon the testimony of the investigator after hearing what she had to say.

Hearing Counsel called Brianna Miller to testify. She testified she was an Investigative Paralegal at OPLC working on the Licensee's case. As part of her duties, she interviewed Ms. Ainenehi. Ms. Miller relayed that the Licensee had worked the 3:00 PM to 11:00 PM shift the day of the incident involving the patient and had done rounds with LNA Ainenenhi around 11:00 PM. Investigator Miller then testified that toward the beginning of rounds, Ms. Ainenehi had indicated she and Licensee had gone into the patient's room and found her sleeping, covered with a lot of blankets, and a pillow on her head. Ms. Ainenehi had explained to Investigator Miller that she had instructed the Licensee to remove the blankets and pillow, and then she left to finish her rounds. Investigator Miller explained that Ms. Ainenehi told her that at some point later in the rounds, the Licensee called for help. When Ms. Ainenehi came to assist him, she saw the patient standing in her doorway with her walker. Ms. Miller clarified that Ms. Ainenehi was assisting another resident and asked the Licensee why he could not help the patient given he was free and nearby. According to Ms. Miller's testimony, Ms. Ainenehi indicated during the interview that the Licensee

appeared to be walking away from the patient instead of assisting her. It was at this point that Ms. Ainenehi noticed the injuries on the patient.

Hearing Counsel stated that the rest of Ms. Miller's testimony would not involve the interview of Ms. Ainenehi. The Presiding Officer therefore asked Ms. Ainenehi if there was anything she wanted to correct or add to Ms. Miller's testimony. Ms. Ainenehi testified that when the Licensee called her about the patient, she came quickly because the Licensee appeared to be walking away from the patient and the patient is a known fall risk. She said this was around midnight and she called the on-duty nurse when she saw the patient's injuries. According to LNA Ainenehi, the nursing home's notes from 09/04/21 did not indicate that anyone had noticed injuries on the patient before midnight on 09/05/21. Board questioning of Ms. Ainenehi revealed that she has occasionally seen bruises on the patient before. Nonetheless Ms. Ainenehi did not know if the patient had previously fallen at the nursing home. She explained the patient would normally be sleeping during the 11:00 PM to 7:00 AM shift.[3]

Investigator Miller then continued with testimony unrelated to LNA Ainenehi's testimony. Investigator Miller agreed with Investigator Belair's previous testimony that the Licensee's characterization of events differed from other staff members. She also noted that between the time of the Hospital's investigation and the Licensee emailing Investigator Belair in December of 2021, the Licensee's explanation as to what happened had changed in terms of timing and when the patient's injuries were first noticed. *Compare* Exh. 1 *and* Exh. 2. Investigator Miller closed her direct testimony by stating that OPLC had more investigation to conduct, including interviewing some additional witnesses. Board questioning of Ms. Miller focused on whether the patient was a fall risk. The Investigator explained that the patient was a fall risk, had a walker but would not always use it, and the nursing home was worried

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[3] A Patient can be deemed a fall risk without any previous evidence of falling.

she might fall. Ms. Miller did not recall seeing any documentation that the patient had previously fallen when reviewing Mount Carmel's nursing records.

The Licensee was provided an opportunity to cross examine the witness but declined. The Licensee was provided an opportunity to testify on multiple occasions throughout the proceeding and declined to do so. The Licensee was also provided an opportunity to have others testify on his behalf and declined to call any witnesses. The Licensee confirmed he was not putting on a case and declined to make a closing statement.

V. **DISCUSSION AND FINDINGS OF FACTS / CONCLUSIONS OF LAW:**

After reviewing all the evidence, and accounting for the presentation and demeanor of all the witnesses, the Board finds, by a preponderance of the evidence, that Hearing Counsel has met its burden of proof. Pursuant to Rule 402.03, Hearing Counsel has shown that Licensee's license should remain suspended on an emergency basis, pending disciplinary adjudication. The central facts in this matter are clear and were uncontested by the Licensee: 1) the investigation into what happened to the patient at the Mount Carmel is ongoing and implicates the Licensee; 2) in 2019 the Licensee entered into a Settlement Agreement for disciplinary allegations related to harming a patient at a nursing home; and 3) the Licensee failed to meet the requirements of probation set forth in that Settlement Agreement, which included providing future employers (including Mount Carmel) with a copy of the Settlement Agreement. Taken together, these uncontroverted facts demonstrate that the Licensee is an "imminent danger to public health, safety, or welfare", RSA 326-B:37, IV, such that his license to practice should remain suspended pending a full disciplinary hearing.

While the Board draws an adverse inference from the Licensee's decision not to testify at the hearing, that finding is not outcome determinative. Hearing Counsel met its burden based upon the totality of uncontested evidence that was presented to the Board. With respect to the patient at Mount Carmel,

the evidence shows nobody who was in contact with the patient on 09/04/21 noticed the bruising on her hands, face, and neck before the Licensee took her to her bedroom for nighttime care around 9:00 PM. The Licensee was then alone with the patient in her bedroom for approximately 17 minutes with no video surveillance. While conducting rounds with the Licensee around 11:00 PM, Modupe Mary Ainenehi noticed that the patient had a pillow on her head and extra blankets over her body, which she explained was not something that the patient would want, and this is something the Licensee should have known when he prepared her for bed. Around midnight, the Licensee asked LNA Ainenehi to assist with the patient, who was standing in the hallway near the doorway to the patient's room. The Licensee was free, able to assist, and walking away from the patient when he made this request, even though the patient was a known fall risk. These uncontested facts, when viewed in light of the Licensee's past similar conduct and decision not to disclose the settlement agreement to Mount Carmel and his other employers, amply support the Board's conclusion in this matter.

VI. CONCLUSION AND DECISION:

Pursuant to RSA 326-B:27(IV), Rule 402.03, and paragraph 4 of the PANP, the Board hereby upholds its emergency suspension of Ari Williams's license as an LNA, pending a full adjudicatory disciplinary hearing in this matter. A Notice of Adjudicative Hearing with an appropriate date/time shall follow.

DATED: 5/3/2022

___/s/ Nikolas K. Frye, Esq.________________
Nikolas K. Frye, Esq., Hearings Examiner
Authorized Representative of the Board of Nursing-
New Hampshire Office of
Professional Licensure & Certification
7 Eagle Square
Concord, NH 03301
Office: 603-271-3825