Office of Attorney General
State of Oklahoma

Attorney General Opinion
2018-304a

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

August 14, 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 agreement in cases 3.005.19, 3.009.19, 3.012.19, 3.015.19, 3.016.19, 3.017.19, 3.018.19, 3.022.19, and 3.023.19. In these cases, the licensees failed to conform to the minimum standards of acceptable nursing, failed to conduct themselves in a professional manner and engaged in acts that jeopardized the life, health or safety of patients. Details of the violations and proposed actions 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 these actions advance the State's policy to protect public health, safety, and welfare by ensuring nurses meet minimum standards of professional conduct.

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Attorney General of Oklahoma

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APPENDIX A

Case No.	Details of Violation	Proposed Action
3.005.19	Licensee acted outside the scope of practice by calling in a prescription for a family friend and faxing a refill request for the prescription without prior authorization from a physician.	Require the completion of education courses, issue a severe reprimand and impose a $500 administrative penalty.
3.009.19	Licensee violated safety and infection control standards by transporting vaccine home, pre-filling and refrigerating overnight approximately 250 syringes, and, on the following day, transporting the syringes to the hospital for administration to hospital staff.	Require the completion of education courses, issue a severe reprimand and impose a $1,000 administrative penalty.
3.012.19	Licensee performed and documented a focused assessment and completed new admission documentation for the resident who arrived after 15-day hospitalization, but failed to request complete discharge paperwork from the hospital or notify the nursing home physician of the resident's admission. As a result, the resident failed to receive physician-ordered medication and was readmitted to the hospital.	Require the completion of education courses, issue a severe reprimand and impose a $250 administrative penalty.
3.015.19	Licensee falsified a resident's observation form to state that the licensee had performed a 15 minute in-room visual observation of the resident. The resident was later found with a clear bag over the head and no respirations or pulse.	Require 1,440 cumulative worked hours of supervised practice to be completed within two years in a hospital and/or healthcare agency, require the completion of education courses and impose a $500 administrative penalty.
3.016.19	Licensee did not perform or document a focused assessment of a resident who fell out of bed, notify the physician, director of nursing, the resident's family or the on-coming licensed practical nurse of the fall, or complete an incident report.	Require the completion of education courses, issue a severe reprimand and impose a $500 administrative penalty.

3.017.19	Licensee, after seeing a resident on the floor next to a wheelchair and assisting the resident back into the wheelchair, did not perform or document a focused assessment, notify the physician, hospice nurse, director of nursing, the oncoming licensed practical nurse or the resident's family of the fall, or complete an incident report.	Require the completion of education courses, issue a severe reprimand and impose a $500 administrative penalty.
3.018.19	Licensee, after being informed of blood on a resident's bed sheets and that the resident fell during the previous shift, did not perform or document a focused assessment, confirm that an assessment of the resident had been conducted during the previous shift, or notify the physician, hospice nurse and resident's family of a change in condition.	Require the completion of education courses, issue a severe reprimand and impose a $500 administrative penalty.
3.022.19	Licensee, after being notified that a resident was complaining of knee pain and difficulty moving leg, did not perform and document a focused assessment, timely schedule a physician-ordered x-ray, or notify nursing home administration and the resident's family of a change in condition or complete an incident report.	Require the completion of education courses, issue a severe reprimand and impose a $500 administrative penalty.
3.023.19	Licensee, while working as the director of nursing at a nursing home, inappropriately delegated wound care to a licensed practical nurse and failed to ensure that staff appropriately managed resident's wound care.	Require the completion of education courses, issue a severe reprimand and impose a $1,000 administrative penalty.