



OFFICE OF THE ATTORNEY GENERAL  
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION  
2026-23A

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

March 17, 2026

Re: Thomas, Case No. 3.2025060106.26

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 to practice in Oklahoma with a single-state registered nurse (“RN”) license, number R0072182.

The Oklahoma Nursing Practice Act (“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 . . . that, in the opinion of the Board, unnecessarily exposes a patient or other person to risk of harm;” “[i]s guilty of unprofessional conduct;”<sup>1</sup> “[i]s guilty of any act that jeopardizes a patient’s life, health or safety as defined in the rules of the Board;”<sup>2</sup> 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)(3), (B)(7), (B)(8), (B)(10).

On December 18, 2025, a Complaint was filed against Respondent’s RN license for the following conduct:

On May 7, 2025, the Arkansas State Board of Nursing (“ARSBON”) issued the following findings of Fact, Conclusions of Law and Order (“ARSBON Order”) that suspended Respondent’s license and privilege to practice in Arkansas until the Respondent completes an addictive evaluation for the following:

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<sup>1</sup> Unprofessional conduct includes “conduct detrimental to the public interest;” or “failure to cooperate with a lawful investigation by Board or Nursing staff” OAC 485:10-11-1(b)(3)(H), (V).

<sup>2</sup> Conduct that jeopardized a patient’s life, health or safety shall include but not be limited to, “[f]ailure to utilize appropriate judgment in administering safe nursing practice or patient care assignment based upon the level of nursing for which the individual is licensed or recognized[.]” OAC 485:10-11-1(b)(4)(D).

## Findings of Fact

1. An investigation was conducted after it was self-reported by Respondent that she had tested positive for alcohol at 0.246, while working at Siloam Springs Regional Hospital. Respondent requested that she be allowed to participate in the Alternative to Discipline program, however, Respondent is not eligible because of past probation discipline history on her license.
2. Records from Siloam Springs Regional Hospital confirm that on March 17, 2022, Respondent was requested to submit to a for cause urine drug screen while at work. The test reported the presence of alcohol at 0.246. Respondent reported that she was subsequently terminated for not disclosing the presence of alcohol prior to the drug screen.
3. Respondent reported to the Board investigator that she was currently under investigation for reporting to work intoxicated, and that she was 100% guilty and in no way was trying to resolve her responsibility for that action.”

On or about June 24, 2024, through November 7, 2024, ARSBON staff made multiple attempts to contact Respondent by electronic mail, messages through the nurse portal, and by certified mail, requesting Respondent provide an addictive evaluation and notifying Respondent of a hearing scheduled for February 20, 2025. Respondent did not contact ARSBON staff or provide the requested addictive evaluation report. The ARSBON concluded that the Respondent was guilty of violating Ark. Code Ann. § 17-87-309(a)(4) and (a)(6) and ordered that Respondent’s license and privilege to practice be suspended until completion of an addictive evaluation.

On August 7, 2025, and September 3, 2025, Respondent failed to cooperate with a lawful investigation by Board staff when the Respondent failed to participate in a telephonic investigative conference with Board staff. Correspondence for the August 7, 2025, and September 3, 2025, telephonic investigative conferences were mailed to the Respondent’s mailing address of record with the Board on July 18, 2025, and August 19, 2025, respectively. The correspondence dated July 18, 2025, was not returned to the Board office. Correspondence dated August 19, 2025, mailed by certified mail was delivered on August 21, 2025.

After a hearing on January 29, 2026, the Board found Respondent in default and the allegations in the Complaint deemed admitted. Respondent’s RN license is severely reprimanded, and Respondent is referred to the Board’s Peer Assistance Program (“PAP”), with Respondent’s RN license temporarily suspended pending the Respondent’s entry into the PAP. If Respondent fails to enter PAP and/or defaults/terminates from PAP, Respondent’s RN license will be revoked for 2 years. If revoked, Respondent must meet the additional requirements in the Board’s Order.

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*