OFFICE OF THE ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2025-30A

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

May 14, 2025

Re: Middleton, Case No. 3.2023110113.25

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 single-state licensed practical nurse license in 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), (7–8).

According to a Board complaint filed on October 1, 2024, the Respondent failed to provide the minimum standard of nursing care to a patient and the Respondent's actions unnecessarily exposed that patient to harm and jeopardized the patient's life. Respondent, while working as a charge nurse on the 6:00 a.m. – 6:00 p.m. shift at a nursing home, required Resident #1 to get out of bed after Resident #1 refused. Resident #1 stated to Respondent that she wanted to stay in bed, was having tremors, feeling dizzy and did not want to walk.[3] The following was observed and heard on a nursing home security camera video:

a. At approximately 8:23 A.M., Resident #1, is observed bent at the hips and coughing. The Respondent can be heard telling Resident #1 to stand up straight and is observed placing Respondent's right hand, from behind Resident #1, on Resident #1's

[1] Unprofessional conduct includes "inaccurate recording, falsifying, altering or inappropriate destruction of patient records," and "conduct detrimental to the public interest." OAC 485:10-11-1(b)(3)(A),(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).

[3] Resident #1 was a seventy-five (75) year old female who had been admitted to the nursing home for skilled care following surgical repair of a right distal femur fracture with open reduction internal fixation.

right shoulder/neck. Respondent's left hand is on Resident #1's back. The Respondent then instructed Resident #1 to walk.

b. At approximately 8:24 A.M., Resident #1 is observed to have knees bending and descending to sit on the Nursing Home floor. The Respondent grabbed the gait belt, which was around Resident #1's chest and under her armpits. Further, the Respondent bent down from behind Resident #1, placed one hand under each of Resident #1's arms to pull Resident #1 to her feet while stating, "stand up, we are not sitting in the floor, come on." Resident #1 is observed walking a few steps with the Respondent, following behind Resident #1.

c. At approximately 8:25 A.M., Resident #1 sinks to the floor and the Respondent attempts to lift Resident #1 from behind. Resident #1 does not attempt to get up off of the floor after this event. The Respondent can be heard telling other Nursing Home staff "she didn't want to get out of bed."

d. From approximately 8:26 A.M. to approximately 8:30 A.M., Resident #1 is observed to be sitting on the Nursing Home floor until the Respondent and two other Nursing Home staff lift Resident #1 into a wheelchair.

Thereafter, Respondent took Resident #1 back to Resident #1's room and placed Resident #1 in her bed. The Respondent failed to initiate cardiopulmonary resuscitation ("CPR"), which is conduct detrimental to the public interest and an act that jeopardized a patient's life, health, or safety. After Respondent placed Resident #1 in bed, Respondent went outside to smoke a cigarette and called the nursing home's Director of Nursing ("DON"). Respondent informed the DON that Resident #1 had passed. The DON informed Respondent that Resident #1 was a full code. Upon Respondent coming back inside the nursing home, the nursing home Activities Director asked Respondent what she could do to help and Respondent, as per the Activities Director, stated "get some F---ing aides." The Activities Director, offered to help get Patient #1 ready for the funeral home, to which the Respondent responded, "I don't know if she even has a funeral home listed." The Activities Director and Respondent went to look at Patient #1's profile and determined that Resident #1 was a full code. The Respondent told the Activities Director that Resident #1 has been "gone for awhile" and "I can go break her ribs."

Furthermore, Respondent falsified Resident #1's nursing home medical records when Respondent documented, "this nurse noting that resident is without any respirations and without an b/p…this nurse started cpr with back board in place and called 911." Respondent failed to initiate resuscitation efforts immediately, instead placed Resident #1 in bed and went outside to smoke a cigarette and proceeded to call the nursing home director to inform them that Resident #1 had passed. On or about November 6, 2023, Respondent was suspended by the nursing home administration pending investigation of Respondent's treatment of Resident #I. On November 9, 2023, the Respondent was terminated from the nursing home for Respondent's "violating resident rights" and "abuse" to Resident #1.

Respondent accepted service of the Notice of Hearing and Complaint on February 6, 2025. Respondent failed to file a written Response within 20 days. On February 27, 2025,

correspondence was sent to Respondent at that same address informing her that she was in default status and that the hearing would proceed.

At the hearing held March 25, 2025, the Board found that Respondent violated the Oklahoma Nursing Practice Act and ordered Respondent's single-state licensed practical nursing license lapsed status be lifted and, thereafter, revoked for a period of one (1) year. Respondent shall, within ninety (90) days prior to the submission of any reinstatement application successfully complete Board approved training in Nursing Documentation, Physical Assessment, The Roles and Responsibilities of the Licensed Practical Nurse in Long Term Care, to include all applicable state and federal regulations, and Critical Thinking, to include moral reasoning, and each course shall meet the requirements outlined by the Board in its Order. Prior to reinstatement of any nursing license, Respondent shall pay an administrative penalty in the amount of One Thousand Five Hundred Dollars ($1,500.00), as well as the cost of the investigation and prosecution of this action in the amount of One Thousand Seven Hundred Twenty-Seven and 52/100 Dollars ($1,727.52), to the Oklahoma Board of Nursing. Payments shall be made by certified check or money order only.

Prior to Respondent's successful completion of the requirements in the Order, any violations of the Oklahoma Nursing Practice Act by Respondent, except as set forth in the Order, may require Respondent's appearance before the Board to show cause why Respondent's single-state license should not be revoked or other such action taken as the Board deems necessary and proper. Upon successful completion of all the terms of the Board's Order, all encumbrances shall be removed from Respondent's single-state licensed practical nurse license. The Board's Order constitutes disciplinary action by the Board and may be used in any subsequent hearings by the Board. Given the serious nature of the allegations, the Board reasonably believes that this 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