OFFICE OF THE ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2026-20A

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

March 17, 2026

Re: Earnest, Case No. 3.2025050015.26

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 is licensed with a single-state registered nurse ("RN") license, number R0059879, which is currently lapsed.

The Oklahoma Nursing Practice Act ("Act") authorizes the Board to impose discipline when a nurse "[i]s guilty of unprofessional conduct"[1] or "[h]as had disciplinary actions taken against the individual's registered . . . nursing license . . . in this or any state, territory or country." 59 O.S.Supp.2023, § 567.8(B)(7), (B)(10).

On February 16, 2025, Respondent submitted to the Board a Reinstatement or Return to Active Status of Licensure, RN Application ("Reinstatement Application"). On December 17, 2025, a Complaint was filed against Respondent's RN license for the following violations related to an Agreed Order with the Texas Board of Nursing ("Agreed Order") that Respondent entered into on February 6, 2024:

> On or about April 16, 2015, Respondent was issued the sanction of Warning with Stipulations through an Order of the Board. On or about May 18, 2016, Respondent completed the terms of the Order.
>
> On or about June 11, 2023, through June 12, 2023, while employed as an RN at a hospital in Dallas, Texas, and in the Charge Nurse role, Respondent failed to appropriately assess, intervene, and/or initiate a rapid response for a patient, who was exhibiting signs and symptoms of respiratory distress when assistance had been requested. Respondent's

[1] Unprofessional conduct includes "conduct detrimental to the public interest" and/or "failure to cooperate with a lawful investigation by Board or Nursing staff." OAC 485:10-11-1(b)(3)(H), (V).

conduct was likely to injure the patient for lack of appropriate nursing and medical care and may have contributed to the patient's subsequent death.

On or about June 11, 2023, through June 12, 2023, while employed as an RN at a hospital in Dallas, Texas, and in the Charge Nurse role, Respondent failed to follow the physician's order to transfer a patient to acute care for evaluation when his symptoms of respiratory distress worsened and when assistance to transfer was requested twice. As a result, the oncoming shift later transferred the patient via EMS, and the patient died after arriving at the hospital. Respondent's conduct likely injured the patient, as the failure to transfer the patient as ordered by the physician caused a delay in emergency treatment for the patient that was needed to prevent further complications and may have contributed to the patient's death.

The Terms of Respondent's Agreed Order include: Respondent's TX registered nurse license was SUSPENDED and said suspension STAYED and Respondent placed on PROBATION for a minimum of 2 years and until Respondent fulfilled additional requirements of the Agreed Order including: Educational courses: Understanding Board Orders, Texas Nursing Jurisprudence and Ethics; Physical Assessment; and Righting a Wrong, within one year of the Agreed Order. Respondent was further required to "work as a nurse in Texas, providing direct patient care in a clinical healthcare setting, for a minimum of 64 hours per month for 8 quarterly periods [2 years] of employment." In accordance with the Texas Board of Nursing guidelines.

On or about May 5, 2025, Board staff received electronic correspondence from the Texas Board of Nursing stating that Respondent has completed only 3 of the 24 months of supervised practice. Respondent has 3 remaining courses outstanding that were due in March. Respondent was granted a 3-month extension to complete the courses.

On July 9, 2025, and August 7, 2025, Respondent failed to cooperate with a lawful investigation by Board staff when Respondent failed to participate in a telephonic investigative conference. The Correspondence for the July 9, 2025, and August 7, 2025, telephonic investigative conferences were mailed to Respondent's mailing address of record with the Board on June 23, 2025, and July 22, 2025, respectively.

After a hearing on January 29, 2026, the Board proposes to lift the lapsed status of Respondent's license and summarily suspend Respondent's license to practice registered nursing pending a hearing on the merits of the Complaint and a determination of whether or not Respondent's license should be disciplined.

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