



OFFICE OF THE ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2026-4A

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

January 8, 2026

Re: Bradshaw, Case No. 3.2025060108.26

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's license to practice licensed practical nursing (LPN) in the State of Oklahoma is currently temporarily suspended after the Board issued an Order of Emergency Temporary Suspension in May, 2025 (see AG opinion 2025-20A).

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).

On September 25, 2025, a Board Investigator filed an Amended Complaint against Respondent's LPN license for the following: On or about June 7-8, 2023, while working as a charge nurse on the 6:00 p.m. to 6:00 a.m. shift at a nursing home, Respondent failed to act and ensure a resident was safe after being notified by a certified nurse aid ("CNA") that resident #1 had activated their call light to report that another resident (resident #2) had been in their room and that resident #1 had awoken to resident #2 "groping her breasts and vagina over her clothes." Respondent was sitting in a recliner in the common area, with ear buds in both ears, sleeping when the CNA came to notify the Respondent of the sexual assault allegation. When awakening, Respondent responded to the CNA, "let me know if it happens again," before going back to sleep. Respondent failed to notify either residents' physician, family, nursing home administration, or document the incident

¹ Unprofessional conduct includes "leaving a nursing assignment or patient care assignment without properly advising appropriate personnel," or "conduct detrimental to the public interest" and "failure to cooperate with a lawful investigation by Board of Nursing staff." OAC 485:10-11-1(b)(3)(F),(H),(V).

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).

in either one of the residents' medical records. Furthermore, Respondent abandoned her position when Respondent was sleeping on duty. Respondent was terminated from the nursing home on June 15, 2023, and is not eligible for rehire.

Additionally, Respondent failed to cooperate with the Oklahoma Board of Nursing's investigation. On or about July 25, 2024, and August 21, 2024, Respondent failed to participate in telephonic investigative conferences with Board staff. The Board sent correspondence for these conferences to Respondent's mailing address of record with the Board, the mail was not returned to the Board office, yet Respondent failed to participate. At a hearing held November 20, 2025, it was determined that Respondent did not receive notice of the previous temporary suspension hearing held on March 25, 2025. On or about May 1, 2025, Respondent submitted a Reinstatement or Return to Active Status of Licensure Application to practice multistate LPN in Oklahoma and on June 13, 2025, submitted a request for hearing on the original Complaint.

At the November 20, 2025 hearing, the Board concluded that Respondent failed to adequately care for a patient or conform to the minimum standards of acceptable nursing practice and Respondent's conduct unnecessarily exposed a patient or other person to risk of harm and jeopardized patients' lives, health or safety; that Respondent lacked sufficient knowledge or reasonable skill by failing to adhere to the minimal standards of acceptable practical nurse practice; and unprofessional conduct. The Board proposed to discipline Respondent's LPN as follows: Respondent's Reinstatement or Return to Active Status of Licensure (LPN) is granted, but Respondent's multistate license is converted to a single-state license, and the multistate licensure privilege deactivated in all party states. Respondent's single-state LPN license is reinstated but reprimanded. Respondent shall within ninety (90) days of the Board's Order complete Board approved courses on Nursing Jurisprudence and Critical Thinking, to include moral reasoning. Within one hundred eighty (180) days of the Board's Order, complete a Board approved course in The Roles and Responsibilities of the Licensed Practical Nurse, to include all applicable state and federal regulations. Respondent must also pay an administrative penalty of two thousand dollars (\$2,000.00).

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