OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA

ATTORNEY GENERAL OPINION
2018-66A

Kim Glazier, Executive Director
Oklahoma Board of Nursing
2915 N. Classen Blvd., Ste. 524
Oklahoma City, Oklahoma 73106

February 28, 2018

Dear Executive Director Glazier:

This office has received your request for a written Attorney General Opinion regarding action that the Oklahoma Board of Nursing intends to take pursuant to consent agreements in cases 3.166.18, 3.179.18, 3.180.18, and 3.182.18. Each case involves the licensee's failure to provide adequate nursing care and therefore compromising vulnerable patients. The details of the violations and the proposed action for each licensee are attached on Appendix A.

The Oklahoma Nursing Practice Act authorizes the Board to impose discipline when a nurse "fails 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," "is guilty of unprofessional conduct," or "is guilty of any act that jeopardizes a patient's life, health or safety." 59 O.S.Supp.2017, § 567.8(B)(3), (7-8). The Board may reasonably believe that the proposed actions are necessary to deter future violations.

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.

MIKE HUNTER
ATTORNEY GENERAL OF OKLAHOMA

AMANDA OTIS
ASSISTANT ATTORNEY GENERAL

313 N.E. 21ST STREET • OKLAHOMA CITY, OK 73105 • (405) 521-3921 • FAX: (405) 521-6246

recycled paper

APPENDIX A

Board Case No.	Details of Violation	Proposed Action
3.166.18	The licensee exhibited impaired behavior at work and later admitted to taking several controlled dangerous substance ("CDS") medications while on duty.	Issue a severe reprimand, require licensee to complete an evaluation, complete periodic drug screenings for 12 months, complete two education courses, and pay a $500 administrative penalty.
3.179.18	The licensee failed to initiate ventilation for a resident, which may have contributed or lead to the resident's death. The licensee has requested to voluntarily surrender her license.	Accept the voluntary surrender, with license not to be reinstated for at least one year. Prior to reinstatement, require licensee to complete two education courses and pay a $500 administrative penalty. Upon reinstatement, place the licensee on supervised practice for 720 cumulative worked hours.
3.180.18	The licensee failed to notify a healthcare provider or the Director of Nursing of a serious change in condition of a resident. The resident later passed away, possibly due to the change in condition and lack of action of the licensee. The licensee has been previously disciplined for failing to initiate CPR on a resident. The licensee has requested a continuance until the licensee is able to attend the hearing.	Grant the continuance, but temporarily suspend the license pending the hearing.
3.182.18	The licensee failed to perform and document a physician ordered focused assessment for a patient. Later the licensee found the patient unresponsive and without a pulse. The licensee then initiated CPR, not in compliance with the standards of the American Heart Association to which the licensee had been certified. The licensee has requested to voluntarily surrender his/her license.	Accept the voluntary surrender, with license not to be reinstated for at least one year. Prior to reinstatement, require the licensee to complete two education courses, submit documentation of CPR certification, and pay a $500 administrative penalty. Upon reinstatement, place the licensee on supervised practice for 1440 cumulative worked hours, excluding home health and hospice.