OFFICE OF THE ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2025-46A

Jenny Barnhouse, Executive Director
Oklahoma Board of Nursing
P.O. Box 52926
Oklahoma City, Oklahoma 73152

August 21, 2025

Re: Lei-Keil, Case No. 3.2023070143.26

Dear Executive Director Barnhouse:

This office has received your request for a written Attorney General Opinion regarding action that the Oklahoma Board of Nursing ("Board") intends to take in the above-referenced case. Respondent holds a multi-state licensed practical nurse (LPN) license in the primary state of residence Missouri. Therefore, Respondent holds a privilege to practice as an LPN in party state, including Oklahoma.

The Oklahoma Nursing Practice Act ("Act") authorizes the Board to impose discipline when a nurse "[i]s guilty of unprofessional conduct[,]"[1] "[f]ails to adequately care for patients or to conform to the minimum standards of acceptable nursing" in a way that "unnecessarily exposes a patient or other person to risk of harm[,]" or "[i]s guilty of any act that jeopardizes a patient's life, health or safety[.]"[2] 59 O.S.2021, § 567.8(B)(3), (7) and (8).

On June 11, 2025, a Board Nurse Investigator filed a Complaint against the Respondent's LPN licensure privilege to practice in Oklahoma for the following conduct. On July 14-15, 2023, Respondent, while contracted to work as an independent contractor LPN working as a charge nurse on the 7:00 p.m. to 7:00 a.m. shift at a Nursing Home in Oklahoma, abandoned her Resident care assignment of 43 Residents, when the Respondent left the Nursing Home without giving a report to another licensed nurse. There were other licensed nurses on duty at the Nursing Home when the Respondent abandoned her shift, without giving report. There was no documented harm to the Respondent's Resident care assignment. The Oklahoma Board of Nursing Abandonment Statement provides Guidelines to specific situations that may constitute abandonment: …examples of abandonment may include but not be limited to: "Leaving the employment site during an

[1] Unprofessional conduct includes "leaving a nursing assignment or patient care assignment without properly advising appropriate personnel;" and "conduct detrimental to the public interest[.]" OAC 485:10-11-1(b)(3)(F), (H).

[2] Conduct that jeopardizes a patient's life, health, and safety includes "[f]ail[ing] to utilize appropriate judgment in administering safe nursing practice or patient care[.]" OAC 485:10-11-1(b)(4)(D).

assigned patient care shift after the nurse has come on duty and accepted the assignment of patient(s) for the shift without properly advising appropriate personnel" and "Leaving without reporting to the oncoming shift." Respondent contacted Nursing Home's Administration at approximately 12:57 a.m. and informed Nursing Home Administration that Respondent's relative "was sick and had to go to the ER." Nursing Home Administration directed the Respondent to "call on-call staffing. At 1:20 a.m. a text came through that she had left the building."

Thereafter, on December 4, 2024, December 19, 2024, and February 5, 2025, Respondent failed to cooperate with a lawful investigation by Board staff when Respondent failed to participate in a telephonic conference with Board staff. The correspondence for December 4, 2024, and February 5, 2025, was mailed to the Respondent's mailing address of record with the Board on November 19, 2024, and January 13, 2025, respectively. The correspondence dated January 13, 2025, was returned to the Board office on February 3, 2025, by the United States Postal Service marked "Return to Sender"/"Not Deliverable As Addressed"/"Unable to Forward."

At the hearing on July 31, 2025, the Board determined that Respondent's leaving an assignment without proper notification to supervisor and failing to give report to another licensed nurse to assume the responsibility for the assigned residents, placed residents at risk during the Respondent's absence from the facility. Therefore, the Board proposes to revoke Respondent's privilege to practice as an LPN in the State of Oklahoma. Respondent is also ordered to pay the cost of the investigation and prosecution in the amount of Nine Hundred Ninety Dollars and 61/100 ($990.61).

It is, therefore, the official opinion of the Attorney General that the Oklahoma Board of Nursing has adequate support for the conclusion that this action advances the State's policy to protect public health, safety, and welfare by ensuring nurses meet minimum standards of professional conduct.

CHERYL DIXON
Deputy General Counsel