**DISCIPLINE COMMITTEE OF THE**

**COLLEGE OF NURSING OF NEW BRUNSWICK**

**B E T W E E N:**

**COLLEGE OF NURSING OF NEW BRUNSWICK ("the College")**

**Complainant**

**- and –**

**ABIOLA MOMOH**

**Registration Number 031283**

**Respondent**

**DECISION and REASONS**

---

**Date of Hearing: June 11, 2026**

**Discipline Committee Panel:** Luc Drisdelle, RN (Chairperson); Claire Goldie, RN (Nurse Member); Christine Flanagan, RN (Nurse Member); Dorina St. Onge (Public Member)

**Counsel:**

- College of Nursing of New Brunswick (the "College") – Melissa M. Everett Withers
- Abiola Momoh (the Member) – Robert Basque K.C.

**OVERVIEW**

On June 11, 2026, a Panel of the Discipline Committee was convened by videoconference.

The parties proceeded on the basis of the Notice of Hearing, the Statement of Uncontested Facts and Plea of No Contest with attached exhibits, the Joint Submission on Order and Costs,

and the College's written submissions on the merits and on order. The Panel also received written submissions from counsel for Ms. Momoh.

Ms. Momoh signed the Statement of Uncontested Facts and Plea of No Contest, in which she stated that she understood fully the nature of the allegations against her, consented to the evidence as set out in the Uncontested Facts being presented to the Discipline Committee, and understood that by pleading no contest she was waiving the right to require the College to prove the allegations against her. Ms. Momoh executed and at the hearing, the Panel conducted a plea inquiry and was satisfied that Ms. Momoh's plea of no contest was voluntary, informed and unequivocal.

**BACKGROUND**

This matter arose as a result of a notification received by the College on May 31, 2024, from the New Brunswick Department of Social Development advising that the Department's Adult Protection Unit had investigated and concluded that Ms. Momoh, a Registered Nurse, had physically abused and emotionally neglected a resident at a nursing home.

The Notice of Hearing dated April 13, 2026, alleges that Ms. Momoh's conduct amounted to professional misconduct as defined in subsection 2(1) of the *Nurses Act*, including acts of client abuse, failures to meet the standards of practice, failures in documentation, and breaches of the Canadian *Nurses* Association's *Code of Ethics for Registered Nurses*.

**EVIDENCE**

The evidentiary record consisted of the Notice of Hearing dated April 13, 2026, the Statement of

Uncontested Facts and Plea of No Contest dated April 13, 2026, with attached exhibits (including the Nursing Home's Restraint Use Policy, the Weekly Restraint Sheet, the clamshell restraint prescription, surveillance video and summary, a letter from the Department of Social Development, and the Resident's Progress Notes), (collective marked as Exhibit 1) and a Joint Submission on Order and Costs dated April 13, 2026 (Exhibit 2). In addition, the Panel was

provided with written submissions from the College on both the merits and proposed order, and written submissions from counsel for Ms. Momoh in support of the proposed order.

**UNCONTESTED FACTS**

As set out in the Statement of Uncontested Facts and Plea of No Contest filed by the parties, the Panel accepted the following facts:

1. Ms. Momoh became a Registered Nurse in 2021. At all material times, she worked at Orchard View Nursing Home (the "Nursing Home") through Plan A, a third-party agency. The Nursing Home is a long-term care facility located in Gagetown, New Brunswick, with a capacity for approximately 40 residents.

2. On September 11, 2023, a new female resident (the "Resident") was admitted to the Nursing Home. The Resident was 71 years old and had a history of dementia, anxiety, depression, and various physical conditions.

3. In the first few days following her admission, Nursing Home staff observed the Resident walking unsteadily, lowering herself onto the floor, and unsafely wandering the units. On September 13, 2023, the Resident was prescribed a clamshell restraint wheelchair on an as-needed (PRN) basis.

4. On September 15, 2023, Ms. Momoh worked a 12-hour night shift at the Nursing Home, beginning at 18:30 on September 15, 2023, and ending at 06:30 on September 16, 2023 (the "Night Shift"). Ms. Momoh was the only Registered Nurse on duty at the Nursing Home during the Night Shift.

5. Surveillance video and a summary of the surveillance video illustrate the events that occurred in the Nursing Home lounge from 22:53 until 05:17 on the Night Shift. Ms.

Momoh restrained the Resident in her clamshell restraint wheelchair from just before 22:53 until shortly after 05:17 on the Night Shift.

6. Ms. Momoh further restrained the Resident by inserting the legs of armchairs into the spokes of the wheels of the Resident's wheelchair and placing another chair in front of the Resident's wheelchair, from 22:56 to 04:23 on the Night Shift, for a period of 5 hours and 27 minutes. During one or more portions of this period, the Resident was asleep, and during some portions of this period, the Resident appeared visibly upset, flailed her arms, and moved her wheelchair several feet forward, dragging the armchairs lodged in the wheels of the wheelchair. Ms. Momoh reinserted the legs of the armchairs into the wheels of the wheelchair and repositioned the Resident's wheelchair in the corner of the lounge at 04:02 on the Night Shift.

7. Ms. Momoh remained seated on the couch in the lounge, within approximately 10 feet of the Resident, with her shoes off, for various periods during the Night Shift, including from 23:38 to 00:57; from 00:59 to 01:47; and from 01:52 to 03:55, for a total of approximately 4 hours and 10 minutes. Ms. Momoh briefly stood up on two occasions: first at 00:57 and again at 01:47.

8. Ms. Momoh did not contact the on-call physician during the Night Shift to seek additional orders to calm the Resident. Ms. Momoh informed the College Complaints Committee that she was hesitant to call the physician to discuss the situation and seek additional orders because she feared that she would irritate the physician and she worried that calling for help would demonstrate a lack of knowledge on her part.

9. On September 20, 2023, the Nursing Home discovered the above events and advised Plan A, the third-party agency, that Ms. Momoh was not to be assigned to the Nursing Home in the future.

10. On October 4, 2023, the Department of Social Development commenced an investigation and on May 30, 2024, concluded that Ms. Momoh physically abused and emotionally neglected the Resident, as described in section 37.1(1)(e) of the *Family Services Act*.

11. Ms. Momoh only made one entry in the Resident's Progress Notes during the twelve-hour Night Shift. The single entry was made at 04:18 on September 16, 2023, and reads as follows: "Resident was +++ agitated and yelling that she is anxious. 1mg Ativan was given to resident at about 2115, resident refused to settle in bed as she was getting up and going into other resident's room. Resident was place [sic] on restrained wheelchair, but she was able to release the breaks and still move around the unit and into other people's rooms. Resident was put in the lounge and closely monitored. Resident slept for about 3hrs and was up around 4am agitated and anxious again."

12. Ms. Momoh did not document any of the following: the Resident's condition and needs before, during, or after her interactions and interventions with the Resident; her assessment of the need to place the Resident in the clamshell restraint wheelchair; the time the Resident was placed in the clamshell restraint wheelchair; her assessment of the need to apply additional restraints; the fact that she applied additional restraints; the time she applied the additional restraints; her assessment of the continued need for restraints; the Resident's responses to the Ativan, the clamshell restraint wheelchair, or the additional restraints; her administration of Ativan to the Resident until approximately seven hours after administration; and the fact that her sole entry in the Resident's Progress Notes was late, and she did not document the times of the applicable interventions.

13. Ms. Momoh failed to practise in accordance with the Nursing Home's Restraint Use Policy, in that she: used inappropriate, unapproved, and non-manufactured restraints on the Resident; failed to document alternate measures that were attempted prior to the application of restraints; failed to use the least restrictive restraint for the shortest duration possible; failed to document the type of restraints, time of application, the

Resident's response, and the frequency of monitoring on the Weekly Restraint sheet; failed to document on the Weekly Restraint sheet at least every two hours with respect to the Resident's level of consciousness, circulatory/respiratory status, behaviour, nutrition/elimination needs, skin integrity, psychological status, and securely and safely applied restraint; and failed to document the removal of the additional restraints and the Resident's response.

14. Ms. Momoh did not contest that the Uncontested Facts constitute professional misconduct as defined in subsection 2(1) of the *Nurses Act*, and she does not contest that she committed acts of client abuse as defined in the ***Standards for the Nurse-Client Relationship***; that she digressed from the ***Standards*** of ***Practice for Registered Nurses***, the ***Standards for the Nurse-Client Relationship***, the ***Standards for Documentation***, and the Canadian *Nurses* Association's ***Code of Ethics for Registered Nurses***.

Ms. Momoh confirmed that she entered her plea of non-contest on an informed, unequivocal, and voluntary basis.

**SUBMISSIONS OF THE PARTIES**

The College submitted that the Uncontested Facts and Ms. Momoh's plea of no contest establish professional misconduct as alleged in the Notice of Hearing, including acts of client abuse, failures to meet the standards of practice, failures in documentation, and breaches of the Code of Ethics.

The College further submitted that the Panel should accept the parties' Joint Submission on Order and Costs as appropriate, proportionate, and in the public interest, consistent with the principles set out in *R. v. Anthony-Cook*, 2016 SCC 43.

Counsel for Ms. Momoh submitted that the Panel should accept the Joint Submission in its entirety, noting that the proposed disposition falls comfortably within a reasonable range of

outcomes and does not approach the high threshold required for rejection under the *Anthony-Cook* public interest test.

**ISSUES**

The issues for determination are whether the Uncontested Facts and Ms. Momoh's plea of no contest establish professional misconduct as alleged in the Notice of Hearing, and whether the parties' Joint Submission on Order and Costs should be accepted.

**DECISION**

Having considered the Statement of Uncontested Facts and Plea of No Contest, the attached exhibits, the Joint Submission on Order and Costs, and the written submissions of the parties, the Panel finds that the allegations in the Notice of Hearing have been proven on a balance of probabilities.

The Panel further accepts the parties' Joint Submission on Order and Costs.

**REASONS**

The Panel's assessment is grounded in the Statement of Uncontested Facts and in Ms. Momoh's plea of no contest. The Uncontested Facts establish that during the Night Shift of September 15–16, 2023, Ms. Momoh improperly restrained a 71-year-old Resident with dementia in a clamshell restraint wheelchair for over six hours and further restrained the Resident by inserting the legs of armchairs into the spokes of the wheelchair wheels and placing a chair in front of the wheelchair for a period of 5 hours and 27 minutes. During this period, Ms. Momoh remained seated on a couch approximately 10 feet away, with her shoes off, for over four hours, while the Resident was at times visibly upset, flailing her arms, and dragging the encumbered wheelchair across the room. Ms. Momoh did not contact the on-call physician, did not adequately document the Resident's condition or her interventions and failed to comply with the Nursing Home's Restraint Use Policy.

That conduct constituted a serious departure from the standards of safe, compassionate, competent, and ethical nursing practice expected of a Registered Nurse, and constituted client abuse within the meaning of the ***Standards for the Nurse-Client Relationship***. The Department of Social Development independently investigated and concluded that Ms. Momoh physically abused and emotionally neglected the Resident. Ms. Momoh's conduct represented a misuse of her power as a nurse over a vulnerable elderly resident with dementia, a betrayal of the trust inherent in the nurse-client relationship, and a disregard for the Resident's dignity, safety, and autonomy. Her conduct adversely affected the standing and good name of the profession.

With respect to sanction, the Panel is satisfied that the proposed disposition is appropriate and proportionate in the public interest, and that it does not meet the stringent threshold for rejection set out in *R. v. Anthony-Cook*, 2016 SCC 43. The reprimand, suspension, remedial education, supervision, performance evaluations, and publication term together address denunciation, specific and general deterrence, remediation, and the maintenance of public confidence in the College's discipline process. The order for costs is also appropriate in all the circumstances.

The Panel is also satisfied that the agreed disposition appropriately reflects the relevant mitigating and aggravating circumstances identified in the parties' submissions, including Ms. Momoh's plea of no contest, her lack of prior disciplinary history, and the fact that her misconduct consisted of a single incident, as well as the seriousness of the misconduct, the vulnerability of the Resident, and Ms. Momoh's disregard for her professional obligations. The proposed Order is consistent with the range of sanctions ordered in similar disciplinary cases involving improper restraint of vulnerable patients or residents.

**ORDER**

Having found the allegations proven and having considered the parties' Joint Submission on Order and Costs, the Panel is satisfied that the following Order is appropriate and proportionate.

1. Ms. Momoh shall appear before a panel of the Discipline Committee to be reprimanded immediately following the hearing of this matter, or on a date to be set by the Registrar, with the text of the reprimand to appear on the College's public register.

2. The Registrar is directed to suspend Ms. Momoh's Certificate of Registration for a period of one (1) month, to commence on the date of the Discipline Committee's written Decision and Order.

3. The Registrar is directed to impose the following specified terms, conditions, and limitations (collectively, the "conditions") on Ms. Momoh's Certificate of Registration:

    a. Ms. Momoh shall complete, at her own expense, and shall provide written confirmation to the Registrar of successful completion of the course "Critical Thinking in Nursing" offered by JCC Inc., or an equivalent course approved by the Registrar, within twelve (12) months of the date of the Discipline Committee's written Decision and Order;

    b. Ms. Momoh shall complete, at her own expense, and shall provide written confirmation to the Registrar of successful completion of the course "Nursing Clients with Dementia" offered by JCC Inc., or an equivalent course approved by the Registrar, within twelve (12) months of the date of the Discipline Committee's written Decision and Order;

    c. Ms. Momoh shall complete, at her own expense, and shall provide written confirmation to the Registrar of successful completion of the course "Documentation in Nursing" offered by MacEwan University, or an equivalent course approved by the Registrar, within twelve (12) months of the date of the Discipline Committee's written Decision and Order;

d. Ms. Momoh shall cause written performance evaluations to be submitted to the Registrar from each and every employer at 3 months, 6 months, 9 months, 12 months, and 18 months after she has returned to the active practice of nursing. Such performance evaluations must be satisfactory to the employer(s) and to the Registrar, and shall address Ms. Momoh's performance including her critical thinking skills; her clinical assessment skills; her documentation; her ability to practice nursing safely, competently, compassionately and ethically; and her adherence to the Standards of

Practice for Registered Nurses, the Standards for the Nurse-Client Relationship, the Standards for Documentation, or the applicable standards of the nursing regulator of the province in which she resides, and employer policies;

e. For a period of one (1) year after her return to the active practice of nursing, Ms. Momoh shall be supervised by a Registered Nurse or a Nurse Practitioner in good standing with the College or with the applicable nursing regulator of the province in which she resides, when applying any type of patient restraint, including environmental, mechanical, physical and chemical restraints. During this one (1) year period, Ms. Momoh shall cause written reports to be submitted to the Registrar by the Registered Nurse or Nurse Practitioner supervising Ms. Momoh's application of any type of patient restraint at 3 months, 6 months, 9 months, and 12 months after her return to the active practice of nursing. Such reports must be satisfactory to the Registrar and shall address Ms. Momoh's application of any type of patient restraint, including environmental, mechanical, physical and chemical restraints; and her adherence to the Standards of Practice for Registered Nurses, the Standards for the Nurse-Client Relationship, the Standards for Documentation, or the applicable standards of the nursing regulator of the province in which she resides, and employer policies in this regard; and

f. Ms. Momoh shall not work independently as a self-employed Registered Nurse and shall not work in a supervisory role until the conditions outlined above in this paragraph 3 have been satisfied and completed and she has an unencumbered Certificate of Registration.

4. For so long as the conditions on Ms. Momoh's Certificate of Registration outlined above in paragraph 3 are in effect:

   a. Ms. Momoh shall provide each employer with a copy of the Discipline Committee's Decision and Order and cause each employer to forward to the Registrar written confirmation of receipt of a copy of the Discipline Committee's Decision and Order within ten (10) days of commencement of employment or within ten (10) days of the issuance of the Discipline Committee's Decision and Order in the case of continued employment with any current employers; and

   b. Ms. Momoh shall notify the Registrar in writing, within ten (10) days of any change in her address or employer, including new employment (casual or permanent), suspension, termination, or resignation from employment.

5. If Ms. Momoh fails to satisfy any of the conditions outlined above in paragraphs 3 and 4 on or before the dates required, Ms. Momoh's Certificate of Registration may be suspended at the discretion of the Registrar until such time as the said conditions have been met. The Registrar may also, if in her sole discretion she determines that the circumstances so warrant, extend the timelines applicable to the conditions outlined in paragraphs 3 and 4.

6. If the Registrar is of the opinion that any of Ms. Momoh's performance evaluations referred to in paragraphs 3(d) and 3(e) indicate that Ms. Momoh is not meeting the standards of practice expected of a Registered Nurse, the Registrar may file a complaint about such failure to satisfy conditions with the Complaints Committee, which may

suspend Ms. Momoh's registration if the Complaints Committee is of the opinion that a danger to the public could result from not suspending her registration.

7. Ms. Momoh is ordered to pay the College costs in the amount of $2,000.00 within six (6) months of the date of the Discipline Committee's written Decision and Order.
8. The Registrar is directed to cause notice of the Discipline Committee's Decision and Order to be published on the College website. The notice shall include Ms. Momoh's name and registration number.

At the conclusion of the hearing, the Panel delivered its reprimand to Ms. Momoh. A copy of the reprimand is attached to these reasons for decision as Appendix "A".

Dated this 18th day of June 2026.

_original signed by_____
Luc Drisdelle, RN, Chairperson

_original signed by_____
Claire Goldie, RN, Nurse Member

_original signed by_____
Christine Flanagan, RN, Nurse Member

_original signed by_____
Dorina St. Onge, Public Member

**Appendix "A"**

**Reprimand**

Ms. Momoh, as you know, this Discipline Committee has ordered that you receive an oral reprimand as part of the sanction imposed upon you.

The reprimand should impress upon you the seriousness of your misconduct. The fact that you have received this reprimand will be reflected in the public disposition of this matter, including publication of the Committee's decision and summary of reasons with reference to your name.

The Committee has found, on the basis of the uncontested facts and your plea of no contest, that you committed professional misconduct when, during the Night Shift, you inappropriately restrained an elderly Resident with dementia by jamming armchairs into the wheels of the Resident's wheelchair, confining the Resident for hours while you sat on a couch approximately 10 feet away with your shoes off.

You failed to assess, assist, or release the Resident throughout this period. You also failed to contact the physician on call, admittedly because you did not want to appear as though you lacked knowledge.

You also failed or elected not to document important information about the Resident during the Night Shift, despite having time to sit on the couch while the Resident slept for a period of time. Your only progress note was made at 04:18, over seven hours after administering medication and approximately five and a half hours after restraining the Resident. Your conduct demonstrated a clear disregard for, and/or lack of understanding of, the standards of practice expected of a registered nurse.

The public is entitled to expect that nurses will act honestly and with integrity in all professional interactions, will exercise reasonable judgment, and will comply with professional and ethical standards. You failed to meet these fundamental obligations - by misusing your power as a registered nurse over a vulnerable elderly resident with dementia, by betraying the trust inherent in the nurse-client relationship through the inappropriate restraint of the Resident, by

neglecting to assess or monitor the Resident while she was restrained, by failing to contact a physician, and by failing to document the restraint and the Resident's condition

You have undermined confidence in your professionalism and in the standards that protect the public and uphold the reputation of the nursing profession.

The sanction imposed in this case, including this reprimand, reflects the seriousness of the misconduct and the need to protect the public and maintain confidence in the profession. We expect that you will use this process as an opportunity to reflect carefully on your professional obligations and to ensure there is no repetition of this conduct.

Thank you for attending today. We will prepare our written reasons in due course.

We are adjourned.