OFFICE OF THE ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2025-28A

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

May 14, 2025

Re: Maldonado-Hevia, Case No. 3.2023110353.25

Dear Executive Director Barnhouse:

This office has received your request for a written Attorney General Opinion regarding the action that the Oklahoma Board of Nursing intends to take in the above-referenced case. Respondent is licensed with an advanced practice registered nurse-certified registered nurse anesthetist (APRN-CRNA) license, which lapsed on December 1, 2024. Additionally, Respondent holds a multistate registered nurse (RN) license in another Nurse Licensure Compact state. Accordingly, Respondent possesses the privilege to practice as an RN in the Party States, including Oklahoma.

The Oklahoma Nursing Practice Act authorizes the Board to impose discipline when a nurse "[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[,]" "[i]s guilty of unprofessional conduct[,]"[1] 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), (7–8).

In a February 2025 complaint, Board staff alleged that Respondent's conduct unnecessarily exposed patients or other persons to risk of harm and jeopardized patients' lives, health or safety. Specifically, on or about November 29, 2023, Respondent, an independent contractor, contracted to work as an APRN-CRNA at a Hospital, failed to conform to the minimum standards of acceptable nursing practice by violating patient safety standards and infection control standards by using the same intravenous (IV) medication bag and IV tubing for at least 18 Patients. In addition, Respondent left uncapped syringes, which had medication drawn up into the syringes, laying on top of the Hospital surgical medication cart and inside an anesthesia medication supply box. RN #1 observed a used IV medication bag and IV tubing hanging uncapped in a surgical suite. RN #1

[1] Unprofessional conduct includes behavior that "fails to conform to the accepted standards of the nursing profession," "which could jeopardize the health and welfare of the people," and include "conduct detrimental to the public interest." OAC 485:10-11-1(b)(3)(H).

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

asked the Circulating Nurse, RN #2, to observe what the Respondent did with the used IV medication bag and uncapped tubing. RN #2 observed Respondent taking the used IV medication bag and uncapped tubing and place the used IV medication bag with tubing into the medication carrying box. RN #1 was notified by RN #2 of what Respondent had done with the IV medication bag and tubing and RN #1 observed the Respondent preparing the next surgical suite for another patient. Respondent removed the used IV medication bag with the uncapped tubing attached and placed the used IV medication bag on an IV pole. RN #1 went to Hospital Administration with concerns regarding Respondent's practice and when Hospital Administration questioned the Respondent if the IV medication bag and uncapped tubing had been used on previous Patient(s), the Respondent stated, "yes, but I wipe down the port with alcohol," while pointing to the uncapped end of the tubing. Hospital Administration informed Respondent that reusing IV medication and IV tubing for multiple patients was not an acceptable practice and instructed Respondent to obtain new IV medication and IV tubing for each patient. Further, Hospital Administration informed Respondent that all syringes should be capped when not in use, for patient safety standards and infection control standards. On November 29, 2023, the Respondent's Hospital contract was canceled by Hospital Administration.

Moreover, the Notice of Hearing was mailed to Respondent by certified mail to the address provided by Respondent to the Board and was returned "Returned to Sender" / "Unclaimed" / "Unable to Forward" on March 25, 2025. Attempts to notify Respondent of the hearing were unsuccessful by mail, telephone, or electronic mail. As of the date of the Board's Emergency Order, Respondent had not responded to any of the telephone calls or emails.

At a hearing held March 26, 2025, the Board proposed an emergency order of temporary suspension, lifting the lapsed status of Respondent's APRN-CRNA license and temporarily suspending both Respondent's APRN-CRNA license and RN privilege to practice pending a hearing on the merits of the complaint. The Board also directed Respondent to file an application for reinstatement with any request for a hearing on the merits of the complaint. Given the serious nature of the allegations, the Board may reasonably believe that this emergency action is necessary to protect public health, safety, and welfare.

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