IN THE COURT OF APPEALS OF NORTH CAROLINA

2021-NCCOA-611

No. COA20-880

Filed 2 November 2021

I.C. No. TA-21057

ESTATE OF MOUY TIENG TANG, by and through TONG NGOUAN TANG, Next Friend and Administrator of the Estate, Plaintiff,

v.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES/DIVISION OF HEALTH SERVICES REGULATION, Defendant.

Appeal by defendant from order entered 11 September 2020 by the North Carolina Industrial Commission ("Commission"). Heard in the Court of Appeals 22 September 2021.

The Duggan Law Firm, PC, by Christopher M. Duggan; and The Law Offices of William K. Goldfarb, by William K. Goldfarb, for plaintiff-appellee.

Attorney General Joshua H. Stein, by Assistant Attorney General Donna B. Wojcik, for defendant-appellant.

ARROWOOD, Judge.

¶ 1 The North Carolina Department of Health and Human Services/Division of Health Service Regulation ("defendant") appeals from the Commission's order awarding damages to the Estate of Mouy Tieng Tang ("plaintiff"). Defendant contends the Commission erred by concluding that defendant breached a duty owed

and that defendant's "attenuated regulation of adult care homes proximately caused Ms. Tang's disappearance." For the following reasons, we affirm the Commission.

I. Background

¶ 2 This appeal arises from the disappearance and death of Ms. Mouy Tieng Tang ("Ms. Tang"). Ms. Tang began living at an adult care home called "Unique Living" in Lawndale, North Carolina on or around 1996. As of 24 January 2008, Ms. Tang was diagnosed with schizoaffective disorder and insulin-dependent diabetes, among other diagnoses, and had prescriptions for anti-psychotic, anti-depressant, and anti-anxiety medications.

¶ 3 On 20 June 2008, the Cleveland County Department of Social Services ("CCDSS") sent a letter to Barbara Ryan ("Ryan"), then Chief of the Adult Care Licensure Section of the Division of Health Service Regulation ("DHSR"). CCDSS expressed concerns "based on a pattern that evolved over the past six months of Unique Living's current management staff failure to maintain the home in a safe operating condition." The letter cited several examples, including: (1) disconnection of water service for approximately five hours on 29 April 2008; (2) additional calls to CCDSS from utility vendors regarding potential disconnection of services; (3) delinquent property taxes in excess of $8,000.00; (4) a recent Type B violation for failure to assure an adequate food supply for residents; and (5) the repossession of the commercial dishwasher on 13 June 2008. Based on these concerns, CCDSS

requested consideration of an immediate suspension of admissions and appointment of a temporary manager at Unique Living.

¶ 4 In response to the letter, DHSR performed an inspection and survey between 8-9 and 16-18 July 2008. A statement of deficiencies and plan of correction form prepared by representatives of DHSR noted several deficiencies with the physical environment at Unique Living. The report noted that at least one resident at Unique Living was known to be "disoriented or a wanderer" requiring each exit door accessible to residents to be equipped with a sounding device activated when the door is opened. Based on the observations of DHSR representatives, seven of the nine exit doors were not equipped with working audible alarms. An interview with the executive director of Unique Living revealed that the two working door alarms were not actively in use. The report also noted that a review of a facility incident report dated 12 July 2008 revealed that a resident had eloped from the facility on 12 July during DHSR's inspection period.

¶ 5 The report also described several interviews with Unique Living staff and administrators. An interview with the activity director on 9 July 2008 "revealed staff performed a 24 hour visual check of each resident every 30 minutes and documented each observation." A 9 July 2008 interview with a Unique Living administrator revealed that the administrator "did not know how long it had been since the facility had an exit door alarm system in place[,]" and a 16 July 2008 interview with the

executive director revealed that "staff [were] unaware that there were old door alarms still in the facility," with the executive director stating that "there were door alarms in the facility" that "just need[ed] to be turned on."

¶ 6 DHSR issued a Type B violation for the lack of door alarms and set a corrective action date of 29 August 2008. Although a Unique Living administrator indicated that staff conducted visual checks of residents every thirty minutes, DHSR did not require Unique Living to place staff members at the exits to monitor residents coming and going. On 1 August 2008, Ryan stated in an email to defendant that she determined that no licensure action would be taken at that time as no serious non-compliance issues had been identified.

¶ 7 Unique Living was also visited on 18 July 2008 by Dennis Harrell ("Harrell"), a DHSR surveyor in the construction section. In a deposition, Harrell testified that he visited Unique Living related to a complaint of raw sewage on the floor and inspected exit doors that could not close and lock but did not "recall alarms being a problem." Harrell clarified that as an employee of the construction section, he was not generally aware of how the adult care section operated. Harrell also conducted a follow-up survey on 29 August 2008, noting a sanitation score of 83.5, below the required minimum of 85, but made no references in his report to the door alarms or whether the exit doors could close and lock.

¶ 8 During August 2008, Ms. Tang was noted as acting increasingly disoriented and was the subject of thirty-minute checks by Unique Living staff. On 3 September 2008, Ms. Tang eloped from Unique Living and was last spotted at 7:36 a.m. outside a nearby school. Unique Living staff notified local law enforcement of Ms. Tang's disappearance at 8:05 a.m. but Ms. Tang was not found.

¶ 9 In response to Ms. Tang's disappearance, DHSR staff returned to inspect Unique Living on 10 September 2008. The report noted the continuing violations with the exit doors, as well as deficiencies with bedding and other furnishing issues. DHSR issued a Type A violation and mandated that Unique Living position staff members to monitor exit doors. Unique Living's license was suspended on 11 September 2008 and Unique Living permanently closed.

¶ 10 Plaintiff commenced this action by filing an affidavit with the Industrial Commission on 16 January 2009. Defendant filed an answer and affirmative defenses on 27 February 2009.

¶ 11 On 15 September 2014, Ms. Tang was officially declared deceased. On 4 September 2015, plaintiff filed an amended affidavit with the Industrial Commission. On 21 September 2015, defendant filed an answer and affirmative defenses to plaintiff's amended affidavit.

¶ 12 Deputy Commissioner Robert J. Harris conducted an evidentiary hearing on 6-7 May 2019. He reviewed the same reports previously discussed and heard

testimony from Megan Lamphere ("Lamphere") in her capacity as the section chief of the adult care section. Lamphere testified that DHSR would typically allow forty-five to sixty days after a corrective action deadline before returning to ensure a facility is in compliance, which Lamphere described as part of "the regulatory process."

¶ 13 On 1 October 2019, Deputy Commissioner Harris entered a Decision and Order in favor of plaintiff, awarding damages of $500,000.00. Deputy Commissioner Harris made findings of fact regarding the events leading up to and including the DHSR inspections in July 2008. He found that DHSR did not direct Unique Living "to do anything beyond the promised 30-minute checks on the residents" to address the door alarm issue, which "did not constitute adequate monitoring of the residents under the circumstances." He also found that "[b]esides the door alarm issue, the sanitation and hygienic violations noted in the July 2008 DHSR survey illustrated the overall appalling condition of Unique Living at that time."

¶ 14 Deputy Commissioner Harris concluded that a special relationship existed between defendant and Ms. Tang and that the public duty doctrine did not apply. He further concluded that defendant had a duty to take reasonable steps to ensure that licensed facilities did not place residents at substantial risk of serious physical harm or death, and that defendant breached this duty. Harris concluded that defendant allowed "Unique Living a month and a half to correct a serious door alarm issue even though Unique Living was known to house a significant number of disoriented

residents, without requiring Unique Living in the meantime to take the immediate reasonable step of having staff constantly monitor the exit doors." He further concluded that defendant "should have expedited the correction date and the follow-up to ensure that the problem had been effectively corrected[.]" On 14 October 2019, defendant appealed the decision to the Full Commission.

¶ 15 The Commission heard defendant's appeal on 10 March 2020. The Commission filed a Decision and Order on 11 September 2020, again awarding plaintiff damages of $500,000.00. The Commission found that numerous violations were noted in the DHSR report, including violations related to housekeeping and furnishings in addition to the lack of adequate door alarms. The Commission also noted DHSR's survey which concluded that "38 of the 66 residents were intermittently disoriented[.]" The Commission found that DHSR did not return to Unique Living after the July 2008 survey to determine whether Unique Living had completed repairs prior to the date of correction, took no further action with respect to any other deficiencies, and "did not require Unique Living to implement any safety precautions in place of door alarms to prevent residents from leaving the facility without staff knowledge." The Commission found that after Ms. Tang's disappearance, "DHSR returned to Unique Living and, finding essentially the same conditions with a lack of working door alarms and lack of resident supervision, as

well as several other violations, permanently shut down the facility on September 11, 2008."

¶ 16 Based on the preponderance of the evidence, the Commission found that "Unique Living's documented lack of resident supervision, coupled with non-working door alarms at the facility in July 2008, presented a substantial risk that death or serious physical harm would occur to one or more of the residents of the facility[,]" which "was foreseeable to DHSR" given the conditions existing at Unique Living in July 2008. The Commission found that defendant had a duty to Ms. Tang pursuant to N.C. Gen. Stat. § 131D-2 *et. seq.*, which was "to license and periodically inspect adult care homes like Unique Living and to take reasonable steps to ensure that the conditions at those facilities did not place residents at substantial risk of serious death or harm." Based on the evidence, the Commission found that "DHSR had the ability and the regulatory authority to take action against Unique Living to prevent harm to its residents but failed to do so." The Commission also found that defendant had failed to present any evidence of an intervening or superseding cause of Ms. Tang's death, and that "although it is unclear what happened to Ms. Tang after she disappeared on September 3, 2008, [it] can be inferred that while lost and wandering without her medications or supervision, she sustained significant pain and suffering before she died." Accordingly, the Commission found "that a fair and just sum to compensate the estate of Ms. Tang for her death is $500,000.00."

¶ 17 The Commission concluded that the public duty doctrine was inapplicable because "[d]efendant's employees had a statutory duty to perform inspections to ensure the safety, health, and welfare of all the residents of adult care homes, including Ms. Tang." This included the duty "to take reasonable steps to ensure that the conditions at those facilities did not place residents at substantial risk of serious death or harm." The Commission concluded that defendant breached its duty "by failing to take appropriate regulatory action to ensure immediate correction of the conditions that existed at Unique Living in July 2008[,]" specifically the "wholly inadequate supervision of residents[.]" The Commission concluded that this breach was a proximate cause of Ms. Tang's disappearance and death, because if DHSR had taken appropriate regulatory action to ensure the conditions at Unique Living were corrected immediately, Ms. Tang "would not have been able to leave the facility unnoticed."

¶ 18 Defendant filed notice of appeal on 9 October 2020.

II. Discussion

¶ 19 Defendant contends the Commission erred by concluding that defendant breached a duty and proximately caused Ms. Tang's disappearance and death. We disagree.

A. Standard of Review

¶ 20 The standard of review for an appeal from the Commission's decision under the Tort Claims Act "shall be for errors of law only under the same terms and conditions as govern appeals in ordinary civil actions, and the findings of fact of the Commission shall be conclusive if there is any competent evidence to support them." N.C. Gen. Stat. § 143-293 (2019). "As long as there is competent evidence in support of the Commission's decision, it does not matter that there is evidence supporting a contrary finding." *Simmons ex rel. Simmons v. Columbus Cty. Bd. of Educ.*, 171 N.C. App. 725, 728, 615 S.E.2d 69, 72 (2005).

¶ 21 "The court's duty goes no further than to determine whether the record contains any evidence tending to support the finding." *Id.* (citation omitted). Thus, "when considering an appeal from the Commission, our Court is limited to two questions: (1) whether competent evidence exists to support the Commission's findings of fact, and (2) whether the Commission's findings of fact justify its conclusions of law and decision." *Id.* (quotation marks omitted).

B. Duty and Proximate Cause

¶ 22 Defendant contends that plaintiff "has failed to submit any competent evidence to establish negligence on the part of any employee" of defendant in support of its overall argument that defendant's limited obligations are statutorily prescribed under N.C. Gen. Stat. § 131D. We disagree.

¶ 23 Under the Tort Claims Act, "negligence is determined by the same rules as those applicable to private parties." *Bolkhir v. N. Carolina State Univ.*, 321 N.C. 706, 709, 365 S.E.2d 898, 900 (1988) (citations omitted). "To establish actionable negligence, plaintiff must show that: (1) defendant failed to exercise due care in the performance of some legal duty owed to plaintiff under the circumstances; and (2) the negligent breach of such duty was the proximate cause of the injury." *Id.* Proximate cause is defined as "a cause which in natural and continuous sequence, unbroken by any new and independent cause, produced the plaintiff's injuries, and without which the injuries would not have occurred," and that it could be reasonably foreseen that "consequences of a generally injurious nature" were probable in the circumstances. *Id.* at 710, 365 S.E.2d at 901.

¶ 24 Pursuant to N.C. Gen. Stat. § 131D-34, a Type A violation "means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility" that results in the substantial risk or actual "death or serious physical harm, abuse, neglect, or exploitation." N.C. Gen. Stat. § 131D-34(a) (2019). A Type B violation is similarly defined but concerns violations which do not result in substantial risk that death or serious harm will occur. *Id.* Both violation types require a plan of correction be submitted to DHHS. *Id.*

¶ 25 Defendant argues these provisions "exclusively set out" defendant's duties relevant to the operation of adult care homes in North Carolina and that the statute affords defendant discretion to allow facilities forty-five days to correct a Type B violation. Although defendant is correct that the statutory scheme does not specifically require defendant to return to the facility to ensure correction of a Type B violation, defendant fails to acknowledge the facts of the case or the standard of review.

¶ 26 In this case, defendant was aware throughout July 2008 that Unique Living had only two working door alarms for a total of nine exit doors and that Unique Living housed multiple residents known to be disoriented. There was competent evidence to support the Commission's finding that the documented lack of resident supervision, coupled with non-working door alarms, posed a substantial risk of death or serious harm to disoriented residents, including Ms. Tang.

¶ 27 Defendant points to the discretion allowed by statute for Type B violations, but defendant's attempts to distance itself from its statutory duties are unavailing. The Commission found that the deficiencies at Unique Living posed a substantial risk of death or serious physical harm to residents, constituting a Type A violation rather than a Type B violation. Although a more hands-off approach may have been appropriate for Type B-level deficiencies, there is no reasonable explanation for defendant's allowance of over a month to correct the door alarm deficiency with no

alternative safeguards and no follow-up to ensure compliance. This included multiple inspections between the date of discovery and date of correction, including a visit by Harrell on the date of correction which was approximately one week before Ms. Tang's disappearance. There was competent evidence for the Commission to find that defendant breached its duty to plaintiff in failing to properly assess the violations at Unique Living and in failing to take reasonable steps to address the deficiencies. There was also competent evidence to support the Commission's findings that there were no intervening or superseding causes and that Ms. Tang sustained significant pain and suffering before her death.

¶ 28 The Commission's findings of fact justify the conclusion that defendant's breach directly and proximately caused plaintiff's injury. As the Commission concluded, it was foreseeable that defendant's failure to exercise its regulatory authority to address the door alarms—at a facility known for past deficiencies and non-compliance—would result in Ms. Tang's injury. Defendant was aware that Unique Living had previous violations and cared for disoriented residents yet failed to adequately address the issue. The Commission did not err in concluding that defendant breached its duty to Ms. Tang, nor in concluding that the breach was a proximate cause of plaintiff's injury.

III. Conclusion

¶ 29 For the foregoing reasons, we affirm the Commission.

AFFIRMED.

Judges CARPENTER and GRIFFIN concur.

Report per Rule 30(e).