BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	)	**FINAL ORDER OF REVOCATION**
Laurelei Bailey, RN	)	**BY DEFAULT**
	)	
License No. 200740325RN	)	**Reference No. 2024010248**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including RNs. Laurelei Bailey (Licensee) was issued a RN License by the Board on February 8, 2007.

This matter was considered by the Board at its meeting on December 18, 2024.

On November 25, 2024, a Notice stating that the Board intended to Revoke the RN License of Laurelei Bailey was sent to Licensee via certified and first-class mail to the address of record.

The Notice alleged that Licensee failed to meet nursing standards in the performance of duties as a school nurse for four (4) schools during the 2023-2024 school year.

The Notice granted Licensee an opportunity for hearing if requested within twenty (20) days of the mailing of the Notice. No such request for hearing has been received by the Board. The Notice designated the Board's file on this matter as the record for purposes of default.

NOW THEREFORE, after consideration of its records and files related to this matter, the Board enters the following Order:

-I-

FINDINGS OF FACT

Based on the evidence submitted through the Notice and the agency file in this case, the Board finds the following:

1. Licensee was issued a RN License in the state of Oregon on February 8, 2007.

2. On or about January 29, 2024, the Board opened an investigation into allegations that Licensee failed to meet nursing standards in the performance of duties as a school nurse for four (4) schools during the 2023-2024 school year.

3. During the 2023-2024 school year Licensee failed to complete the majority of the required teacher/staff notifications regarding students with serious health issues, including seizures, food intolerance, vision impairment, severe allergic reactions including anaphylaxis, asthma, and mental health conditions, raising the risk to those students.

4. During the 2023-2024 school year Licensee failed to complete the majority of nursing charting in students' electronic health records; almost every student chart was incomplete. A majority of student charts were missing multiple items which should have been included by Licensee, including provider orders, nursing assessments, parent contact, teachings and delegations records.

5. During the 2023-2024 school year, Licensee failed to complete over 120 care plans, delegations and teachings within her caseload.

6. Licensee delegated duties to several unlicensed assistive personnel (UAPs) but did not indicate if the 60-day or 180-day reviews were completed.

7. During the 2023-2024 school year, the majority of students with reported health conditions were never assessed by Licensee.

8. During the 2023-2024 school year, Licensee had 12 instances of failing to respond to calls from staff and not being available to staff for consultation, as assigned.

9. During the 2023-2024 school year Licensee's conduct and performance raised concerns about her cognitive status, orientation and critical thinking skills. Licensee was observed to have difficulty following or remembering simple directives, communicating effectively and professionally, accomplishing assigned duties in a timely or accurate manner, and she struggled with her orientation to time, place and situation.

10. Licensee failed to cooperate with the Board's investigation by failing to respond to the Board's requests to schedule an interview and for requests for information sent to Licensee on July 8, 2024, July 10, 2024, July 30, 2024, and August 29, 2024.

11. Licensee failed to comply with the Board's Order for Evaluation issued on October 18, 2024.

12. On November 25, 2024, Board staff mailed a Notice of Proposed Revocation to Licensee via first-class and certified mail. The Notice granted Licensee twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

- II-

CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Licensee, Laurelei Bailey, and over the subject matter of this proceeding.

2. That Licensee's conduct is in violation of the following statutes and rules:

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined *[cert. ef. 01/01/2023]*
Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:

(2) Conduct related to achieving and maintaining clinical competency:
(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;

(3) Conduct related to the client's safety and integrity:
(a) Developing, modifying, or implementing policies that jeopardize client safety;
(b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment;
(c) Failing to develop, implement or modify the plan of care;
(g) Improperly delegating the performance of a nursing procedure to a UAP;
(h) Failing to clinically supervise a UAP to whom a nursing procedure has been delegated.

(4) Conduct related to communication:
(a) Failure to accurately document nursing interventions and nursing practice implementation;
(b) Failure to document nursing interventions and nursing practice implementation in a timely, accurate, thorough, and clear manner. This includes failing to document a late entry within a reasonable time period;
(c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to:
(C) Failing to document information pertinent to a client's care;
(f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care; or
(g) Failing to communicate information regarding the client's status to other individuals who are authorized to receive information and have a need to know.

(7) Conduct related to impaired function:
(a) Practicing nursing when unable or unfit due to:
(B) Psychological or mental impairment as evidenced by documented deterioration of functioning in the practice setting or by the assessment of an LIP qualified to diagnose mental conditions or status.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined *[Cert. ef. 07/01/2024]*
Conduct derogatory to the practice of nursing is conduct that adversely affects the health, safety, and welfare of the public; that fails to conform to OAR 851-045 scope and standards of practice; or that fails to conform to accepted standards of the nursing profession. Such conduct includes, but is not limited to:

(10) Conduct related to the licensee's relationship with the Board:
(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege;
(c) Failing to provide the Board with any documents requested by the Board;
(d) Violating the terms and conditions of a Board order;

3. That Licensee defaulted on the Notice by not requesting a hearing within the allotted twenty (20) days and, as a result, pursuant to ORS 183.417(3), the Board may enter a Final Order by Default.

-III-

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and the Board being fully advised in the premises, it is hereby:

ORDERED that the Registered Nurse License of Laurelei Bailey is REVOKED.

DATED this 18 day of December, 2024

FOR THE BOARD OF NURSING OF THE STATE OF OREGON

[redacted]
Aaron Green, CNA
Board President

TO: Laurelei Bailey:

You are entitled to judicial review of this Order pursuant to ORS 183.482. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within sixty (60) days from the date of service of this Order.

If, after a minimum of three (3) years, you wish to reinstate your license, you may submit an application for reinstatement to the Board.

BEFORE THE OREGON STATE BOARD OF NURSING
STATE OF OREGON

IN THE MATTER OF:	)	**FINAL ORDER**
	)	
KATHLEEN MARIE DAY, LPN	)	OAH Case No. 2024-ABC-06592
	)	Agency Case No. 22-00832
License No. 081055156LPN	)	
	)	

This matter came before the Oregon State Board of Nursing (Board) at its December 18, 2024, meeting to consider the Proposed Order issued by Senior Administrative Law Judge (ALJ) Alison Greene Webster on November 14, 2024. The Proposed Order provided Kathleen Day (Licensee) with information on filing exceptions. The Board did not receive any exceptions to the Proposed Order.

After considering the record, the Board adopts the ALJ's History of the Case, Evidentiary Rulings, and proposed sanction. The Board has modified the Issues, Findings of Fact, Conclusions of Law, and Opinion as explained below and adopts the following Final Order.

HISTORY OF THE CASE

On April 24, 2024, the Board issued an Amended Notice of Proposed Revocation of Licensed Practical Nurse License to Licensee alleging violations of the Nurse Practice Act,[1] ORS 678.111(1)(f) and (g) and Board rules promulgated thereunder. Licensee timely requested a hearing on the proposed revocation.

On June 17, 2024, the Board referred the hearing request to the Office of Administrative Hearings (OAH). The OAH assigned Senior ALJ Alison Greene Webster to preside at hearing.

On August 7, 2024, ALJ Webster convened a prehearing conference by telephone. Assistant Attorney General (AAG) Lauren Rauch participated for the Board with agency representative Heather Primus. Licensee did not call in for the conference. During the conference, ALJ Webster set the matter for hearing to begin on October 8, 2024. Thereafter, OAH issued the Notice of Hearing to the parties.

On September 9, 2024, the Board filed a Motion for Qualified Protective Order and form of order. On September 11, 2024, the Board filed notice that AAG Kristen Williams would be appearing in this matter as joint counsel with AAG Rauch. On September 17, 2024, ALJ Webster granted the Board's motion and issued the Qualified Protective Order.

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[1] The Board modified this term as used throughout the proposed order to reflect that the Nurse Practice Act is singular. See OAR 851-006-0140(11).

ALJ Webster convened the hearing as scheduled on October 8, 2024, in Portland, Oregon. AAG Rauch and AAG Williams represented the Board, with agency representative Heather Johnson, RN. Licensee Day appeared without counsel. The following individuals testified at the hearing: Licensee; Dani Theil, Investigator, Oregon Department of Human Services, Adult Protective Services; Daniel Werle, Nurse Practitioner, Oregon Health and Sciences University; and Heather Johnson, RN, Investigator for the Board.

The hearing record remained open for receipt of written closing briefs. The Board filed its closing brief on October 25, 2024. Licensee did not file a closing brief. The record closed on November 1, 2024, the deadline for Licensee's response brief.

ISSUES[2]

1. Whether Licensee engaged in conduct derogatory to the standards of nursing (ORS 678.111(1)(f)) and/or violated the standards for professional nurses (ORS 678.111(1)(g)) in one or more of the following ways:

a. By neglecting patient HG, as that term is defined in OAR 411-020-0002(1)(b)(A)(i).

b. By failing to document the use of tampons in connection with the care of HG's chronic chest wound.

c. By using tampons in HG's chronic wound without a provider's order authorizing that use.

f. By using her hand to measure the depth of HG's wound, packing the wound with her fingers instead of a sterile Q-tip, using a wet washcloth to clean the inside the wound, and failing to understand the specifics of HG's wound care orders, including the order to use Kerlix inside the wound.

g. By failing to report the wound's pungent odor and increased drainage to the RN Case Manager or HG's physician.

h. By failing to document in HG's daily assessment sheet those occasions when, in changing the wound dressing, Licensee could not locate all of the tampons that she had used.

i. By failing to establish or maintain professional boundaries and performing non-nursing services for HG.

2. If Licensee violated ORS 678.11(1)(f) and/or (g) in one or more ways set out above, whether the Board may revoke Licensee's LPN license.

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[2] The Board modified the Issues identified by the ALJ to remove Issues 1.d and 1.e because the Board is not relying on those allegations in this Final Order. The removal of those allegations does not change the outcome of the order adopted by the Board.

EVIDENTIARY RULINGS

Board Exhibits A1 through A14 were admitted into the record without objection.

FINDINGS OF FACT

1. Licensee has held a Board-issued Licensed Practical Nurse (LPN) license (license no. 081055156LPN) since December 18, 1981. (Ex. A1.)

2. Licensee has worked as a home health nurse for BrightStar Care, an in-home care and medical staffing agency since 2015. (Ex. A14 at 5; test of Day.) At all times pertinent to this matter, Licensee worked under the supervision of Wendy Kucherhan, RN, a Clinical Director and RN Case Manager for Brightstar Care. (Ex. A14 at 6-7.)

3. As an LPN performing wound care, Licensee's scope of practice is limited to providing focused assessments of a wound and caring for the wound in the manner directed by a licensed independent practitioner's treatment plan.[3] LPNs are not authorized to perform a comprehensive assessment of a patient or issue wound care orders. (Test of Johnson.)

4. The patient at issue in this case, HG, was born in 1948. HG had a prior medical history of rheumatoid arthritis (RA), chronic obstructive pulmonary disease (COPD), lung cancer and, in 2014, the removal of his right lung (pneumonectomy). Following the pneumonectomy, HG developed an esophago-pleural fistula in his right chest. In November 2018, he underwent surgery at OHSU's Cardiothoracic Surgery Clinic to repair the esophageal defect. This open window thoracostomy surgery (which included an Eloesser flap procedure) left HG with a chronic wound of the right thoracostomy cavity. (Test. of Werle; Ex. A10 at 4, 6.)

5. Licensee began providing in-home care to HG's thoracotomy wound in the fall of 2019. Initially, HG's physician's home health wound care orders directed that HG's wound dressing was to be changed twice a day.[4] After a few months, HG's physician approved a change to HG's wound care orders to require that the wound dressing be changed at least once per day. (Test. of Day; Ex. A7 at 4.)

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[3] A licensed independent practitioner means a health care professional who is authorized by Oregon statute and permitted by law to independently diagnose and treat. This includes a licensed medical doctor, a Nurse Practitioner, or a Physician Assistant. (Test. of Johnson.) *See also* OAR 851-006-0120(2).

[4] On September 16, 2019, HG's physician's office issued the following orders for HG's wound care:

> Patient's thoracotomy wound can be changed by any person with knowledge of his wound. It should be packed with kerlix gauze that has been soaked with saline or daykine solution. The kerlix can be put within the wound with cotton applicators. It should be changed approximately two times a day but can be done more or less based on dressing.

(Ex. A7 at 3.)

6. The wound care orders from HG's licensed provider team set out the specific steps for caring for HG's chronic wound, including the removal of old dressing, cleansing of the wound, application of new dressing, and the materials to be used in caring for, packing, and dressing the wound. (Test. of Werle; Ex. A7.).

7. As of March 2020, HG's wound care orders stated, in pertinent part, as follows:

1) Wound Care Site is: Right Chest thoracic cavity
2) Type of Wound: Surgical
3) Measure and assess wound and document each: Week
4) Frequency of Wound Care: Q day 7 days [per] week
5) Remove old dressing and change gloves. Use adhesive remover if needed.
6) Cleanse Wound site with: NS, Irrigation of NS with syringe, Skin Barrier Prep

* * *

9) Pack wound with: Other – tampons

* * *

12) Cover Wound with Dressing of: ABD Pad or island dressing
13) Secure Dressing with: Tape – type: Paper

(Ex. A7 at 5.)

8. On or about July 17, 2020, HG went to OHSU's Cardiothoracic Surgery Clinic for a wound management follow-up visit. On discharge, HG's physician issued the following instructions for HG's chronic chest wound:

> Do not pack the wound anymore. Do not insert any foreign object into the wound. Cover only the outside of the wound with dressing to avoid soiling your clothes.

(Ex. A7 at 6.)

9. In July 2021, HG was hospitalized at OHSU, where the thoracic surgery team performed a washout and debridement of his chronic chest wound. (Ex. A10 at 6.) On July 29, 2021, following HG's discharge from the hospital, HG's provider team modified HG's wound care plan specifically with regard to packing the wound. The revised wound care plan stated, in pertinent part, as follows:

> FREQUENCY of Wound Care: Once daily.
> Wound care SITE: Lateral right chest.
> TYPE of Wound: Surgical
> MEASURE length, width, depth and document – done in frequency: Once a month
> REMOVE old dressings, wash hands and change gloves. Count number of dressings removed from packing and document.
> CLEANSE Wound in Shower with warm tap water then irrigate interior wound with syringe catheter tip.

SKIN PREP: Apply after light dusting with Nystatin Antifungal powder. Apply powder 1st, seal in with skin prep & then re-apply another layer of powder to create a "crust."

Pack with gently-moistened Kerlix gauze – no sanitary napkins or tampons – cover with dry gauze and minimal tape. Document number of Kerlix rolls inserted; pack tightly enough to fill all areas of wound.

-- Dan Werle, NP 7/29/21

(Ex. A8 at 2, bolded text written by hand.)

10. HG's physician's office notified RN Kucherhan of the provider team's changes to HG's wound care plan and RN Kucherhan promptly notified Licensee of the changed orders. (Test. of Day.)

11. HG's provider team specifically ordered the use of Kerlix to pack HG's wound in part because, in addition to absorbing the exudate, Kerlix helps with debridement inside the wound cavity. Kerlix rolls can be tied together and packed into all areas of the wound cavity. (Test. of Werle.)

12. In November 2021, HG sought emergency medical treatment for tremors. (Exs. A7 and A9.) He was admitted to OHSU where both the emergency department physician and the thoracic surgery team evaluated his chronic right chest wound. During the thoracic surgery team's washout of the wound, they found old tampons inside the wound cavity and removed them. (Ex. A11 at 14.)

13. The discharge notes from HG's November 7-8, 2021 stay at OHSU state as follows:

Your wound does not appear infected. A change in wound care was recommended: "Daily dry dressing changes with kerlix, + additional changes PRN if saturated." A new order was placed for your wound care RN to follow.

(Ex. A7 at 7.)

14. Each day that Licensee visited HG to provide in-home care, she completed a BrightStar Care Client Assessment for Wound Care sheet (Client Assessment sheet). The Client Assessment sheet is a pre-printed form containing various sections to be completed and boxes to be marked by the nurse performing the assessment. The Client Assessment sheet is designed to document the patient's status, the condition of the wound, the treatment provided, and other information pertinent to the client's in-home nursing care. There are sections on the sheet related to the patient's mental status; respiratory condition; cardiopulmonary status; musculoskeletal status; wound location; wound type, stage, and size (length, width, and depth); the nature and amount of exudate; and whether there is an odor. There is also a section to document and describe the treatment provided. (Exs. A4, A5 and A6.)

15. On many of the Client Assessment sheets Licensee completed during the period of

January 29, 2022 to March 28, 2022, Licensee also added notations to indicate if and when she provided other services to HG, including meal preparation, cleaning the kitchen and bathroom, laundry, and shopping. (*See* Exs. A4, A5 and A6; test of Day.)

16. On HG's Client Assessment sheet for January 29, 2022, Licensee documented the following: In the Mental Status section, Licensee marked "Forgetful." In the Respiratory section, Licensee marked "Wheezes" and "Labored Resp." She noted that HG was "Ambulatory" and that his oxygen saturation was 98%. (Ex. A4.) Regarding the wound, Licensee marked "serosanguinous" and "bloody" to describe the exudate. (*Id.*) She wrote "XL amt" to describe the amount of drainage and "pungent" to describe the odor. (*Id.*) She noted in the treatment section, "Dressing removed; area cleansed; repacked [with] Kerlix, covered [with] pad & tape." (*Id.*) Licensee also added at the bottom of the sheet that she provided "meal prep," "kitchen & bath," and "laundry." (*Id.*)

17. On HG's daily Client Assessment for February 13, 2022, Licensee noted as follows: In the Mental Status section, Licensee marked "Forgetful" and "Other – Tired!" (Ex. A5 at 13.) In the Respiratory section, Licensee marked "Wheezes" and Labored Resp." (*Id.*) She marked "no current concerns" with regard to Elimination. (*Id.*) She noted that HG was "Ambulatory" and that his oxygen saturation was 97%. (*Id.*) Regarding the wound size, Licensee noted, "Depth of cavity unknown" and width, "10 in." (*Id.*) Licensee again marked "serosanguinous" and "bloody" to describe the exudate. (*Id.*) She marked "Large" to describe the amount of drainage and "pungent" to describe the odor.[5] (*Id.*) In the Treatment section, she wrote, "Dressing removed; area cleansed; repacked [with] Kerlix, covered [with] pad & tape." (*Id.*) Licensee also noted that she provided "meal prep," "kitchen & bath," "laundry" and "shopping" services. (*Id.*)

18. On HG's Client Assessment Sheet for March 1, 2022, Licensee noted the following: In the Mental Status section, Licensee marked "Forgetful." (Ex. A6 at 1.) In the Respiratory section, Licensee marked "Lungs Clear" and "Labored Resp." (*Id.*) She marked "Incontinent" with regard to Elimination. She marked the box to indicate that HG was "Ambulatory" and

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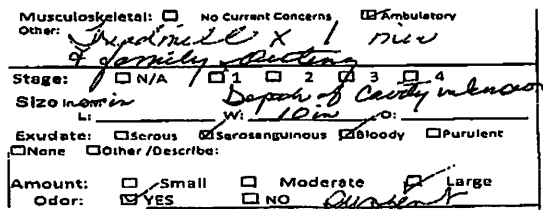
[5] On this particular assessment sheet, in the section of the form to describe the wound, there is a slash mark through the stage 3 box. See excerpt of Exhibit A5, page 13 below:



It is unclear if this slash mark through the 3 box is intentional and meant to describe the wound stage, or if it is an extension of the handwriting directly above and below the box. Licensee handwrote the words "family outing" just above the wound stage boxes and the tail of the lower-case "g" (in the word "outing") extends into the stage 3 box. (*Id.*) Licensee also wrote "Depth of cavity unknown" directly below the wound stage boxes and the top of the "f" in "of" appears to extend into the stage box. (*Id.*) This is the only completed assessment sheet in the record with a slash mark through a wound stage box. (*See* Exs. 4, 5, and 6.)

added, "unstable gait." (*Id.*) She noted that his oxygen saturation was 98%. (*Id.*) With regard to the wound, Licensee again marked "serosanguinous" and "bloody" to describe the exudate. (*Id.*) She wrote "XL Large" to describe the amount of drainage and "pungent" to describe the odor. (*Id.*) In the Treatment section, she wrote, "Dressing removed; cavity & area cleansed, repacked covered [with] pad & tape." (*Id.*) Licensee marked the "supply" box and added, "Supply bought for next treatment." (*Id.*) Licensee also noted that she provided "meal prep," "kitchen & bath," and "laundry" services. (*Id.*)

19. On HG's March 18, 2022 Client Assessment sheet, Licensee documented the following: In the Mental Status section, Licensee marked "Forgetful." (Ex. A6 at 18.) She added, "Forgetting to eat dinner; breakfast." (*Id.*) In the Respiratory section, Licensee marked the "Lungs Clear" and "Labored Resp." boxes. (*Id.*) She marked "Incontinent" with regard to Elimination. (*Id.*) She marked the "Ambulatory" box, adding "unstable gait." (*Id.*) With regard to the wound, Licensee noted the depth of the wound was "unknown." She did not mark any boxes to describe the exudate but wrote "XL Large" to describe the amount and "pungent" to describe the odor. (*Id.*) She documented the following treatment: "Dressing in garbage can/saturated. Area cleansed; repacked [and] covered." (*Id.*) Licensee again added that she provided "meal prep," "kitchen & bath cleaned," and "laundry" services. (*Id.*)

20. On March 20, 21, 22, 23, 24, 25, 26, and 27, 2022, Licensee noted on HG's daily Client Assessment sheets that she found dressing from the wound in the "trash" or "garbage," as opposed to covering the wound. On each of these sheets, Licensee documented that she cleansed the wound area, repacked, and covered the wound. (*See* Ex. A6 at 20-27.)

21. On HG's Client Assessment sheet for March 28, 2022, Licensee again noted that the length and depth of the wound was "unknown." (Ex. A6 at 28.) She did not mark any boxes to describe the exudate but noted the amount was "XL Large." (*Id.*) She marked "yes" and wrote "pungent" to describe the odor. (*Id.*) In the Treatment section, Licensee wrote, "'Dressing in garbage,' area cleaned; repacked & covered." (*Id.*) Licensee again added that she provided additional services of "meal prep," "kitchen & bath cleaned," and "laundry x2 loads." (*Id.*)

22. During the period from January 29, 2022 to March 28, 2022, Licensee used tampons to pack HG's wound. She did not document her use of tampons in HG's daily Client Assessment sheets. She also did not record the number of tampons she packed in, or removed from, the wound each day. (Test. of Day.)[6]

23. On the night of March 28, 2022, HG fell into the bathtub in his bathroom and could not get up. Emergency medical responders responded and had to break down HG's front door to enter his apartment. HG refused medical services and refused transport to the hospital but accepted their assistance in returning him to his bed. (Test. of Day.)

24. Licensee learned of HG's fall and the Clackamas Fire District's forceable entry into HG's apartment the following morning. She came to HG's home around 11:30 a.m. to check on

[6] The Board removed a footnote that was not necessary to Finding of Fact 22. The Board did not otherwise modify the finding and the removal of the footnote does not affect the outcome of the order adopted by the Board.

his welfare. She found HG in bed. He was short of breath, confused, and unable to complete a sentence. She urged him to go to the emergency department. HG agreed, but only if his best friend would drive him there because he did not want to incur the bill for an ambulance ride. Licensee contacted HG's best friend, who agreed to the transport. Licensee also contacted her supervisor, RN Kucherhan, to notify her of HG's condition and his need for transport to the emergency department. (Test. of Day; Ex. A3 at 2.)

25. Before HG was transported to the hospital, Licensee cared for HG's wound. He had already removed the previous day's wound dressing prior to Licensee's arrival. At approximately noon on March 29, 2022, Licensee took the following steps to treat the wound: She placed ½ roll of kerlix into the cavity, added three tampons on top of the kerlix to absorb excessive fluid, and then added a sanitary pad with a fourth tampon placed as a wick to absorb any fluid flowing from the wound. She then completely covered the wound opening with 4-inch by 12-inch tape. HG's best friend transported HG to the OHSU Emergency Department at approximately 12:30 p.m. (Test. of Day; Ex. A3 at 2.)

26. HG was admitted to OHSU on March 29, 2022 with a diagnosis of acute hypoxemic respiratory failure, acute delirium, and septic shock secondary to right chest wall wound. (Ex. A10 at 4.) He was transferred to the medical intensive care unit (ICU) due to his acute hypoxemic respiratory failure and intubated. (*Id.* at 6.) At some point on March 30, 2022, ICU medical personnel removed three tampons from HG's wound cavity. (Ex. A11 at 11; test. of Thiel.) Then, on March 31, 2022, the OHSU thoracic surgery team performed a washout and debridement of the wound. During that surgical procedure, the team found two more old tampons deep in the wound cavity, which they removed. (Test. of Thiel; Exs. A11 at 11, A10 at 17.) HG's medical team identified the old tampons removed from the wound cavity as the source of HG's infection. (Test. of Werle.)

27. In early April 2022, the Oregon Department of Human Services, Adult Protective Services section (APS) received a complaint alleging that Licensee's ongoing use of tampons to pack HG's wound was both contrary to HG's physician's wound care orders and the cause of HG's wound infection that required hospitalization and surgery in late March 2022. APS Investigator Dani Thiel opened a neglect/abuse investigation on April 4, 2022. During her investigation of the complaint, Ms. Thiel interviewed 11 witnesses, including many members of the OHSU thoracic surgery team. In a report completed on June 25, 2022, Ms. Thiel concluded that the allegations of neglect by Licensee were substantiated. Specifically, APS found that Licensee had neglected HG as that term is defined in OAR 411-020-0002(1)(b)(A)(i) by failing to provide HG with the basic care or services necessary to maintain his safety, which resulted in physical harm to HG. (Test. of Thiel; Ex. A11 at 19.)

28. APS's determination that Licensee had engaged in abuse by way of neglect was based on the following findings:

- HG has a chronic chest wound that necessitates daily wound care.
- Licensee is a nurse and was doing HG's daily wound care.

- HG's wound care orders specified that tampons were not to be used.

- HG's wound care order directed that the number of dressings inserted into and removed from the wound were to be counted.

- On March 29, 2022, HG was admitted to the hospital for an infection in the chest wound.

- On March 30, 2022, three old tampons were found and removed from HG's wound cavity.

- On March 31, 2022, HG required thoracic surgery and two additional old tampons were found deep in the wound cavity and removed.

- Licensee had a history of using tampons to pack HG's wound despite doctor's orders not to do so.

- In November 2021, HG was seen in the Emergency Department and old tampons were found in and removed from HG's wound cavity.

- Licensee was not counting the number of dressings or tampons she used during dressing changes.

- Licensee's use of tampons in HG's wound contributed to HG's infection and need for hospitalization and surgery in late March 2022.

(Ex. A11 at 19-20; test. of Thiel.)

29. Following the APS investigation and report, the Board also received a complaint about Licensee's use of tampons in caring for HG's wound. On October 20, 2022, Board Investigator Heather Johnson, R.N., interviewed Licensee about her provision of wound care to HG. In the October 20, 2022 interview, Licensee reported the following:

- When providing in-home care for HG's chest wound, Licensee was in regular contact with RN Kucherhan regarding HG's status and condition. Licensee provided updates at least once or twice a week.

- RN Kucherhan came to HG's home and assessed his wound and Licensee's wound care procedures on at least a quarterly basis and more often if Licensee notified her of a concern.

- Licensee used her gloved hand to measure the depth of HG's wound. She was not able determine the full depth of the wound because it was deeper than the length of her hand. She did not use a medical Q-tip to measure the wound depth because it was not long enough and not flexible enough to go with the curves inside the cavity.

- Licensee occasionally purchased dressing supplies for HG's wound with her own money

and had HG reimburse her. Eventually, Licensee took on the responsibility of ordering all of the wound dressing supplies on HG's behalf.

- Licensee also took on the responsibility for HG's grocery shopping. She did so in part because she wanted to monitor his nutritional intake. HG had caregivers that could have done his shopping but Licensee believed these caregivers were going "way too heavy on carbohydrates" and not getting HG enough protein in his diet.

- In March 2022, Licensee discovered that HG received a five-day shut off notice because he had forgotten to pay his electricity bill. Licensee paid the bill with her own money to avoid the shutoff. She was eventually reimbursed by Brightstar after HG went into the hospital.

- During the first three months of 2022, before HG went into the hospital, Licensee used Kerlix inside HG's wound and laid three tampons on top of the Kerlix as an added layer of absorption. She also attached a tampon to the abdominal (ABD) pad that she placed on top of the packing. She then secured the Kerlix packing, tampons, and ABD pad with 4-inch surgical tape.

- On those occasions when HG removed the dressing from the wound on his own, Licensee would sometimes find tampons on the floor or in the trash can. She attempted to account for all of the tampons she had used in caring for the wound the previous day, but there were times when she could not locate all of them. She would use a penlight to look inside the cavity and a gloved hand to feel around inside the cavity in search of old packing material.

- As a Brightstar employee, Licensee was instructed that she should not communicate directly with HG's physician's office about issues with HG's wound care. Licensee was advised that only the Clinical Director or another RN at Brightstar could contact the patient's provider on the patient's behalf.

- Licensee reported the wound's pungent odor to her supervisor, RN Kucherhan. Licensee believed that RN Kucherhan was in contact with HG's physician about having the wound cultured. Licensee also understood from conversations with RN Kucherhan that HG's physician's office was not responsive when contacted with concerns about HG's wound condition.

- HG's wound care orders did not specifically address the procedure for cleaning the wound. Licensee used a warm washcloth to wipe down the skin around, and the opening of, the wound.

(Ex. A14 at 7-10, 14, 16, 22-25, 28-30, 32-33, 36-37, and 47.)

30. Appropriate wound measurement techniques do not include using one's hand as a measurement tool. Wound depth is usually measured by inserting a medical Q-tip in the deepest part of the wound. It is also contrary to accepted standards of nursing to use one's hand and

fingers to pack a wound or to insert a hand into the wound in search of, to remove, old packing material. Additionally, generally accepted nursing practices disapprove of using a washcloth to clean the interior of a wound due to the risk of infection and damage to the wound tissue. (Test. of Johnson.)

31. Documenting what dressing is being put on and in a surgical wound is an essential nursing practice required of all nurses to ensure that no foreign body is left in the wound cavity, because foreign material in the wound cavity can lead to infection and sepsis. A nurse's failure to document the number of dressings (be it Kerlix rolls or tampons) inserted into and removed from a chronic chest wound is contrary to accepted nursing practices. (Test. of Johnson.)

32. Acceptable and prevailing nursing practices require that nurses accurately document their nursing interventions and the implementation of care plans. An LPN performing in-home wound care should enter accurate and complete information into the patient's record, including the specific material used to pack the wound and the number of items placed in and removed from the wound cavity. The nurse should document all information pertinent to the patient's care, such as changes in the wound's size, exudate, odor, and any concerns that the wound is infected. In addition, the nurse should document communications with other members of the patient's health care team relevant to the patient's status and continuity of care. (Test. of Johnson.)

33. During the period of January 29, 2022 through March 28, 2022, Licensee did not document in HG's Client Assessment sheets that she spoke with RN Kucherhan and raised concerns about HG's wound odor and/or excessive drainage. Licensee also did not document in HG's Client Assessment Sheets that she suspected the wound was infected or that she had requested RN Kucherhan contact HG's physician's office to get the wound cultured. (Test. of Johnson.)

34. There is a power differential in the nurse-patient relationship. The patient depends on the nurse to have the knowledge, skill, ability, and competency to provide the care the patient needs in the particular situation. The patient is dependent upon the provision of care and may be vulnerable to the influence of the nurse's power. For this reason, nurses are obligated to establish and maintain professional boundaries with their patients, and not blend their personal and professional relationships. This is especially true in the home health care setting. Nurses should only perform skilled nursing services and should not take on other, non-nursing tasks for the patient such as shopping for supplies and groceries, preparing meals, doing laundry, and the paying the patient's bills. (Test. of Johnson.)

CONCLUSIONS OF LAW[7]

1a. Licensee violated ORS 678.111(1)(f) and (g) by neglecting patient HG, as that term is defined in OAR 411-020-0002(1)(b)(A)(i).

[7] The Board modified the Conclusions of Law identified by the ALJ to remove 1.d and 1.e because the Board is not relying on those allegations in this Final Order. The removal of those allegations does not change the outcome of the order adopted by the Board.

1b. Licensee violated ORS 678.111(1)(f) and (g) by failing to document the use of tampons in connection with caring for HG's chronic chest wound.

1c. Licensee violated ORS 678.111(1)(f) and (g) by using tampons in HG's chronic wound without a provider's order authorizing such use.

1f. Licensee violated ORS 678.111(1)(f) and (g) by using her hand to measure the depth of HG's wound, using her fingers to pack the wound, using a washcloth to clean the wound opening, and failing to understand the specifics of HG's wound care orders.

1g. Licensee violated ORS 678.111(1)(f) and (g) by failing to document reporting her concerns about the wound's pungent odor and increased drainage to the RN Case Manager.

1h. Licensee violated ORS 678.111(1)(f) and (g) by failing to document in HG's daily assessment sheet those occasions when, in changing the wound dressing, Licensee could not locate all of the tampons that she had used.

1i. Licensee violated ORS 678.111(1)(f) and (g) by failing to maintain professional boundaries and by performing non-nursing services for HG.

2. For the violations of ORS 678.11(1)(f) and (g) set out above, the Board is authorized to revoke Licensee's LPN license.

OPINION

In this case, the Board asserts that, in providing in-home wound care to patient HG, Licensee engaged in conduct derogatory to the standards of nursing under ORS 678.111(1)(f) and violated the standards for professional nurses under ORS 678.111(1)(g) in several different ways. The Board has the burden of establishing, by a preponderance of the evidence, that Licensee violated provisions of the Nurse Practice Act and that the proposed sanction is appropriate. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Dixon v. Board of Nursing*, 291 Or App 207 (2018) (the standard of proof that generally applies in agency proceedings, including license-related proceedings, is the preponderance of the evidence standard); *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

Applicable law and rules

ORS 678.111 sets out the causes for discipline of nurses, and provides, in part:

(1) Issuance of the license to practice nursing, whether by examination or by

indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

* * * * *

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted under ORS 678.010 to 678.448.

In OAR chapter 851, division 45 (rules adopted under ORS 678.150), the Board established standards of practice for LPNs and Registered Nurses. "Conduct derogatory to the standards of nursing" is defined in OAR 851-045-0070. At all times pertinent to this matter, the rule provided, in relevant part:[8]

Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:

(2) Conduct related to achieving and maintaining clinical competency:

(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;

(b) Performing acts beyond the authorized scope or beyond the level of nursing for which the individual is licensed.

* * * * *

(3) Conduct related to the client's safety and integrity:[9]

* * * * *

[8] OAR 851-045-0070 was amended by BN 3-2024, effective July 1, 2024. All citations herein reference the version of OAR 851-045-0070 in effect at the time of the alleged violations (2021 and 2022).

[9] The term "Client" is defined in OAR 581-001-0030(4) as follows:

> "Client" means an individual, family, facility resident or group engaged in a professional relationship with a licensee and the recipient of nursing services. For the purposes of these rules the terms "client", "patient" and "resident" are interchangeable and have the same meaning.

(b) Failing to take action to preserve or promote a client's safety based on nursing assessment and clinical judgment.

* * * * *

(o) Failing to establish or maintain professional boundaries with a client.[10]

* * * * *

(4) Conduct related to communication:

(a) Failure to accurately document nursing interventions and nursing practice implementation.

* * * * *

(c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to:

* * * * *

(C) Failing to document information pertinent to a client's care.

* * * * *

(f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care.

* * * * *

(8) Conduct related to other federal or state statute or rule violations:

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[10] The term "Professional boundaries" is defined in OAR 581-001-0160(7) as follows:

> "Professional Boundaries" means the nurse and client therapeutic relationship limitations that guide appropriate and professional interactions. The licensee or certificate holder and the client establish a relationship where the client depends on the licensee or certificate holder to have the knowledge, skills, abilities, and competencies to provide the care needed by the client. This relationship has a space between the needs of the client and the ability of the licensee or certificate holder to provide that care. That space is a professional boundary and is applicable in and out of the practice setting. The licensee or certificate holder has power in that the client is dependent upon the provision of care and the client is vulnerable to the influences of this power. Violation of this space between power and vulnerability through the blending of the personal and professional relationship constitutes a boundary violation.

* * * * *

(e) Neglecting a client.

Violations[11]

a. Neglect

In paragraph III of the Amended Notice, the Board first alleges that Licensee violated ORS 678.111(1)(f) and (g) by neglecting patient HG. As set out above, under OAR 851-045-0070(8)(e), neglecting a patient (as the term is defined under applicable statute or rule), constitutes conduct derogatory to the standards of nursing. Here, there is no dispute that APS found that Licensee neglected HG as that term is defined in OAR 411-020-0002(1)(b)(A)(i). The APS rule defines abuse, by way of neglect, as follows:

(1) "Abuse" means any of the following:

* * * * *

(b) NEGLECT

(A) For the purposes of these rules, neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure:

(i) Results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or

(ii) Creates the risk of serious harm to the adult.

Following an investigation into Licensee's conduct in caring for HG's chronic wound, APS determined that Licensee failed to provide the basic care or services necessary to maintain HG's safety, which resulted in physical harm to HG. Specifically, APS found that Licensee used tampons to pack HG's chest wound after she had been directed by HG's licensed providers not to use tampons in the wound. APS further found that Licensee's use of tampons in the wound contributed to HG's infection and need for hospitalization and surgery in late March 2022. Information gathered by the Board during its investigation into Licensee's conduct corroborated the circumstances that led to APS's substantiated finding of neglect. Licensee continued to use tampons in caring for HG's wound in contravention of HG's provider orders and her failure to remove and account for all tampons placed in the wound cavity caused harm to HG. By neglecting HG under OAR 411-020-0002(1)(b)(A)(i), Licensee also violated ORS 678.111(f) and (g). The Board has proven this violation of the Nurse Practice Act.

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[11] The Board modified the Opinion section to remove discussion of Violations d and e because the Board is not relying on those allegations in this Final Order. The removal of those allegations does not change the outcome of the order adopted by the Board.

b. Failing to document use of tampons

The Board next alleges that, between January 29, 2022 and March 28, 2022, Licensee violated ORS 678.111(f) and (g) by failing to document her use of tampons in changing the dressing on HG's wound. As set out above, conduct derogatory to the standards of nursing includes failing to conform to accepted nursing practices, failing to accurately document nursing interventions, and failing to document information pertinent to the patient's care. OAR 851-045-0070(2)(a), (4)(a), and (4)(c)(C).

The record establishes that, during the period from January 29, 2022 to March 28, 2022, Licensee failed to document in HG's daily Client Assessment sheets her use of tampons to pack or dress HG's chronic wound. Licensee's failure to document the use of tampons included the failure to record the number of tampons she used to pack or dress the wound and the number she recovered or removed from the wound cavity each day. Licensee's failure to document her use of tampons for HG's chest wound and her failure to record the number of tampons placed in (or on) the wound and the number recovered or removed from the wound constitutes conduct derogatory to nursing standards under the Board's rule. Accordingly, the Board has established that Licensee's conduct in this regard violated ORS 678.111(f) and (g).

c. Failing to follow provider orders

In paragraph V of the Amended Notice, the Board alleges that, subsequent to July 29, 2021, at a time when HG's provider orders specifically prohibited the use of sanitary napkins and tampons in HG's wound, Licensee violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a), (2)(b), and (3)(b) by continuing to use tampons in caring for HG's wound without a provider's order authorizing that use.

As previously discussed, an LPN's failure to conform to the essential standards of acceptable and prevailing nursing practice and performing acts beyond the authorized scope of care constitutes conduct contrary to the standards of nursing under OAR 851-045-0070(2)(a) and (2)(b). And, under OAR 851-045-0070(3)(b), the failure to take action to preserve or promote patient safety based on nursing assessment and judgment constitutes conduct contrary to the standards of nursing.

Licensee was aware of the July 29, 2021 wound care order prohibiting the use of tampons and sanitary napkins in HG's wound. Nevertheless, on multiple occasions subsequent to that date, she used tampons in caring for HG's wound. On those occasions when Licensee used tampons in or on the wound, she acted in direct contravention of HG's wound care orders. By acting in direct contravention of HG's wound care orders, Licensee violated ORS 678.111(1)(f) and (g). She failed to honor her professional responsibility to adhere to the provider's wound care orders. She also acted outside the authorized scope of care when she used of tampons in caring for HG's wound. Moreover, Licensee exhibited poor judgment in this situation and put HG's safety at risk. As set out in the findings, Licensee's ongoing use of tampons in the wound contributed to HG's infection and septic shock and his need for hospitalization and surgery in late March 2022.

The fact that HG preferred that Licensee use tampons when packing the wound because they were more absorbent, less expensive than Kerlix, and more readily available than Kerlix is no defense to Licensee's misconduct. As an LPN, Licensee had no authority to override the wound care orders of HG's provider team. All Licensee was authorized to do in this situation was advocate for HG's preferences with HG's licensed providers and notify her supervisor, the RN Case Manager, or HG's providers of HG's preferences and the expense and scarcity of Kerlix at the time. Consequently, the Board has established Licensee violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a), (2)(b), and (3)(b) by using tampons in HG's wound care in contravention of provider orders.

f. Failing to meet wound care standards

The Board also alleges that Licensee failed to meet current wound care standards in nursing and violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a) and (3)(b) when she measured the wound with her hand, used her fingers instead of a sterile Q-tip to pack the wound, cleaned inside the wound with a washcloth, and failed to verbalize an understanding of HG's wound care orders (including the use of Kerlix).

As previously discussed, conduct derogatory to the standards of nursing includes the failure to confirm to acceptable and prevailing nursing practice standards as well as taking actions that create a risk to the client's safety. OAR 851-045-0070(2)(a) and (3)(b). Here, the evidence establishes that Licensee attempted to measure the depth of the wound by inserting her gloved hand into the wound cavity. The evidence also establishes that using one's hand to measure the depth of a wound is not an acceptable or prevailing nursing practice. The evidence establishes that Licensee used her fingers to pack Kerlix in the wound and used a wet washcloth to clean the skin in and around wound opening. As RN Johnson testified at hearing, neither of these procedures conform to the essential standards of acceptable and prevailing nursing practice. In addition, the evidence establishes that Licensee failed to adhere to the provider's wound care orders and failed to appreciate rationale for the provider's specific directive to pack the wound with Kerlix to both debride the cavity and absorb the exudate. Accordingly, the Board has established that Licensee failed to meet current wound care standards in nursing and failed to exercise good judgment. In so doing, Licensee violated ORS 678.111(f) and (g).

g. Failing to report wound condition to RN Case Manager or HG's licensed provider

The Board next alleges that, during the first three months of 2022, Licensee violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a), (3)(b), and (4)(f) by failing to report the wound's pungent odor and increased drainage to her RN Case Manager or HG's licensed provider.

As noted previously, conduct derogatory to the standards of nursing includes failing to conform to acceptable and prevailing nursing practice standards, taking actions that create a risk to the client's safety, failing to document information pertinent to the client's care, and "failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care." OAR 851-045-

0070(4)(C)(f).

In her interview with the Board investigator, Licensee claimed that she communicated her concerns about the wound's pungent odor and excessive exudate to her supervisor on several occasions. Licensee stated her belief that RN Kucherhan contacted HG's physician's office with these concerns on several occasions but HG's providers were not responsive or willing to address the issue. Regardless of whether Licensee did, in fact, elevate her concerns about the condition of HG's wound to her RN supervisor, she did not conform to acceptable and prevailing nursing practices because she did not document having done so. There is nothing in HG's in-home health care records or HG's Client Assessment sheets during this period to indicate that Licensee reported to RN Kucherhan concerns about an infection in the wound. There is also nothing in HG's in-home health care records to corroborate Licensee's claims that RN Kucherhan contacted HG's providers with these concerns on multiple occasions without receiving any meaningful response.

By failing to document that she had concerns about the wound's pungent odor and increased drainage and failing to document that she reported her concerns about an infection in the wound cavity to her RN Case Manager or HG's licensed provider team, Licensee violated ORS 678.111(1)(f) and (g). Licensee's failure to document her concerns about an infection in the wound, failure to document information pertinent to HG's care, and failure to document any communications to RN Kucherhan regarding HG's status constitute conduct derogatory to nursing standards under OAR 851-045-0070(2)(a), (3)(b), and (4)(f).

h. Failing to document notification to RN Case Manager or HG's licensed provider

The Board alleges that, between January 29, 2022 and March 28, 2022, Licensee violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a), (3)(b), and (4)(a), and (4)(c)(C) by failing to document that she had notified her RN Case Manager or HG's licensed provider when she could not track all the tampons used in HG's wound care.

As above, conduct derogatory to the standards of nursing includes the failure to accurately document nursing interventions and practices and the failure to document information pertinent to the patient's care. OAR 851-045-0070(4)(a) and (c). As Licensee acknowledged during her investigatory interview, there were occasions when she could not account for or locate all of the tampons used in caring for the wound the previous day. While there were instances where Licensee noted in HG;s Client Assessment sheet finding dressing from the wound in the trash or garbage, Licensee did not document those occasions when she was unable to account for all of the tampons. Licensee also did not document that she promptly notified RN Kucherhan of those occasions when she could not account for all of the tampons used the previous day, although Licensee has claimed that she did so.

Licensee's failure to accurately document in HG's medical records her procedures in caring for HG's wound and her failure to document those instances when she could not account for all of the tampons used in dressing the wound constitute conduct derogatory to the standards of nursing under OAR 851-045-0070(2)(a) and (4)(a) and (c). Similarly, Licensee's failure to document that she notified the RN Case Manager of the situation constitutes conduct derogatory

to nursing standards. Consequently, the Board has established Licensee's violation of ORS 678.111(1)(f) and (g) and the above-cited provisions of OAR 851-045-0070 in this regard.

i. Failing to maintain professional boundaries

Finally, the Board alleges that Licensee failed to establish and maintain professional boundaries with HG and violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(2)(a), (3)(o) by performing non-nursing services, including buying wound care supplies, groceries, and prescription medications for HG, and paying HG's March 2022 utility bill with her own money.

As noted above, conduct derogatory to the standards of nursing includes failing to establish or maintain professional boundaries with a client. The Board has defined professional boundaries as "the nurse and client therapeutic relationship limitations that guide appropriate and professional interactions." OAR 581-001-0160(7). As RN Johnson testified at hearing, the nature of the nurse-patient relationship is one in which the patient depends on the nurse to have the knowledge, skill, ability, and competency to provide the care the patient needs. The nurse has power in the relationship because the patient is dependent upon the provision of care and is vulnerable to the influence of the nurse's power. A nurse has an obligation not to violate the boundary between power and vulnerability by overstepping and blurring the line between a professional and personal relationship. In the setting of home heath care, the nurse should perform only skilled nursing tasks and should not take on other, non-nursing services for the patient.

The evidence establishes that during the course of providing in-home wound care to HG, Licensee took on the responsibility for ordering wound care supplies on HG's behalf. She also took on responsibility for HG's grocery shopping. She regularly prepared his meals, did his laundry, and cleaned his kitchen and bath. She also, on one occasion, paid his overdue electric bill with her own money. By performing these other services for HG, Licensee improperly blurred the line between a professional and personal relationship. Accordingly, the Board has also proven that Licensee violated ORS 678.111(1)(f) and (g) by failing to maintain professional boundaries with HG. *See* OAR 851-045-0070(3)(o).[12]

Sanction

The Board proposed to revoke Licensee's LPN license for violating ORS 678.111(1)(f) and (g). The Board alleged that each violation provides independent grounds to revoke the license.

As set out above, the Board has established numerous instances in which Licensee deviated from the standards of practice for LPNs and engaged in conduct derogatory to the standards of nursing described in ORS 851-045-0070 in providing in-home care to HG's chronic chest wound. The Board has proven that Licensee violated the Nurse Practice Act by neglecting HG, as that term is defined under Oregon law. Licensee failed to provide the basic care necessary to maintain HG's health and safety and her failure to provide this basic care caused or contributed to HG's chest wound infection, septic shock, need for hospitalization, and surgery.

[12] The Board modified this paragraph to clarify its rationale.

The Board has also proven that Licensee violated ORS 678.111(1)(f) and (g) when she used tampons in caring for HG's wound. Not only did Licensee fail to conform to acceptable nursing standards in this regard but she also acted beyond the authorized scope of care and in direct contravention of the wound care orders established by HG's provider team. Licensee was well-aware of the July 29, 2021 written directive to pack the wound with Kerlix gauze and not use tampons or sanitary napkins, yet she continued the use of tampons in caring for the wound until HG was hospitalized with sepsis on March 29, 2022.

Additionally, the Board has proven that Licensee violated ORS 678.111(1)(f) and (g) in several other ways, including by using her hand as a measurement tool inside the wound cavity, using her fingers and not a sterile Q-tip to pack the wound, using a wet washcloth to clean the wound, and failing to document in HG's medical record information pertinent to HG's care (*i.e.*, the ongoing use of tampons in the wound, the instances when she could not account for all the tampons used, her concerns about an infection in the wound, and her communications with RN Kucherhan about those concerns). Lastly, the Board also established that Licensee engaged in conduct derogatory to nursing standards by failing to maintain professional boundaries with HG in violation of OAR 851-045-0070(3)(o).

It is within the Board's discretion to revoke Licensee's LPN license for engaging in conduct derogatory to nursing standards and violating provisions of the Nurse Practice Act. On this record, the Board has demonstrated sufficient justification to do so. Indeed, the violations proven herein are both serious and numerous. Licensee's conduct created a situation that resulted in serious harm to her patient. The violations proven herein indicate that Licensee cannot be trusted to adhere to the essential standards of acceptable and prevailing nursing practice in the future. Consequently, revocation of Licensee's LPN license is warranted.

FINAL ORDER

The Oregon State Board of Nursing hereby issues the following order:

Kathleen Marie Day's Licensed Practical Nurse License (License no. 081055156LPN) is REVOKED.

[redacted] 12-18-24

Aaron Green, CNA
Board President

APPEAL

You are entitled to judicial review of this order. If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 *et seq*.

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	) **STIPULATED ORDER FOR**
Steven Fierro, RN, APRN-NP	) **REPRIMAND OF LICENSE**
	)
License No. 10009255 10009255	) **Reference No. 2023080264**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including APRN-NPs.

Steven Fierro (Licensee) was issued an APRN-NP License by the Board on June 6, 2023.

On or about August 29, 2023, the Board received information that Licensee failed to adequately assess, develop a treatment plan for, or document care provided to a patient.

On or about November 28, 2023, the Board received information that Licensee failed to adequately assess, develop a treatment plan for, and document care provided to a second patient. Additionally, it was identified the Licensee failed to maintain professional boundaries in their communications with the patient and violated patient confidentiality.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f), OAR 851-045-0070 (2)(a), (3)(a)(c)(o), (4)(a)(c)(C), (8)(b)(h), and OAR 851-055-0020.**

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(Effective date 01/01/2023)

Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:

(2) Conduct related to achieving and maintaining clinical competency:

(a)Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established;

(3) Conduct related to the client's safety and integrity:

(a)Developing, modifying, or implementing policies that jeopardize client safety;

(c)Failing to develop, implement or modify the plan of care;

(o)Failing to establish or maintain professional boundaries with a client

(4) Conduct related to communication:

(a)Failure to accurately document nursing interventions and nursing practice implementation;

(c)Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to:

(C)Failing to document information pertinent to a client's care;

(8) Conduct related to other federal or state statute or rule violations:

(b)Violating the rights of privacy, confidentiality of information, or knowledge concerning the client, unless required by law to disclose such information;

(h)Engaging in other unacceptable behavior towards or in the presence of a client. Such conduct includes but is not limited to using derogatory names, derogatory gestures or profane language

851-055-0020 Scope of Practice for Licensed Nurse Practitioners (NP)

(1) Purpose of Scope of Practice:

(a) To establish acceptable levels of safe practice for the nurse practitioner.

(b) To serve as a guide for the Board to evaluate nurse practitioner practice.

(c) To distinguish the scope of practice of the nurse practitioner from that of the registered nurse.

(2) The role of the nurse practitioner will continue to expand in response to societal demand and new knowledge gained through research, education, and experience.

(3) The nurse practitioner provides holistic health care to individuals, families, and groups across the life span in a variety of settings, including hospitals, long-term care facilities and community-based settings.

(4) Within his or her specialty, the nurse practitioner is responsible for managing health problems encountered by the client and is accountable for health outcomes. This process includes:

(a) Assessment;

(b) Diagnosis;

(c) Development of a plan;

(d) Intervention; and

(e) Evaluation.

(5) The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:

(a) Promotion and maintenance of health;

(b) Prevention of illness and disability;

(c) Assessment of clients, synthesis and analysis of data and application of nursing principles and therapeutic modalities;

(d) Management of health care during acute and chronic phases of illness;

(e) Admission of his/her clients to hospitals and/or health services including but not limited to home health, hospice, long term care and drug and alcohol treatment;

(f) Counseling;

(g) Consultation and/or collaboration with other health care providers and community resources;

(h) Referral to other health care providers and community resources;

(i) Management and coordination of care;

(j) Use of research skills;

(k) Diagnosis of health/illness status; and

(l) Prescribing, dispensing, and administration of therapeutic devices and measures, including legend drugs and controlled substances as provided in the Nurse Practice Act, consistent with the definition of the practitioner's specialty category and scope of practice.

(6) The nurse practitioner scope of practice includes teaching the theory and practice of advanced practice nursing.

(7) The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her nurse practitioner expertise by consulting with or referring clients to other health care providers.

(8) The nurse practitioner will only provide health care services within the nurse practitioner's scope of practice for which he/she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic coursework, workshops, or seminars, provided both theory and clinical experience are included.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Nurse Practitioner License of Steven Fierro be reprimanded.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event licensee engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of their license to practice as a Nurse Practitioner.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce them to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

[redacted]

Steven Fierro, RN, APRN-NP

12/04/24
Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Board President

12/18/24
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	)	**STIPULATED ORDER FOR**
Lesley Heinsch, RN	)	**CIVIL PENALTIES**
	)	
License No. 200342294RN	)	**Reference No. 2023090117**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including RNs. Lesley Heinsch was issued a Registered Nurse license by the Oregon State Board of Nursing on November 25, 2003.

On or about May 20, 2024, the Board received information that Licensee failed to renew their Registered Nurse license timely, practicing as a Registered Nurse without an active license for 76 days.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f), ORS 678.117 (1)(2)(a)(b)(3)(4)(5), and OAR 851-001-0009 (1)(2)(a)** which reads as follows:

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case, and except as provided in ORS 678.138:
(1) The Oregon State Board of Nursing may refuse to issue a license to practice nursing by examination or indorsement or a nurse internship license or may revoke or suspend a license, issue a limited license, censure or reprimand or place on probation, subject to any conditions imposed by the board, a person issued a license, for any of the following causes:
(f) Conduct derogatory to the standards of nursing.

ORS 678.117 Procedure for imposing civil penalty; amount; rules.
(1) The Oregon State Board of Nursing shall adopt by rule a schedule establishing the amount of civil penalty that may be imposed for any violation of ORS 678.010 to 678.448 or any rule of the board. No civil penalty shall exceed $5,000.
(2) In imposing a penalty pursuant to this section, the board shall consider the following factors:
(a) The past history of the person incurring the penalty in observing the provisions of ORS 678.010 to 678.448 and the rules adopted pursuant thereto.
(b) The economic and financial conditions of the person incurring the penalty.
(3) Any penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the board considers proper and consistent with the public health and safety.
(4) Civil penalties under this section shall be imposed as provided in ORS 183.745.
(5) All penalties recovered under this section shall be credited to the special account described in ORS 678.170.

OAR 851-001-0009 Imposition of Civil Penalties
Imposition of a civil penalty does not preclude disciplinary sanction against the license or certificate holder and disciplinary sanction against the license or certificate does not preclude imposing a civil penalty. Criminal conviction does not preclude imposition of a civil penalty for the same offense.
(1) The Board will consider factors listed in ORS 678.117 (2) when determining the amount of civil penalty to be imposed and per ORS 678.117 (1), no single violation civil penalty shall exceed $5000.
(2) A civil penalty of up to $100 per day of occurrence is assessed for the following:
(a) Practicing as a Licensed Practical Nurse (LPN), Registered Nurse (RN) , Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), Certified Nursing Assistant (CNA), Certified Medication Aide (CMA) without a current license or certificate or Board required concurrent national certification; or prescribing, dispensing, or distributing drugs without current prescription writing authority, due to failure to renew and continuing to practice.

851-045-0070
Conduct Derogatory to the Standards of Nursing Defined
Conduct derogatory to the practice of nursing is conduct that adversely affects the health, safety, and welfare of the public; that fails to conform to OAR 851-045 scope and standards of practice; or that fails to conform to accepted standards of the nursing profession. Such conduct includes, but is not limited to:
(9) Conduct related to licensure violations:
(b) Practicing nursing without a current Oregon license;

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Board impose civil penalties against the RN License of Lesley Heinsch in the amount of $25.00 per day of occurrence for 76 days of unlicensed practice as an RN, for a total of $1,900.00.

Licensee admits that the above statements are accurate, and that Licensee's actions constitute a violation of the Nurse Practice Act.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order for Civil Penalties, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress, or coercion have been used to induce the Licensee to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee shall make **24 monthly payments of $79.17**. The first payment is to be received by the Board by the first day of the month following the Board's acceptance of this Stipulation and thereafter, a payment on the 1st day of every month until the whole sum is paid.

Payments shall be made payable to the Oregon State Board of Nursing at 17938 SW Upper Boones Ferry Road, Portland, OR 97224 by check or money order; alternatively, payment may be made online by logging into your Oregon State Board of Nursing Licensing Portal and clicking on Pay Civil Penalty Fees.

Licensee understands that if payment is 90 days overdue from the date due as stated in this Stipulation, collection of the Civil Penalties will be assigned to the Oregon Department of Revenue pursuant to ORS 293.321. Final amounts due may include collection fees imposed by the collector and the accrual of interest, up to the statutory maximum permitted by ORS 82.101, in addition to the unpaid principal amount. In the event any amount is assigned for collection, the Licensee may be subject to further disciplinary action by the Board which could include suspension, revocation, or denial of licensure.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Civil Penalties.

[redacted]

Lesley Heinsch, RN

12/08/24

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Board President

12/18/24

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	) **STIPULATED ORDER FOR**
Teresa Horn, LPN	) **REPRIMAND OF LICENSE**
	)
License No. 201130336LPN	) **Reference No. 2022110045**
	) **and No. 2024060283**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including LPNs, pursuant to ORS 678.010 to 678.448.

Teresa Horn (Licensee) was issued a LPN License by the Board on July 25, 2011.

While employed with an assisted living facility on or around October 2022, License failed to ensure a resident received ordered medications and failed to ensure the resident's medical power of attorney (POA) was involved in changes to the resident's care plan. During the Board's investigation, Licensee failed to cooperate with requests made by the Board to provide a responsive statement and schedule an interview with the investigator.

While employed with a different assistant living facility on or around April 2024, Licensee practiced nursing without an active Oregon LPN license. In addition, licensee failed to complete a fall assessment on a resident and failed to ensure resident orders were processed in a timely manner leading to a delay in treatment for a resident.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.021 and ORS 678.111(1)(f)(g) and ORS 678.158 and OAR 851-045-0070(2)(a). (3)(b). (4)(a), (g). (9)(b). (10)(a), (c).**

ORS 678.021 License required to practice nursing.
It shall be unlawful for any person to practice nursing or offer to practice nursing in this state or to use any title or abbreviation, sign, card or device to indicate the person is practicing either practical or registered nursing unless the person is licensed under **ORS 678.010 to 678.410** at the level for which the indication of practice is made, and the license is valid and in effect.

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:
(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
(f) Conduct derogatory to the standards of nursing;

(g) Violation of any provision of **ORS 678.010 to 678.448** or rules adopted thereunder.

ORS 678.158 Continuing authority of board upon lapse, suspension, revocation or voluntary surrender of license or certificate.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:
(2) Conduct related to achieving and maintaining clinical competency:
(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.
(3) Conduct related to the client's safety and integrity:
(b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.
(4) Conduct related to communication:
(a) Failure to accurately document nursing interventions and nursing practice implementation.
(g) Failing to communicate information regarding the client's status to other individuals who are authorized to receive information and have a need to know.
(9) Conduct related to licensure violations;
(b) Practicing nursing without a current Oregon license.
(10) Conduct related to the licensee's relationship with the Board:
(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege;
(c) Failing to provide the Board with any documents requested by the Board.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Licensed Practical Nurse License of Teresa Horn be reprimanded.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event licensee engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of their license to practice as a Licensed Practical Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, licensee waives the right to an administrative hearing under **ORS 183.310 to 183.540**, and to any judicial review or appeal

thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce them to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

[redacted]

Teresa Horn, LPN

12/10/24

Date

FINAL ORDER

Based on the above stipulations and pursuant to **ORS 183.417(3). ORS 678.111(1)(f), (g), and ORS 678.158 and OAR 851-045-0070(2)(a). (3)(b). (4)(a), (g). (10)(a), (c)**. IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Aaron Green, CNA
Board President

12/18/24

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	)	**STIPULATED ORDER FOR**
Mary Hughes, CNA	)	**REPRIMAND OF CERTIFICATE**
	)	
No. 000034999CNA	)	**Reference No. 2024020266**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including CNAs. Mary Hughes was issued a CNA certificate by the Board on June 18, 1996.

On or about 2/26/24, the Board received information that the Certificate Holder, Mary Hughes, was abusive toward a resident. It was alleged that the Certificate Holder went to the resident's room, pulled his blankets off him while he was in his recliner and told him he had to go to bed. When he refused, she became rude toward him and dropped the call light on his lap as she was leaving.

Certificate Holder has completed a continuing education course: Resident Rights in Senior Care Settings.

By the above actions, the Certificate Holder is subject to discipline pursuant to ORS 678.442(2)(f) and OAR 851-063-0090(3)(g) which read as follows:

ORS.678.442 Certification of nursing assistants; rules
(2) In the manner prescribed in ORS chapter 183, the board may revoke, suspend or deny a certificate issued under this section, reprimand a nursing assistant or place a nursing assistant on probation for a period of time and subject to any conditions specified by the Board for the following reasons:
(f) Conduct unbecoming of a nursing assistant in the performance of duties.

851-063-0090 Conduct Unbecoming a Nursing Assistant ***{cert. ef. 8/1/21}***
ORS 670.280 authorizes the Board to discipline nursing assistant certificates for conduct that is not undertaken directly in the course of CNA duties, but that is substantially related to the fitness and ability of the applicant or CNA to engage in activities of the CNA profession for which a CNA certificate is required. Such conduct is considered to be conduct unbecoming a CNA, and includes, but is not limited to:
(3) Conduct related to client safety and integrity
(g) Failing to respect the dignity and rights of clients, inclusive of social or economic status, age, race, religion, gender, gender identity, sex, sexual orientation, national origin, nature of health records, physical attributes and disability.

Certificate Holder wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Certificate Holder:

That the CNA Certificate of Mary Hughes be reprimanded.

Certificate Holder understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Certificate Holder understands that in the event they engage in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against their certificate, up to and including revocation of their certificate to practice as a CNA.

Certificate Holder understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Certificate Holder understands that by signing this Stipulated Order, they waive the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Certificate Holder acknowledges that no promises, representations, duress or coercion have been used to induce them to sign this Order.

Certificate Holder understands that this Order is a document of public record.

Certificate Holder understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Certificate Holder has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

[redacted]

Mary Hughes, CNA

11/27/24

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Aaron Green
Board President

12/18/24

Date

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	**) STIPULATED ORDER FOR**
Kayla Martinez, RN	**) PROBATION**
	)
License No. 202209012RN	**) Reference No. 2024060268**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Kayla Martinez (Licensee) was issued an RN license by the Oregon State Board of Nursing on June 30, 2022.

On or about June 26, 2024, the Board received information that Licensee tested positive for Fentanyl after Pharmacy concerns regarding dispensing and charting.

An audit of documentation revealed Licensee withdrew (2) pills, documented administering (1) pill and could not otherwise account for missing pill. No harm to patient was reported.

Licensee acknowledged that she took pain medication from the facility. Licensee has since obtained medical care and is compliant with recommended treatment.

Licensee has since entered themselves into outpatient treatment and is cooperating with the Board.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f) and OAR 851-045-0070(4)(c)(E) and (8)(k)(l) which read as follows:

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.
In the manner prescribed in ORS chapter 183 for a contested case:
(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:
(4) Conduct related to communication:
(c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or agency records. This includes but is not limited to:

(E) Falsifying data;
(8) Conduct related to other federal or state statute or rule violations:
(k) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled medications to any person, including self, except as directed by a person authorized by law to prescribe medications;
(l) Unauthorized removal or attempted removal of medications, supplies, property, or money from anyone in the work place.

Licensee admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Licensee wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the Registered Nurse license of Kayla Martinez of be placed on Probation. The Licensee's compliance with this agreement will be monitored by the Oregon State Board of Nursing from date of signature on the Stipulated Order. Licensee must complete a twenty-four (24) month period of probation to begin upon Licensee's return to supervised nursing practice at the level of a Registered Nurse. Licensee must practice a minimum of sixteen (16) hours per week on average, and no more than one (1.0) FTE in a setting where Licensee is able to exercise the full extent of scope of duties in order to demonstrate whether or not Licensee is competent. Limited overtime may be approved on occasion.

Licensee must comply with the following terms and conditions of probation:

1) Licensee shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.

2) Licensee shall have thirty-six (36) months from Board acceptance of this Stipulated Order to complete twenty- four (24) months of monitored practice.

3) Licensee shall notify Board staff, in writing, prior to any change of contact information which includes address, email address, and phone number.

4) Licensee shall maintain an active license.

5) Licensee shall inform Board staff in advance of any move from Oregon. If Licensee leaves the State and is unable to practice in the State of Oregon, Licensee's probationary status will be re-evaluated. If monitoring is approved and transferred to another Board of Nursing, Licensee shall successfully complete all requirements of the Board Order of the other jurisdiction. Licensee shall be required to ensure the Oregon State Board of Nursing receives quarterly reports documenting the Licensee's compliance. Failure to comply with this reporting requirement shall be considered a violation of this Order. While licensee practices in another state, those hours will only be counted toward her Oregon probation if the position meets the monitoring requirements per line ten (10) of this stipulated order.

6) Licensee shall maintain monthly contact by phone, electronic or virtual methods to designated Board staff for interviews during the probationary period. Frequency or type of contact may be

reviewed and revised periodically at the discretion of Board staff. This includes being required to attend an in-person meeting.

7) Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether a felony, misdemeanor, violation, or citation within ten (10) days of the occurrence.

8) Licensee will not look for, accept, or begin a new nursing position without the approval of Board staff. This includes changes of the employer itself or changes within the facility or institution

9) Licensee shall inform current and prospective employers of the probationary status of Licensee's license, the reasons for Licensee's probation, and terms and conditions of probation. If there is a Nurse Executive, that person is to be informed of Licensee's probationary status. The Nurse Executive will receive a copy of the Stipulated Order for Probation when Licensee is employed.

10) Licensee shall work under the direct observation of another licensed healthcare professional, who is aware that the individual is on probation, who is working in the same physical location (e.g. clinic, unit, building, etc.), is readily available to observe Licensee's practice and provide assistance and who has taken the required Board approved Monitor/Supervisor training. Licensee shall be employed in a setting where Licensee's nursing supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, Licensee may be restricted from practicing as a nurse.

11) Between quarterly reporting periods, the Nurse Executive or a person designated by Licensee's employer, shall inform Board staff of any instance of the Licensee's non-compliance with the terms and conditions of this Stipulated Order, or of any other concern there may be regarding Licensee's work-related conduct or personal behavior that may affect Licensee's ability to practice as a nurse.

12) Licensee shall notify Board staff when there is a change in status of employment including resignations, disciplinary actions, and terminations. Licensee shall immediately notify Board staff if they will be unable to meet the minimum monitored practice requirement of 16 hours per week or 64 hours per month due to leave from work. The inability to meet the monitored practice requirement due to leave may extend the probationary period.

13) Licensee: shall not have access to narcotics or controlled substances, carry the keys to narcotics storage, or administer narcotics at any time or under any circumstances or until Licensee receives written approval from Board staff.

14) Licensee shall not work in any practice setting in which on-site monitoring is not available. This generally includes home health agencies, traveling agencies, nursing float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home

hospice, and night shifts outside of acute care settings.

15) Licensee shall not be a nursing faculty member or an advance practice preceptor.

16) Licensee shall not be approved for enrollment in clinical practicum hours for the purposes of obtaining an additional degree or license.

17) Licensee shall cease practicing as a nurse if there are concerns about Licensee's ability to practice safely or at the request of Board staff. Practice may resume when approved by the Board staff, in consultation with Licensee's employer.

18) Licensee shall participate in and comply with any treatment recommendations set forth by a third-party evaluator approved by the Board. Licensee shall ensure that Board staff receive monthly status reports from the treatment provider. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.

19) Licensee shall participate in the Board's random drug testing program. Failure to comply with random urine, blood, hair, nail, or any other requested drug test shall result in Licensee's immediate removal from nursing practice. Licensee shall submit to observed tests to determine the presence of unauthorized substances immediately upon request by Board staff or Licensee's employer. Licensee shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Stipulated Order. Upon request of Board staff, Licensee shall obtain a substance use disorder evaluation by a Board approved third party evaluator. Licensee understands that Licensee is financially responsible for any and all costs related to testing and evaluating. Licensee's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Stipulated Order.

20) Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while participating in the Board's random urine drug testing program, except as provided in Section 20 below. Licensee shall avoid any over-the-counter products and food items containing alcohol, THC including CBD products, and poppy seeds.

21) Licensee may take medication for a documented medical condition, provided that Licensee obtains such medication only by a legal prescription written by a person authorized by law to write such a prescription. Licensee will notify Board staff within 72 hours in the event Licensee is prescribed such medication, and shall sign a release of information authorizing the prescribing person to communicate with Board staff about Licensee's medical condition. Licensee shall produce the medical records pertaining to the medical condition and medication use. Licensee will discard any unused prescription medications when it is no longer needed or expired.

22) Licensee shall cease practicing as a nurse upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. Practice may resume only when approved in writing by Board staff, in consultation with Licensee's employer.

23) Licensee shall notify any and all healthcare providers of the nature of Licensee's diagnoses to ensure that Licensee's health history is complete before receiving any treatment, including medical and dental. Licensee shall provide Board staff with the names and contact information of any and all health care providers. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's healthcare providers and release Licensee's medical and treatment records to the Board. Licensee is financially responsible for any costs incurred for compliance with the terms and conditions of this Stipulated Order.

24) Licensee shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.

25) Licensee shall cooperate fully with Board staff in the supervision and investigation of Licensee's compliance with the terms and conditions of this Stipulated Order.

Licensee understands that the conduct resulting in the violations of law, described in this Stipulated Order are considered by the Board to be of a grave nature and if continued, constitutes a serious danger to public health and safety.

Licensee also understands that in the event Licensee engages in future conduct resulting in violations of the law or terms of probation the Board may take further disciplinary action against Licensee's license, up to and including revocation of Licensee's license to practice as a Registered Nurse.

Licensee understands that this Stipulated Order will be submitted to the Board of Nursing for approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce Licensee to sign this Stipulated Order.

Licensee understands that this Stipulated Order is a public record.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands the Stipulated Order completely, and freely signs the Stipulated Order.

IT IS SO AGREED:

[redacted]

Kayla Martinez, RN

11/20/24

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Aaron Green, CNA
Board President

12/18/24

Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	) **STIPULATED ORDER FOR**
Sheena Newman, RN APRN-NP	) **REPRIMAND OF NURSE**
	) **PRACTITIONER LICENSE**
	) **WITH CONDITIONS**
	)
License No. 201809675NP-PP	) **Reference No. 2023020127**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including APRN-NPs. Sheena Newman Licensee was issued an APRN-NP license by the Board on October 25, 2018.

On or about February 15, 2023, the Board received information that Licensee had prescribed medications, including controlled medications, to a family member without establishing a patient/provider relationship. Licensee prescribed medications to her family member between March 2020 and February 2023. Licensee failed to complete any documentation related to the prescribing. Licensee failed to collaborate with the family members other healthcare providers.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.111(1)(f) and OAR 851-045-0070(2)(a).**

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:
(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
(f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to:

(2) Conduct related to achieving and maintaining clinical competency:

(a) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

(4) Conduct related to communication:

(c) Failure to document data and information pertinent to a client's status.

(i) Failing to communicate information regarding the client's status to members of the practice team in an ongoing and timely manner as appropriate to the context of care.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

That the APRN-NP License of Sheena Newman be REPRIMANDED.

Licensee will complete the following continuing education courses within 6 months of the date a Final Order is issued:

PBI – Medical Ethics and Professionalism (15 CME - $1450.00)
PBI – Proper Prescribing (21 CME - $1895.00)

Should Licensee fail to complete these courses within the required time of 6 months, Licensee shall be referred back to the Board for consideration of further disciplinary action. Board staff may substitute a course comparable in cost and content if the assigned course becomes unavailable.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event they engage in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against their license, up to and including revocation of their license to practice as an APRN-NP.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, they waive the right to an administrative hearing under **ORS 183.310 to 183.540**, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce them to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

[redacted]

Sheena Newman, RN APRN-NP

11/22/2024
Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Aaron Green, CNA
Board President

12/18/24
Date

PLEASE RETURN ALL PAGES OF THIS STIPULATED ORDER AFTER SIGNING

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	)	**FINAL ORDER OF DENIAL OF**
Holly Vandoren	)	**REGISTERED NURSE LICENSE BY**
	)	**DEFAULT**
	)	
Registered Nurse License Applicant	)	**Reference No. 2023110048**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating, and disciplining certain health care providers, including Registered Nurses and Registered Nurse license applicants, pursuant to ORS 678.010 to 678.448. Holly Vandoren (Applicant) applied for a Registered Nurse license in the state of Oregon in or about July 2023.

This matter was considered by the Board at its meeting on December 18, 2024.

On October 2, 2024, a Notice of Proposed Denial of Registered Nurse License was sent to Applicant via certified and first-class mail to Applicant's address of record.

The Notice granted Applicant an opportunity for hearing if requested within sixty (60) days of the mailing of the Notice. No such request for hearing has been received by the Board. The Notice designated the Board's file on this matter as the record for purposes of default.

NOW THEREFORE, after consideration of its records and files related to this matter, the Board enters the following Order:

I

FINDINGS OF FACT

Based on the evidence submitted through the Notice and the agency file in this case, the Board finds the following:

1. In or about July 2023, Applicant submitted an endorsement application for Registered Nurse license.

2. The Board opened an investigation into concerns about the legitimacy and adequacy of Applicant's nursing education and school transcript. One of those concerns was whether Applicant completed a final clinical practicum as per Oregon's requirements.

3. On May 14 and 15, 2024, Board staff sent an email and mailed a letter, respectively, to Applicant's addresses of record requesting they schedule an interview and submit a written statement with information about their clinical practicum.

4. On July 12, 2024, Board staff mailed a second letter to Applicant's address of record requesting they schedule an interview and submit a written statement with information about

their clinical practicum. No response was forthcoming.

5. On July 19, 2024, Board staff called Applicant's telephone number of record and got an automated message that it was not in service.

6. Applicant failed to complete a final clinical practicum as per Oregon's requirements.

7. On September 18, 2024, the Board voted to issue a Notice of Proposed Denial of Registered Nurse License.

8. On October 2, 2024, Board staff mailed a Notice of Proposed Denial of Registered Nurse License to Applicant via first-class and certified mail. The Notice granted Applicant sixty (60) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the relevant portions of Board's files would be the record for purposes of default.

II

CONCLUSIONS OF LAW

1. That the Board has jurisdiction over Applicant, Holly Vandoren, and over the subject matter of this proceeding.

2. By failing to schedule an interview with the Board, Applicant engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(10)(a) and is subject to denial pursuant to ORS 678.111(1)(f) and (g).

3. By failing to submit the requested written statement, Applicant engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(10)(a) and (c) and is subject to denial pursuant to ORS 678.111(1)(f) and (g).

4. Due to the lack of the final clinical practicum, Applicant's education does not include a clinical component that meets the definitions in OAR 851-006-0030(5) and 851-006-0140(15). Accordingly, Applicant's education does not meet the requirements of ORS 678.040(2)(b) and the application may be denied pursuant to ORS 678.111(1)(g).

5. That Applicant defaulted on the Notice by not requesting a hearing within the allotted sixty (60) days and, as a result, pursuant to ORS 183.417(3), the Board may enter a Final Order by Default.

III

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and the Board being fully advised in the premises, it is hereby ORDERED that the Application for Registered Nurse

license is denied.

12-18-24

Date

FOR THE OREGON STATE BOARD OF NURSING

[redacted]

Aaron Green, CNA
Board President

TO Holly Vandoren:

You are entitled to judicial review of this Order pursuant to ORS 183.482. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within sixty (60) days from the date of service of this Order.

BEFORE THE OREGON
STATE BOARD OF NURSING

In the Matter of	)	**STIPULATED ORDER FOR**
Ashley Wolfe, RN	)	**CIVIL PENALTY**
	)	
License No. 097000569RN	)	**Reference No. 2024100283**

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Ashley Wolfe (Licensee) was issued a license by the Board on July 9, 1997.

On or before February 11, 2024, Licensee was due to renew their RN license. Licensee failed to timely renew, and the license expired on February 11, 2024.

From the date Licensee's license expired on February 11, 2024, until Licensee submitted an application for reactivation on October 30, 2024, Licensee unknowingly continued to practice nursing with an expired license.

The Board received substantiated information establishing that Licensee practiced approximately 500 hours, the equivalent of 50 days (10-hour shifts) between February 11, 2024, and October 28, 2024.

By the above actions, Licensee is subject to discipline pursuant to **ORS 678.021, ORS 678.111(1)(f), ORS 678.117(1), (2)(a), (b)(3)(4)(5), OAR 851-001-0009(1), (2)(a) and OAR 851-045-0070(9)(b)** which reads as follows:

ORS 678.021 License required to practice nursing.
Except as provided in ORS 676.347, it is unlawful for any person to practice nursing or offer to practice nursing in this state or to use any title or abbreviation, sign, card or device to indicate the person is practicing either practical or registered nursing unless the person is licensed under ORS 678.010 to 678.410 at the level for which the indication of practice is made and the license is valid and in effect.

ORS 678.111 Causes for denial, revocation or suspension of License or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:
(1) Issuance of the license to practice nursing, whether by examination or by endorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
(f) Conduct derogatory to the standards of nursing.

ORS 678.117 Procedure for imposing civil penalty; amount; rules.
(1) The Oregon State Board of Nursing shall adopt by rule a schedule establishing the amount of civil penalty that may be imposed for any violation of ORS 678.010 to 678.448 or any rule of the board. No civil penalty shall exceed $5,000.

(2) In imposing a penalty pursuant to this section, the board shall consider the following factors:
(a) The past history of the person incurring the penalty in observing the provisions of ORS 678.010 to 678.448 and the rules adopted pursuant thereto.
(b) The economic and financial conditions of the person incurring the penalty.
(3) Any penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the board considers proper and consistent with the public health and safety.
(4) Civil penalties under this section shall be imposed as provided in ORS 183.745.
(5) All penalties recovered under this section shall be credited to the special account described in ORS 678.170.

OAR 851-001-0009 Imposition of Civil Penalties
Imposition of a civil penalty does not preclude disciplinary sanction against the license or and disciplinary sanction against the license or certificate does not preclude imposing a civil penalty. Criminal conviction does not preclude imposition of a civil penalty for the same offense.
(1) The Board will consider factors listed in ORS 678.117 (2) when determining the amount of civil penalty to be imposed and per ORS 678.117 (1), no single violation civil penalty shall exceed $5000.
(2) A civil penalty of up to $100 per day of occurrence is assessed for the following:
(a) Practicing as a Licensed Practical Nurse (LPN), Registered Nurse (RN) , Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), Certified Nursing Assistant (CNA), Certified Medication Aide (CMA) without a current license or certificate or Board required concurrent national certification; or prescribing, dispensing, or distributing drugs without current prescription writing authority, due to failure to renew and continuing to practice.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined
(cert. ef. 01/01/2023 and cert. ef. 07/01/2024)
Conduct derogatory to the practice of nursing is conduct that adversely affects the health, safety, and welfare of the public; that fails to conform to OAR 851-045 scope and standards of practice; or that fails to conform to accepted standards of the nursing profession. Such conduct includes, but is not limited to:
(9) Conduct related to licensure violations:
(b) Practicing nursing without a current Oregon license.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Board and is agreed to by Licensee:

That the Board impose a civil penalty against the RN License of Ashley Wolfe in the amount of $1,250.00: $25.00 per day, per 50 incidents.

Licensee admits that the above statements are accurate, and that Licensee's actions constitute a violation of the Nurse Practice Act.

Licensee understands that this Order will be submitted to the Board for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order for Civil Penalty, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress, or coercion have been used to induce the Licensee to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee shall make *24* monthly payments of **$52.08**. The first payment is to be received by the Board by the first day of the month following the Boards acceptance of this Stipulation and thereafter, a payment on the 1st day of every month until the whole sum is paid. Please note that your payment amount was rounded, which means that your final payment may be less or more than the monthly payment listed above.

Payment may be made online by logging into your Oregon State Board of Nursing Licensing Portal and clicking on Pay Civil Penalty Fees; alternatively, payments shall be made payable to the Oregon State Board of Nursing at 17938 SW Upper Boones Ferry Road, Portland, OR 97224 by check or money order.

Licensee understands that if payment is 90 days overdue from the date due as stated in this Stipulation, collection of the Civil Penalty will be assigned to the Oregon Department of Revenue. In the event any amount is assigned for collection, the Licensee may be subject to further disciplinary action by the Board which could include suspension, revocation, or denial of licensure.

Licensee understands that federal law requires state licensing boards to report adverse actions (resulting from formal proceeding) to the National Practitioner Data Bank (NPDB) within 30 days from the date the action was taken.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Civil Penalty.

[redacted]

Ashley Wolfe, RN

12/11/24

Date

ORDER

IT IS SO ORDERED:

BOARD OF NURSING FOR THE STATE OF OREGON

[redacted]

Aaron Green, CNA
Board President

12/18/24

Date